[2012] UKFTT 116 (HESC)

The First-tier Tribunal

(Health, Education and Social Care Chamber)

Primary Health Lists

Appeal Number: PHL/15358

Before :

Mr Brayne (Judge)

Dr Freeman

Mr Cann

Between

Dr Pius Stambuli

(GMC registration number 2278706)

Appellant

and

Gloucestershire PCT

Respondent

DETERMINATION AND REASONS

The Appeal

1. By notice dated 24 January 2011 Dr Stambuli appeals against the decision of the Respondent, set out in its letter dated 21 December 2011, to remove his name from its performers list.
2. The Respondent's decision was made on the ground of efficiency, under Regulation 10(3) and (4)(a) of the National Health Service (Performers' List) Regulations 2004, as amended,(referred to below as the 2004 Regulations).

3. On 23 November the Tribunal directed that Dr Stambuli be allowed to amend his appeal to include, as an alternative to removal under Regulation 10, contingent removal under Regulation 12(1). Reasons for that decision are set out in the Tribunal's directions dated 24 November 2011.

The legal framework for removal

4. Regulation 10(3) of the 2004 Regulations provides as follows:

> *The Primary Care Trust may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.*

5. The relevant subparagraph of Regulation 10(4)(a) described the particular condition relied on by the Respondent as follows:

> *his continued inclusion on its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case").*

The legal framework for contingent removal

6. Under Regulation 12, as an alternative to removal, the PCT (and on appeal the Tribunal) may, instead of removal, determine to remove contingently; it must then specify conditions for the practitioner's inclusion in the performers list with a view, in an efficiency case, to removing any prejudice to the efficiency of the services in question.

Background to the Respondent's decision

7. The following chronology is based on that prepared by the Respondent for the Tribunal. We have seen the relevant documents, and though Dr Stambuli contests the opinions and decisions set out in the chronology, he does not dispute the chronology itself.

8. In August 2009 the Respondent made a formal referral of Dr Stambuli to NCAS (the National Clinical Assessment Service). Dr Stambuli had previously confirmed in writing to the Respondent that he wished to have an NCAS assessment.

9. The NCAS assessment took place during February and March 2010. The NCAS draft report is dated 21 May 2010 and was made available to Dr Stambuli and the PCT.

10. A suspension hearing took place on 4 August 2010. At that time Dr Stambuli's advisors had informed the Respondent that Dr Stambuli did not contest the findings of the NCAS assessment, and that he wished the panel to consider a voluntary withdrawal from practice.

11. On 6 August 2010 the PCT wrote to Dr Stambuli stating that the panel had agreed to a voluntary withdrawal.

12. The final NCAS report was issued on 12 August 2010.

13. Dr Jonathan Hayes, investigation officer on behalf of the Respondent, subsequently conducted a further review of Dr Stambuli's practice, visiting on four occasions during October 2010

14. On 20 August 2010 Dr Stambuli wrote to the Respondent terminating his GMS (General Medical Services) contract. The PCT agreed to the termination having effect on 30 September 2010.

15. On 23 September Dr Stambuli applied to withdraw from the Respondent's performers list, but was informed on 25 September 2010 that only the Secretary of State could consent to such a withdrawal while there was an ongoing investigation. Dr Stambuli withdrew this application on 27 September 2010.

16. On 30 September 2010 Dr Stambuli terminated his GMS contract with the PCT.

17. The running of Dr Stambuli's former practice was contracted on an interim basis to the Emerson Green Medical Practice from 1 October 2010 to December 2010.

18. On 15 December the PCT held an oral hearing, which Dr Stambuli did not attend; following this the decision letter of 21 December 2010 to remove Dr Stambuli from the Respondent's performers list was issued.

The Respondent's case

19. The Respondent provided a case summary dated 22 August 2010, drafted by Ms Khalique of counsel, who also represented the Respondent at the hearing. This refers to a number of concerns going back "some considerable time". In accordance with Tribunal directions issued on 17 June 2011 the Respondent now limits its submissions to events from 2002/2003 onwards. These are summarised in paragraphs 5 to 31 of the submissions. However, under the heading "The Respondent's case before the [First-tier Tribunal] " the essence of the Respondent's case is identified as follows:

> The PCT's case is that Dr S's performance has fallen below acceptable standards in respect of four areas of practice as found by the PCT …and in several other areas identified by the NCAS report. However, the focus of this appeal will be on the areas set out at paragraph 29 [below]. The nature and degree of the deficiencies in his performance are such that his continued inclusion on the Performers list would prejudice the efficiency of the service and pose a risk to the safety of patients. In support of its case, the PCT relies upon the NCAS findings and those of the PCT investigators…

20. Paragraph 29, which was referred to in the above summary, referred to findings of the PCT panel of 15 December 2010 of

    i. Poor clinical management

ii. Poor record keeping

iii. Failure to consistently perform appropriate clinical assessments

iv. Failure to consistently provide or arrange inspections

21. The Tribunal adjourned the hearing part-heard on 23 November 2011, and issued a direction allowing Dr Stambuli to amend his grounds of appeal to include contingent removal and requiring him to submit his proposals for appropriate conditions.

22. After these proposals were received, the Respondent made final written submissions. These were, in summary, that Dr Stambuli had failed to produce any credible evidence in support of contingent removal, that his approach to this issue demonstrated a lack of insight on his part, that the GMC report supported the Respondent's case for removal, and that no purpose would be served by maintaining on the performers list a doctor who himself had confirmed he had no intention to return to general practice.

The appellant's case

23. Dr Stambuli gave five reasons for appealing in the notice of appeal. They can be summarised, using his own numbering, as follows:

    1. The PCT allegations are false and most, or all, are fabricated and not supported by credible evidence.
    2. The allegations have virtually all been made on previous occasions and fully resolved.
    3. Dr Stambuli worked tirelessly for his patients over 23 years, and his patients were always happy with the care provided. He has never caused harm to a patient.
    4. The PCT has targeted him for ten years, making criticisms which were unjustified and related to a chronic lack of support for his practice, in particular in IT systems and in training.
    5. The allegations do not justify removal.

24. A sixth paragraph explained his motivation for appealing, which is to restore his professional reputation.

25. Following the adjournment on 23 November 2011 Dr Stambuli further submitted that he should in the alternative to being restored unconditionally to the performers list, be subject to contingent removal.

Our powers on appeal

26. A decision to remove a performer's name from the list maintained by any PCT on any of the grounds provided under the NHS Regulations is subject to appeal to the First-tier Tribunal.

27. The powers of this panel are to be found in Regulation 15 of the 2004 Regulations, which provides as follows:

> (1) *A performer may appeal (by way of redetermination) to the [First-tier Tribunal] against a decision of a Primary Care Trust as mentioned on paragraph (2) by giving notice to the FHSAA*
>
> *(2) The Primary Care Trust decisions in question are decisions-*
>
> *.....*
>
> > *(d) to remove the performer under regulations 8(2), 10(3) or (6),.....*
>
> *(3) On appeal the FHSAA may make any decision which the Primary Care Trust could have made.*

History of these proceedings

28. By agreement with the parties, the hearing was initially listed for three days.

29. On 21 and 22 November 2012 the Tribunal heard oral evidence from the PCT's witnesses, and also from one of Dr Stambuli's witnesses.

30. On 23 November the Tribunal, having notified the parties of its intention to do so, heard submissions on whether Dr Stambuli should be permitted to amend his grounds of appeal and seek as an alternative conditional removal. The Tribunal agreed to allow this amendment to his grounds, adjourned part-heard, and issued directions to enable Dr Stambuli to assemble and submit the relevant evidence and proposals for conditional removal.

31. At a telephone case management hearing on 5 January 2012 both parties agreed to the Tribunal reaching its decision without further oral evidence or submissions. Judge Brayne agreed to this in light of the fact that Dr Stambuli's cross examination of PCT witnesses had enabled him to give substantial evidence by way of introduction to his questions, and also because he, and his remaining witness, had already provided written statements.

32. The panel met on 22 February 2012 to consider the evidence and reach its decision.

The written evidence

33. We had available to us the following written documentation. References are to the hearing bundles.

34. Section A1 contained documents relating to the Dr Stambuli's history with the PCT, including correspondence and meeting notes.

35. Section A2 contained the Respondent's documents relating to appraisal, quality assurance, investigation of Dr Stambuli, and the PCT's decision of

21 December 2010, and included anonymised patient records referred to in the review of Dr Hayes.

36. Section B contained correspondence which the PCT had received from Dr Stambuli during the investigation process and following the decision of 21 December, as well as earlier correspondence from Dr Stambuli to the PCT and other bodies.

37. Section B also contained documents, including statements, received from Dr Stambuli during the course of the investigation and following the lodging of this appeal, including a number of statements written by Dr Stambuli personally. Section 4 contained documents submitted by the parties to the Tribunal. Section 5 comprised witness statements and character references.

38. Following the hearing on 21 to 23 November 2011 we received Dr Stambuli's proposals and evidence relating to contingent removal. He also made available a GMC competence assessment and peer review which took place during September and October 2011.

39. We were also provided with copies of email correspondence between Dr Stambuli, the Respondent, and the Associate Postgraduate Dean at the Severn GP School.

40. Dr Stambuli's made final written submissions dated 26 January 2012.

41. The above written evidence need not be summarised here, but relevant parts will be referred to in the reasons for our decision.

The oral evidence

42. The oral evidence is not available in the bundles, and is therefore summarised.

43. As a result of the decision not to take further oral evidence, Dr Stambuli and Mrs Stambuli did not give oral evidence. However, Dr Stambuli's made a number of statements during cross examination, which are included in the following summary.

44. The witnesses all adopted their witness statements, which are found in the bundles at section C5. The oral evidence in each case commenced with cross examination of the witness.

<u>Oral evidence of Tracey Cubbage, Head of Governance for the PCT</u>

45. Ms Cubbage denied that the primary aim of the exercise had been to remove Dr Stambuli as the last single handed practitioner in the area, or that he had been targeted. It had been her role to pull together the evidence, but the PCT's panel made the decision. She confirmed that there was not one single incident which had led to the PCT's decision, but a whole range of issues over a number of years.

46. Dr Stambuli stated that in 2001 the PCT had referred to a very high quality of patient care, and asked why his practice was being accused of not

providing a proper service to patients, such as call-recall, when the practice had limited resources. Ms Cubbage stated that on the PCT's Quality Outcomes Framework (QOF) Dr Stambuli's practice had not scored as highly as other practices. It had been the lowest scoring practice in the PCT area, and had been given significant leeway. She had personally spent a lot of time supporting Dr Stambuli in achieving points on the assessment in relation to, for example, templates and computer back-up systems, and had herself input data, knowing that the practice was struggling. Dr Stambuli put to the witness that she had failed to mention that the practice had an inadequate computer system and had had no funding for many years, and had not been able to input data. He said the PCT should not have compared the practice with those that had adequate systems. Ms Cubbage refuted the suggestion that the practice had inadequate systems, and said these were the same as those in other practices. She accepted that the practice's QOF scores had been improving, but they remained lower than any other practice.

47. Dr Stambuli referred to a mention in Ms Cubbage's statement of failure to send patients with diabetes for eye testing. He said the issue had already been resolved, and the inclusion of this matter after it had been resolved showed an ulterior motive. He said the allegation that he had failed to send data about these patients was untrue, as he had sent the information by other means, not via the computer. Ms Cubbage said the issue was an example, and the retinopathy service had themselves repeatedly raised the issue that they could not get a list of diabetic patients from the practice.

48. Ms Cubbage told the panel that she believed participation in the QOF process was obligatory, but in any event Dr Stambuli had said that he wanted to participate and that he aspired to score the full 1000 points. She acknowledged that a practice which was having difficulties with its computers would have some difficulties with submitting data for the QOF. However, she said that the PCT had made available a worker to support the practice with data quality, and that person had helped to extract the date from paper records. She acknowledged that if the QOF did not record the data automatically, for example in relation to the number of patients with asthma, it did not indicate failure of diagnosis or treatment. She also acknowledged that the low scores in the organisational domains in the QOF, and in relation to an absence of written policies, did not necessarily mean that correct procedures were not applied in the practice. She said there had not been appropriate organisational policies in place, particularly in relation to responding to letters and emails. Many colleagues had found it difficult to correspond with the practice, though she accepted that these difficulties related to organisational and not clinical issues. Though the data support worker had found unopened correspondence, she had not reported unopened clinical correspondence. Ms Cubbage was unable to say that these problems with policies or procedures impacted on patient care.

49. Ms Cubbage referred to what she called “very very good results” on independent patient satisfaction assessments. The practice scored amongst the highest in the PCT area.

50. She referred to difficulties in arranging appraisal of Dr Stambuli over the course of three years.

51. In her witness statement Ms Cubbage had referred to 19,000 unfiled test results discovered after Dr Stambuli’s practice had been taken over by Emerson Green Medical Centre. She explained that this meant that when a test result for a patient is received by a practice, this should be allocated on the electronic patient record, so that any doctor could refer to this test result. She said that results were not, as far as she knew, also sent to a practice on paper. She accepted that a failure to file a test did not mean that a doctor could not have seen that result. In response to this evidence, Dr Stambuli was given the opportunity for additional cross examination, and stated that he did use to look at each result individually as it came in on paper.

Oral evidence of Andrew Kinnear, Head of Avon Information and Management Technology Consortium

52. Dr Stambuli put it to Mr Kinnear that despite the latter’s claim to have given the practice a lot of IT support from 2004 onwards, up to his retirement, he had applied for support for training and updated systems, and after six years some systems had been delivered; he said that the practice had then gone through a whole year waiting for the system to be installed, and the practice had then had to ask for help to show how to use the system. Only occasional help had been received, and a lot of what had been requested was not in fact received. The question which followed this statement was to ask why the witness had put the practice in that position for such a long time.

53. Mr Kinnear answered that his team had provided greater levels of individual support than for any other practice, and training that was not normally provided, given that Dr Stambuli’s practice was struggling. Normally the training was provided to practices in common, not individually. The practice had in any event been informed of available training. All practices followed a common process for applying for hardware and equipment, and the applications were assessed against standard criteria. An application using the standard process had not been received until 2009, but in fact the support team had paid numerous visits to the practice over the years to assess their IT requirements. Equipment had been delivered even though the normal process had not been followed. With particular reference to the issue of the scanner, this had been delivered and training provided, though typically users did not need training.

54. Dr Stambuli suggested to Mr Kinnear that EMIS (the IT system in use in the PCT area) training had not been completed, to which Mr Kinnear

replied that such training events had been made continuously available. The training was well publicised and, if desired, it was hard to believe Dr Stambuli could not access it.

55. Mr Kinnear said that the IT system requested by the practice had been installed at a time convenient to the practice, and the records confirmed this (although he did not have the record to show the Tribunal). Dr Stambuli stated in response that the system was not installed until after he had resigned from practice. Mr Kinnear stated, however, that all jobs not yet completed were highlighted, and there had been nothing outstanding from 2009.

56. Mr Kinnear confirmed to the Tribunal that he knew of the delivery and installation of the scanner, and agreed that it had taken a year from being requested.

57. He said that all practices had the same level of access to training, and Dr Stambuli's practice had not been sidelined. He said that a data quality facilitator would visit the practices to help them with data coding, and a named individual had spent considerable time in the practice. He thought that six visits had taken place from the data quality team since 2007.

58. On re-examination Mr Kinnear stated that it was well established that the responsibility for having a functioning IT system was that of the practice.

59. In response to the Tribunal's questions, Mr Kinnear said his team had gone above and beyond the call of duty to support the practice. There were no personal issues and he had sent an engineer out more often than to any other practice.

60. He was asked if he could explain an email which was appended to his statement. This email, at AK1, advised his team that they had to be "sqeaky clean" in relation to Dr Stambuli's practice, because of previous complaints. He said that there were a number of practices where he would warn visiting engineers of issues which might arise, such as problems with particular parking arrangements. He did feel a need to be mindful in relation to Dr Stambuli's practice. He told the Tribunal that he had installed the NHS Practice system in 2000 and knew it to be working at that time, despite constantly being told it was not. There were even emails in the bundle which could only have been received if the system was working.

61. Dr Stambuli was allowed the opportunity to cross examine on issues which had arisen from the Tribunal's questions. He put it to Mr Kinnear that every time he had tried to get an engineer it had been impossible. Mr Kinnear replied that if a problem was reported, an engineer would be sent, though access had frequently been refused by the practice. Dr Stambuli asked Mr Kinnear why he was prepared to believe reports from his staff rather than to visit the practice himself, to which Mr Kinnear replied that he

had five and a half thousand users, in 110 practices, and did not have time, and had, in any event, not been asked to visit personally.

Oral evidence of Dr Hayes, clinical governance lead for the PCT

62. Dr Hayes told Dr Stambuli that he had used both paper and computer records to identify random patients for his own review. He had found examples of discrepancies between the records. Details had tended to be more brief on the computer records. He had not been surprised to find such discrepancies. Knowing that Dr Stambuli had experienced difficulties with the IT systems, Dr Hayes said he had placed more reliance on the paper records.

63. Dr Stambuli referred to a discrepancy which Dr Hayes had mentioned in his witness statement. The patient concerned had had a prescription for asthma (see paragraph 20.2 of Dr Hayes' statement). Dr Stambuli put it to Dr Hayes that this was not an example of faulty prescribing, and the patient himself would never have experienced the receipt of both Ventolin and Salbutamol. He said that the computer record could not be altered to remove the repeat prescription of Ventolin, but the pharmacist had changed the patient to Salbutamol because it was cheaper; Dr Stambuli said that he had therefore amended the written record. In reply Dr Hayes said that his experience of the patient record system was that it worked perfectly well, and did allow removal of a prescription, together with the insertion of the reason. He said for the particular patient concerned there was no paper record of that prescription, only on the computer record, which showed both prescriptions (Ventolin and Salbutamol) had been issued on the same day. There was nothing to show that the prescription had not been issued or that it had been generated in error. If such a patient had been admitted to hospital, the record accessible to the hospital would have shown prescription of both medications. Dr Hayes added that he was not in a position to check with all possible pharmacies whether this patient had in fact received both forms of medication, and that the purpose of his review was to triangulate with the NCAS report, after Dr Stambuli had alleged that this report was unfair. He confirmed to Dr Stambuli that the version of EMIS he was using in his own surgery was the same as that provided to Dr Stambuli. The surgery which had taken over Dr Stambuli's practice had found it to be working perfectly.

64. Dr Stambuli put it to Dr Hayes that the assumption that the patient had received both forms of medication showed Dr Hayes to be motivated to find fault; Dr Hayes replied that all he could take into account was what was prescribed on the records, and no part of the record showed that the prescription had not been given out. He had been motivated to see if there was any concern for patient safety, as four cases highlighted in the NCAS assessment had indicated significant risk. He needed, on behalf of the PCT, to mitigate against that risk to make sure a patient did not come to harm. Asked why he did not check with the patient, Dr Hayes said this had not occurred to him. His role was to notify those patients identified as

being at potential risk to the Emmerson Group, the successors of Dr Stambuli. Those who were now registered with other practices had been advised to check for duplication of repeat prescriptions.

65. Dr Stambuli asked Dr Hayes what he had found wrong in relation to Dr Stambuli's prescriptions of Methotrexate. Dr Hayes referred to four patients who had that form of prescription, or AZT; the protocol required regular blood monitoring as these were immuno-suppressive medications. Standard practice was to do a full blood count monthly. The records showed that three of the four patients were not getting regular monitoring. All local blood tests were centrally recorded and accessible to practitioners, so he had been able to check on the relevant systems, and he had found Dr Stambuli's patient records, which did not show regular monitoring, were consistent. In other words, unless the tests had been carried out by a non-local hospital – for which no evidence was available, and for which there was no reason – the required blood tests had not been carried out monthly.

66. Dr Stambuli put it to Dr Hayes that all the patients on immuno-suppressant forms of medication had had this treatment originated in hospital, and together with the hospital the practice had ensured monthly checks were carried out. He said he would not have given any medication until he was sure of the result of the monthly checks, but the hospital test records did not go into his practice's records. None of the patients showed anything wrong, and they were not at risk. It was wrong to suggest they were not being monitored. Dr Hayes could have found this out by talking to the patients themselves.

67. Dr Hayes replied to this point by saying that one of the patients was on Warfarin, and was indeed shown to have monthly tests, but had not been recorded as having a monthly blood count as part of those tests. Talking to the patient would not have revealed whether he was being appropriately monitored, as the patient would have assumed he was being monitored as blood samples were being taken.

68. Dr Stambuli put it to Dr Hayes that maybe the results had been misplaced, but in any event he would not have given the prescription without being sure of the monitoring results. Dr Hayes then referred to the responsibility for monitoring, which he said rested with the GP and not the originating hospital. Once the practice had been taken over, Dr Hayes had been able to check the monthly monitoring results through the local system, and these were now being routinely carried out. Dr Stambuli again stated that he had not missed a single patient, and would phone up a patient who had not attended for monitoring. Dr Hayes replied that any test result carried out locally was automatically entered into the patient's electronic record, as well as going to the relevant GP's inbox, so he had been able to check against these records. Dr Stambuli said in response that EMIS was not always working, and all his practice results had been received on paper.

69. Dr Stambuli put it to Dr Hayes that no harm had come to any of his patients. Dr Hayes replied that this was disingenuous. One lady had died from a gastric haemorrhage, and one from osteoporosis. Dr Stambuli disputed this, and referred to his written statements.

70. Dr Stambuli said he could not find any record of any patient who had died from a gastric haemorrhage. Dr Hayes referred to the patient by initial (IC) and to the patient record appended to his report to the PCT. The patient had died on admission to hospital. He said he was not stating any cause of death, but simply noting the absence of prescribed medication to protect the lining of the stomach, which was indicated for a patient receiving non-steroidal anti-inflammatory medication.

71. He said that the QOF results were not themselves the cause of concern, but because these were significantly different from those of other practices, he had felt a need to report this to the PCT board. He had initially defended the practice, knowing that there were difficulties with the computer system, which he thought explained the QOF results. Having been challenged by .a Board member as to how confident he was in believing that, he had felt he did not know. As a result he and a colleague had visited he practice.

72. He confirmed that Dr Stambuli was extremely popular with patients, and there was no concern over accessibility. He confirmed that there was no trend of under investigation of patients.

73. He denied Dr Stambuli's suggestion that he had asked Emerson Green, the successor practice, to report negatively to the PCT. A report received from the practice about out of date medication had been submitted without any such request. He accepted that he did not draw adverse inferences from this fact.

74. Dr Hayes said that there was not one single issue that would make him concerned as to risk. The concern was based on an overall picture, after seeing notes from 40 patients, which revealed a number of "soft" and serious concerns, of a number and severity which he would not expect to find. The concern was magnified because this was a single-handed practice, in that Dr Stambuli did not have the benefit of being part of a team. A mistake was more likely to be picked up by a colleague than by a single handed practitioner, for example the failure to demonstrate monitoring of blood test results. Dr Stambuli put it to him that he had seen only patient records, not actual patient care, and suggested that Dr Hayes may not have understood the records, which could not reflect the actual level of care. Dr Hayes agreed he could not know what was said and done during the consultations with patients, and could only refer to what was written down. He said it was part of the doctor's professional responsibility to ensure that what was recorded was accurate.

75. Dr Hayes then answered the panel's questions. He said that there had been a computer on the desk in the consulting room, and paper records

were stored upstairs. In some cases there were paper records and computer records for the same patient, but not always. It was not uncommon for some practitioners to prefer to use paper records. The system allowed for clerical staff to transfer information from paper records.

76. Dr Hayes said he understood the responsibility for providing and maintaining IT hardware to a practice to be that of the PCT, but the responsibility for choice of software, and dealing with any problems with the software, was that of the practice. It was the responsibility of the practice to back up data. A practitioner having problems could contact EMIS for support and help. If bespoke training was requested, it could be purchased by the practice. No practice was obliged to use a computer system. It was the practitioner's responsibility to ensure that they were adequately trained in the use of the software they had chosen to use. The PCT did, however, co-ordinate training provision, which was the most economical approach, and practices would pay for the training selected.

77. He said that he had selected the 40 patients for review who had had a medication review. It had been good practice to carry out such review. But it was a cause for concern if a practitioner was issuing repeat prescriptions and not carrying out reviews.

78. He said that of the 26 practices for which he was responsible, there had been two others giving rise to significant concerns since he took on the clinical governance role in 2007. He was not aware of any patient complaints, other than one which the PCT had not referred to in its decision. He was not aware of any concerns raised by community nursing staff. No concerns had been reported in relation to controlled drugs. He had not carried out a validation exercise on Dr Stambuli's disease registers.

79. Dr Hayes was asked to comment on patient Ms A. The prescription record showed that this patient was receiving six 100 mg prescriptions per year, which for a patient with asthma was not clinically appropriate. He would be uncomfortable prescribing such medication more than three times in a year, and even three times was not good management of the condition. It led to increased risk of osteoporosis.

80. He was asked about patient IC, the patient who had had a gastrointestinal bleed. The prescription record showed Naproxen was prescribed. This is, Dr Hayes said, known to cause ulceration in due course and should be used for acute conditions., for two to four weeks. Prescribing it for a longer period would be a cause of concern. The appropriate dose would be one tablet two or three times per day. The prescription shown in this patient's record was of under one per day, but for the full year. Dr Hayes said he would be concerned at the patient having exposure for a full year. The tablet could be prescribed with an enteric coating, but this did not eliminate the risk of ulceration.

81. Given the issues raised by the panel, we allowed further cross examination. Dr Stambuli repeated that he was not aware of patient IC, but accepted that she had been admitted urgently to hospital. He would have remembered this, since such a mistake would remain in his memory. He did not recall any inquest. He asked Dr Hayes to comment, from the patient notes, on when this patient was referred to hospital and when commenced on Naproxen. Dr Hayes replied, after referring to the notes, that she was referred to hospital in March 2009, and first prescribed Naproxen in January 2001. There was nothing in the record to indicate other gastric symptoms. Dr Stambuli commented that the patient, having had these medications for this period, could not have had gastric symptoms. Dr Hayes agreed that there was no evidence in the record of any symptoms before the referral to hospital, but when they did occur it was too late to do anything about it.

82. Dr Stambuli then referred Dr Hayes to his evidence on the patient who had been prescribed repeat steroids for asthma. He said he had prescribed medication for preventing osteoporosis and sent her for a scan almost a year earlier. Dr Hayes confirmed this was shown in the notes, although the record did not show prescription of calcium and vitamin D before October 2009, and correspondence showed the scan to have been initiated by the hospital. Dr Stambuli then commented that the patient had not attended for a scan when he had advised this earlier. He said this patient was well known to him and he had advised her of the risk of osteoporosis.

83. On re-examination Dr Hayes referred to patient CM, for whom monthly blood tests were appropriate. Patient records indicated tests undertaken April 2010, in response to a hospital request; May 2010, carried out in hospital accident and emergency; June 2010 at Dr Stambuli's surgery, but no further tests until October, by Dr Stambuli's successors.

<u>Oral evidence of Dr M Rhodes, senior assessment advisor, NCAS</u>

84. Dr Rhodes said that he designed the assessment methods, and trained and accredited the NCAS assessors. He quality assured the NCAS reports, but had not taken part in Dr Stambuli's assessment. He said he was able to make no comment on Dr Stambuli's own practice. He could not comment on what a PCT did with the resulting recommendations. He could not comment on any steps taken, or not taken, in relation to any action plan following the report.

85. Asked by the panel how the report on Dr Stambuli compared to others seen by Dr Rhodes, of which there had been some 200, he said it was poorer than many that he had seen. Dr Stambuli had been assessed as satisfactory in relation to patient relationships, but unsatisfactory in relation to clinical management and prescribing. Asked how that assessment related to what was acceptable, Dr Rhodes said NCAS did not decide on fitness to practise. The word "poor" in the assessment was used to

indicate that a practitioner had not reached the standards expected of a practitioner in that position (meaning, in the present case, expected of a single-handed practitioner). Poor meant that something needed to be done by way of improvement.

86. Dr Rhodes stated that the options set out in the report, including at page 63 close supervision, change to working status, restrictions on his practice, and a structured development programme, as well as performers list action or GMC referral, were tailored to this particular case. They were intended to mean that close supervision, rather than removal from the list, was an alternative, though he added that the NCAS report was one piece of information which the PCT would take into account, not the sole source.

87. Dr Stambuli was given the opportunity for further cross examination, and asked Dr Rhodes if NCAS would ever consider the outcomes of clinical care of all patients across the board, in spite of what appeared in the records or what was observed. Dr Rhodes replied that the assessors would take into account such information if it had been supplied.

Evidence of Dr Josephine Owen-Jones, clinical assessor NCAS

88. Dr Stambuli asked this witness about paragraph 47 of her statement, in which she had referred to the behavioural assessor's conclusion that "Dr Stambuli would not be overly responsive to considering new approaches or evaluating his own behaviour." He asked her to explain this. She said that this had been drafted not by her but by the behavioural assessor. She said it was not her own conclusion, but she agreed with it because it was part of the report.

89. Dr Stambuli asked if this meant that he was incapable of improving his knowledge and performance. Dr Owen-Jones replied "No; these are recommendations made by the case assessor; there are areas that need to be looked at, for example empathy", which was covered at page 63 of the report.

90. The witness confirmed that she had not looked at patient morbidity or satisfaction. The NCAS assessors would only have looked at that if the data had been provided.

91. Dr Stambuli challenged the conclusion in the report (paragraph 25) that he did not assess patients properly, and on that occasion failed to take a history. He said he had known that patient for 20 years. Dr Owen-Jones replied that the assessor would sit in and then check the record to see if there was an accurate account, and would look at the background history to see if there was anything relevant. The assessor would look at the patient summary, and for this patient there was no indication of the relevant history in that summary.

92. Dr Stambuli asked the witness if she could refer to a particular case where a patient had come to harm as a result of his performance. The answer

was “no”, but the whole point of the exercise was to look at his performance in the round, and to triangulate the data.

93. Dr Stambuli put it to the witness that he had warned the NCAS assessors that the computer system was unreliable. Dr Owen-Jones accepted this, but said apart from getting help logging on she had encountered no problem with the system. She had been able to access data. Dr Stambuli said she could not have placed reliance on this data, but Dr Owen-Jones stated that it reflected what had been entered.

94. Asked in what way he had been inadequate in terms of assessment of patients, Dr Owen-Jones, after referring to page 13 of the report for overall findings, said that she had found his performance inconsistent. In some areas he did a very good job, which is normal. No-one can be good all the time. She could not comment on how the PCT interpreted the report.

95. She told Dr Stambuli that she was unwilling to comment on the actions of the PCT she had been an “evidence gatherer” not a “recommendation maker”.

96. The panel explored her evidence further. Asked what she understood the word “poor” to mean, she said it was below the standard of an average medical practitioner. Assessors were not looking for excellence, but for safe, acceptable practice, which was up to date. A poor performer would be an outlier from the broad range of practitioners. Some examples of poor practice did not carry great weight, or were not far out from the broad range. She said she had seen worse doctors, and she had seen better doctors.

97. Asked to comment on the range of recommendations, she said it meant that these could work in Dr Stambuli’s case, so that he could remain in practice with restrictions, for example. Asked to comment on what level of supervision might be appropriate, as that was included in the recommendations, she said she could not comment.

98. After further exploration of the meaning of “poor” Dr Owen-Jones said it meant not “below average” but “unacceptable”.

99. She was asked if she could reconcile the statement at paragraph 47 of her statement, about Dr Stambuli being not overly responsive to considering new approaches or evaluating his own behaviour, with the recommendations at page 63 of the report, which she had already commented on. In reply she said she did not mean that Dr Stambuli could not remediate his performance. What she meant was that he may find it more difficult than others, but he was capable of remediating the deficiencies.

<u>Evidence of Margaret Collier, former receptionist</u>

100. Ms Collier corrected her statement. She had worked at the practice from September 2009 to December 2010. She then answered Ms Khalique’s questions as follows.

101. She worked Monday to Friday, 9 am to 1 pm. She had received her EMIS training from Mrs Stambuli. She had taken on board what she was required to do, but was aware EMIS was capable of more. It could log practice notes, but she had not been told how to do this. She was new to the job, and accepted the way the practice worked. Both she and Mrs Stambuli were short of knowledge and had tried to get hold of the PCT on a number of occasions.

102. She was aware of the EMIS helpline. She had obtained help from them on the phone when she had difficulty logging in. They had never been called out, but the practice was always in a rush, dealing with patients. She was aware that EMIS charged for coming out, and it was not her job to book such assistance. If she had suggested this to Dr and Mrs Stambuli, she would not have got a good response.

103. She had called out a young man from the PCT a couple of times, for help with a labelling machine, but this had never been properly sorted until the practice was taken over. She had also asked for help with the scanner, which never seemed to work. She therefore carried on filing manually, or, as she put it, “we carried on in our own tinpot way”. She accepted the way the practice worked, which was to handwrite notes. With hindsight she could have been more forward in demanding help.

104. She was unaware of any engineer ever having been turned away, as stated by Mr Kinnear. When the practice was taken over, a member of staff in the new practice knew how to work the scanner.

105. She confirmed that the computers in the practice worked, but all she used them for was the appointments.

106. She told the panel that all correspondence relating to clinical matters was seen by Dr Stambuli in person. Dr Stambuli would make all necessary referrals, and there was no system in place for checking these were followed up. Blood test results were delivered daily by courier, and seen by Dr Stambuli immediately.

107. She said everyone had been devastated when Dr Stambuli was required to finish. She had been forbidden from allowing patients to sign the petition to the PCT.

Our Consideration

108. The evidence is very clear that Dr Stambuli was a dedicated GP in his years at Mangotsfield Surgery, much appreciated by his patients. It is also clear that he has been greatly stressed by the events which followed the NCAS review, culminating in this appeal.

109. It is also clear that Dr Stambuli does not accept any of the alleged deficiencies in his performance. In none of his evidence, whether written or in the course of making statements while cross examining witnesses, or in correspondence with the PCT, did we identify any evidence that he accepted there may be a problem. Given this consistent approach, we

accept that he is genuinely puzzled and upset at the findings of NCAS, of Dr Hayes, and the decision of the PCT. Given that he accepted none of the criticisms, it was entirely appropriate that he chose to exercise his right to appeal against the decision to remove him from the performers list. This remains the case, even though he had decided not to seek to resume practice as a GP, as he wished to address the allegations of poor performance.

Contingent removal

110. As is recorded in our adjournment decision, the evidence that Dr Stambuli was capable of remediation, and our consequent decision to adjourn to allow him to make proposals for appropriate conditions, was based on the evidence of Dr Owen-Jones. In discussing whether to allow an amendment of his grounds of appeal and in our written adjournment directions, we explained that if Dr Stambuli was to make a case for contingent removal, he would need to put forward a plan for remediation, and in order for this to be realistic he would have to show a willingness to accept and address identified problems.

111. We recorded in that decision that the PCT witnesses were willing to assist Dr Stambuli in compiling a remedial plan, but that any expenses incurred would have to be met by Dr Stambuli.

112. We find, however, that Dr Stambuli had wholly failed to address the question of remediation, in part because he does not appear to understand what it involves, in part because he continued to focus on what the perceives as his history of persecution by the PCT, and in part because he does not understand that if he seeks to propose contingent removal, it is for him to propose suitable conditions. To propose conditions which are realistic, he necessarily must entertain the possibility that such conditions are necessary, and that he must set objectives which will improve his standards of performance. He produced no evidence from which we could conclude that he understood this.

113. After the adjournment we received from Dr Stambuli a letter with enclosures, dated 15 December 2011. Dr Stambuli says he d contacted relevant organisations (NCAS, BMA, Postgraduate Medical School Dean). The contact with the BMA appears to have related to obtaining advice in the Tribunal proceedings, and was not relevant to contingent removal. It is therefore not considered further.

114. He said he had yet to receive a clear commitment to provide help and advice. He stated: “My brightest hope for coming up with a sound Action Plan is the proposed meeting between the Severn Deanery Postgraduate Dean and myself on 21.12.2011.” He then referred to the “attached action plan for myself as a provisional proposal”.

115. Dr Stambuli also referred to the GMC report of his assessment which “looks and sounds dreadful, but when considering realistically my adverse

life circumstances in the past 3 years and in particular in the past 18 months, to me the report is indeed better than I had expected…"

116. The letter Dr Stambuli received from NCAS on 7 December 2011 stated that NCAS would be willing to work with him and with the PCT to develop an action plan, but it would could only be realistically progressed on the conclusion of the appeal. This in itself would be fatal to a decision to order contingent removal, if Dr Stambuli's proposals for development required help from NCAS.

117. The letter from Dr Morrison, Associate Postgraduate Dean, went no further than to propose a meeting. However emails were subsequently provided by the PCT, which Dr Morrison had copied to them, providing more recent evidence of his discussion with Dr Stambuli. Dr Morrison's email included a summary of his meeting with Dr Stambuli , Dr Morrison confirmed that Dr Stambuli had no intention of returning to general practice, and that this made it difficult to achieve the necessary conditional reinstatement onto the performers list which would accompany any remedial action. Dr Stambuli is recorded as predicting a favourable GMC outcome during this meeting.

118. The above email was copied to Ms Cubbage, and in a subsequent email to her Dr Morrison confirmed that Dr Stambuli had not shared the GMC performance assessment report with Dr Morrison.

119. The provisional action plan submitted by Dr Stambuli comprised a ten page form headed "NCAS Resource Practitioner action plan" which Dr Stambuli had partially completed. There was no substantive information contained in the form, and nothing which can be described as a plan. He had not completed any objectives, and in fact the only new information was a reference to possibly working in paediatrics, which would be irrelevant to contingent removal from the performers list to which this appeal relates..

120. We allowed Dr Stambuli to make proposals for remediation, in view of the unequivocal evidence of Dr Owen-Jones, referred to above, that Dr Stambuli was not incapable of this. However the above plan from Dr Stambuli provided the panel with no basis for making an order under Regulation 12. There is no evidence from which we could identify appropriate conditions which should be imposed. Contingent removal is not an option. It would require a degree of insight into his deficiencies, and he has not demonstrated such insight in the proposals submitted. Any support would require some continuing practice as a GP, which he has no intention of resuming.

121. We do note, however, that in his letter explaining his attempts to comply with the Tribunal's directions to produce an action plan, Dr Stambuli appeared fixated on his past problems, rather than on the issue of identifying steps he could take to address acknowledged concerns. We also note his comment to Dr Morrison that he expected a favourable

outcome from the GMC assessment ; this is wholly out of line with the report from the GMC, which is emphatically negative, and inconsistent with what Dr Stambuli stated in his letter to the Tribunal, which was a recognition that the GMC report looked bad. His failure to disclose this to the Associate Dean is not consistent with insight or co-operation.

122. We therefore consider that the PCT's written final submissions, that Dr Stambuli's approach to the contingent removal possibility revealed a lack of insight, are well founded. He has clearly failed to understand that what was required was evidence of realistic proposals for addressing areas of performance which needed improvement. Instead, he submitted further details of his history with the PCT and evidence of a discussion with the Associate Dean which was partly based on a premise which he should have known was false (a good GMC assessment outcome).

123. The Tribunal felt that Dr Owen-Jones' evidence left the Tribunal with little option other than to allow Dr Stambuli an opportunity to make a case for contingent removal. It appeared to us that she demonstrated an unwillingness to use clear unambiguous language, and to seek to avoid responsibility for expressing opinions on matters clearly within her professional competence and remit. She appeared to be somewhat confused as to the meaning of the meaning of "poor", and her reference to "below average" turned out on her own admission to be plainly wrong. Had she show willingness to express views which her own findings clearly warranted, the adjournment and fruitless pursuit of a plan for contingent removal might have been avoided. (It was not, at that stage, open to the Tribunal to form any conclusions on the evidence, so we had to accept the evidence that remediation was an option.)

<u>Removal</u>

124. At the time of taking oral evidence, there were two principal sources of evidence which the PCT relied on in opposing the appeal by the PCT. (We now also have the GMC assessment, which is considered later.)

125. In his written comments, Dr Stambuli appeared to believe the NCAS assessors were biased against him. We see no credible evidence of bias. NCAS is set up as an independent body, and was invited to assess the practice by Dr Stambuli. There is no evidence at all of the PCT influencing its investigation or conclusions. Detailed examples are given for the findings, which, summarised at page 56, show performance "significantly below the level expected of a general practitioner", with "significant areas of core clinical practice where Dr Stambuli's performance was either inconsistent or poor". Poor practice was identified in areas of clinical management including, prescribing; infection control; record keeping; use of resources; and managing the practice.

126. Dr Hayes' own investigations are fully documented in his witness statement and report to the PCT. We are quite satisfied that he used an appropriate methodology, and has provided clear reference to the sources

of each of his findings. We refer to paragraph 20 or his witness statement, and accept the truth of his conclusions that of the forty cases reviewed (chosen, as he explained orally, at random) he identified 17 examples of poor practice. He identified poor summarising, duplicate medications being prescribed, examples of unusual doses of medication, examples of inappropriate onward referrals to secondary care, and examples suggesting a lack of awareness of drug safety or drug interaction, as well as problems with patient monitoring.

127. Dr Stambuli's cross examination of the witnesses, during which he in fact gave evidence as well as putting questions, has, in our view, done nothing to cast any doubt on the findings of poor practice in both investigations. We are clear from Dr Hayes' answers that the particular examples Dr Stambuli focused on that Dr Stambuli prescribed anti-inflammatory medication inappropriately and dangerously to a patient over a long period; that the prescription record showed at best unacceptable overlap between two forms of medication for asthma; and that Dr Stambuli failed to show that he was monitoring the patient receiving Methotrexate. His suggestion that the patient receiving long-term non-steroidal anti-inflammatories was happy with the medication itself showed a serious lack of insight. We mention these matters not because they are pivotal, but because they were instances from the review of Dr Hayes which Dr Stambuli chose to focus on. He failed to undermine the conclusions presented by Dr Hayes that there were, in the random samples reviewed, serious concerns revealed in the records.

128. Dr Stambuli's reference to patient satisfaction, and his view that he did not harm patients, do not alter our conclusions. Patients had good reason for satisfaction, in that Dr Stambuli worked long hours and was very approachable, and clearly knew his patients. But a patient cannot evaluate the quality of the medical expertise applied to his or her care in a professional manner. Indeed it is worrying that Dr Stambuli referred to the patient being content to be on anti-inflammatory medication, as what he should have done is explained to her why it was only available as an option for short term flare ups. It is worrying that a decision on which inhaler should be prescribed appears to have been left to the pharmacist, and that Dr Stambuli felt (wrongly) that he could not correct the computer record to remove the abandoned prescription.

129. We have now seen the GMC report. On page 101 the summary and conclusions show that he was found competent in no area of performance, and unacceptable in areas of assessment, investigations, treatment, records, maintaining good medical practice, patients, and colleagues. In other clinical care the report found his performance to be a cause for concern. The eventual decision of the GMC is unlikely to be favourable to Dr Stambuli. The report was not available to the PCT, but we must put ourselves in the position of the PCT and take account of evidence now

available. The inescapable conclusion is that the GMC report corroborates the findings of the NCAS panel and of Dr Hayes.

130. Dr Stambuli relies on difficulties with his computer system. However his own witness confirmed that the computer was working while she was there, and that items not in use were quickly put to use when the practice was taken over following Dr Stambuli's retirement. We accept the evidence of Mr Kinnear, that appropriate support and training were available or provided throughout the period we are concerned with. We also note that it was at all times Dr Stambuli's responsibility to maintain good patient records. He was free to do so manually, but having decided to use the computer, any records thus created were his responsibility. His witness, when referring to the "tinpot system" in place, was probably accurate in capturing the quality of the practice's record keeping and administrative procedures. We do not accept that it was appropriate to blame the PCT for these shortcomings. Indeed his obsession with the PCT in itself appears to indicate a worrying lack of judgment. There is no objective evidence that he received less than the appropriate support, or that he was singled out as a single-handed practitioner.

131. For the avoidance of doubt we make clear that we base our findings not on the reasons for the PCT's initial concerns – the QOF scores in particular. The evidence we rely on is the NCAS report, Dr Hayes' review, related documentation, and the GMC report.

132. Our conclusion is that the Respondent's decision to remove Dr Stambuli from its performers list was very clearly justified in light of his poor performance as a medical practitioner. The PCT was rightly concerned with Dr Stambuli's performance, and with potential risks to patient health and safety.

Order

133. The appeal against the decision to remove the appellant from the Respondent's performers list is dismissed.

H Brayne

Judge of the First-tier Tribunal

22.2.2012

Health Education and Social Care Chamber
First Tier Tribunal