PROTECT

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

Case No: PHL/15464

Tribunal Members

Mrs Debra Shaw - Chairman
Dr Howard Freeman - Professional Member
Mrs Vivien Lee - Member

BETWEEN

DR CORDELIA ANYIAM-OSIGWE
GMC No: 2979784

Appellant

and

NHS HAMMERSMITH AND FULHAM

Respondent

Heard on 7th, 10th, 11th, 12th and 13th September 2012

DECISION WITH REASONS

Representation and Witnesses

For the Appellant: Dr O Ogunsanya, Blackstones Solicitors. Dr T Adenaike appeared as an expert witness.

For the Respondent: Mr D Bradly, Counsel, instructed by Capsticks Solicitors. Dr A Steeden appeared as a witness on behalf of the PCT, Dr M Rhodes appeared as a witness on behalf of NCAS and Dr C Robinson appeared as an expert witness.

The Application

1. This is an appeal by Dr Cordelia Anyiam-Osigwe (Dr A-O) against the removal of her name from the Medical Performers List of NHS Hammersmith and Fulham (the PCT) under the provisions of Regulations 10(4)(a) and 12(3) of the National Health Service (Performers Lists) Regulations 2004 (as amended) and associated regulations (the PLR) on grounds of inefficiency and breach of a contingent removal condition.

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History and Background

2. Dr A-O has been included in the PCT's Performers List (PL) since 2001. She entered into a GMS contract with the PCT's predecessor to provide NHS medical services at Old Oak Surgery, Uxbridge Road, London W12, as a sole contractor in 2004.

3. The PCT began to receive complaints about Dr A-O and the practice from 2007 and issues were identified in three separate investigations by the PCT's Quality and Outcome Framework Team (QOF) in April 2008, by an independent organisation, Nina Murphy Associates (NMA), in July 2010 and by NCAS in mid 2011.

4. An Action Plan was agreed with the Appellant after the QOF review. Following the NMA assessment a Remedial Notice was served on her and she was contingently removed from the PCT's PL on 19 August 2010, under conditions which, inter alia, required her to agree to an NCAS assessment and to submit six monthly retrospective audit reports to the PCT relating to her clinical practice during the preceding three months, to cover record keeping, prescribing antibiotics, blood tests ordered and appropriateness and the management of the patient complaints. The conditions stated the first report was due in February 2011.

5. On receipt of the draft NCAS report on 5 August 2011, together with several notices from NCAS requiring the PCT to take immediate action because of patient safety concerns, the PCT suspended Dr A-O on 17 August 2011 and commenced steps to remove her from its PL.

6. The PCT hearing on 15 November 2011 to remove Dr A-O was adjourned pending receipt of the final NCAS report. Her suspension was extended until 16 February 2012 and she was removed from the PCT's PL at the reconvened hearing on 6 February 2012 on the following grounds:

   (1) The Appellant breached Contingent Removal conditions placed upon her by the PCT

   (2) The Appellant's clinical skills are inadequate

   (3) The Appellant's clinical record keeping is poor

   (4) The Appellant's use of resources is inefficient

   (5) The Appellant's maintenance of good medical practice and insight into her deficiencies is poor

   (6) The Appellant retrospectively amended records of her consultations with patients without recording a reason for or a date of those amendments

   (7) The Appellant failed to notify the PCT of the GMC Interim Orders Panel Proceedings and the outcomes of those proceedings that were adverse to her, in breach of the PLR.

7. The PCT referred Dr A-O to the GMC by letter dated 16 December 2010 and conditions were imposed on her registration at an Interim Orders Panel (IOP) hearing on 8 March 2011. Following a complaint by the PCT to the GMC that Dr A-O had breached her conditions of suspension by screening abnormal blood results before forwarding them to locums she employed at the practice, the GMC conducted a further IOP hearing on 10 February 2012 and suspended Dr A-O for breaching her suspension order in this way. At that hearing Dr A-O told the IOP that she recognised she required refresher training, that she had sought the Deanery's advice in respect of her further training needs, and that the Deanery had recommended her attendance on a GOP training scheme called the Induction and Refresher Scheme.

8. Dr A-O appealed against the PCT's decision to remove her on 5 March 2012.

The Law

9. The legal framework for this appeal is largely contained in the PLR which, inter alia, set out the criteria by which appeals are to be considered.

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

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

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

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

    9.5 We also took into account the relevant sections of the "Primary Medical Performers Lists Delivering Quality in Primary Care" guidance issued by the

Department of Health in 2004 (DOH Guidance), including sections 7 and 17, and the GMC's "Good Medical Practice" (GMP).

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

Preliminary matters

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

11. The Tribunal confirmed to the parties that its remit extended only to considering Dr A-O's appeal against removal and it could not consider any appeal against her contingent removal or suspension.

12. The Tribunal also confirmed that as this appeal was against removal on grounds of efficiency, it could not determine that Dr A-O was unsuitable to be included in the PL.

Consideration of Evidence and Submissions with our Conclusions

13. Over the course of the hearing, which lasted for five days, we were presented with a vast amount of evidence. We have considered all of that evidence, including the written evidence, the oral evidence and the closing submissions at the hearing. We have also had regard to the legislation and documents set out in paragraph 9 above. For the purposes of our consideration of the evidence and this decision, we agreed the best course to adopt would be to identify and then summarize the most pertinent evidence for each of the different issues which had been raised by the PCT in support of its allegations of efficiency and breach of a contingent removal condition, before fully considering those issues. The fact that we have not specifically referred to all of the evidence does not mean that we did not consider it, but simply that we have restricted our summary of the evidence and the submissions herein to that which we consider most relevant to our conclusions.

(1) The Appellant breached Contingent Removal conditions placed upon her by the PCT

14. The conditions in the PCT's letter dated 20 August 2012 informing Dr A-O of her contingent removal stated that the first of her periodic audits report to the PCT was due in February 2011.

15. Dr A-O did not produce such report by that date. Despite this, Dr Hill, the then Medical Director of Practitioner Performance at the PCT, wrote to Dr A-O on 3 May 2011 confirming that the outcome of the PCT's review of her contingent removal conditions on 31 March 2011 was that the it was satisfied with her current level of compliance with the conditions and especially with the NCAS assessment.

16. Dr Hill wrote again to Dr A-O on 30 June 2011 with a proforma listing the PCT's current contingent removal conditions and requested a progress report with supporting evidence for each condition by 20 July 2011. The proforma stated that no audit report had been received.

17. The PCT wrote to Dr A-O on 19 August 2011 to inform her of her suspension for three months from 17 August 2011. That suspension was extended until 16 February 2012.

18. Dr A-O did not provide an audit report until the day of the reconvened removal hearing on 6 February 2012. The audit she produced related only to two areas of her practice (prescribing antibiotics and the management of the patient complaints), rather than the four areas required by the terms of the contingent removal (which also included record keeping and blood tests ordered and appropriateness).

19. Dr A-O contended that she was in a very difficult situation in February 2011 when the first audit was due; she had lost her salaried GP, the practice nurse was not working and she had to run the surgery with various locums. She also became unwell and whilst she tried as much as she could, in the circumstances she had to focus on patient care and keeping the practice running smoothly. She submitted she had been frightened by the terms of earlier PCT letters and was too frightened by the PCT's attitude to contact it to explain the situation and to ask for an extension. In retrospect, she wished she had written to the PCT before she was admitted to hospital in August 2011.

20. Dr A-O's representative submitted that once Dr Hill wrote to Dr A-O on 3 May 2011 confirming that the outcome of the PCT's review of her contingent removal conditions on 31 March 2011 was that it was satisfied with her current level of compliance with the conditions, the PCT was under an obligation to discharge the conditions imposed on Dr A-O.

21. Counsel for the PCT acknowledged that the PCT had informed Dr A-O in its letter that, as at 31 March 2011, its Primary Care Decision group had been satisfied with her current level of compliance with her contingent removal conditions, but submitted that the outcome of the review which was the subject of the letter was to maintain the conditions and it was not possible to read the letter as any sort of waiver of the conditions. He also pointed out that Dr Hill had again written to Dr A-O on 30 June 2011 seeking a progress report, including a proforma describing each of the conditions, with the words 'not done yet' recorded against the condition which, required her to submit six monthly retrospective audit reports, but Dr A-O had failed

to respond to this. He submitted that Dr A-O's evidence to the Tribunal was that she had been frightened by the terms of earlier letters and not that she had believed the letter from the PCT had waived her contingent removal conditions but, in any event, her evidence was not credible. He further submitted the second audit was due in August 2011 and that Dr A-O's suspension from the PL should have eased the time pressures upon her and should not have prevented her from carrying out and submitting an audit in respect of her last three months in practice, either on time or when she had come out of hospital. He pointed out that despite being suspended, she had managed to submit some audit immediately prior to the hearing on 6 February 2012.

22. Having considered all of the evidence relating to this issue we consider that Dr A-O clearly breached her contingent removal condition to provide the first of her periodic audit report to the PCT by February 2011. Even if she believed Dr Hill's letter dated 3 May 2011 confirming that the PCT was satisfied with her current level of compliance with the conditions waived the requirement to provide this audit, we consider that Dr Hill's second letter dated 30 June 2011 made it very clear that this was not the case and this condition had not yet been fulfilled. Given that Dr Hill's first letter clearly referred to Dr A-O's "current level of compliance" and the Primary Care Decision group's decision "to maintain the PCT's previously agreed conditions", we are not persuaded that Dr Hill's first letter could possibly be interpreted as placing the PCT under an obligation to discharge the contingent removal conditions it had imposed. Furthermore, we do not consider Dr A-O's explanation that she was too frightened by the PCT's attitude to contact it to explain the situation and to ask for an extension to be reasonable for a professional person subject to contingent removal conditions. Nor are we persuaded by Dr A-O's submissions to explain her failure by reference to her health, given that she failed to mention this at her contingent removal hearing and that she told us that she was in pain from March/April 2011, which was after the due date for the first audit report.

23. However, we do not consider Dr A-O breached her contingent removal condition to provide a second retrospective audit in August 2011 (the precise date being 20 August 2011, that is, twelve months from the date of her contingent removal), since we take the view that once she was suspended on 19 August 2011 her contingent removal conditions no longer applied, because suspension requires practitioners to be treated as though their name has been removed from the PL and they cannot perform any aspect of any primary medical service for any patient (DOH Guidance).

(2) <u>The Appellant's clinical skills are inadequate</u>

24. Dr A-O's representative submitted that NCAS had examined 28 cases of clinical care, out of which 24 were said to be satisfactory and 4 were poor.

25. Counsel for the PCT submitted that concerns about the Appellant's competence as a doctor were expressed by NMA in their first report in July 2010 and these concerns were confirmed in the NCAS report, which is highly critical of Dr A-O's clinical

skills and concludes that she was performing significantly below the level expected of a GP principal and her overall performance without adequate direct supervision had the potential to place patients at significant uncontrolled risk. It also states that the breadth and depth of the concerns, across the scope of Dr A-O's clinical practice and her managerial roles, raised serious questions about her fitness to practise. NCAS alerted the PCT to the seriousness of the concerns by telephone and several e-mails and letters and advised that the PCT should refer Dr A-O to the GMC.

26. He also pointed out that the patient records assessed by NCAS had been considered for the purposes of this appeal by an independent expert, Dr Robinson, who had given evidence which identified and focused upon the patient care which caused the most concern. Counsel submitted that Dr Robinson was speaking from a position of considerable authority (in particular as a long time GP trainer), his evidence was fair and reasonable and it was challenged in respect of some only of the patients he identified. By contrast, he contended that the evidence of Dr Adenaike, Dr A-O's expert witness, should be rejected, as her approach to giving evidence was wholly unsatisfactory in that she had not been prepared to express any criticisms of Dr A-O in her report and could not have been telling the truth when she said that the passages in her report, which were identical to passages in Dr A-O's comments on the draft NCAS report prepared by Nabarro LLP (her previous solicitors), were her own work.

27. He further submitted that Dr A-O had herself challenged Dr Robinson's evidence in respect of some only of the patients he identified and that the only patients remaining the subject of disagreement between the parties on the evidence were patients D3, D16, D17, D18 and D20.

28. Patient D3 was a 28 year old male who attended on 14 July 2009 requesting the anti-depressant sertraline to be restarted. NCAS reported that Dr A-O recorded in her history that he was 'desperate because he had suicidal ideation' but there was no record of her having undertaken an assessment of mental health or the degree of suicide or self-harm risk. It considered Dr A-O should have used an appropriate tool such as PHQ-9 or HADS in line with NICE guidelines before restarting a prescription for anti-depressants and wrote to the PCT to alert it to take any action it deemed necessary to protect the safety of patients.

29. Dr Robinson gave evidence that Dr A-O should have assessed the patient's depression at that point because of his suicidal ideation, but conceded that it was not necessary to use a particular tool and that the NCAS report was incorrect in so far as it failed to indicate the patient was being weaned off anti-depressants.

30. Dr Adenaike's expert report stated that Dr A-O knew the patient well, the records documented his desire to be weaned off medication, but he clearly had insight and needed to recommence his medication and unless he was actively suicidal, which was not the case, the only appropriate action was to recommence his medication. Dr A-O had made a judgment based on her knowledge of the patient and come to the conclusion he was not suicidal. In her opinion personal knowledge of the patient was more valuable than any assessment tool.

31. On being questioned at the hearing Dr Adenaike conceded that there was nothing in the records to show that Dr A-O had put herself into a position to assess a suicidal intention or otherwise. She also accepted that Dr A-O's prescription of sertraline for three months was too great a quantity and Dr A-O should have arranged a follow-up appointment.

32. Dr A-O gave evidence that the patient came into the surgery on the way to the gym. He was being disruptive in reception screaming for tablets. She came out of a consultation in her surgery, asked what was the matter and he told her he needed the tablets because he was suicidal. Dr A-O told him not to upset the other patients, took him into the empty nurses' room and questioned him. She considered he was not suicidal and was being disruptive and naughty. She gave him medication but asked him to return a day or two after that conversation and he returned for blood tests; he was not lost to the practice. She prescribed 50mg sertraline for three months because she believed he could handle this amount because he had previously been on 150mg then 100mg. In her practice anyone with depression was asked back a week or two later and had blood tests to exclude any other problem. Dr Raji had previously appropriately referred this patient to a psychologist on two occasions but he failed to attend. After talking to him she had been satisfied he was not suicidal and had called his bluff.

33. On cross-examination, Dr A-O reiterated that she considered the patient could handle 50mg sertraline for three months because he had handled that amount before when he was on 150mg for a month. She considered she had followed him up by asking him to return for a blood test, which was carried out on 15 July 2009.

34. On being questioned by Dr Freeman, Dr A-O conceded that, on reflection, she would have prescribed two weeks of sertraline for this patient and although her entry in the records on 14 July stated "Appointment for blood test on Monday" she had planned to review him at that appointment and the entry should have stated "Appointment for blood test and review on Monday".

35. Patient D16 was a 59 year old man. The records show a PSA result of 8.45ng/ml on 13 April 2010. On 19 May 2011 a PSA result of 10.4ng/ml was recorded, with Dr A-O noting an abnormal PSA and to contact the patient. On 26 July 2011 Dr A-O recorded having a discussion with the patient about his recently rising PSA and referring him to a urologist for further investigation and management.

36. Dr Robinson's evidence was that Dr A-O should have arranged to see the patient to take a history relating to his prostate when she received the PSA figure in 2010 and carried out a rectal examination, which is an essential part of the assessment once a raised PSA level is received, and necessary to ascertain if cancer is suspected and a two week referral is required. When Dr A-O received the PSA figure in 2011, although she had commented he was away, she should have written to him about the result stressing the importance of being seen quickly. Even when she saw the patient on 26 July she did not carry out a rectal examination or refer him under the two week rule and he was not seen by a consultant until 21 September, some two months after his referral and four months after receipt of the raised PSA result.

37. At the hearing Dr Robinson conceded he had not been aware of the racial variation resulting in black people having higher PSA than Caucasians and that it was probably not absolutely necessary, but it was good practice, to carry out a rectal examination. However, he maintained a two week referral should have been made in 2010 and also in 2011.

38. Dr Adenaike's expert report stated that Dr A-O had been unfairly criticised; the patient was abroad and the notes showed Dr A-O had appropriately tried to contact him and made an urgent referral when she saw him on his return from holiday.

39. On being questioned at the hearing Dr Adenaike conceded that she should have noted in her report that the patient should have been referred under the two week rule.

40. Dr A-O gave evidence that the patient had a habit of coming for blood tests en route to the airport and he was not in the country on both occasions when she received the PSA results. There was no point in writing a letter because she knew he was going to be out of the country and not due to return for about a year, but in May 2011 she had left a message with his wife to ensure he would come back on his return. She pointed out that the referral letter she wrote on 27 July 2011 was under the 'Choose and Book' system but was headed "urgent appointment"; it was a two week referral and the hospital followed it up with an urgent appointment.

41. Patient D20 was a 28 year old female with a BMI of 37.3 who requested the combined oral contraceptive pill (COC) when Dr A-O saw her on 24 December 2010. The notes record that Dr A-O discussed the contraindication of weight and possible thrombosis and then prescribed the COC. NCAS criticised this as the guidance from the Faculty of Family Planning and Reproductive Health Care states that for women with a BMI of 35 – 39, the risks of COC generally outweigh the benefits, because of the increased risk of venous thromboembolism (VTE).

42. Dr Robinson's evidence was that although Dr A-O did discuss the risks with the patient and the patient's choice was for COC, the notes record she was a recent ex smoker, which combined with her BMI, reinforces the recommendation that the COC should not have been prescribed for this patient. Not only did this put the patient at risk, she suffered a deep vein thrombosis (DVT) on 3 May 2011, some five months after the COC was prescribed, with the COC being the most likely cause.

43. Dr Adenaike's expert report stated that the proposed prescribing of the COC was fully discussed with the patient, including the risks and side effects, notwithstanding which the patient indicated it was her preferred choice of contraception. In addition, the current guideline not to prescribe is for a BMI of over 39 and the COC is still prescribed to women with high BMI provided the benefits outweigh the risk, the women are adequately counselled and there is no absolute contra-indication.

44. On being questioned at the hearing Dr Adenaike could not remember if she had seen the earlier entries in the records showing the patient had been a smoker.

45. Dr A-O gave evidence that she had discussed the contra-indications and other options with the patient but she did not want them. Her representative submitted that the evidence showed the patient had been on other methods of contraception that

caused her unwanted side effects and the prescription of COC was reasonable in the circumstances as the risk of DVT and VTE is higher in pregnancy.

46. We have concentrated on consideration of these three cases as we consider them to be the most egregious examples of inadequate clinical skills.

47. In the case of patient D3 we note that Dr A-O conceded that on reflection she would only have prescribed two weeks of sertraline, as opposed to a three month supply, which we consider to be excessive for a patient with suicidal ideation, however well the practitioner knows the patient. We accept the submission from the PCT that her reason for giving it to him – that he had such a prescription before and could cope with it – is not credible. Furthermore, Dr A-O failed to convince us that she had arrange a follow up appointment for review; we were confused by, and sceptical of, her evidence relating to the date of the follow up appointment and note that Dr A-O conceded her notes failed to record that the appointment mentioned in the records on 14 July for a blood test on Monday was also supposed to be for review. We consider that if that really had been her intention at the time she did not need to give him the potentially risky prescription for a three month supply of sertraline .

48. In the case of patient D16, whilst we accept Dr A-O would have been aware that this patient spent long periods of time outside the country, we are not persuaded by her explanation that heading up the letter dated 27 July 2011 under the 'Choose and 'Book' scheme with the words "urgent appointment" constitutes a referral under the two week rule, as evidenced by the fact that he was not seen by a consultant until 21 September 2011.

49. In the case of patient D20 we consider that given all of the contra-indications, a prescription for the COC was, at best, reckless. We do not accept Dr A-O's explanation why she prescribed it; nor do we accept that the prescription of COC was reasonable in the circumstances as the risk of DVT and VTE is higher in pregnancy. We do not dispute that practitioners should take a patient's preferences into account, but we also consider that they must be prepared to refuse a patient's request if they consider it to be too risky and therefore not in the patient's best interests. Indeed, the patient went on to suffer a DVT, with the COC being the most likely cause.

50. We consider that in a sample of only forty one records, for three patients to be put at potential risk is an unacceptably high percentage;

(3) <u>The Appellant's clinical record keeping is poor</u>

51. We note that when NMA reviewed Dr A-O's record keeping for the first time in July 2010 they concluded that her clinical records were wholly inadequate; there were multiple examples of consultations where no records were made and some records were so poorly structured and fragmented that they could not be understood effectively. We also note that when NMA reviewed Dr A-O's record keeping for the second time in December 2010, they concluded that the vast majority of the consultation records reviewed were acceptable and that their concerns were

limited to the quality of the recording, as opposed to the clinical care provided, although they did consider there was room for improvement.

52. However, any signs of improvement were not identified by the NCAS assessment in June 2011, which identified ninety incidences of poor record keeping from the forty one sets of patient records considered. Dr Adenaike submitted that the record keeping was as adequate as that of most average GPs but then took issue with only nineteen of the NCAS criticisms and also concluded that in the examples available Dr A-O's record keeping was frequently inadequate.

53. Dr A-O did not challenge this ground and apologised for the quality of the content and brevity of her notes. She submitted that she has attended courses on record keeping to remedy her deficiencies and is working with the Deanery to improve the quality of her entries.

54. We do not accept a similar amount of deficiencies would be found in a similar sample from an average GP. When asked what the purpose of medical records was, Dr A-O told us they were mainly for the continuation of care of patients and for legal purposes in the event of a complaint. We are not sure that she appreciates they are required so that any practitioner who views them can see the past history, especially in London where there is such a mobile population. Given the level of deficiencies in Dr A-O's record keeping and the evidence of a prolonged history of her failing to address this issue, we are not entirely convinced that she would maintain an acceptable standard of record keeping in the long term, although we note her insight and reassurances in relation to this issue.

(4) <u>The Appellant's use of resources is inefficient</u>

55. NCAS identified one example of satisfactory practice, and seventeen examples of poor practice in relation to use of resources. By the time of the Schedule of Agreement and Disagreement drawn up by the parties' respective expert witnesses, Dr Adenaike agreed with some elements of this complaint.

56. The areas remaining in dispute were that Dr A-O carried out bloods, smears and vaccinations and also saw a patient for INR (blood coagulation) results and monitoring that could have been done by a more appropriate member of staff, she did not follow guidelines and used more expensive drugs for patient D17, and she made six, fifteen minute appointments for blood tests on 21 April 2011 and eight, fifteen minute appointments for blood tests on 19 April 2011.

57. Having heard and considered the evidence, we accept that when Dr A-O did not have a nurse her work was disrupted and she still had to deliver her contractual obligations. We also accept that patient D17 had worked at the practice for over twenty years since well before Dr A-O took over, she was Dr A-O's previous practice manager and she was conversant with drugs. Given that she refused to take the cheaper drugs for her condition, we accept that Dr A-O could not leave this patient's neuropathic pain untreated and, in the particular circumstances, we consider the more expensive drug she prescribed was acceptable.

58. Our main concern in relation to inefficient use of resources was in relation to the fifteen minute appointments for blood tests. Dr A-O gave evidence that these were also used as follow up appointments for diabetic patients and patients with coronary heart disease and that the PCT had encouraged practices to start in-house phlebotomy services as local enhanced services. Her representative submitted that the PCT should not be able to dictate how Dr A-O should use her time as an NHS independent contractor and that the allegation was an abuse of the PCT's statutory power.

59. We note that Dr A-O did not substantiate her claim with copies of the relevant appointment records. She submitted she was not able to do so as she did not think she could access the practice computer whilst suspended. We are not persuaded by this explanation; as the contractor Dr A-O was aware that had access to the practice whilst suspended, as evidenced by her having screened blood tests whilst suspended in breach of the conditions imposed by the IOP of the GMC. Given this was the case, we consider she could have either printed off the relevant appointments herself or asked the Practice Manager to do so. Furthermore, we note Dr Adenaike, her expert witness, confirmed six to twelve blood tests per hour can be undertaken and we consider twelve per hour, i.e. five minutes for each, is the norm. Given this, we consider these appointments were an inefficient use of NHS resources.

(5) The Appellant's maintenance of good medical practice and insight into her deficiencies is poor

60. We considered whether Dr A-O had maintained good medical practice by comparing some examples of Dr A-O's practice to some of the requirements in GMP. Section 2(a) of GMP stipulates that good clinical care must include "adequately assessing the patient's condition, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient." We considered Dr A-O's actions in relation to patient D3 and concluded her failure to assess his mental state breached this requirement.

61. Section 2(c) of GMP stipulates that good clinical care must include "referring a patient to another practitioner, when this is in the patient's best interests." We considered Dr A-O's failure to refer patient D16 under the two week rule breached this requirement.

62. Section 3(b) of GMP stipulates that in providing care a practitioner must "prescribe drugs or treatment, including repeat prescriptions, only when [they] have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs". We considered the prescribing of the COC by Dr A-O for patient D20 despite the contra-indications breached this requirement.

63. Section 3(b) of GMP stipulates that in providing care a practitioner must "keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment." By her own admission, Dr A-O failed to keep sufficiently full and detailed records in breach of this requirement.

64. Section 3(g) of GMP stipulates that in providing care a practitioner must "make records at the same time as the events [they] are recording or as soon as possible afterwards." Dr A-O admitted amending the records of patient D20 six months after the consultation and out of the sample of only forty-one records, NCAS found four other examples of records that had been changed retrospectively, without a recorded reason and date of the amendment in the record and wrote to the PCT about these examples to enable it to take any action it deemed necessary. Accordingly, we consider Dr A-O breached this requirement.

65. Section 14(e) of GMP stipulates that practitioners must work with colleagues and patients to maintain and improve the quality of their work and to promote patient safety. In particular they must "respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary." The PCT indicated in its response to this appeal that following the NMA report in July 2010, it had attempted to engage with Dr A-O and afford her the opportunity to remedy the identified failings and had then imposed contingent removal conditions, which included undergoing an NCAS assessment. The NCAS report of that assessment found one of the examples of Dr A-O's poor practice was that she failed to submit her last appraiser's statement from November 2010, despite a number of requests, and reported she did not have a Personal Development Plan (PDP). It also found that despite the NMA reports of July and December 2010 outlining areas where Dr A-O's practice needed improvement, she did not mention these areas as relevant for her to focus on when asked to identify her learning needs for the coming year in her final interview. Accordingly, we consider Dr A-O breached this requirement.

66. In relation to probity, section 56 of GMP states that probity means being honest and trustworthy, and acting with integrity, and section 57 stipulates that practitioners must ensure that their conduct at all times justifies their patients' trust in them and the public's trust in the profession. We consider Dr A-O's retrospective amendment of patient records without recording the date or reason for doing so breached these requirements. We are also concerned by Dr A-O's failure to ensure the professional qualifications that she holds are correctly written and displayed. When questioned about stating her qualification as "RCGP" on her response to the NCAS referral form Dr A-O told us this was a typographical error and she should have stated "RCP (Ireland)" as she had stated on her curriculum vitae. However, the PCT informed us that "RCGP" is also displayed on the practice website. We consider it is a very serious matter for any practitioner to incorrectly or falsely claim to hold qualifications they do not possess, and this is clearly a breach of GMP probity requirements.

67. We have considered Dr A-O's insight into her deficiencies. She gave evidence denying she has poor insight into her deficiencies "whatever they are" and acknowledging she has room to improve. When asked what deficiencies she was aware of, she identified record keeping and audit. However, when asked what action she had taken after issues with her record keeping were first drawn to her attention by NMA, she told us she had only looked at colleagues' records and had discussions with them because she had had overwhelming issues over the past two years, her mobility was impaired, she was in pain, and she had had to conserve her energy for running the surgery. She admitted that, in retrospect, she should have attended a course at the time but when she was active after surgery she had embraced the things she needed to do. When asked to explain why the NCAS assessors still had significant concerns about

her record keeping, several months after the NMA reports, Dr A-O submitted they had been looking at her previous notes.

68. Dr A-O was also unable to tell us the details of her most recent PDP in 2011, although she recalled trying to register for a course on the management of musculoskeletal disorders. However, she told us she had now completed a number of courses and attended the Deanery, some volunteers had come to the surgery and she had gone through the process of consultation with them, with good feedback from both the educator and the volunteers. She had also learned to do audits and whilst suspended has attended courses on communication, management, leadership and taking on board criticism. We note Dr A-O's CPD evidence indicates attendance in late 2011 on, inter alia, a communication skills workshop, core skills in clinical & service audit, and the importance of good record keeping in Primary Care.

69. When asked how long she thought it would take her to reach the position of being able to practise independently and safely as a GP, Dr A-O responded she did not need time and she was ready.

70. When questioned further about her preparedness for returning to work, Dr A-O told us she had the confidence to go back to her work and after the courses she had attended and paid for she knew that the issues in question were not going to reoccur. She had in place a partner as clinical lead and other doctors would be joining the practice to share the other services between them so that she would not be isolated. She had identified a tutor at the Deanery and made all arrangements as far as possible to go forward. If she were to return to work tomorrow, she had the knowledge, experience and information she had acquired from all the courses she had attended and she would maintain her learning as an ongoing process.

71. When asked if she only envisaged returning to her practice, with her patients, Dr A-O confirmed that she did. When further asked about the IOP conditions in place which, inter alia, prevent her from working independently and require her to confine her medical practice to general practice posts where her work would be closely supervised by a named GP Trainer, Dr A-O confirmed she had not planned to work independently and she had no qualms about returning to her practice; she knew it would be expensive but it was a sacrifice she was prepared to make for her patients.

72. We consider Dr A-O's insight into her deficiencies to be woefully inadequate. She only identified record keeping and audit as deficiencies and we consider she has failed to demonstrate any genuine or lasting understanding of the wide ranging deficiencies in her practice, of the need for remedy, or the need for intervention in the absence of remedy. We are particularly concerned that when asked how long she thought it would take her to reach the position of being able to practise independently and safely as a GP, Dr A-O responded she did not need time and she was ready. We are also perturbed by Dr A-O's lack of understanding of the IOP's condition that she must confine her medical practice to general practice posts where her work would be closely supervised by a named GP Trainer. Dr A-O confirmed that she only envisaged returning to her practice, with her patients, and did not appear to understand that this condition would restrict her to working in a practice in which there is a GP Trainer by whom she would be closely supervised.

PROTECT

(6) The Appellant retrospectively amended records of her consultations with patients without recording a reason for or a date of those amendments

73. Dr A-O conceded that she had retrospectively amended some records of her consultations with patients without recording a reason or a date for those amendments.

74. By way of example, the audit trail shows that on 3 June 2011 Dr A-O amended the note of her consultation on 24 December 2010 with patient D20. The original entry states "discussed C/I, wt" [cardiac infarction, weight], but the words "possible thrombosis, (no F/H), migraine" [family history] were added on 3 June 2011, almost six months after the consultation..

75. Dr A-O's evidence was that she could not remember why she had made this amendment. When reminded that the records showed this patient had been seen on 3 May 2011 with symptoms confirmed as a DVT the following day, Dr A-O conceded that she had been aware of this when she amended the computer entry one month later but submitted she had just said to herself she had seen this lady in the past with a DVT and she "just sort of updated the results." She added that she had a bad habit of updating records but not with any adverse or bad intent.

76. The audit trail shows that Dr A-O amended this entry one month after this patient suffered a DVT and three days before the commencement of the NCAS assessment. Dr A-O was cross-examined by Counsel for the PCT and asked questions by the Tribunal why she had made the amendments and at no point did she give a clear and acceptable answer to the Tribunal. We do not find Dr A-O's evidence on this issue to be credible and must conclude that Dr A-O was trying to ensure the records could rationalise her prescription of the COC for this patient, which she knew in hindsight to be inappropriate and potentially dangerous. We consider this action was totally unacceptable.

(7) The Appellant failed to notify the PCT of the GMC Interim Orders Panel Proceedings and the outcomes of those proceedings that were adverse to her, in breach of the PLR

77. Dr A-O did not notify the PCT of the Interim Order Conditions imposed by the GMC IOP on 8th March 2011, despite the fact that she was obliged to do so by the conditions themselves. Her representative submitted that the PCT was aware of the conditions, as it is the GMC's usual practice to inform the PCT with whom a practitioner has a contract, of any conditions imposed on the practitioner's practice. The PCT was informed of the conditions by the GMC and on 6 February 2012 Dr A-O's legal representative at the time also confirmed at the PCT Panel hearing to consider the removal of Dr A-O that he had notified the PCT in September 2011 of the outcome of the IOP hearing.

78. Given these circumstances, although we note that Dr A-O breached this condition, we accept that she may have believed it was sufficient for the PCT to be informed by another source and we do not place much weight on this ground.

79. Taking all of the evidence and our conclusions for each of the above grounds into consideration, we proceeded to consider the options in relation to our determination.

80. We considered the proven deficiencies were too serious and wide ranging for us to allow the appeal unconditionally.

81. We went on to consider whether to remove or contingently remove Dr A-O and the mitigating factors. We acknowledge that Dr A-O is not a wholly incompetent doctor and that she has demonstrated a commendable commitment to her patients and worked for long hours. We also note that she felt overwhelmed when the other GP and the practice nurse left.

82, We also take account of Dr A-O's ill health and subsequent operation in August 2011, although we note she did not proffer this explanation at the removal hearing on 17 August 2011 or at her NCAS occupational health assessment in June 2011, when she indicated she was currently well and that although she had recently injured her left knee and ankle following a fall the previous week, this had not caused any significant mobility problems. Dr A-O contradicted this evidence before us, when she explained her health problems had started in September /October 2010 when she suffered from impairment in her walking and pain in her hip, which had built up gradually, becoming very painful in March/April 2011 and unbearable in August 2011 when she had had to undergo an operation.

83. We also take account of the numerous testimonials and the petition from Dr A-O's patients, although we consider these must be balanced against the complaints received by the PCT about Dr A-O and/or her staff, which Dr A-O told us had all been resolved, despite the evidence from the PCT clearly showing this was not the case.

84. We note that Dr A-O submitted she was the only black, female, single-handed GP within the PCT area and implied this may have influenced the PCT process. No evidence was adduced in support of this submission.

85. Notwithstanding the above factors, we are so concerned by Dr A-O's grievous lack of insight and her retrospective amendment of patient records, that we do not consider her contingent removal would remove the prejudice to the efficiency of services which would result from her continued inclusion on the PCT's PL.

86. We also consider Dr A-O's breach of the contingent removal condition to provide retrospective six monthly audits, the examples of her inadequate clinical skills, her poor clinical record keeping, her inefficient use of resources and her poor maintenance of good medical practice, together with her failure to provide the Tribunal with any realistic proposals as to how a contingent removal might be structured for her return to practise, support our decision. At the hearing it was clear to us that Dr A-O had not properly considered the implications of the conditions imposed by the GMC IOP and she was unequivocal in her assertions that she was ready to return to her practice, and only her practice, despite this not being possible under the terms of those conditions.

PROTECT

Decision

87. For all the above reasons we unanimously find that Dr A-O's continued inclusion in the Performers List would be prejudicial to the efficiency of services which those included in the PCT's Performers List perform and we dismiss her appeal against removal from the PCT's Performers List.

National Disqualification and supplementary matters

88. We did not hear submissions on national disqualification pending our determination on the grounds of efficiency. We are content to determine this issue upon the basis of written representations alone, or, if the parties wish, an oral hearing will be held on a date to be agreed. The parties are invited to submit their representations on national disqualification no later than 28 days after the date that this decision was sent to them.

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

Dated this 24th day of September 2012

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