

## Primary Health Lists

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

Heard on 4 November at Canterbury County Court

BEFORE  
Professor Mark Mildred – Judge  
Dr Howard Freeman – Professional Member  
Ms Mary Harley – General Member

[2016] 2698.PHL

BETWEEN

Dr Pia Holwerda

Applicant

v

NHS Commissioning Board  
(South East)

Respondent

### DECISION

Background

1. The Appellant is a General Practitioner who is now senior partner at the White House Surgery in Folkestone. Concerns were raised in relation to her prescribing of controlled drugs in October 2009 by the police. In June 2010, during a controlled drugs inspection at White House Surgery, the Practice requested support from a clinical adviser to guide the Appellant on managing her prescriptions.
2. Following the meeting on 6 January 2011, a number of recommendations were made including that the Appellant should not prescribe for known drug addicts (in accordance with an arrangement already in place with the Practice); the Appellant should ensure that patients she was having difficulty managing were discussed at weekly clinical meetings with her partners at the Practice; and the Practice should monitor prescription requests for benzodiazepines, so as to ensure they were not ordered too frequently.
3. In July 2014 further concerns about the Appellant's prescribing were received from a pharmacist who was seeing patients being regularly prescribed medicines of abuse for a month, but were being prescribed it more frequently

than once a month. A controlled drugs (CD) investigation was instigated. Between 30 July 2014 and 16 October 2014, specific details relating to four patients (patients A – D) were received and reviewed. The recommendations arising from the investigation included that the CCG prescribing team discuss the concerns with the Appellant, to review the repeat prescribing Standard Operating Procedure for CDs; and to identify a mentor to help the Applicant.

4. In October 2015 Ms Nicola Fitzgerald was assigned the management of the concerns.
5. A clinical advisor, Dr Peter Le Feuvre, conducted a record audit of 30 records and completed a report with his findings on 20 January 2016.
6. On 23 February 2016, the PAG meeting was held, during which Dr Le Feuvre's report and the Appellant's email submissions in response to it were considered.
7. On 26 February 2016 the Appellant was advised of the outcome of the meeting which was that the Panel decided the Appellant's case should be referred to the Performer's List Decision Panel ("PLDP") to consider proposing conditions on her inclusion on the medical performer's list.
8. The Appellant was notified of the requirement for her to attend a record keeping course within 3 months, to obtain a mentor and for her surgery to review their policy on controlled drugs. A date was also set for the PLDP Panel Meeting. She was invited to submit any further comments she may have for the PLDP to take into consideration by the 10 March 2016
9. On 10 March 2016 the Appellant commented on the PAG proposed referral to the PLDP by email.
10. On 17 March 2016, the PLDP agreed with the decision of the PAG recommending imposing conditions on the Appellant's inclusion in the Performers List.
11. On 21 April 2016, the PLDP met to impose the conditions. The Appellant had the opportunity to be in attendance and to submit representations, but she did not appear or submit any representations.
12. On 27 April 2016 the Appellant was notified by letter that the PDLP had decided that her continued inclusion in the Performers List would be subject to the following conditions:
  1. You must not prescribe drugs listed in Schedules 1-4 of the Misuse of Drugs Regulations 2001 with immediate effect and must inform the controlled drugs accountable officer (CDAO) for the CCG in which you carry out primary medical services of this condition;
  2. You must have an educational supervisor nominated by yourself and approved by your responsible officer. The educational supervisor is required to submit monthly reports to NHS England for the first 3 months from the date of appointment.

**3.** You must a) design a personal development plan (PDP) in conjunction with your educational supervisor, to be approved by your responsible officer (or their nominated deputy with specific aims to address the deficiencies in the following areas of your practice: i) Controlled drug prescribing ii) Clinical record keeping b) You must give the local office a copy of your approved PDP within two months of these condition becoming effective. c) You must give NHS England a copy of your approved PDP on request.

**4.** You must undertake a record keeping course within 3 months and embed the learning into your practice. Evidence of embedded learning will be assessed by the conduct of a records audit by NHS England 6 months after the completion of the record keeping course.

**5.** You must inform the following parties that your registration is subject to these conditions: a) Any organisation or person employing or contracting with you to undertake medical work b) Any locum agency or out of hours service you are registered with or apply to be registered with (at the time of your application or that you are currently registered with c) In the case of locum applications your immediate line manager at your place of work (at least 24 hours before starting work) d) Any prospective employer or contracting body (at the time of application) e) The GMC.

**13.** On 25 May 2016 the Appellant appealed to the First-Tier Tribunal on the grounds that (a) she was a very competent GP and, although there were shortcomings that needed to be addressed, she did not feel that she was unsafe to continue working while this was taking place and (2) she was changing her practice by writing fuller records and using clinical read codes; she had identified various BMA and MDU courses and had found an educational supervisor and had written her PDP to discuss with him..

#### The hearing

**14.** The Appellant appeared in person and the Respondent was represented by Mr Matthew Corrie of Blake Morgan LLP.

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

**16.** In the event the issues before us were narrow: (a) should the Appellant's continued inclusion on the Performers List be subject to conditions to prevent any prejudice to the efficiency of the services she provides and (b) if so, what should those conditions be?

#### The evidence

**17.** Ms Fitzgerald described the transactions between the Respondent and the Appellant as detailed in her witness statement and said that she was not aware of any remedial work undertaken by the Appellant.

**18.** She was unaware of any approaches by the Appellant for help. Dr Holwerda had informally mentioned that she had asked Dr Korja to be her mentor but

there had been no formal contact. The Respondent might be able to provide support for finding courses.

19. Dr Le Feuvre presented his report. He had been offered the records of 59 of Dr Holwerda's patients and had selected 30 to review on an *ad hoc* basis. He spent a full day at the practice examining those records.
20. Dr Le Feuvre reported, using the Respondent's Record Report template that 14 of the 30 patients' records were acceptable, 12 gave cause for concern and 4 were unacceptable.
21. The unacceptable patient records were of (a) a prescription of opioids by telephone without safety-netting when a face-to-face consultation should have taken place; (b) a prescription of Tramadol by telephone without an assessment or examination of the patient or discussion of other possible symptoms and without a follow-up being arranged or safety-netting; (c) a telephone prescription of 60mg of morphine to a patient on the equivalent of 18mg, too large a jump in dose and (d) a prescription of a Buprenorphine patch without a full history or examination.
22. Dr Le Feuvre considered that it was usually inappropriate to prescribe strong analgesia over the telephone and without face-to-face assessment because it is impossible to pick up non-verbal clues. It was normal to progress one step at a time up the range of stronger analgesics, as set out in the WHO analgesic ladder. Although the WHO ladder was a very recent tool, the principle had been familiar to doctors for a long time.
23. After prescription of a strong analgesic a follow-up appointment should be made to safety-net the patient and assess the benefits and side-effects of the treatment. Consultations should be coded by the nature of the presenting complaint to allow searching an follow-up. None of the 30 patient records examined were appropriately coded.
24. The cause for concern patient records were of (a) failure to examine, review current medication and safety-net a patient with back pain; (b) a prescription of a Buprenorphine patch without mentioning discontinuing the current Co-codamol; (c) ) a prescription of a Buprenorphine patch without discussion or examination and in addition to the current Co-codamol; (d) ) a prescription of Tramadol without discussion or examination and in addition to the current Co-codamol; (e) a prescription of a Buprenorphine patch and Tramadol at the same time to a patient who had had neither analgesic before; (f) an ongoing prescription of Lorazepam with no evidence of guidance for usage or assessment of the patient; (g) a prescription of Fentanyl patches without going to the maximum dosage of Tramadol; (h) prescription of Tramadol to a patient with severe migraines on a long-term basis contrary to NICE advice; (i) prescription of Tramadol for relatively acute back pain without a recorded history or examination and failure to safety-net; (j) failure to record a history or examination of a patient with ongoing abdominal and back pain and a prescription of a Buprenorphine patch to a patient previously taking Paracetamol, an excessive leap on the pain ladder; (k) a prescription of 10mg

slow release morphine to a patient not currently taking any regular analgesic and (l) a prescription of slow release morphine to a patient with knee pain with no trial of weaker Opioids or alternative analgesics.

- 25.** In addition Dr Le Feuvre identified 5 safety concerns in relation to patients (a), (b), (c) and (d) in paragraph 22 above and patient (e) in paragraph 23 above and reported that there was no evidence of the recorded coding in the records.
- 26.** Dr Le Feuvre had training from NCAS in assessing performance twice between 2011 and 2014. He had been a clinical adviser from 2007 and this was the first practice assessment he personally had undertaken although he had reviewed record reviews undertaken by others.
- 27.** He accepted that prescription of strong analgesia over the telephone might be appropriate where a doctor was fully satisfied of the nature and cause of pain and that it was more appropriate than any other prescription or intervention. If dosage or medication was unusual, it should be fully explained in the records. Dr Holwerda's record-keeping was inadequate and her prescribing was such that a restriction on her prescribing controlled drugs was reasonable and proportionate.
- 28.** Dr Holwerda was registered in 1988, became a GP in 1994, began work at White Horse Surgery in 1996 first as a long-term locum and then as a partner. She explained that her problems in 2009 to 2011 arose from her treating addicts who were not straight with her of whom she had been too trusting. In those days there were no provisions for specialist treatment for them which was now provided by a specialist agency.
- 29.** She acknowledged that her main problem was in not recording everything that she had done. She had looked at the records of the patients referred to in Dr Le Feuvre's report and concluded that the problem was that they were a snapshot of a patient at a particular time. In a 10 minute consultation there was not enough time to make full records and code the consultation: if she did that, she would fall behind.
- 30.** She took as an example patient (d) under paragraph 22 above and explained that he suffered severe osteo-arthritis of the spine, he had been suffering back pain for at least 20 years, seen several specialists and tried several treatments but his pain was getting worse while he waited for an X-ray. He normally took paracetamol or co-codamol, sometimes at an increased dose and at the home visit consultation it was unclear why his pain was getting worse. It may have been a flare-up of his osteo-arthritis for which his normal analgesic would have been ineffectual. It was not nerve pain so Amitriptyline and Gabapentin would not have been appropriate and the patient could not take anti-inflammatories because of his stomach problems. He was old and unsteady on his feet so he should not be given anything which would make him drowsy.

- 31.** Without going through all Dr Le Feuvre's report Dr Holwerda could not say which criticisms she accepted. He had only looked at the computerised records but could have gone back to the manuscript. She did accept that the prescription to patient (c) at paragraph 23 above may have been too high. The patient at (l) in paragraph 25 above also had very severe back pain with sciatica which had just recommenced.
- 32.** Dr Holwerda told us that she was now trying to write things down more. She had not yet been on a record-keeping course or begun to address the other proposed conditions. The whole of 2016 had been very stressful with 10,000 patients, 2 partners retired and her remaining partner was off sick for months.
- 33.** Dr Holwerda said they had been advertising for locums, long-term locums and partners but it was hard to find them. She had not tried to get any support for herself. The practice was trying to take non-essential work away from GPs through the use of nurse practitioners and admin workers.
- 34.** Dr Korja, who had agreed to act as Dr Holwerda's educational supervisor, was a long-standing GP in the area who worked as a locum in the practice and was an educational supervisor in the area. Dr Holwerda had had informal chats with him between sessions at her practice but no formal supervisions, thinking this should wait until the appeal was concluded.
- 35.** Dr Holwerda had not shared her PDP with anyone and had not thought to submit it to the Tribunal. She could not say offhand everything that was in it but it included what she intended to do to improve her record-keeping. She said that it would also have included prescribing and controlled drugs. She could not remember what else it contained but she had included a lot of things she intended to do.
- 36.** Although it was hard to find a record-keeping course Dr Holwerda had identified some online modules; she had not asked Dr Korja for advice about this.
- 37.** Dr Holwerda considered that most criticisms of her prescribing were unjustified but accepted that people could be concerned because her records inadequately recorded the rationale for what she did. She accepted the need for retraining on record-keeping and coding and the need for her to look at her prescribing.
- 38.** Dr Holwerda told us that Condition 1 would make life very difficult because she was often the only doctor in the surgery, especially after 1700. She works 10 sessions per week, has about 120 face to face consultations per week and has about 15 telephone consultations per day on average.
- 39.** She accepted that a new prescription for morphine, diamorphine or dihydrocodeine would not be needed every week and could not comment on Dr Freeman's suggestion that it might be only once every 2-3 months. She identified that the main problem would be if she was not allowed to prescribe Co-codamol.

40. Dr Holwerda told us that record-keeping and coding were important because of the threat of litigation. She said that a lot of detail in the records does not help but that, although the essentials were usually recorded, she could see that it would help to include more detail. She was used to making free-style records rather than coding: for her it was quicker because she had always done it that way.
41. Dr Holwerda agreed that it was only Condition 1 that was a problem for her and within that only new prescriptions. Most repeat prescriptions were done by 1600 when there were others present in the surgery. Locums often refused to sign repeat and new prescriptions that they had not initiated themselves.
42. For Dr Holwerda the ability to prescribe Co-Codamol and Co-dydramol was crucial: she made very few new prescriptions for the Benzodiazepines. If she could not, it was cause a problem but the problem was surmountable.
43. In cross-examination Dr Holwerda accepted that lack of records makes it very difficult to know what has taken place and that the safety of patients was paramount. She accepted that she had not taken any real steps to address the record-keeping and prescribing concerns and had not engaged in the 2015/16 GP appraisal process.

#### Submissions of the parties

44. Mr Corrie submitted that the real issue was whether Condition 1 was reasonable and proportionate in all the circumstances of the case. In the light of the serious concerns about Dr Holwerda's prescribing of controlled drugs in 2009 to 2011 and the new problems reported by a pharmacist in 2014, he submitted that it was. In effect the pharmacist's concern was that, monthly prescriptions were given to a patient more frequently than monthly.
45. Dr Le Feuvre's report revealed an unacceptable level of satisfactory consultations or records of them (only 14 out of 30) and 5 safety concerns in 30 cases. Dr Holwerda presented a risk in her prescribing and record-keeping.
46. Further Dr Holwerda lacked insight and had failed to engage with the remediation process. Nothing had happened since April 2016 to progress matters. Without insight her practice would not improve.
47. The only difficult issue for the surgery would be Dr Holwerda's inability to prescribe Co-Codamol: nothing else would present a practical problem to the surgery. Proportionality required that concern for public safety predominated over the interests of Dr Holwerda.

48. Dr Holwerda relied on the evidence she had given and submitted that, whilst there were areas in which she needed to improve, she was not an unsafe or bad doctor.

### Discussion

49. Because Dr Holwerda was unrepresented Dr Freeman put a series of detailed questions to Dr Le Feuvre on his experience, methodology and the cogency of his conclusions about the 16 unsatisfactory consultations. On the basis of Dr Le Feuvre's answers the Panel is satisfied that his conclusions regarding the 4 unacceptable reviews, the 12 cause for concern cases and 5 safety issues were and are sound.
50. The Panel was conscious that it did not have copies of the actual patient records. Dr Holwerda, to the extent that she disputed Dr Le Feuvre's conclusions (of which she had over 9 months notice), could and should have provided evidence from those records to support her arguments – all the more so as she sought to minimise Dr Le Feuvre's report as a series of snapshots taken at a particular moment in an ongoing course of care.
51. Indeed, Dr Holwerda told us that she had reviewed the records the night before the hearing. At that stage it was far too late to mount a reasoned case against the allegations. This was symptomatic of Dr Holwerda's approach.
52. Although the conditions did not come into effect because Dr Holwerda appealed against them her case was at heart only that Condition 1 was unworkable and disproportionate. In that context (where the need for improved record-keeping, a PDP and an educational supervisor were all accepted) we found it frankly astonishing that Dr Holwerda had not thought to bring her PDP to the hearing, could not remember most of its content, had not shown it to anyone, had had no formal sessions with Dr Korja and had not begun the process of remediation.
53. Further we do not accept Dr Holwerda's evidence that she could not find an appropriate record-keeping course. It is well-known that her Defence Organisation can provide or signpost her to such a course. Dr Holwerda was asked about the importance of record-keeping 3 times before, in addition to the risk of litigation, she acknowledged its importance in providing continuity of clinical care.
54. Dr Holwerda explained her failure to engage with the 2015/16 GP appraisal process by saying that she was very stressed and was trying to keep it together.
55. Our impression was that Dr Holwerda was overwhelmed by the pressures of running her practice and providing primary care to 10,000 patients. In our judgement she has allowed these pressures to compromise her safe prescribing and her record-keeping. In addition to the cases reviewed by Dr Le Feuvre the original concerns prompting the Respondent's action were a report of a pharmacist that one of Dr Holwerda's patients was able to present



a monthly prescription for an abusable medication more often than monthly and the early replacement of a lower dose of morphine by a hospital with a higher dose.

56. In our judgement conditions are needed to regulate Dr Holwerda's medical practice. We find that she lacks insight and puts the exigencies of her situation before more general good medical practice.
57. Subject to some semantic changes, Conditions 2, 3 and 4 are necessary and will be imposed.
58. The difficulty for the Panel is to be satisfied how to frame Condition 1 to allow the surgery to continue to provide care to 10,000 patients with only 2 resident full-time doctors and locums who are unwilling to sign prescriptions generated by Dr Holwerda.
59. On analysis during the hearing it transpired that the only controlled drug that Dr Holwerda regularly needs to prescribe for the first time to a patient is Co-Codamol.
60. We find that Dr Holwerda's prescription of controlled drugs generally needs to be restricted pending retraining at least (in view of her problems in 2009 and subsequently) and that it is proportionate to impose such a condition.
61. In our judgement it would be consistent with patient safety to allow Dr Holwerda to prescribe Co-Codamol to a patient who had not been prescribed it by the surgery before, once with a supply sufficient for 1 week provided that no further prescription is given to that patient by her.

**62. Conditions of inclusion**

1. Save that you may prescribe not more than 60 tablets of Co-Codamol once to a patient who has not previously been prescribed Co-Codamol by any doctor at White House Surgery within the previous 6 months, you must not prescribe any of the drugs listed in Schedules 1-4 of the Misuse of Drugs Regulations 2001 with immediate effect and must inform the controlled drugs accountable officer (CDAO) for the CCG in which you carry out primary medical services of this condition;
2. You must have an educational supervisor nominated by yourself within 28 days and approved by your responsible officer. The educational supervisor is required to submit monthly reports to NHS England for the first 3 months from the date of appointment.
3. You must a) design a personal development plan (PDP) in conjunction with your educational supervisor, to be approved by your responsible officer (or their nominated deputy) with the specific aims of addressing the deficiencies in the following areas of your practice: i) Controlled drug prescribing ii) Clinical record keeping  
(b) You must give the local office of NHS England a copy of your approved PDP within two months of these condition becoming effective.

- (c) You must give NHS England a copy of your approved PDP on request.
4. You must undertake a record keeping course within 3 months and embed the learning into your practice. Evidence of embedded learning will be assessed by the conduct of a records audit by NHS England 6 months after the completion of the record keeping course.
5. You must inform the following parties that your inclusion in the Performers List of NHS England is subject to these conditions:
- a) Any organisation or person employing or contracting with you to undertake medical work.
  - b) Any organisation to whom you apply for work for which inclusion in the NHS England Performers List is necessary.
  - c) Any locum agency or out of hours service you are currently registered with or apply to be registered with at the time of your application.
  - d) Any prospective employer or contracting body at the time of application
  - f) The General Medical Council (GMC)

**Judge Mark Mildred**  
**Primary Health Lists**  
**First-tier Tribunal (Health Education and Social Care Chamber)**

**Date Issued: 14 November 2016**