IN THE FIRST TIER TRIBUNAL (PRIMARY HEALTH LISTS)

Case No: FHS/15205

Listed at: Leeds
On: 18,19 February and 26 March 2010.

PANEL

MS M LEWIS - TRIBUNAL JUDGE
DR I LONE - PROFESSIONAL MEMBER
MRS I DALE – MEMBER

Between

DR SIMON DARLEY
(GMC Number 2772365).

Appellant

AND

CENTRAL LANCASHIRE PRIMARY CARE TRUST

Respondent

APPEAL BY DR SIMON DARLEY AGAINST A DECISION TO REMOVE HIM FROM THE PRIMARY HEALTH CARE LIST

DECISION AND REASONS

The Appeal

1. This is an appeal by Dr Simon Darley against the refusal of Central Lancashire Primary Care Trust ('the PCT') communicated by letter dated 17 August 2009 to remove him from its Performers' List under Regulation 10 of the National Health Service (Performers' List) Regulations 2004 for both suitability and efficiency. This appeal comes before us by way of a re-determination.

2. The Appellant was represented by Mr Sutcliffe, Solicitor. The Respondent was represented by Mr Anderson, Counsel.

3. The Appellant called no witnesses. The Respondent called Christine Martin head of GP Contractors, Victoria Birchall lead prescribing advisor, pharmacist, Dr Angela Manning PCT GP advisor, Dr Paul Kelly who undertook a review of the Appellant's practice and patient records and Dr Stephen Ward Director of the PCT.

4. The Tribunal considered 6 lever arch files of evidence but the main evidence was contained in Volume 1, 2 and 6: witness statements. Dr. Darley had requested that a large number of patient records were included but these were largely unsolicited. At the adjourned hearing, we were presented with a supplementary bundle of evidence by the Appellant, so that we could fully understand the position of the referral by the PCT of Dr. Darley's case to the GMC.

5. The Tribunals directs that there be no disclosure or publication of any matter likely to lead members of the public to identify any of the Appellant's patients, who are referred to by only their initials.

Decision

6. Our unanimous decision is to dismiss the appeal and direct the removal of Dr. Darley's name from the Performers' list of this PCT.

Reasons

The PCT decision under appeal

7. Following a hearing on 10 August 2009 which Dr. Darley did not attend due to ill health and was not legally represented but where a number of factors and mitigation were raised on his behalf by two colleagues. The matters raised in that letter now form the basis of the allegations before us, so we record those to avoid duplication. .

Allegation 1

The patient ‘HD’ was a seventy-eight year old patient seen on 3 September 2007, where the medical notes record that the patient ‘had partially lost the use in her right hand’. The treatment was ‘review in fourteen days’, which was of concern because the symptoms were suggestive of a stoke and required more than a fourteen day review.

Allegation 2

‘Overdue monitoring checks’. Ms Birchall and her team reviewed one hundred patient records in cases where the patient was being prescribed four or more drugs. There were eighty-two cases where blood tests or blood pressures were overdue and thirty-three cases where a review was required by a GP or a practice nurse.

Allegation 3

‘Poor record keeping’. The Respondent commissioned a report from an independent GP, Dr Kelly who selected twenty-five records at random from two days in September 2008, when the Appellant held a normal surgery. He judged the records not against the standard of an experienced GP but the summative assessment standard of a GP registrar which they must meet to qualify as a GP. Eleven of the twenty-five acute consultation records were unacceptable and twelve of the sixteen chronic records were unacceptable. The prescription record was unacceptable in four out of seventeen acute cases and ten out of fifteen chronic cases.

Allegation 4

‘Inadequate storage of patient records’. The Respondent’s concern related to records being kept on open shelves in an unlocked room. Other patient records were distributed in a chaotic manner around the practice.

Allegation 5

‘Matters arising from the provision of minor surgery’. This related to two cases. The Appellant accepted that he had administered a local anaesthetic to the correct area of the scalp but became confused and removed the wrong cyst, causing the patient in her words ‘absolute agony’. The Respondent was concerned that it took the Appellant three months to respond to the complaint and that when discussing it with Miss Kirwan, he made an inappropriate remark ‘buy one, get one free’. The Appellant disputed making this remark, although this was not challenged by his representative at the disciplinary hearing. In relation to patient CG he had removed a dermatofiabroma from her thigh. She made a complaint that the surgery was conducted with the door open, that the Appellant carried out the procedure whilst positioned between her legs and that he gave her a paper towel to stem blood flow from the injection site.

Allegation 6

'Prescribing practice including management of Benzodiazepine'. The Appellant accepted that he was an exceptionally high prescriber. He explained this by the demographics of a new and developing practice. The Respondent did not accept that this could be explained by him practising in an area of social deprivation. The concern was that he was seen as 'a soft touch'.

The amended grounds of appeal

8. In his original grounds of appeal dated 13 September 2009 Dr. Darley challenged the PCT's handling of their investigation which had not been carried out in an objective and non-biased manner. It failed to take into consideration his overall historical performance or the effect of his divorce in 2007 and that his difficulties with his wife who was also his practice manager existed before then. .

9. The amended grounds of appeal submitted on 17 December 2009 were drafted by his current legal representatives whom he instructed in November 2009 but adopt the first grounds. However by the conclusion of the case some of the allegations were conceded.

10. In particular and replying to the points raised by the PCT:-

(i) Patient 31 was suffering from Osteoarthritis and it was wrong to suggest that her stiff hand was symptomatic of a stroke. She was discharged by the stroke team on 7 September 2007. No CVA was diagnosed.

(ii) There was no particularisation of a lack of overdue checks.

(iii) The method by which cases were selected for examination by Dr. Kelly was not fair.

(iv) The Appellant had taken steps to have fireproof cabinets installed by the end of May 2009 but this did not go ahead as by then the practice had closed.

(V) Patient CG: 'cyst' case. This had been resolved to the satisfaction of the patient. He denied making the remark 'buy one, get one free'.

(vi) The PCT had not provided evidence of the allegation that the patient's prescription was being withheld due to an outstanding amount of rent owed to the Appellant.

(vii) High level of Benzodiazepine accepted by the date of the amended grounds. Appellant had worked with Benzodiazepine Counsellor since January 2009 to help reduce dependency upon the patients in his list.

The Law:

11. The parties were in agreement as to the applicable law.

a. This appeal proceeds by way of redetermination of the PCT's decision (Section 49M (3) and Regulation 15 (1) of the 2004 Regulations).

b. We may make any decision which the PCT could have made (Section 49M (4) National Health Services Act 1977 and Regulation 15 (3) of the 2004 Regulations).

c. By Regulation 10 (3) of the 2004 Regulations, a performer may be removed from the
List where any of the conditions in Regulation 10 (4) are satisfied, including:

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

d. Regulations 11 (5), 11 (6) and 11 (7) set out criteria which are to be taken into account in determining an efficiency case.

e. The burden of proof is upon the Respondent .

f. The standard of proof which we should apply in determining any factual issue is the balance of probabilities, in accordance with the guidance of the House of Lords in *Re D* [2008] UKHL.

g. In an efficiency case we may, instead of deciding to remove the performer from the List, decide to remove him contingently (Regulation 12 (1) of the Regulations).

h. By Regulation 12 (2):

> *"If [the Panel] so decides, it must impose such conditions as it may decide on his*
> *inclusion in [the List] with a view to –*
> *(a) removing any prejudice to the efficiency of the services in question …"*

Background

12. The Appellant qualified as a doctor in 1982. For the first seven years he held a number of hospital appointments but for the last twenty years he has worked in general practice. Between 1989 and 1992 he was involved in a partnership in Ormskirk. In 1993 he set up as a single handed GP in Ormskirk. His wife was his practice manager. There was no history or complaints or particular concerns about the Appellant who was an elected member of his Local Medical Committee for ten years and the local Hospitals Ethics Committee for seven years. During 2004 the PCT targeted successive GPs in the area with high Benzodiazepine prescribing rates. The Appellant had accumulated quite a large number of Benzodiazepine users. There was a concern about the Appellant's high prescribing rate.

13. When the new GP contract was issued in 2004 the Appellant scored well on the QOF (voluntary Quality and Outcomes incentive programme). However in 2007 – 2008 his total SND was 79.5 compared to 96.6 the previous year and 92.7 in 2008 – 2009.

14. During 2007, the Appellant suffered a number of domestic and financial difficulties due to the breakdown of his marriage which he felt contributed to the low QOF score. Prior to 2007, since graduating in 1982, he had only received one complaint in 1995. There were various issues relating to the Appellant's performance during 2008. There were two issues, a continued concern about his Benzodiazepine prescribing and record storage. There was a concern that his paper records were filed on an open shelf and not in lockable fire proof cabinets. The PCT position was that they had sought to support the Appellant. However, they were concerned that it took from 23 July 2008 to 10 November 2008 to hold a meeting. The document at Bundle 2, page 410 sets out an outline of the issues raised in relation to Dr Darley from a meeting on Monday 10 November 2008. The issues were:-

(i) Issue regarding delays in processing repeat prescriptions for a nursing home raised by a number of pharmacists in the area.

(ii) Complaint regarding clinical treatment highlighted an inconsistency in the patient's account the Doctor's response as to where an injection was administered to a young child. The Care Commission upheld the complaint. The issue was in relation to whether the Practice Nurse was present which he had said was the case but this proved to be wrong.

(iii) Complaint dated 8 May 2009 regarding the site of sebaceous cyst. The PCT acted as 'honest broker' for this complaint.

(iv) PALS contact relating to delay in copying notes.

(v) The Appellant had not undergone his 2007/2008 appraisal. It had been cancelled on two occasions when scheduled. The Appellant

(vi) Court Field Lodge Nursing Home contacted the PCT to raise concerns regarding the Appellant's visits to see patients on three occasions. Vitamin B12 injections were administered and not recorded. The Appellant was also witnessed re-sheathing a needle used to administer injection by a patient's grandson. The Appellant arrived at the nursing home unannounced.

(vii) Commissioning requests for information were not being responded to.

(viii) QOF – low achievement as practice not providing evidence for a number of key indicators.

(ix) Prescribing of Benzodiazepine well above PCT average. Offer by PCT medicine management to provide assistance. No co-operation.

(x) PCT had been trying to facilitate a meeting since 23 July 2008.

15. Following the meeting on 10 November 2008, Dr Darley stated that action would be taken. By letter dated 19 January 2009 the PCT directed the Appellant to stop certain minor surgery procedures.

16. On 30 January 2009 Dr Darley had a meeting with Dr Mannings, Maureen Kirwan, Peter Higgins and Helen Gilbert. A letter setting out the conclusions of the investigation was sent on 6 February 2009. The Appellant set out his response in volume 1 pages 127-131. He disputed most of the concerns. On 31 March 2009 the Appellant tendered his resignation from general practice and intended to close his practice on 30 June 2009. He went off sick on 21 April 2009 and locums covered his practice.

17. At that point it was the Respondent's intention was that the Appellant should undergo a NCAS assessment. The case was referred to NCAS on 27 April 2009 but it was delayed because the Appellant then went off sick. Dr. Darley did not think a referral to NCAS was appropriate until his Occupational Health Check had taken place, his appraisal had taken place and he has further reviewed his position.

18. The PCT were concerned that with Dr. Darley off sick a trainee practice manager was in charge so made a visit on 29 April 2009. Whilst the visit was intended to be supportive Ms Martin was alarmed at the state of the practice. The premises were dirty. The trainee practice manager showed Ms Martin a bin liner containing a large quantity of unused drugs, one of the items was a controlled drug. The burglar alarm was inoperable. The Appellant had a few weeks earlier in a fit of temper ripped the control panel from the wall. The

paper patient records were stored in a room on open shelves with the room unlocked. There was an issue as to whether the staff had been told to pack things up by the Appellant. Ms Martin observed numerous patients' documents stored in piles, boxes and bags in various rooms, some intermingled with the Appellant's personal documentation. There were syringes and needles accessible at various locations. There were three further packets of controlled drugs in an unlocked cupboard in the treatment room. Her view was that this was a longstanding state of affairs. The layers of dust suggested to her that the place had not been properly cleaned for some time.

19. The Respondent's staff made a further visit on 1 May 2009, because of what Ms Martin had observed. Various photographs were taken, which we saw. The Appellant was sent a remedial notice (Volume 2 pages 179-183). The Appellant did not attend the Performance Panel but was represented by his LMC representative. The PCT commissioned a medication review from Victoria Birchall.

20. In a letter dated 18 June 2009 the Appellant was notified of his interim suspension of registration by the Interim Orders Panel of the General Medical Council under Section 41 A (i) of the Medical Act 1983 as amended. The Appellant did not attend the meeting and was not represented. He was suspended for a period of eighteen months beginning on 17 June 2009. We read the transcript of proceedings. In reaching their decision the Panel had noted various enclosures from the PCT dated 5 May 2009, PCT concerns about significant delays in the growing number of concerns raised, such that the case was notified to the Contractor Performance Assessment Committee (CPAC) on 11 September 2008 and 25 March 2009. The CPAC instructed a referral to be made for a NCAS assessment.

Oral Evidence

21. We do not propose to set out all the oral evidence but to highlight the main areas of agreement and disagreement, points that emerged during the hearing and points that emerged during cross-examination.

22. It would be fair to say that Dr Darley's position changed somewhat during the proceedings. By the end he accepted most of the allegations. Mr Anderson's opening position was that this was not a case where the PCT were prepared to consider conditions or a NCAS referral. The Panel indicated that they would have to consider conditions and they queried whether a 'remedial package' was going to be put forward on behalf of Dr Darley. On the second day of the hearing, we were presented with a list of conditions that Dr Darley was prepared to agree to which included:

- Not to practice as a sole practitioner.
- In future, not to manage his own premises.
- To have a full medical assessment prior to return to work.
- To arrange for a new mentor via the PCT.
- To undergo refresher training on EMIS record keeping.
- To discuss prescribing practice with the PCT.

- If so advised, to refrain from treating patients with drug dependency problems.
- Not to undertake minor surgery.
- To undertake a NCAS assessment. (this was added later).

23. Christine Martin is the head of GP Contractors. When she visited the practice on 29 April 2009, concerns were raised with her immediately by the trainee practice manager. She had been told to box up the contents of a room ready for collection by Dr Darley. She was concerned at the state of the premises. Dr Darley's explanation was that this was a room that was not used.

24. When cross-examined, she accepted that the boxes could have been part of a packing up process. All the practices that she knew had lockable fireproof cabinets for patient records. In response to the medical member, she confirmed that that she hadn't checked whether the room where the patient records were kept was locked and believed that it was possible by means of a Yale lock. A locum was present doing paperwork. It should be noted that it is part of Dr Darley's case that no locum employed by him had complained about his record keeping or the state of the premises.

25. Victoria Birchall is the Lead Prescribing Advisor (West Lancashire). She visited the surgery on 30 April 2009 and completed an inventory of all medication found. She visited the practice again on 1 May 2009 with Dr Manning, Ms Perris QOF Programme Manager, Andrew Wood Programme Manager for Health Standards and a police officer who was to remove any controlled drugs. She did not find any on that visit. She led a team of three other pharmacists reviewing over one hundred patient records. The primary purpose of the review was to ensure patient safety and inform the practice who had taken over Dr Darley's patients of any work that needed to be done. There was a concern that Dr Darley was amongst the highest prescribers of Benzodiapapine. He did not take advantage of the PCT took kit offered during 2004-2007 to reduce use including the services (free of charge) of a counsellor. His reasons for this related to costs. Miss Birchall and her team reviewed one hundred patient records in cases where the patient was being prescribed four more drugs (as these patients were more likely to need intervention). There were 82 cases where blood tests or blood pressures were overdue and 33 cases where review was required by the GP or the practice nurse, particularised in her report. In his report, Dr Kelly provided some insight into how the problem was caused, namely that the Appellant did not use a computerised recall system in the EMIS practice computer.

26. Miss Birchall prepared a demographic chart to establish that Dr Darley did not have an unusually high number of old or young patients which was part of his explanation for his high prescribing rate. She had not discussed it with Dr Darley, who in his witness statement commented upon his prescribing without benefit of patient records or seeing this report. In response to questions from the medical member she confirmed that the practice had no attached pharmacist.

27. Dr Angela Manning visited the surgery on 28 February 2008 for an annual QOF framework review visit. She raised the issues of purchasing lockable fireproof cabinets which was not a QOF indicator but Dr Darley was aware that he could receive monies for part of the cost. A follow up visit on 10 March 2008 confirmed that appropriate and emergency drugs were now available which had been a concern. She visited again on 1 May 2009. She also found the room being used by Dr Darley's locum chaotic with no clear organisation. He had vacated the room because it was needed for evening surgery. When she visited again on 5 May 2008 the room was in a similar state. Dr Manning confirmed that the PCT appraisal process was completely separate to her function. In response to the medical member she confirmed that she had no job description and was merely an advisor to the PCT. She could only think of one other PCT where it was not mandatory to have lockable fire proof cabinets.

28. Dr Kelly is a part time General Practitioner and has been a GP trainer from 1989 to 2004. Between 1995 and 2003, he was a Summative Assessment Marker assessing doctors at the end of vocational training . He stated that during calibration he was neither a 'hawk' nor a 'dove'. The medical member having made his own assessment felt that that Dr Kelly had been very fair in his report and that he might reasonably have been somewhat harsher in his criticisms. He raised this point giving examples from patient records so that the Appellant's representative could deal with it.

29. Dr Kelly's statement and oral evidence highlighted a number of concerns about particular patients. Some like repeating B12 injections every three to four weeks, did not risk harming the individual. Other examples such as prescribing twenty-eight tablets of Zopicione a potent hypnotic to treat insomnia in a patient without any recorded assessment of current mood, but with a previous history of self-harm, dependant personality, depression and anxiety, exposed the patient to a grave risk of further self-harm and eight days later is recorded as suicidal. It was expected for the GP either not to prescribe what he did or use much smaller quantities. Similarly, a patient on Thyroxine replacement therapy for an underactive thyroid when in fact the blood test did not fully support the diagnosis and subsequently increasing the dose despite the normal range carried a major risk of harm.

30. A further example was a patient with a history of smoking and no recording of blood pressure being prescribed a combined oral contraceptive pill which was in clear breach of the advice of the Family Planning Association and the British Pharmaceutical Association. Dr Darley's response to that was that it was the patient's wish despite being advised of the dangers. However this was not recorded in the notes.

31. Patient 31 or HD was an eighty year old woman who also submitted a witness statement supporting Dr Darley. She stated that her reference to partial loss of her right hand was an after-thought at the end of her visit on 3 September 2007. The patient was subsequently seen in hospital on 7 September with multiple TIAs or transient ischaemic attacks a type of mini-stroke.

32. Dr Kelly did not meet with Dr Darley and was not asked to follow up his investigations with him.

33. Maureen Kirwan report for the Performance Panel on 10 August 2009. She is the head of Patient Experience. She first attended a meeting with Dr Darley on 11 December 2008. This was more formal at his request. Dr Darley told her that he had been through a difficult time as his marriage had broken down and his wife had been his practice manager. Her role was to be supportive but he said things were on the up. He didn't respond to her attempts to offer support. However, the more she found out the more anxious she got. The meetings with Dr Darley took place away from the practice at his request. A learning point that had come out of the case that they needed to see doctors in their own practice very early on.

34. When cross-examined, she accepted that Dr Darley's response wasn't wholly unusual but was outside a time frame that she hoped he would respond in. A letter she wrote on 23 July 2008 offered two dates to set up a meeting with Dr Darley. It is now known that that meeting did not take place until 10 November 2008. The point was pursued in cross-examination. She accepted that there may well have been reasons but her overall point was that it felt like a delay and delays were unusual. Whilst it was Dr Darley's choice to have a LMC representative available and to deal with issues in a more formal manner, she stressed that her intention to be supportive and helpful.

35. A second meeting took place on 30 January 2009 to discuss the report of the investigation into the then-concerns. Ms. Kirwan accepted when cross examined that many had been resolved or action put in place. A date had been set for an appraisal, a follow-up meeting had been set for the QOF assessment and the Benzodiapapine drug counsellor was then in place. However, concerns raised by local community pharmacist in repeated delays by Dr Darley's practice to deal with repeat prescriptions. There were concerns about the lack of Practice Nurse. In response to questions from the medical member she confirmed that there had been a change of policy re: practice nurses. She did not know if there had been an audit carried out on procedures performed by GPs with a special interest in performing minor surgery.

36. In his written and oral evidence Dr Darley described how his personal difficulties started to arise during 2005 – 2006. He accepted that he had taken on too much work. Following his 2007 QOF visit his minimum practice income guarantee was reduced by £400 per month. He also incurred financial hardship as successive tenants had failed to pay rent. Whilst he accepted he had overworked, this included extended opening hours at the surgery. Dr. Stephen Ward, the Medical Director to the PCT did not appear to take any active part in the investigation carried out by his team. In evidence he volunteered that a learning point that had come out of this case was that a meeting should be set up with a doctor whose QOF score has dipped significantly.

37. During 2004 he accepted the PCT had targeted successive GPs in the area with high Benzodiapapine prescribing rates. His response was that patients simply moved GPs to avoid the stress of working through managed programme. He had accumulated quite a large number of Benzodiapapine users because of that. Many patients had long term mental illness and a history of drug abuse. He eventually ended up with thirty to forty patients of all ages who were erratic with their excessive requests for prescription medicines.

38. Dr. Darley's QOF achievements in 2005/06 were above 1000 (maximum available 1050), in 2006/07 they were 965 (maximum available 1000) but in 2007/08 he was expected to achieve 652 points. He stated that a number of factors, namely domestic and financial difficulties, contributed to his achieving low scores in 2007/08.

39. Whilst he was in support of any scheme to help reduce the patient's dependency upon Benzodiazepine, the financial position of the Practice at the time was such that he couldn't commit to further costs. He was cross-examined by Mr Anderson on this point and it transpired that the main costs would be administrative costs in inviting patients to attend the surgery. He didn't have to pay for the counsellor. Dr Darley reiterated the reasons why he had initially refused a NCAS assessment. He wished to await the outcome of any Occupational Health Check. . Dr Darley was signed off sick between 20 April 2009 and 1 December 2009. He did continue to correspond with the PCT. On 8 April 2009, an Occupational Health Report was sent to Maureen Kirwan stating that '*there was no apparent evidence of any physical or mental illness which would adversely affect Dr Darley's performance at work*'. However, the report also stated '*since I did not see Dr Darley for an assessment prior to this visit, it is not possible for me to advise whether there are any clinical signs of depression of anxiety which would have led to his alleged performance deficiencies*'. The PCT relied upon this report in part to state that there was no mental illness. Dr. Darley also wished to undergo his yearly appraisal.

40. Dr. Darley appeared to change his mind as to whether he accepted Dr Kelly's reports. There was a break in the proceedings whilst Dr Darley had the benefit of giving his representative instructions. It appeared that he wished to challenge that his record keeping was 'chaotic', a word used by Dr Kelly. Having taken advice, he accepted that his records were not adequate.

41. Dr. Darley stated that he hadn't employed a cleaner as it was too expensive. He stated that he had gone as far as actually ordering lockable fire proof patient record cabinets but retracted from that when he was cross-examined and pressed to produce an invoice or some other tangible proof.

42. Dr, Darley confirmed to us that it was his case that he was fit to return to work. It was his intention to work as a locum. .When cross-examined he said that his divorce and related financial matters had not been resolved. We had noted correspondence that court proceedings had been adjoined due to his being unfit to attend. .

43. When questioned by the non-legal member he agreed that it was now much harder to work as a General Practitioner without a practice nurse and had relied on members of staff but did not say that they had appropriate training. He agreed he had a problem with delegation. He accepted that at times he had been unable to make decisions and his sleep patterns had been poor and his appetite had been poor too.

44. In response to the medical member he agreed that his notes were inadequate. He had not asked anyone to be his mentor, but did not think he would find it a problem when he returned to work.

Submissions

45. The Respondent had submitted that the six allegations were made out, albeit they were not listed in any particular order of severity. Mr. Anderson had prepared an opening case summary, these and our notes of his closing submissions were taken of and are referred to in our conclusions. He addressed the issue of conditions and that in particular an NCAS assessment should not be a substitute for our decision. It should have taken place before the hearing and the viability of any recommendations could have been at issue in the case. His first position was that if we found in the PCT's favour that logic would dictate that National Dis-qualification would follow. His second position was that if Dr. Darley who had now begun the process for undergoing a GMC assessment could, on satisfactory conclusion of the assessment, reapply to any PCT..

46. In his written closing submission Mr. Sutcliffe came much closer than in the amended grounds of appeal to accepting the allegations made by the PCT. The allegation in relation to patient HD was an isolated incident. Overdue monitoring checks were due to not using his EMIS system efficiently but this could be corrected by training as acknowledged by Dr Kelly. It was now not disputed that Dr Darley had kept poor medical records. It was accepted that organised and secure storage of patient records was mandatory and that there had been failings in this regard. This is something that could easily be corrected by working in an organised and efficient practice. The issues around the provision of minor surgery are isolated and were responded to in a timely manner. Dr Darley had given his account of his prescribing practice and the difficulties he had had with his particular list. It was significant that the new practice where patients had been transferred had a similar level of prescribing to Dr. Darley. Nevertheless, Dr Darley recognised the concerns expressed by the PCT and would agree to discuss the prescribing practice with the PCT and if so advised, refrain from treating patients with drug dependency problems. The problem would be remedied and protect patient welfare.

47. In summary it was Dr Darley's case that we should look at the position at the date of the hearing. Dr Darley accepted the report of Dr Kelly, recognised the importance of good record keeping and was committed to future improvement. He had been through a very bad period which had

Conclusion and Reasons

48. The conclusion we reach is that the allegations made by the Respondent are on balance made out on the evidence.

49. We are not satisfied that the allegations are such that the Appellant is unsuitable to be included on the List of the Respondent. The only evidence relied upon to prove unsuitability is the Appellant's failure to move on and deal with matters raised by the PCT. Whilst of concern we are not satisfied that that evidence is of such weight that it makes the appellant unsuitable.

50. In looking at the "efficiency" ground we have considered the guidance given by the Tribunal in the case of **Wahab–v- Medway PCT** [2006] 13421. This includes the seriousness of the deficiencies or conduct identified, the range of those deficiencies, the explanations offered by the practitioner, the likelihood of those deficiencies or conduct being remedied in the near to medium term, patient welfare and the efficient use of NHS resources, but balancing those against the proper interests of the practitioner in preserving the opportunity to work with the NHS, which includes both pursuing his professional interests and earning money.

51. We conclude that we find as follows. In relation to Allegation 1, the Appellant's treatment was to 'review in fourteen days'. The Appellant made a number of defences to the allegations. In the first grounds of appeal he stated that the patient had 'fairly recently had a suspected CVA and was already under the care of the stroke team but this was incorrect. By the second grounds of appeal, his position was that the symptoms could have been osteo-arthritis. There was more to the presentation which justified a different approach but the Appellant failed to record it. We find that essentially this was a matter of poor record keeping which in the interests of patient safety was indefensible.

52. With regard to Allegation 2 'overdue monitoring checks' the Appellant failed to use the computerised recall system in his EMIS practice computer. He should have been more up to date with his training. However some checks were overdue from 2004 so cannot be accounted for by failing to properly use the EMIS annual recall. All patients have a review date on their prescribing screen and this allows review of patients' medical conditions, for arranging investigations and review of medication prior to reauthorisation. From the audit carried out by Miss Birchall, it was apparent that the review of medication was not systematic and regular.

53. At the conclusion of the hearing, allegation 3 ‘poor record keeping’ was conceded. However we do record concern that Dr Darley did not readily and consistently make this concession. In his first grounds of appeal and witness statement appeared to be discussing individual cases of record keeping without having sight of the records. Even allowing for the stress of a hearing, his position did become defensive. Overall, we have to say that this is not the standard of record keeping that would be expected of a doctor who has been in practice for over twenty years. The records were brief and inadequate and it would be very difficult for another colleague to provide continuity of care because of the poor standard of record keeping.

54. Allegation 4 ‘inadequate storage of patient records’ was a requirement of this PCT. We apply our specialist knowledge and are aware that it would not be a requirement in every area. This was brought very firmly, we accept, to Dr Darley’s attention. Quite simply he failed to deal with it. In evidence he provided a number of explanations, going so far in oral evidence to suggest that he had actually ordered the cabinets. There is no evidence that happened. Put together with the chaotic scenes that were found when the PCT made their visits in March and April 2009, this adds up to a picture of a practice that was not being well managed. .

55. The Appellant also claimed that the patient record room was kept locked but was not locked on 29 April 2009 and 1 May 2009. More particularly the trainee practice manager who had previously worked at the practice as a receptionist told Miss Martin that it was never locked. This therefore seems more likely, as there would be no reason for her not to be accurate on that point.

56. Allegation 5 ‘matters arising from the provision of minor surgery’ to JG and CG. The basic facts of the case of JG were not disputed. We accept that the PCT was reasonable to be concerned that it took two months for Dr Darley to make any response and that he was flippant as regards the seriousness of the matter, when he remarked at a meeting on 30 January that it was ‘buy one, get one free’. We found the evidence of Miss Kirwin to be measured and moderate and we have no reason to think that she was not accurate in her recall of that remark. Moreover, it was not challenged by the Appellant’s LMC representative at the original hearing before the PCT. The prominence of that remark is perhaps because Dr Darley has denied it rather than accepting that he made the remark and acknowledging that it was wholly inappropriate.

57. Also of concern is the case of CG. In his letter dated 9 January 2009 Dr Darley admitted that he was positioned between the patient’s legs as the best place to operate and that he gave paper towels to stem blood flow. At the meeting on 30 January 2009 he appeared to accept the criticism but in a meeting on 20 February 2009 was back to defending his position. In his second grounds of appeal he ‘wholeheartedly accepted the criticism’ and in his oral evidence he denied that he had operated between the patient’s legs and stated that he had worked from the side. The use of paper towels to

58. Allegation 6 ‘prescribing practice including management of Benzodiazapine’. The PCT has made out its case based on Miss Birchall’s report that the common practice involved two or more hypnotics prescribed together above the maximum licensed dose, frequently with opiates. The Appellant prescribed a lot more than other GPs in his area. The problem was long-standing since at least 2004. . The Appellant accepted that he was an exceptionally high prescriber. We do not accept this can be explained by the demographics of the area or high levels of social deprivation. That is not supported by the analysis carried out by Miss Birchall of the practice. It cannot be explained as the Appellant suggested in his first grounds of appeal that the patients were moving, to avoid the Benzodiazapine counsellor as this service did not commence until late 2007.

59. Overall, we find the PCT has made out its case that from 2004 to 2007 they sought to reduce dependency on Benzodiazapine which whilst the Appellant indicated that he agreed with the aim, he did not take active steps until January 2009. The Appellant was prescribing heavily and he should have accepted help immediately.

60. Inefficiency having been established, we next look at the options of removal or inclusion or the option of contingent removal or conditions.

61. We are aware, that as a specialist Tribunal, that the National Clinical Assessment Service (NCAS) identify issues that need to be remedied and make recommendations as to how these could be addressed. We are aware that there are number of components of the assessment, including occupational health assessment, behavioural assessment, assessment of clinical form and clinical performance. Assessment is not designed to be ‘summative’ in nature i.e. pass or fail but to be ‘formative’ or educational in approach. Recommendations arising from the assessment are worded in general terms, to enable negotiation of the detail between the doctor, referring organisation and educationalists involved in the action planning stage of the process. NCAS would not be in a position to advise a PCT to remove a doctor from their List. That is a decision for the PCT.

62. With regard to a NCAS assessment, we gave active consideration to this possibility. It would seem to be a standard way forward in this type of case. As we indicated at the beginning of the case we were somewhat surprised that Dr Darley had not put together a more detailed ‘personal development plan’. (He could have self referred to NCAS, so that the loss of support of the PCT would not be determinative). We have no power to order the PCT to co-operate with a NCAS assessment. We could have adjourned the case and invited them to do so but we were not asked to take that course. A NCAS assessment, as we have observed, would make recommendations that Dr Darley may or may not agree with. Any order we make must have the benefit of certainty and be workable with conditions and a practical way forward.

63. Overall, we find that there are a number of issues that remain outstanding. Some of the allegations found proven relate to Dr Darley being a poor manager rather than clinical competence. However we do have concerns about his insight and true willingness to change.

64. There are positives that can be made about Dr Darley's twenty year medical career, particularly his QOF assessments. A medical report from Dr. Darley's GP dated 5 June 2009 stated that he was undergoing antidepressant medication and had been referred for counselling. It is clear that Dr. Darley went through a very difficult time due to his divorce and what preceded it but that matter is still outstanding, which may or may not affect his ability to take remedial action and resume work.

65. We are therefore not satisfied that at this point there any conditions that we can attach that will provide the necessary safeguards for patient welfare and the efficient use of NHS resources. .

66. Logic would dictate that due to the failings that we have identified that National Disqualification should follow. However we find that on the facts of this case that it is possible that following this appeal hearing Dr. Darley may when stronger and in better health be able to put together a remedial package which would allow him to re-approach this PCT or another PCT. This might include an NCAS assessment or a GMC assessment which he has begun to put in place. A GMC assessment could take up to two years but is still, we are satisfied, within a time frame that would not justify National Disqualification at this time.

Decision

The appeal is dismissed.

Melanie Lewis
First Tier Tribunal Judge