IN THE FIRST TIER TRIBUNAL **PHL15217**
HEALTH EDUCATION AND SOCIAL CARE CHAMBER
PRIMARY HEALTH LISTS
Heard at Leeds Magistrates Court
22 and 23 July 2010

BEFORE

JUDGE ATKINSON

DR S SHARMA

MR R RHODES

BETWEEN

DR U STEIN
(Registration number 6111159)

(Appellant)

and

CENTRAL LANCASHIRE PRIMARY CARE TRUST

(Respondent)

Representation:

For the Appellant: None
For the Respondent: Mr Anderson of Counsel

DECISION AND REASONS

The Appeal

1. This is an appeal by Dr Stein against the decision of the respondent notified on 16 October 2009 to refuse his application for admission on to the respondent's performers list under the Health Services Act 2006 (as amended) and associated regulations.

The Background and Proceedings

2. The appellant is a citizen of a member state of the EU. In 2007 the appellant began work as a locum at various UK prisons and was admitted on to the Northumberland PCT performers list.

3. In 2008 the appellant began working at HMPs Garth and Wymott. The arrangements for provision of his services were made with an agency known as Care UK with the appellant working on a self employed basis.

4. On 19 January 2009 the appellant applied to join the respondent's list.

5. By a decision notified on 16 October 2009 the respondent refused the application for inclusion on the respondent's list on the basis that

    i. There were grounds for considering that his admission would be prejudicial to the efficiency of the services under regulation 6(1)(e)

    ii. The appellant was currently subject to an investigation into his professional conduct under regulation 4(4)(i)

    iii. The appellant was subject to an investigation into his professional conduct by another PCT which might lead to his removal from the list under regulation 4(4)(k)

6. On 6 November 2009 the appellant appealed to the tribunal.

7. Appeals to the tribunal are by way of redetermination.

The Law

The relevant law is to be found in the 2006 Health Services Act as amended together with associated regulations. Reference to the relevant law as set out in The National Health Service (Performers Lists) Regulations 2004 is made within the body of the determination.

The documents and evidence

8. The appellant and respondent submitted originating documentation which was compiled into bundles marked A and R. A is paginated to A28 and R is paginated to R72.

9. For the hearing the respondent produced a number of documents that were compiled into a bundle by the administration of the tribunal and indexed and paginated to 593.

10. For and in the course of the hearing the appellant produced a number of additional documents which have been marked appellant's supplementary bundles 1 and 2 together with the results of a survey of patient satisfaction

11. At the hearing the respondent also produced additional documentation comprising: determination of PHL case number 15233 concerning the present appellant and Northumberland PCT; and official DoH guidance to PCTs on the checking of references.

12. Mr Anderson on behalf of the respondent indicated that the respondent would also rely on the oral evidence of: Ms C Martin, head of GP contractors; Ms M Kirwan, assistant director of quality; Dr Manning, medical advisor to the respondent; and Dr Cottam, GP trainer and tutor.

Preliminary matters

13. At the outset of the hearing the appellant indicated that he would be relying on his own oral evidence. Over the course of the first day of the hearing it emerged that the appellant wished to call a number of witnesses; but he had made no arrangements for their attendance.

14. The tribunal considered whether or not it would be appropriate to adjourn. The tribunal took the view that the appellant had had more than sufficient opportunity to prepare his case. The tribunal noted that the present appeal proceedings had begun in November 2009; had been adjourned in March 2010 to enable other PHL proceedings involving the appellant and Northumberland PCT to be determined; and that detailed directions had been issued in June 2010 by the tribunal on matters relating to legal representation, attendance of witnesses and case preparation. The tribunal noted that the appellant had elected not to be legally represented and had failed to fully comply with directions.

15. In those circumstances the tribunal considered that it was not in the interests of justice to further adjourn the proceedings and that that the tribunal would be able to justly and fairly determine the appeal without adjournment.

Opening submissions on behalf of the Respondent

16. Mr Anderson in opening referred to his skeleton and made further submissions which may be summarised as follows. The tribunal is entitled, by way of redetermination to make any decision which the respondent could have made. The respondent's case now has three strands: prejudice to

efficiency under regulation 6(1)(e); failure to provide references under regulation 6(1)(b); and relevant investigations under 4(4)(i) and (k) which amounted to further matters falling under the prejudice to efficiency grounds. It is accepted that the ground relating to references had not been included in the respondent's decision letter; however the evidence showed that the appellant had been aware throughout that his references in support of his application for inclusion were not satisfactory.

17. The respondent had grounds for considering that the appellant's inclusion on the performers list would be prejudicial to the efficiency of services for a number of reasons:
    i. The appellant had engaged in ad hoc consultations with prisoners away from his surgery.
    ii. The appellant's medical notes of consultations relating to the prescribing of analgesia such as a tramadol were inadequate
    iii. Dr Clapp of Care UK had expressed the view that the appellant had potential learning needs in relation to the prescribing of analgesia
    iv. Dr Cottam had undertaken a detailed consideration of the medical notes of patient AR which showed that there were multiple failures
    v. Dr Cottam had sampled a number of records at random which showed that the appellant's standard of record keeping was inadequate

18. The respondent's grounds for considering that the appellant's references were not satisfactory were that: the references either failed to address the appellant's standard of prescribing or were from non-clinical referees.

Oral Evidence on behalf of the respondent

Summary of oral evidence of Dr Manning, medical advisor to the respondent

19. Dr Manning in oral evidence adopted her statement of 1 July 2010 as evidence in chief. It is not necessary to fully rehearse the contents of her statement here. In brief Dr Manning was responsible for, amongst other things, considering whether or not the appellant's references in support of his application were satisfactory. The appellant provided references from two colleagues in Germany. They were not considered satisfactory because they failed to comment on the appellant's prescribing. The appellant provided two further references, from a pharmacist and a nurse. They were considered not to be satisfactory because they were not clinical references.

20. Dr Manning's further oral evidence may be summarized as follows. Dr Manning did not consider the references from the nurse and pharmacist to be

clinical references because they were not from doctors. It was custom and practice that the referees be doctors. A pharmacist and nurse had different training from a GP. It was accepted that a pharmacist may be in a better position than a doctor to comment on the cost effectiveness of prescribing.

21. The appellant had been put on notice that the German references were not acceptable as set out in an email dated 30 April 2009(p 556 main bundle) and that the nurse and pharmacy references were not acceptable as set out in an email dated 19 August 2009 (p40 main bundle).

22. Dr Manning would not be able to approve as satisfactory the four references when taken together and would need to take such an issue to a core performance group for such a decision to be made.

Oral evidence of Ms C Martin, head of GP contractors

23. Ms Martin in oral evidence adopted her statement of 28 June 2010 as evidence in chief. It is not necessary to fully rehearse the contents of her statement here. In brief Ms Martin is involved in the day to day administration of the performance list and is a member of the core performance team that made the decision to refuse admission. She worked with Dr Manning in making arrangements for obtaining references from applicants for inclusion on the performers list. In September 2009 she became aware that prison service healthcare staff had raised concerns about the appellant and that a meeting had been arranged with Care UK to consider these matters.

24. Ms Martin did not consider references from a nurse and pharmacist to be satisfactory.

Oral evidence of Ms M Kirwan, assistant director of clinical quality

25. Ms Kirwan in oral evidence adopted her statement of 1 July 2010 as evidence in chief. It is not necessary to fully rehearse the contents of her statement here. In brief Ms Kirwan chairs, amongst others, the core performance team which made the decision to refuse inclusion. At the team's meeting on 8 October 2010 the group was made aware of the fact that Northumberland PCT were making inquiries into the appellant on matters concerning prescribing and potential failures in respect of a patient (now known as AR).

Oral evidence of Dr Cottam, GP trainer Blackpool PCT and North Lancashire PCT

26. Dr Cottam prepared two reports dated 13 May 2010 and 30 June 2010. He confirmed that they were true and accurate.

27. In the report of 13 May 2010 Dr Cottam concluded:

    i. The standard of clinical records prepared by the appellant in respect of patient AR is inadequate

    ii. The appellant at a consultation with AR on 20 May 2009 had failed to put himself in a position to make an accurate diagnosis and had failed to examine AR

    iii. At consultation with AR on 16 July 2009 the appellant failed to record AR's history and the standard of care fell below an acceptable standard by the appellant failing to make an urgent referral

28. In the report of 30 June 2010 Dr Cottam set out his methodology in conducting a dip sample of records prepared by the appellant at consultation. He concluded

    i. The overall standard of records is inadequate

    ii. The lack of mental health assessment records and the information noted gave rise to concerns about the quality of clinical management

29. Dr Cottam in his second report also expressed the view that consultations in a public place such as a corridor or waiting area would generally be regarded as unprofessional.

30. Dr Cottam's further oral evidence may be summarized as follows.

31. Good record keeping is essential in all cases, irrespective of time constraints placed on a clinician. The time constraints placed on the appellant were no greater that that which a GP would face in everyday practice. The fact pre-existing records may not have been good is not a reason not to make good records. If a clinician's working environment was so bad that they could not meet the requirements of good record keeping then an official complaint should be made.

32. It was noted that the appellant had put forward evidence that his colleagues were equally bad in keeping records; however his colleagues had made detailed notes of the consultations they had had with AR. Even if the appellant's colleagues were performing at the same level as the appellant, then that would be matter of concern.

33. It was accepted that the appellant had put forward a reasonable explanation for the use of certain drugs, eg on a beta blocker; however that reasoning had not been included in the patients notes.

34. Dr Cottam in his second report had considered 20 random sample records prepared by the appellant. That would be sufficient to obtain a view as to whether or not there was a general problem. The same sample number would be used to form a general view whether a practice list had 1600 or 16,000 patients in considering a practice for pre-training approval.

35. In respect of the entries concerning AR: where there is a lump on the testicle or contiguous to the testicle then urgent referral was required. The appellant had failed to make such a referral.

36. The entries in the record by the appellant concerning AR showed a change in his condition between 20 May 2009 and 16 July 2009. The entries on 20 May 2009 include the abbreviation NAD, no abnormality detected, and make no reference to a lump. The entry on 16 July 2009 includes reference to rice corn lumps. Subsequent medical reports by others show progression of the condition by reference to multiple lumps.

37. It was accepted that it was reasonable for the appellant to conduct consultations in the segregation unit provided that the privacy and dignity of the patient were maintained.

38. It was accepted that the Dr Cottam had not interviewed the appellant in the course of compiling his assessment report of 30 June 2010. It was accepted that the analytical tool used as part of the methodology in compiling the 30 June 2010 report had been used predominantly on computerized records rather than the Lloyd George paper records used by the prison service; however it was expected that the same information would be entered under both systems. It was accepted that the tool may have been used to analyse paper records on only one occasion.

39. It was accepted that Dr Cottam had not considered the working environment and allegations that the appellant was working within a shambolic prison system. In those circumstances it was all the more important that good records were kept.

40. It was accepted that in coming to his opinion that the appellant had not examined patient AR on 20 May 2009, Dr Cottam was not aware that patient AR had made similar allegations against other doctors. If the appellant's notes are accurate then the appellant had examined AR on that occasion. Dr Cottam's view of whether or not the appellant had examined AR was that, based on the notes, the appellant had examined AR on 20 May 2009.

41. It was accepted that in analysing the records Dr Cottam had not had access to the whole file where there may have been other relevant entries. The entries, if not recording the history, in any event should refer back to the previous history and note whether or not there is no change.

42. It was accepted that retrieval of information is easier on a computer system; however data entry is no quicker.

43. It was accepted that the appellant in particular cases had made fair clinical decisions; however the expected reasoning was not recorded.

Oral evidence on behalf of the appellant

Summary of oral evidence of Dr Stein

44. The appellant did not prepare a statement for the hearing but relied on a variety of documents. Because of the need to accommodate professional commitments it was agreed that the appellant would give evidence on the first day and be recalled after the oral evidence of Dr Cottam had been taken.

45. The appellant's evidence may be summarized as follows.

46. In May 2009 the appellant was informed that the PCT had suspended him. The appellant first learnt of complaints about his work on 29 May 2009. Care UK said that they would begin an investigation into matters but the appellant heard nothing abut such inquiries.

47. By the end of August still nothing had happened. Some of the allegations related to over prescribing; however the appellant was not responsible for that. It was only in course of the present hearing that the appellant realized that this allegation was no longer pursued.

48. The appellant had not engaged in consultations in the prison corridor as alleged. There had been two occasions in 12 months when, on being approached by patients he conversed with them in an area just outside the consulting room. The area was within the medical unit and was not a public place. The GMC IOP had considered this matter and concluded that such exchange was a matter of normal practice.

49. The appellant had undertaken assessments at the segregation unit to determine whether or not a prisoner was fit for such confinement. His modus operandi in such circumstances had not been considered unprofessional.

50. Care UK had made inquires into aspects of the appellant's prescribing but had not consulted the appellant in the course of their investigation.

51. The allegations of poor record keeping made against the appellant are equally applicable to entries in the record made by other doctors: see for example the entries at pages 150, 152, 161 and 162 of the main bundle. There are many other examples.

52. The appellant was working in a difficult environment. The patient files were incomplete with missing sheets; clinicians were subject to time constraints; a number of prisoners attempted to obtain drugs for their currency value within the prison system rather to meet clinical needs; new receptions were not accompanied by discharge notes.

53. The appellant has worked in UK prisons for 3 years and worked at a walk in centre for over 1000 hours without complaint.

54. The reference by Care UK to the appellant having learning points about the step ladder for analgesia is denigrating. The appellant has been using this approach for 25 years and has a specialism in clinical pharmacology. The appellant has worked as consultant in the US on such matters. Care UK had not discussed these matters directly with the appellant.

55. Patient AR was not an easy patient. He had extensive prescriptions for pain relief and had been seeing doctors about his testicles since July 2008. In the course of his clinical management he had complained about not being examined when he had been.

56. On examination on 20 May 2009 the appellant had observed a slight lump on the testicle and two lipomas on his chest. This was evidence showing that an examination had taken place. Two months later there had been no change.

57. A further two months later, on 14 September 2009 he was seen by a colleague, where he was seen to have an enlarged testicle and no lumps. The urologist on review on 28 September 2009 made no mention of lumps.

58. In retrospect the appellant's description of lumps in July were cysts or convolutes. There had been no red flag indicating that an urgent referral was necessary. AR was subject to infections and this may have accelerated the growth of cancer.

59. The appellant had kept a diary note of the number of times files went missing over a period of one month. They are set out in the appellant's supplementary bundle 1.

60. As to the provision of references; the appellant had expected guidance from the PCT. The appellant had been unable to obtain references from Care UK; and because of the turnover of colleagues at prison, he could not call upon them either.

61. It was accepted that as a self employed doctor, the appellant could have ceased working within the prison service.

62. It was accepted that the appellant had answered questions put to him by two patients whilst they were waiting outside his surgery. One of the patients had asked, in the presence of another, if his analgesia could be increased and the other patient had then made a request in similar terms. The appellant did not regard that as a breach of confidentiality given the circumstances that surround prison health care. The appellant had indicated to the patients that he would consider their requests on return to his surgery. It is accepted that the appellant, having decided to increase the dosage may not have made entries to that effect in the patient records.

63. The appellant when visiting the segregation unit would not take the patient records with him. They were very large files. It was appropriate that he took a notebook and subsequently transcribed his notes into the records on return to the surgery.

64. The appellant had been told that his foreign references were not accepted. His German colleagues did not understand the British system and may have misunderstood the reference form.

65. The GMC IOP had considered his case and decided not to place any conditions his registration because he was not a danger to the public. The appellant was not aware of whether or not the GMC were continuing with any investigations into his circumstances.

66. It was accepted that the entries for AR on 20 May 2009 and 16 July 2009 were scanty and did not set out the history. That did not mean that the patient was not treated properly. It was not accepted that the entries on 20 May 2009 and 16 July showed a change in respect of the appellant having cancer; although it was accepted that there was a difference between the entries, with the earlier entry indicating NAD and the latter entry recording two lumps. It was not accepted that a referral was required in those circumstances. The appellant had not got a lump on the testicle. It was on the upper pole. The appellant had no doubts, and as such a referral was not necessary.

67. It was accepted that the appellant had told the IOP that he had made a mistake in AR's case; however that was before he had had an opportunity to see the records.

68. It was accepted that the entry on 16 July 2009 stated that the lump was on the testicle and not on the pole. It is accepted that the note is insufficient. However the lumps observed on that occasion are not connected to the patient's testicular cancer.

69. It is also accepted that the entries in some of the cases noted in Dr Cottam's second report are insufficient; however they are taken out of context. To assess clinical concerns the whole file is required.

The Respondent's closing submissions

70. Mr Anderson, on behalf of the respondent, relied on the response to the notice of appeal, his skeleton argument and made a number of further submissions which may be summarized as follows.

71. The respondents case for refusal of inclusion on the list now rested on two grounds.

72. The first was under regulation 6(1)(e). The tribunal's attention was drawn to the distinction between powers of removal on grounds of efficiency and the powers to refuse admit on grounds of efficiency. In particular regulation 6(1) provided that refusal to admit may be made on *'any grounds for considering that admitting [an applicant] to [the] performers list would be prejudicial*' . This did not require the respondent to show that admission would be prejudicial; merely that there were grounds for so considering.

73. The evidence showed that the appellant had undertaken an ad hoc consultation with one prisoner about the patient's level of analgesia in front of another prisoner whilst outside his surgery and had subsequently failed to make a appropriate entry in the patient record.

74. It was accepted that inquires by and on behalf of Care UK did not show that the appellant's prescribing in prison led to a rise in prescribing in moderate analgesia; however Care UK were concerned about the adequacy of the appellant's notes and that the appellant had some potential learning needs about choice of agents or the analgesic ladder and evidencing decision making.

75. The reports of Dr Cottam, showed that the concerns were well founded. It was accepted that it was difficult on the evidence to conclude that the appellant had not examined patient AR on 20 May 2009. However the appellant now admitted that the records of consultation for AR were scanty. In oral evidence the appellant had attempted to decouple his own entries describing AR's condition from the eventual diagnosis that AR had testicular cancer by introducing new evidence that the lump on AR's testicle was in fact on the pole. The appellant's own entry in the record fails to make that distinction; and in any event Dr Cottam's opinion was that if the lump was contiguous to the testicle a referral should have been made. Further it was significant that the appellant in oral evidence failed to accept that his own entries of 20 May 2009 and 16 July 2009 showed a change in AR's condition.

76. The second report of Dr Cottam showed conclusively that the appellant's record keeping is of a poor standard. The appellant had failed to attempt rebut but a few of the examples given. The appellant's response that the poor record keeping is reflective of the poor working environment does not engage the respondent's concerns. The appellant's allegations of a poor working environment are not supported in evidence by any other source; were introduced at a late stage as an ambush on the respondent's position; and are not supported by any formal complaint made by the appellant.

77. The second ground of refusal to admit the appellant is that of unsatisfactory references under regulation 6(1)(b). The appellant had been provided with three opportunities to provide satisfactory references and even to date had failed to do so. The first two references failed to comment of the appellant's prescribing. The second two references were not from clinical sources and as such were not acceptable.

78. The cumulative effect of all the evidence was that the appeal should be dismissed.

The Appellant's closing submissions

79. The appellant on his own behalf made a number of submissions that may be summarized as follows.

80. The appellant relied on the documentation that he had submitted to support his appeal. It was accepted that everybody had a responsibility to engage in continuing training; however the appellant did not need training on the step ladder approach to prescribing analgesia. That was a basic element in GP practice on which he did not need to be trained.

81. It was accepted that some of his entries in the records lacked detail; however the deficiencies had been identified in one case only : that of AR. Dr Cottam agreed that the appellant's decisions had made clinical sense. Patient safety was not just a matter of adequate record keeping: there had been no complaints about his clinical work whilst working in the prison service or when he had worked at walk in centres.

82. In relation to the appellant's references: the respondent had failed to offer guidance about what was required. He had not been told that references from a nurse and pharmacist were not acceptable. The appellant had not subsequently addressed these concerns because other matters about his record keeping and clinical issues had come to the fore.

83. Dr Cottam's second report was based on single sheet records, rather than looking at the patient's file as a whole. The single entries did not reflect the

record keeping and the matters raised in the report had not been discussed with the appellant; as such he had not had the opportunity to explain the significance of the entries recorded.

84. The appeal should be allowed.

Assessment of Evidence

85. The tribunal considered all the evidence and the submissions.

86. At the outset of the hearing the documentation revealed that a significant number of facts were not in dispute. In the course of the hearing both parties made a number of concessions or admissions. Further, many of the core issues over which there is dispute are matters of interpretation rather than disputes over primary facts. In those circumstances it is not necessary for the tribunal to set out exhaustively all the facts in this case. Accordingly, the relevant findings of fact have been set out under the section below headed Decision and Reasons.

Decision and Reasons

87. Looking at the evidence as a whole, the tribunal directs that

the appellant is refused inclusion to the respondent's performers list because :

1. there are grounds for considering that admitting the appellant to the list would be prejudicial to the efficiency of services which those included on the list perform

and

2. the references provided by the appellant's referees are not satisfactory

88. In coming to this decision the tribunal reminds itself that it proceeds by way of redetermination; that is to say that it must determine matters afresh on its own merits and is not limited to a mere review of the respondent's decision. The tribunal notes that the respondent's decision letter of 16 October 2009 makes no mention of dissatisfaction with the appellant's references. However, in determining this matter afresh the tribunal finds that the appellant was aware from 30 April 2009 that his references were unsatisfactory; and was put on further notice of the issue by email dated 19 August 2009. In those circumstances, the appellant has not been unfairly prejudiced by the respondent's omission of such a ground from its decision letter of 16 October

2009 nor by the tribunal taking these issues into account in the proceedings before it.

89. The tribunal also notes and accepts the important distinction referred to by Mr Anderson between the grounds for refusing admission under regulation 6(1)(e) – grounds for considering there would be prejudice to services; and grounds for removal under regulation 10(4): continued inclusion would be prejudicial. The test for refusal of admission sets a lower threshold for the respondent than the test for removal.

Grounds for considering that admitting the appellant to the list would be prejudicial to the efficiency of services

Ad hoc consultations

90. The appellant accepts that he engaged in conversation with patients, each in the presence of the other outside his consulting room, about varying their level of analgesia and that he may not have made an entry in the appropriate patient records.

91. The tribunal finds that the significance of this event contributes to the overall thrust of the respondent's case: that there are concerns about the adequacy of the appellant's record keeping. In addition, the tribunal is of the view that in the context of a prison system where medication is regarded and used as currency, any engagement in such matters would be wisely undertaken in the privacy of a consulting room via an appropriate appointment system.

The concerns expressed by UK Care: prescribing and learning points

92. The tribunal notes that Care UK, through Drs Lloyd and Dr Clapp, expressed a number of concerns about the appellant. The tribunal finds that the significance of those concerns relate to the adequacy of the appellant's record.

93. There is limited evidence before the tribunal from Care UK: only a short letter from Dr Lloyd and emails from Dr Clapp. The tribunal attaches little weight to the opinion of Dr Clapp, that the appellant has potential learning points, because the learning points are not clearly identified nor are they set out in detail; and further, the opinion has not taken into account any response from the appellant.

94. As noted above the real significance of the evidence of Dr Lloyd is that it raises concerns about the appellant's record keeping. Such concerns have now been the subject of investigation which are considered below.

The adequacy of the appellant's records and the case of AR

95. In the case of AR, the respondent's position, broadly speaking is that the appellant should have referred AR on consultation on 16 July 2009 and the entries on his record are inadequate. AR was in fact not referred to a specialist until seen by a colleague of the appellant in September. AR was in consequence diagnosed with testicular cancer and appropriately treated. The appellant's position is that there were no red flags on examination of either 20 May 2009 or 16 July 2009 that indicated referral was necessary.

96. The appellant now accepts that his entries on consultation with patient AR on 20 May 2009 and 16 July 200 are scanty and lack detail.

97. Further, the tribunal finds that on the appellant's own account the entry of 16 July 2009 is inaccurate for the following reasons.

98. The appellant's position, that it was not necessary for him to make a referral to a specialist on 16 July 2009 because there were no red flags indicating that he should do so, is based on a lump noted at the consultation being on the pole of the testicle, rather than the testicle itself. However, the tribunal notes that the entry for 16 July 2009 reads

rice corn like lumps on L testicle

99. There is no mention of the pole of the testicle: contrary to the account now presented by the appellant. The tribunal finds the appellant's evidence to be irreconcilable with the written record and that there can be no satisfactory explanation for recording an observation, that there is a lump on the pole of the testicle, in terms as *on L testicle* .

100. Given these findings the tribunal finds it unnecessary to trace further the unfortunate development of AR's cancer. The primary finding that the tribunal makes in this matter is that the entries in the record made by the appellant are inadequate.

The second report of Dr Cottam – the dip sample

101. The tribunal finds that the significance of Dr Cottam's second report lies in showing whether or not the inadequate record keeping accepted and demonstrated in the case of AR should be viewed as a one–off and atypical of the appellant's performance; or otherwise.

103. The tribunal finds that the evidence of Dr Cottam shows that the complaint of record keeping is not limited to the case of AR. The tribunal

accepts that Dr Cottam as a GP trainer has considerable experience in assessing the standard of record keeping. The tribunal accepts the opinion of Dr Cottam that of the 20 records sampled the majority showed poor levels of documentation with gaps in the history, examination and clinical reasoning. The tribunal notes that the extent of inadequacy ranged from the absence of recording the presence or absence of red flag symptoms; the failure to mention potential mental health problems; lack of clinical reasoning or working diagnosis/formulation/impressions; and lack of explanation for particular courses of treatment to manage the patients condition or follow up.

Conclusion on grounds for considering prejudice to efficiency .

104. The tribunal in considering all the evidence finds that there are reasonable grounds for considering that there would prejudice to the efficiency of the provision of services if the appellant were included on the list.

105.The tribunal has considered the evidence as a whole and notes that it is not necessary to come to a conclusive view of whether there would be prejudice to efficiency as noted previously in the context of removal. The evidence shows that there are real concerns about the adequacy of the appellant's record keeping. That is sufficient to meet the relatively lower threshold of regulation 6(1)(e).

106. The tribunal rejects the submissions of the appellant that his working conditions resulted in the records being inadequate. Even if the tribunal were to take the appellant's case at its highest and to accept (which it does not) that the appellant was working within a shambolic system of health care management, the standard of record keeping did not meet an acceptable level. Indeed, as Dr Cottam remarked, in such circumstances the need for proper entries in the records becomes all the more important.

107.Further the tribunal finds that the appellant's submission that he was no worse than his colleagues, even if true, does not excuse the standard of his record keeping. The proper response to such a proposition is only that inquiries should be made of his colleagues.

Findings on the appellant's references

108. Given what is said above, the tribunal finds it necessary to deal with the appellant's references only briefly. The appellant provided references from 2 German referees. They were unable to comment on the appellant's prescribing. The tribunal finds those references self evidently to be unsatisfactory.

109. The appellant was given the opportunity to make good his references.

He provided two further references: from the health care manager, said to be a nurse, at Care UK and a pharmacist at HMP Garth. They commented on all the relevant dimensions required by the request for references, including prescribing.

110.The respondent took the view that the third and fourth references were not satisfactory because they were not clinical references, by which it was meant that they were not from doctors.

111.The tribunal finds that it is not axiomatic that the regulations require that references must be given by a doctor. That would be to put form above substance. However, in the circumstances of the present case the tribunal finds that it would be unlikely that, without more, a pharmacist and a nurse who had worked with the appellant would be in a position to comment on all the dimensions required.

112. The tribunal finds that even taking together all four references submitted by the appellant, they are not satisfactory because no one single referee has been able to comment on the whole range of dimensions and therefore able to present a complete, unified picture of the appellant.

113.Accordingly, the references relied on by the appellant are not satisfactory.

Summary

The tribunal directs that Dr Stein is not to be included on the Central Lancashire Primary Care Trust performers list under Regulation 6(1)(b) and 6(1)(e) of the performers lists regulations.

The appeal is dismissed.

Signed

Judge of the First Tier Tribunal Dated