THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

CASE NUMBER 13919

BETWEEN

DR ANDREW HELLYAR
(GMC Registration No: 2273251

Appellant

and

SOUTH WEST ESSEX PRIMARY CARE TRUST

Respondent

Appeal Panel: Mrs D Shaw Chairman
Dr P Garcha Professional Member
Mrs J Purkis Member

Heard between 4th and 8th February 2008 at NHS Litigation Authority, Napier House, High Holborn, London WC1V 6AZ

Appeal against the decision of the Respondent to remove the Appellant from its Performers List pursuant to section 10 of The National Health Service (Performers Lists) Regulations 2004

DECISION WITH REASONS

A. Preliminary matters

1. Prior to the commencement of the hearing all three panel members had signed a declaration confirming they had not had any prior interest or involvement in the appeal which would preclude them from considering the evidence in an independent and impartial manner.

2. The persons who appeared before the Appeal Panel were:

Mr Michael Mylonas	- Counsel for the Respondent
Mr Stephen Janisch	- Radcliffes LeBrasseur Solicitors
M r Lee Biddle	- Radcliffes LeBrasseur Solicitors
Dr Susan Bellworthy	- Witness for the Respondent
Ms Linda Connelly	- Witness for the Respondent
Ms Sara Lamb	- Witness for the Respondent
Ms June Mason	- Witness for the Respondent
Ms Carol Saunders	- Witness for the Respondent
Dr Upesh Chauhan	- Witness for the Respondent
Ms Wendy Alleway	- Witness for the Respondent
Ms Carol Line	- Witness for the Respondent
Ms Maureen Midgen	- Witness for the Respondent
Ms Brid Johnson	- Witness for the Respondent
Ms Vicki Johnson	- Witness for the Respondent
Ms Barbara Stuttle	- Witness for the Respondent
Mr C Stoneham	- Witness for the Respondent
Dr Richard Grew	- Witness for the Respondent
Mr Peter Greenwood	- Witness for the Respondent
Dr Andrew Hellyar	- the Appellant
Mr Oliver Hyams	- Counsel for the Appellant
Ms Angela Walsh	- Abrahams Dresden Solicitors

Ms Elizabeth Hellyar - Witness for the Appellant
Mrs Barbara Hellyar - Witness for the Appellant

B. History of the Appeal

(NB. Reference throughout to parties and documents is as follows:

Dr Hellyar	*= Dr Hellyar /Appellant*
South West Essex PCT	*= the PCT /Respondent*
Appellant's Bundle	*= AB*
Respondent's Bundle	*= RB*
Witness Statement	*= WS*
GMC Interim Orders Panel decision	*= IOP Decision*
Page(s)	*= p(p))*

1. Following a meeting of a South West Essex PCT Panel on 14th June 2007 the PCT wrote to Dr Hellyar on 19th June 2007 to inform him he had been suspended from the PCT's Performers List pursuant to its powers under Regulations 13 (1)(b)(c) and (d) of the NHS (Performers Lists) Regulations 2004 (the Performers Lists Regulations)

2. He was also removed from the PCT's Performers List on grounds of efficiency and unsuitability pursuant to Regulations 10(3) and (4)(a) and (c) of the Performers Lists Regulations.

3. The PCT also indicated it would apply to the Family Health Services Appeal Authority (the FHSAA) for Dr Hellyar's national disqualification and report his actions to the General Medical Council (the GMC).

4. On 17th July 2007 Dr Hellyar appealed against the PCT's decision pursuant to Regulation 15 of the Performers Lists Regulations and served Notice of Appeal on the FHSAA pursuant to Rule 6 of the Family Health Services Appeal Authority (Procedure) Rules 2001 (the Procedure Rules) and annexed a copy of the disputed decision (RB *pp1049-1080)* and a concise statement of his grounds of appeal *(RB pp 1082-1083).*

5. The PCT responded to Dr Hellyar's grounds of appeal on 7th August 2007 *(RB pp 1084-1085)*.

6. When it became clear that the appeal would last several days, the substantive hearing was listed from 4th to 8th February 2008.

7. The GMC Interim Orders Panel decision was issued on 1st August 2007. It imposed conditions on Dr Hellyar for eighteen months as follows:

    1. You must notify the GMC promptly of any professional appointment you accept for which registration with the GMC is required and provide the contact details of your employer and PCT on whose Medical Performers List you are included.
    2. You must allow the GMC to exchange information with your employer or any organisation for which you provide medical services.
    3. You must inform the GMC of any formal disciplinary proceedings taken against you, from the date of this determination.
    4. You must inform the GMC if you apply for medical employment outside the UK.
    5. You must confine your medical practice to posts within the National Health Service and not undertake any private practice.
    6. You must confine your medical practice to general practice posts in a group practice.
    7. You must inform the following parties that your registration is

subject to the conditions, listed at (1) to (6) above: 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 application).
c. Any prospective employer (at the time of application).
d. The PCT in whose Medical Performers List you are included, or seeking inclusion (at the time of application).

C. The Appeal

(i) Jurisdiction

The National Health Service (Performers List) Regulations 2004

10(3) The Primary Care Trust may remove the performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.

10(4) The conditions mentioned in paragraph (3) are that-
(a) his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the performers list perform ("an efficiency case");
(b) he is involved in a fraud case in relation to any health scheme; or
(c) he is unsuitable to be in that performers list ("an unsuitability case")

13(1) If a Primary Care Trust is satisfied that it is necessary to do so for the protection of members of the public or is otherwise in the public interest, it may suspend a performer from its performers list, in accordance with the provisions of this regulation –
(a) while it decides whether or not to exercise its powers to remove him under regulation 10 or contingently remove him under regulation 12;
(b) while it waits for a decision affecting him of a court anywhere in the world or of a licensing or regulatory body;
(c) where it has decided to remove him, but before that decision takes effect; or
(d) pending appeal under these Regulations.

15(1) A performer may appeal (by way of redetermination) to the FHSAA against a decision of a Primary Care Trust mentioned in paragraph (2) by giving notice to the FHSAA.

(2) The Primary Care Trust decisions in question are decisions – *(inter alia)* … (d) to remove the performer under regulations 8(2), 10(3) or (6), 12(3)(c) or 15(6)(b);

(3) On appeal the FHSAA may make any decision which the Primary Care Trust could have made.

(4) Where the decision of the FHSAA on appeal is that the appellant's inclusion in a performers list is to be subject to conditions, whether or not those conditions are identical with the conditions imposed by the Primary Care Trust, the Trust shall ask him to notify it within 28 days of the decision (or such longer period as the Trust may agree) whether he wishes to be included in its performers list subject to those conditions.

(5) If the performer notifies the Primary Care Trust that he does wish to be included in its performers list subject to the conditions, it shall so include him.

(6) Where the FHSAA on appeal decides to impose a contingent removal - (a) the Primary Care Trust and the performer may each apply to the FHSAA for the conditions imposed on the performer to be varied, for different conditions to be imposed, or for the contingent removal to be revoked; and (b) the Primary Care Trust may remove the performer from its performers list if it determines that he has failed to comply with any such condition.

(ii) Preliminary issues

1. Scope of the appeal

1.1 The parties agreed that the areas at issue in the appeal were as set out in the IOP's decision, namely:

(1) Patient records

(i) record handling

(a) the absence of any system for the maintenance of accurate records on behalf of patients - leading to failure to make records appropriately in connection with referrals, immunisations etc

(b) the records were handled in such a way that their confidentiality was placed at risk - that is, they were left on the floor of the dental surgery, were left available for access by unauthorised persons and were left in an area known as the tea room

(ii) failure to maintain records (overlaps with failure to maintain records concerning immunisation material and patients to whom immunisation has been administered) and not making accurate or contemporaneous records consistent with good medical practice (GMP) - including failure to deal with documentation and incoming mail from hospitals in connection with referrals and failure to record matters in terms of reviews of patients receiving repeat prescriptions

(2) Immunisation

systemic failure to adopt any system regulating the preservation, cataloguing and administration of immunisations, including:

(a) alleged failure to destroy old vaccines and keep records with regard to their destruction

(b) failure to monitor temperature of fridge in which vaccines stored

(c) absence of system to regulate batch numbers

(d) failure to lodge returns with regard to maintenance of vaccination immunisation records

(3) Accommodation

(i) failure to provide seating accommodation and telephone facilities

(ii) inadequate provision of any facility for storage of records etc

(4) Practitioner's attendance at the surgery

practitioner over-extended himself by taking on additional responsibilities outside those within his own practice

(5) Issues of lack of probity

(i) practitioner was evasive and obstructive with regard to the Performance Advisory Group (PAG) investigation

(ii) practitioner gave false address when registering himself as a patient with Dr Dey

(iii) the use of funding earmarked for particular schemes for acquisition of property, which was personal to the practitioner and the mis-description of that property within records maintained by him

(6) Issues of general governance

(i) practitioner left his practice in a fashion of abandonment in August 2006

(ii) practitioner accessed patient information after leaving practice, culminating in treatment of a former patient

(iii) practitioner failed to recruit adequate staff in the form of a practice nurse

1.2 The Respondent did not seek to reopen on appeal those issues on which the PCT Panel did not uphold the findings of the PAG.

2. Burden and Standard of Proof

(a) The burden of proof lay with the PCT.

(b) This tribunal is a civil and not a criminal tribunal. The standard to which we must be satisfied is whether facts or allegations are proved on the balance of probabilities, whether it is more likely than not to be true. The Panel recognises that where serious allegations are raised, cogent and compelling evidence is required if they are to be found proved. When considering whether we are satisfied that an allegation is established

we bear in mind that the more serious the allegation, the less likely it is that it occurred and the stronger should be the evidence

(iii) Evidence

Over the course of the hearing, which lasted for five days, we were presented with a vast amount of written and oral evidence. There were approximately 1500 pages of written evidence in the Appellant's and Respondent's bundles together with their Skeleton Arguments and Closing Submissions and almost 200 pages of notes of the oral evidence. For the purposes of our consideration of the evidence and this decision we agreed the best course to adopt would be to identify and then summarize the most pertinent evidence for each of the different issues which had been raised by the PCT in support of its allegations of unsuitability and efficiency before fully considering those issues.

D. The Evidence

1. Patient records

1.1 record handling

(ii) (a) the absence of any system for the maintenance of accurate records on behalf of patients - leading to failure to make records appropriately in connection with referrals, immunisations etc and

(b) the records were handled in such a way that their confidentiality was placed at risk - that is, they were left on the floor of the dental surgery, were left available for access by unauthorised persons and were left in an area known as the tea room and

(ii) failure to maintain records (overlaps with failure to maintain records concerning immunisation material and patients to whom immunisation has been administered) and not making accurate or contemporaneous records consistent with good medical practice GMP) - including failure to deal with documentation and incoming mail from hospitals in connection with referrals and failure to record matters in terms of reviews of patients receiving repeat prescriptions

1.2 In its opening skeleton argument the PCT submitted it was a central plank of the Performance Advisory Group (PAG) Report that Dr Hellyar's system for maintaining records was inadequate.

1.3 The PAG submitted photographic evidence *(RB pp351-372)* taken on 29th September 2006 of the state in which the records were stored at the South Ockenden Health Centre (SOHC), both downstairs in the "tea room" and upstairs in Mrs Hellyar's Dental Suite

1.4 The PAG Report considered *(RB pp 159-165)*, inter alia, the appropriateness of Dr Hellyar's storage arrangements and whether these provided appropriate confidentiality, the availability and ease of retrieval of records and the absence of records from his practice.

1.5 The PAG took Dr Hellyar's period of responsibility as being from 19 May 2003 to 30 September 2006.

1.6 The PCT upheld all of the PAG's allegations relating to Dr Hellyar's failure to maintain his patient medical records in an orderly way, to provide a reliable retrieval system for the records, to ensure the records remained confidential and to make entries in the records when appropriate.

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1.7 Linda Connelly, Dr Hellyar's receptionist at the SOHC during the period in question, gave evidence *(WS RB pp277-284)* that initially, the records were just left in the middle of the floor of the dental waiting room and dental patients would have to step over them. They were subsequently put in two filing cabinets, which would be left unlocked, and for which Dr Hellyar held the keys, but as they wouldn't all fit into the two cabinets, some of the notes were put in the dental storage room (upstairs) and remained there even after the practice and filing cabinets moved downstairs.

1.8 She submitted that she, Dr Hellyar, Mrs Hellyar, her dental nurse and dental receptionist would also have access to this storage room, which was never locked when staff were about, but would be locked if there was no one in the Dental Suite.

1.9 She went on to confirm that a few weeks ago (ie before her statement dated 04.01.07) Mike, the dental receptionist, brought down some records from the storage room and placed them in the tea room. They were mostly "1s of 2s" ie older records when a continuation pack had been started.

1.10 Subsequently, Maureen (Midgen), one of the dental receptionists, had told her the (upstairs) store room was "all clear".

1.11 At the hearing she gave evidence that the records were moved over from Dr Bellworthy's surgery in cardboard boxes to the dental waiting room until the two filing cabinets were moved over later that day and that the records may only have been on the floor of the dental waiting room for a day at most. The older records then went into the dental storage room, which was situated in a corridor inaccessible to the public behind a coded security door and the more recent records were stored in the two filing cabinets in the dental waiting room, which was kept locked outside surgery hours, or where a member of staff was always present if patients were there.

1.12 She also confirmed the tea room was kept locked and the SOHC kept a master key.

1.13 She submitted that when the records were moved down to the tea room she and Gloria Parnell had put the majority of them in alphabetical order and stacked them in boxes, which took a couple of weeks., but when the Aveley staff came over they moved them around and did whatever they wanted with them.

1.14 Sara Lamb, Dr Hellyar's Practice Nurse, gave evidence *(WS RB pp285-293)* that when Dr Hellyar's daughter Lizzie began working at the practice in April or May 2004 she would never put the notes back in the filing cabinets in the right order. Many sets of notes would go missing and they would often have to write up a new set of notes because the original packets could not be found, but the new sets would not be tied up with the originals and, on occasions, even the new sets would go missing.

1.15 She submitted that on one occasion she had been unable to find the notes of an elderly patient presenting with an infection, leading to her prescribing an antibiotic to which the patient was allergic. When Dr Hellyar had had a go at her over this incident she told him the situation with the notes had to be sorted out because it was dangerous to work without them, but although he agreed with her, nothing changed

1.16 June Mason, Practice Manager for Dr Bellworthy when Dr Hellyar worked

there and now Primary Care Information Manager at the PCT, submitted (*WS RB pp263-270)* that when Dr Hellyar first moved into the SOHC, staff from Contractor Services in Clacton had moved the records over in shoe boxes. Dr Hellyar had collected and moved the two filing cabinets over himself, although she assumed he would have needed at least one more filing cabinet for the amount of records he needed to store.

1.17 She had been told by the PAG that the records were moved down to the tea room when Dr Hellyar moved downstairs, but she was not aware of records on the floor there until she went to help with SystemOne computer training in March 2006. She submitted that it appeared that records for new patients which arrived were thrown on top of the records that were still in boxes in the tea room.

1.18 At the hearing she explained she knew each filing cabinet drawer would hold 250 records (so two filing cabinets could hold only 2000 records).

1.19 When she first went to help at the practice on 7th March 2006 she noticed manual records in boxes in the tea room and she looked for records there when helping with the disease registers; they were not in alphabetical order. She felt this was having an awful impact on the efficiency of the practice because the receptionist could not deal with enquiries and what should have taken two minutes to locate would result in a thirty minute unfruitful search. In other practices the notes were all kept in filing cabinets. In evidence she reported no significant change by 22-23rd May when she returned to assist with SystemOne training

1.20 Gloria Parnell, Dr Hellyar's former receptionist, gave evidence *(WS AB pp 152-155)* that when the patient records were brought down from the upstairs store room at the end of July 2006 they were transferred alphabetically in cardboard boxes and she helped to carry them down and sort them out. Once moved, the notes were filed alphabetically into larger, open topped boxes on top of an examination couch in a locked, small room next to Dr Hellyar's room and that space was tight, so some boxes had to be placed underneath the couch on the floor.

1.21 She submitted that when the Aveley staff came over and supposedly "reorganised" the reception area they disrupted everything and all their files were moved around and it was total chaos. She thought it was because they were not used to using paper files as everything was computerised at Aveley. She resigned because she could not stand the upheaval; important documents such as referrals were lost and it was very difficult for the doctors to find anything at that time.

1.22 Carol Saunders, Practice Nurse at Aveley, gave evidence *(WS RB pp 213-214)* that when she went over to the SOHC she had difficulty finding the baby notes; some were in the A-Z filing cabinets, some were in containers on the window sill and some were in the store room. She could not find them all and she only attended two baby clinic sessions there and then asked if someone else could go as she felt the system had collapsed because there was no doctor or nurse or Manager there at the time.

1.23 Dr Chauhan, who worked as a locum doctor for Aveley, gave evidence *(WS RB pp218-222)* that the Lloyd George records were not up to date and were all over the place and it was very chaotic. He submitted nothing had been filed for months and it was impossible to know if a patient had been referred or not, or what their test results were. He said he could see the staff hadn't been used to having any kind of procedures in place and after three or four weeks he had had enough and raised the alarm bells. He had never felt so insecure anywhere else he had worked.

1.24 In his oral evidence he submitted most of the patients' notes did not have

medical conditions listed on the computer; if a patient had seven or eight medications for different conditions there was nothing to link them. Blood results, X-ray results and referrals were not available on the computer. If he wanted to check if a patient had been referred he had to go through the paper records, which was very time consuming if a patient was in the room.

1.25 There were a couple of quite a big piles of loose papers going back three or four months; if they had been actioned and filed as they arrived they would not have been there.

1.26 He did not recognise the situation Gloria Parnell had described and did not understand what she meant by reorganising the reception area: he was the first doctor there and none of the Aveley staff came with him, so how could they have disrupted the records? He had not seen anyone moving things around and he had to search for things himself if no reception staff were available.

1.27 When he started there the radiology results were on computer but there was no pathology link so he had to look for the paper part of the results.

1.28 Although Dr Hellyar was around during the first week he was still trying to get used to the system so he didn't mention the problems with the notes to him.

1.29 Dr Benavides, who worked as a Salaried GP for Aveley, gave evidence *(WS RB pp215 –217)* that when she worked at the Bluebell surgery for two or three weeks in August/ September 2006 it was difficult to advise patients if they asked about their referrals because even if she could find their records, there was nothing entered in them or on the computer to indicate whether they had been referred or not. Many of the consultations were a waste of time because she could not tell patients anything.

1.30 She also referred to the pile of loose papers going back several weeks. She submitted that she had spent one morning just going through a black box that was full of such papers, which included test results, discharge letters, hospital review details and A & E reports and she had followed these letters up where appropriate before summarising the correspondence on the computer.

1.31 She submitted there was no order to the patient notes at all and that many of the records were in boxes on the floor of the tea room, with others in carrier bags there, either on the floor or window sills.

1.32 Wendy Alleway, who had been part of the PCT team which carried out a QOF Review Visit to Dr Hellyar's practice in January 2006 *(WS RB pp244-251)*, submitted that it was a very lengthy process to summarise records onto the computer. When she had visited Dr Hellyar's practice she had been quite alarmed at the lack of management, systems and protocols. She had spoken to various colleagues and formed an action plan, then spoken to Dr Hellyar to tell him she would deploy two members of (PCT) staff to help get the practice up to speed. She indicated in the QOF Report in February 2006 that she believed the practice could achieve the desired requirements the following year if medical records were completely summarised and entered on the computer and the practice followed the action plan.

1.33 In May 2006 June Mason went in with Michaela Tall to try and sort out the computer and to compile disease registers, but they reported back that the Practice Manager, Lizzie Hellyar, didn't seem to be absorbing what they were telling her about how to input into the system in and maintain and develop it.

1.34 Wendy Alleway was concerned that the practice did not respond to the support and went to Brid Johnson and Barbara Stuttle to voice her clinical and nursing concerns and her role then ended in May 2006, when she handed over to the Clinical Governace Team..

1.35 Maureen Midgen, who was Mrs Hellyar's receptionist and who worked part-time for Dr Hellyar, gave evidence *(WS RB pp 339-341)* that since August 2006 she was aware of packets of GP medical records in a heap on the floor of a room in the Health Centre; some were in boxes and some were lying on top of the boxes. A few boxes contained records in alphabetical order, but most were not in such order and sometimes she could look for notes for a while and still not find them. It was difficult and dangerous just to get into the room because all the floor area was covered, although it was tidier now and a path had been cleared through the middle.

1.36 She confirmed there were two full filing cabinets in the reception area, where the records were stored more or less alphabetically and that some records had been stored for months in the upstairs dental storeroom., some but not all of which were returned to the medical practice in September 2006 (although on cross examination she was not sure when they came down, but reaffirmed a few were left upstairs).

1.37 The new practice had brought in more filing cabinets in October 2006.

1.38 Brid Johnson, Head of Transformation and Clinical Standards at the PCT, gave evidence *(WS RB pp 1086-1089)* that her involvement started when Vicki Johnson, who had taken over as practice Manager at Dr Hellyar's practice, telephoned her on 21st September 2006 with a number of concerns. She had then visited the practice with Dr Grew on 28th September when the staff had walked them around and given examples of their concerns. She saw the records in boxes stacked up on the floor (of the tea room) and was told they had been there a long time.

1.39 They were also shown a pile of correspondence which Drs Benavides and Chauhan had started to action. It was described to them as having been the height of a green wheelie bin pile. They were shown forms which had not been actioned, which made them decide a full assessment was necessary.

1.40 At the hearing she confirmed that the PCT had been reasonably happy with Wendy Alleway's action plan and arrangements for staff to go in and had left the situation on that basis provided it was kept up to date. She recalled the PCT had tried to support the practice and between May and September 2006 the issues with the practice were regularly discussed, particularly with regard to the partnership, although she questioned how much support could be given once Dr Hellyar had announced his resignation in June.

1.41 Vicki Johnson, Practice Manager of the Aveley Medical Centre and now of the Bluebell Surgery in the SOHC, gave evidence *(WS RB pp234-239)* that she had joined the Aveley partnership in 2004 and had been made a partner there after eighteen months. When she first came over to the Bluebell Surgery she had been amazed to see boxes of patients' records on the floor as the Aveley practice had been paperless for almost fifteen years and that medical records (some of which were second or temporary sets) were stored in vegetable boxes on the floor.

1.42 She was aware that a number of patients had complained they had not been referred to hospital and that other doctors working at the Bluebell Surgery had been writing new referral letters, which could have been duplicates but there was no way of knowing if this was the case as no record of a referral had been made either in the medical records or on the computer. The problem with records and referrals was happening frequently and Dr Chauhan became very stressed by it and asked not to work there any more.

1.43 She submitted there was a wheelie bin in reception which contained three black bin liners full of papers, waiting to be shredded, which included letters, x-ray reports and blood test results, with no way of knowing if they had been dealt with as nothing had been recorded on the computer or in the notes. Dr Benavides had been going

through these papers and entering the relevant information on the computer and following up with the patient or hospital where necessary.

1.44 At the hearing she refuted the allegation Dr Hellyar had left the records in a good state and it was Aveley who messed up the records, asking why they would want to do that. When Aveley brought in three new desks and three new computers there was bound to be an element of disruption in the reorganisation but the records were just as Dr Hellyar had left them; Dr Chauhan could not have disrupted 2,200 records on his own. She had looked at the records herself and they were in an appalling state; they were in piles on the floor, stacked high on the couch and underneath it (in the tea room). The majority were in boxes but others were on the floor; there were probably 200 sets of notes. Linda Connelly had told her the records were always kept in vegetable boxes and not kept anywhere else apart from the two filing cabinets.

1.45 CL, one of Dr Hellyar's patients, gave evidence *(WS RB pp223-228)* that at the end of May 2006 she handed in at the surgery a discharge letter from Oldchurch Hospital indicating she would have to be referred back to hospital for a hip replacement. She saw Dr Hellyar in early June 2006, two weeks later and two weeks after that as she was in a lot of pain and he would reassure her that her referral was in hand, but when Vicki Johnson had subsequently telephoned Oldchurch Hospital she was told it did not have a referral letter for CL and she was not on any waiting list.

1.46 She subsequently saw Dr Benavides and then resorted to a private consultation but even then she was told the earliest date she would be operated on was April 2007. She submitted the whole episode was a total shambles on account of Dr Hellyar failing to refer her in June 2006.

1.47 CS, another of Dr Hellyar's patients, gave evidence *(WS RB pp229-233)* that he suffered with heartburn and reflux, but despite Dr Hellyar assuring him he had referred him to Basildon Hospital for an endoscopy , when he had heard nothing for six months and telephoned the hospital, he was told it had no record of any such referral, and so he had to ask Dr Hellyar to refer him privately although in the meantime Basildon contacted him for a breath test so it was possible Dr Hellyar had referred him again, but for the wrong test

1.48 When he requested repeat prescriptions from Dr Hellyar following the increase in dosage recommended at his private consultation, Dr Hellyar repeatedly continued to prescribe the wrong dosage as it was wrongly recorded on the computer. His staff could never find anything and on one occasion he had to wait almost forty-five minutes for them to find his prescription.

1.49 Dr Richard Grew, consultant clinical co-ordinator for the PAG, gave evidence *(WS RB pp1090-1091)* that when he visited the SOHC with Brid Johnson to try and substantiate the information they had received, he saw Dr Benavides trying to enter data on the computer and to rationalise the notes all around the floor and the unsorted, incomplete immunisation records, unactioned pathology and radiology reports, and the unanswered, unfiled letters. He also noted the Coroner's request had not been actioned. Patient safety concerns precluded them from leaving things as they were for Dr Hellyar to explain; everything needed to be immediately sorted out.

1.50 Peter Greenwood, Secretary of the Essex PAG, was called to answer questions at the hearing. He confirmed that when Dr Grew and Marilyn Quade visited the practice on behalf of the PAG in September 2006 they were particularly concerned by the substantial amount of documents which had not been actioned at the practice for about three months and by the fact there appeared not to have been any systems in place of any substantial nature when Dr Hellyar was running the practice, giving rise to an adverse risk to patient care.

1.51 They both told him of the records "dumped" in the tea room, some loose, some in carrier bags and some in cardboard boxes and they decided they should obtain photographic evidence of that room. Mr Greenwood went a couple of days later to take the photos that appear in the bundle *(RB pp351-372)*. Some were of the tea room and some were of the dental store room *(see RB pp371)*, where he was certain he saw about a dozen medical records.

1.52 Dr Hellyar's evidence *(WS AB pp1.1-41)* covers his interpretation of events in great detail. His evidence specifically relating to these allegations is set out at paragraphs 59 to 68. He explained his card system for repeat prescriptions was kept in the office where the prescriptions were generated and adhesive proformas for review of oral contraception and HRT.

1.53 He submitted patients' notes were placed in alphabetical order in the filing cabinets apart from the notes placed alphabetically in the transfer boxes in the dental storeroom and these had been brought down by Gloria (Parnell), Linda (Connelly) and Mike (Lenton) in the transfer boxes and placed in the middle consulting room (the tea room) in his surgery before the beginning of August 2006. The notes from newly joined patients were added to these, all were alphabetically arranged in boxes, and these boxes placed tidily on top of the examination couch and below the couch on the floor.

1.54 Dr Hellyar contended that when he had moved to the SOHC from Dr Bellworthy's practice, the notes were placed alphabetically in transfer boxes which were placed by the Health Authority team transferring the notes on the floor at the far end of the dental waiting room, whilst their filing cabinet was emptied and re-sited there for the notes to be re-loaded alphabetically. The process took all day and dental patients were not exposed to the notes, which were supervised by Linda Connelly at all times. The filing cabinets were locked and the waiting room was locked when the clinics closed, so members of the public had no access to the notes. Furthermore, the dental clinic staff were all trained in patient confidentiality and there was no suggestion they gained access to the notes.

1.55 The room the notes were transferred to (before August 2006) in Dr Hellyar's surgery was not a tea room. It was a consulting room used, when not needed for consulting, to house, inter alia, a trolley with self-contained tea-making facilities for occasions when his staff were denied access to the SOHC tea room. It was lockable and had a secure door which was closed when his surgery was in session. Patients and non-clinic staff did not access the room. In addition to housing the boxes of notes it also housed the packaged computer hardware for six months while the refurbishment works were under way elsewhere in his clinic. They had no other storage areas.

1.56 Dr Hellyar submitted that patients' medical notes are regularly "moved by persons other than" practice staff in just about every practice across the country. There was a courier van which collected and delivered notes between Clacton (Health Authority (HA) notes 'clearing house') and GPs' clinics. Members of the HA GP Support Staff helped move the notes from Dr Bellworthy's practice to the SOHC on day 1 of his practice there. When Mike helped the receptionists to move the notes he was a member of the dental team with documented training in confidentiality. He was hardly a member of the general public called in off the road. He worked in conjunction with (and supervised by) Gloria and Linda. There was no evidence he gained access to the individual notes. Dr Hellyar contended it was entirely appropriate to obtain assistance from known and responsible Health Centre occupants in moving items. The people concerned were working alongside his staff and there was no evidence that any unauthorised access to individual case notes was made.

1.57 In his oral evidence he explained how he often produced a hand-written or

word-processed referral letter. He was not aware of very many referral letters going unanswered but he was aware of long delays before appointments were given and he had discussed “non-appointments” (referrals that had not gone through) with colleagues at meetings he attended at Basildon Hospital; it was perplexing as referral letters were sent by a daily courier collection rather than by post.

1.58 Photocopies were made of referral letters and kept alphabetically in a large file in the office at the surgery. Sometimes, but not always, a copy was also given to the patient. Sometimes a copy was also put with the patient’s records but Dr Hellyar acknowledged there should also have been an entry in the records as well.

1.59 He gave explanations for why he thought the two patients who had given evidence had not received appointments. He understood from a conversation with the consultant’s secretary that one patient he referred (“CS”) was offered, and took up, an appointment to see a Nurse Practitioner in Gastroenterology, but he acknowledged the patient was justifiably annoyed as the practice did prescribe the wrong dosage of medication a couple of times, for which he did apologise to him. He was sure he had referred the other patient (“CL”) for an X-ray to Basildon Hospital rather than Oldchurch Hospital.

1.60 He also submitted he reviewed repeat prescriptions on an ad hoc basis, usually with the patient present. He acknowledged this was not done on a regular basis but he did see patients frequently and would only prescribe short courses of medication and ask patients to return for review if there were mental health issues or the drugs had street value.

1.61 Dr Hellyar’s evidence in relation to storage of the medical records, initially u upstairs in the dental store room and then downstairs in the consulting room (tea room) essentially mirrored that of Linda Connelly, Sara Lamb and Gloria Parnell.

1.62 The practice had started to cull notes when it had moved across from Dr Bellworthy’s surgery because of the limited space available there had been no space to put another filing cabinet. After the refurbishment of the downstairs rooms was completed he had no sensible answer as to why he did not purchase more cabinets.

1.63 He had seen the notes in the consulting room before he left; he was pretty confident they were in boxes; some contained a couple more than they could comfortably contain with some on top of the couch and some underneath it. He did not recognise the photographs (taken by the PAG) showing higgledy-piggledy notes in that room.

1.64 <u>In response to questions</u> Dr Hellyar accepted the critical and fundamental importance of having up to date records. He qualified this by submitting it was critical if the absence of the notes in a particular situation caused a critical incident, but accepted it was not ideal to conduct surgeries without ready access to the patients’ notes.

1.65 He did not accept Sara Lamb’s evidence that the state of the records made it dangerous to carry on her work there. He had been aware she was frustrated but could not recall her telling him it was dangerous.

1.66 Nor did Dr Hellyar accept June Mason’s evidence that in May 2006 the consulting room downstairs where records were stored was in a state of disarray. She had said some records were thrown on top of boxed records but Dr Hellyar contended there was no evidence things were “thrown” and this on its own did not paint a picture of chaos and shambles. He would not accuse her of lying but felt she had misremembered or exaggerated although he accepted it may not have been the tidiest room in the SOHC and having new patients’ notes thrown on top of records was not part of any filing system for new patient records. However, it was a room in use, not a

bottomless pit into which notes were thrown to allow them to disappear. A lot of the witnesses had come from paperless practices or were describing a very busy practice in cramped circumstances which was necessarily untidy. He did recall difficulty with the notes and storing them.

1.67 He had not actively allowed the situation which Dr Chauhan had described of a bundle of papers three to four months old to arise; it may have developed and he accepted it was incumbent upon him to quickly join up incoming results and letters with patient records and it was his responsibility to monitor and do something about the systems in place if they broke down. Although he did not know how the situation had arisen he accepted responsibility for not doing something about it.

1.68 Dr Hellyar conceded that both Linda Connelly and Sara Lamb had complained about filing and he did not resolve the problem to his complete satisfaction but that was not to say he did not attempt to deal with it; there were repeated conversations with the girls about filing and the importance of allowing Lizzie Hellyar to do her management work.

1.69 He did not accept Dr Chauhan's evidence that it was difficult to follow up referrals because of the way he maintained records; he kept referral letters in a big file so patients could ask the receptionists what was happening and they didn't have to make a doctor's appointment

1.70 Dr Hellyar admitted the protocol requiring incoming mail to be date stamped was not always followed. He would cajole the girls to use the date stamp but if they did not he would write the date in. The letters and reports without a date stamp or written date probably arose as a result of his having to take time off after he was assaulted, during which time the reception staff were thrown into disarray, although he was not offering this as an excuse. He only learned of this bundle when he saw the PAG report.

1.71 Lizzie Hellyar's evidence *(WS AB pp2.1-9)* was that she joined her father's practice in November 2003, attended a Practice Manager's course from January to March 2004 and when Gloria Parnell arrived in March 2006 she was able to assume the function of practice manager and spend the time required for audit and data entry. She left the practice at the end of August 2006 on the understanding the Aveley practice and practice manager, Vicki Johnston, would be taking over the running of the practice. She overlapped with the new Aveley team for about two weeks.

1.72 When she left Lizzie informed Vicki Johnston that they were newly computerised and there was a large amount of data which still needed to be entered on the system.

1.73 Their referrals file was sorted alphabetically by surname and enabled them to check the position very quickly if a patient asked for information about a referral. From the beginning of the computerised practice referrals were done by Linda Connelly directly onto the patients' notes. They were typed and sent and a copy was saved on the computer system. Prior to this Dr Hellyar would write referrals by hand there and then and they would take a photocopy and send the referral off by courier in the red sacks provided. Alternatively, referrals were typed on Dr Hellyar's or her laptop, printed and sent, copied to the file and sent out.

1.74 In the January QOF visit the main issue identified to Lizzie was that of the entry of data from the paper notes into the computer records and she took this up as her priority over the following months.

1.75 Lizzie did not recognise the description of the practice given from the September PAG visit. At the end of August 2006 they had put the patients' notes into the downstairs store room but as they did not know how the new administration were planning to use the space they had done no more in regard to the filing of notes by the time she left. Old notes and new patient notes were stored alphabetically in this room

prior to being summarised and entered onto the computer system. The notes were waiting archiving and, as far as they were concerned, they were in temporary storage.

1.76 In response to questions Lizzie maintained all incoming mail was date stamped by the SOHC.

1.77 She accepted that the bundle of papers three to four months old should have been actioned, although she submitted some of the information such as duplicated pathology results would already have been on the computer system and minor injuries could have been read and filed, that is a lot of it was information which could have been recorded in other ways.

1.78 She did not accept the downstairs room in which records were stored was in disarray. It was only ever a temporary arrangement when they were moving. Before Aveley came in notes were moved to there from upstairs; they were old records with the most recent notes stored in the filing cabinets.

1.79 She submitted the notes were in constant use, often by her when she was starting to get the practice ready for the new computers and trying to summarise the notes and compile disease registers. However, she was not dyslexic and she was not aware she put the notes back in the wrong place; sometimes records were not kept in one place as several people could have taken them. Linda Connelly may have used a tagging system when removing notes but other people didn't; it would take too long. For example twenty notes might be needed for a doctor's surgery, twenty for a nurse's surgery, fifty for an audit.

1.80 The criticisms in the QOF Report following the January 2006 visit of there being a lack of systems and processes did not clarify the practice had only just received computers; most of the criticisms related to them activating the computer system and loading data.

1.81 Their relationship with the PCT had been difficult since she joined. They had very little space and no lease. It was a temporary arrangement whilst they sought more permanent accommodation so when they asked for things to get ready for the new computer system the PCT was unwilling to provide them and they got practically no response. They weren't even sure if they could hold clinics in the SOHC; one day they found it was shut for a leaving party and the PCT had to intervene to get it to open up. When Dr Hellyar first handed in his notice and the patients organised a petition then the PCT became more willing to speak to them

1.82 Mrs Hellyar's evidence *(WS AB pp 3.1-7)* was that when Dr Hellyar was allowed to come and use temporary facilities at the SOHC she agreed he could place two filing cabinets containing patient records in the dental waiting room as this was more secure than the entrance area which he had been offered and, as no space was allocated to him, as a temporary measure, he could share her office where his files would be more secure. When he was eventually allocated a permanent but small room downstairs, space was still at a premium so he continued to utilise the dental storeroom on the first floor for some of the old notes.

1.83 Mike Lenton was seconded by Mrs Hellyar to help out in Dr Hellyar's surgery for a couple of hours a week for a few months. He carried down the medical notes which had been stored in transfer boxes and finished working for Dr Hellyar at the end of July 2006. In August he went on holiday for two weeks and when he came back he only worked in the dental area.

1.84 Mrs Hellyar was sure there were no medical notes left in the dental store room after July 2006 because a bulky new piece of dental equipment was purchased and placed in the space vacated by the boxed medical notes.

1.85 In response to questions Mrs Hellyar reconfirmed there were no notes left in the

dental store room in September 2006. When asked to comment on this by the PAG in October she looked in the store room and promptly wrote back to tell the PAG there were no notes left there.

1.86 When shown photos at the hearing of notes in disarray which had been taken by the PAG at the end of September *(RB pp351-372)* Mrs Hellyar could not see anything in them which specifically identified the dental store room except image 351.

1.87 Returning records to Customer Services – a further issue relating to the state of records and systems and failure to deal with documentation and incoming mail highlighted at the appeal was the return, or failure to return records to Customer Services, who repeatedly requested with increasing urgency the return of outstanding medical records in letters dated 31st October 2006, 17th January and 17th February 2007 *(RB pp 386-388)*. The PCT submitted neither Dr Hellyar nor Lizzie Hellyar, as Practice Manager, had any explanation for their ignorance of these letters and that in cross-examination Lizzie Hellyar demonstrated the same skill as her father for conjuring up excuses in relation to documentation, claiming the letter dated 17th February 2007 was the first request she had seen from Customer Services telling her how to deal with any records that had been lost.

1.88 Coroner's Case - yet another issue relating to the state of records and systems and failure to deal with documentation and incoming mail highlighted at the appeal was the Coroner's case.

1.89 At the hearing Dr Hellyar gave evidence that he remembered the patient well, that he had received a request for a medical report from the Coroner's office via Dr Bellworthy's surgery and he knew he had hand-written and sent a report. This conflicted with his earlier written response in June 2007 to the PAG Report allegations in which he confirmed he had typed the report *(RB p835 para 2.34).*

1.90 Dr Hellyar submitted this was a legitimate and genuine mistake on his part and that he had typed the first report and hand-written the second report. The typed report would have been saved to disk rather than hard drive and left in a filing cabinet at the SOHC. He contended he would have returned the patient's notes to the Health Authority after he had done the first report so he did not have them to do the second report.

1.91 Counsel for the PCT submitted that in any event it required the Coroner/ Coroner's Officer to send no fewer than four requests to Dr Hellyar and to chase him twice by telephone, all of which was to no avail because the Inquest went ahead ten months after the death *without* any report from him. He submitted that notwithstanding the account provided after the event by Dr Hellyar in evidence, it was useful to note the very specific account prepared by the Coroner's Officer dated 6th October 2006 *(RB p376)* where in the second bullet point he recorded a conversation with Dr Hellyar which noted *".. he will complete the report directly"*. There was no reference there to him having prepared not one but two reports. Counsel submitted that was because Dr Hellyar had not prepared any reports at all and his oral evidence and his witness statement on this issue were contradictory, unsupportive and untruthful.

1.92 Counsel further submitted that in Dr Hellyar's earlier written response in June 2007 to the PAG Report allegations *(RB p835 para 2.34)* he had submitted that the Coroner did not chase him for a report following 6th October 2006 and that if the Coroner had required a report for the inquest she would have chased him further and she would have adjourned the hearing of the inquest. In these circumstances he contended there were no adverse consequences of the medical reports he had prepared not being received by the Coroner. Counsel contended this ignored the fact that the Coroner had already sent three chasing letters and made two chasing phone calls and to suggest that the Coroner should have chased further was a surprising assertion on Dr Hellyar's behalf.

1.93 Counsel also contended that Dr Hellyar's statement ignored the fact that the Coroner may very well have been inconvenienced at the time. The Coroner's letter to Mr Greenwood *(RB p377)* stated that *"Dr Hellyar's lack of cooperation might well have caused the Inquest to be adjourned and this would have caused upset to the family"* and that whilst the report from the patient's GP may have been of seminal importance to the Inquest findings, Dr Hellyar stated blithely after the event that "there were no adverse consequences". Counsel submitted that was a matter of good fortune alone and Dr Hellyar's arrogance and disregard both of the Coronial Office and of the family's convenience were a damning indictment of his attitude to his own responsibilities.

2. Immunisation

2.1 systemic failure to adopt any system regulating the preservation, cataloguing and administration of immunisations

(a) failure to destroy old vaccines and keep records with regard to their destruction

(b) failure to monitor temperature of fridge in which vaccines stored

(c) absence of system to regulate batch numbers

(d) failure to lodge returns with regard to maintenance of vaccination immunisation records

2.2 The PCT upheld the PAG Report's concerns that Dr Hellyar failed to provide a safe system, or any system of immunisations for his patients, to destroy out of date vaccines, to monitor the temperature of the vaccines fridge or to keep records of vaccine batch numbers administered to patients and to send immunisation returns to the Health Authority (HA) *(RB pp1053-1055)*

2.3 Linda Connelly's evidence was that was that Lizzie Hellyar took over the immunisation sheets after Sara Lamb left but towards the end, she hadn't been doing them properly and she wouldn't fill out any of the batch numbers.

2.4 Sara Lamb gave evidence at the hearing that when she was at the practice the vaccines were definitely not out of date and there was a chart stuck on the fridge. She also thought there was a thermometer built into the fridge but she was not completely sure about that.

2.5 Carol Saunders evidence primarily related to immunisations (see paragraph 1.22 above). She submitted many weeks' worth of HA sheets were still at the practice and had not been sent off, thereby interfering with the smooth running of the system from the HA's end.

2.6 She also found an entry in a baby's notes saying the baby had had a pre-school immunisation, which the receptionist said Dr Hellyar had told her to write. She was unable to continue until she checked on the computer and in the baby's "red book that the correct immunisation had been given.

2.7 At the hearing she submitted it was difficult and time-consuming to find the baby notes. She also had to search and find for herself the HA sheets, which were not in date order and she did not think had been sent off because both the top copy and the second copy were still there although the top copy should have been sent off.

2.8 She was concerned the system had collapsed because there was no doctor, nurse or manager at that time.

2.9 Vicki Johnson's evidence was that when the Aveley team arrived they found the baby immunisations were a complete mess as no white sheets had been completed and returned to the HA, immunisations had not been recorded on the computer and when a mother came in asking for a booster for her baby, it was not clear what injection the baby had been given previously, nor was the child registered and the baby's red book was incomplete. Furthermore, batch numbers had not been recorded and if it had been necessary to recall a faulty batch of vaccine, the practice wouldn't have been able to notify anyone as there was no tracking at all. In addition, there was no thermometer in the fridge and the fridge contained out of date vaccine.

2.10 At the hearing she submitted the white sheets were originals, not copies, and she was not aware that any had been returned to the HA. She considered that if Lizzie Hellyar had been working with Sally at the HA, the Return Immunisations Sheet which Sally sent to her on 29th September 2006 *(RB pp714-715)* would have indicated if any white sheets had been returned.

2.11 She also confirmed there was no internal thermometer in the fridge, only an external one.

2.12 She had not seen out of date vaccines but Carol Saunders had.

2.13 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 69 to 78. He submitted that they ran immunisation clinics in similar ways to every other surgery he knew, with a dedicated vaccines fridge with an internal thermometer. Sara Lamb, the practice nurse, had been sent on a Primary Care course which included an immunisation practice update and she maintained and ordered the vaccine supplies, ensured rotation of vaccines and compiled the fridge temperature log which was kept in clear plastic and stuck on the fridge for easy viewing. The log was available at each of the nGMS assessment visits and was checked by Brid Johnson at the 2005 visit.

2.14 As a small practice they carried only small amounts of childhood vaccines at any one time. They could obtain more on three to seven days' notice. For other vaccines patients were given a prescription and told to report back straightaway for the immunisation.

2.15 They organised childhood immunisation clinics in the morning of one day each week so if there were any untoward reactions the mother could bring the child back that day.

2.16 Sara Lamb, and after she left, Lizzie Hellyar, were responsible under Dr Hellyar's directions for completing the childhood immunisation returns and the system was identical to that at Acorns, Dr Dey's and Dr Bellworthy's. The type of vaccine, its make and batch number were recorded in the patients' notes and usually in the baby's "red book". When they began to convert to computerisation Dr Hellyar mistakenly recorded the immunisations in the patient journal rather than a dedicated file, which he submitted might be the reason why some patients' records appeared incomplete.

2.17 The white sheets were completed and when full, sent to the HA. Dr Hellyar was not aware of any delays when Sara Lamb did them but after she left he accepted Lizzie sent the returns late. Some of the white sheets were marked "copy", which signified they were a copy of the returned white sheet, thereby informing the incoming manager from Aveley that there was no need to recall those patients. The white sheets not marked "copy" were current sheets requiring action by the Aveley team.

2.18 Dr Hellyar had no knowledge of an out of date vaccine left in the fridge when the practice was handed over to Aveley; no one had indicated the vaccine type or patient's name attached to it. He pointed out the practice nurse was not allowed to administer vaccines unless there was a doctor in clinic and she checked the vaccines with him before administration.

2.19 At the oral hearing Dr Hellyar explained that not a lot of children came to the immunisation clinics and it could take three or four weeks before the white sheet list of names had all been in for vaccination. Aveley had a greater immunisation workload.

2.20 He had undertaken an immunisations audit in November 2006 *(AB AH1 pp167-170)* which did not support the finding in the PAG Report that their system for immunisations was inadequate in either coverage or recording.

2.21 In response to questions Dr Hellyar accepted responsibility for Lizzie having failed to return the white forms on time. He also accepted there was a more appropriate place to store the immunisation records on the computer but disputed it was difficult for the practice nurse to find the information once she knew where to look.

2.22 His practice was not unusual in returning forms late to Child Health but he accepted it may have stuck out because of the number of times Child Health had to phone for them.

2.23 He contended his system was not unfit for purpose when considered in the round with other surgeries and their practices.

2.24 Lizzie Hellyar's evidence *(WS AB pp2.1-9)* was that they did not use the white child health sheets in the clinics. Instead, she conducted audits of the data, filled in the sheets with the relevant information and sent them back to the Child Health department. If children did not attend she would retain the sheets to try to contact the parents to attend for immunisations. This might explain why some of the returns were sent in late. She received great support from Sally in Child Health who would monitor the returns and alert her to any outstanding information required and provide her with additional or duplicated sheets for submission.

2.25 When Vicki Johnson came she handed over the immunisation return forms she had completed. She handed over outstanding white sheets and also copy white sheets which had already been completed and sent. The sheets with the word "copy" written on were ready for filing and Vicki Johnson assured her she had staff who could complete and submit the outstanding forms and although Lizzie offered to stay and assist, she told her it was not required.

2.26 At the oral hearing Lizzie confirmed immunisations were recorded on the computer in the journal entries and batch numbers were recorded on the white sheets sent to Child Health and in individual notes so it was not correct, as Ms Johnson had suggested, that a faulty batch of vaccines could not be recalled.

2.27 The thermometer was kept outside the fridge; there were two vaccine fridges and one had a LCD display and they also kept a thermometer but she could not recall which fridge they were talking about. Although she never personally took readings they were taken and recorded and she had seen the notebook in which they were recorded.

2.28 In response to questions Lizzie acknowledged that she did not return the white sheets regularly or on time.

3. Accommodation

3.1 (i) failure to provide seating accommodation and telephone facilities

(ii) inadequate provision of any facility for storage of records etc

3.2 The PCT upheld the PAG Report findings that Dr Hellyar failed to provide surgery accommodation that was not suitable for purpose, there being at one time or another, no proper or adequate storage facilities for medical records, no or no adequate consultation room, no proper waiting facilities as there were no chairs, no or insufficient telephones

3.3 The inadequate provision of any facility for storage of records etc is largely covered in section D1 above.

3.4 The IOP decision points out *(page 17 paras C-D)* that the accommodation provided by Dr Hellyar to his patients was provided for the use of the surgery by the PCT itself. This encompassed the initial temporary accommodation, the suggested porta-cabin accommodation and the permanent rooms at the SOHC finally allocated to Dr Hellyar.

3.5 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 79 to 86. He disputed the allegations, submitting he was twice assessed by outside GPs and Health Care managers including Brid Johnson and Wendy Alleway. They had as much storage as they could muster in the circumstances. The SOHC had a large, well-appointed, comfortable waiting room which all the clinics there used, approximately fifteen metres from the reception office, with numerous chairs including high-backed chairs for elderly patients.

3.6 When his rooms were refurbished he was invited to use one as a waiting room and to provide seating for it but he declined for confidentiality reasons as anyone in that room could clearly hear anything said in the office. He preferred the larger, existing waiting room and to collect his patients from there, observing them as they walked the distance to the consult room.

3.7 The practice had two wireless handsets and Dr Hellyar used a mobile telephone 24 hours a day. He was unaware patients had trouble accessing the practice by phone. He was aware the Aveley/Bluebell surgery staff had trouble operating the call diversion system with his original telephone system, resulting in numerous occasions when the patients were left without out of hours cover at evenings and weekends.

3.8 He had organised a land-line link to the dental suite for their use with a wireless "roving" telephone system because they were not initially given any office space or allowed to install a land-line and he used his mobile phone with his mobile number printed on prescription sheets and the practice leaflet. The system worked well and they were regarded as easily contactable by the out of hours service and local pharmacists.

3.9 There was little time spent on accommodation issues at the oral hearing.

4. Practitioner's attendance at the surgery

4.1 practitioner over-extended himself by taking on additional responsibilities outside those within his own practice

4.2 The PCT upheld the PAG Report findings that Dr Hellyar took on an excessive workload by undertaking several other appointments in addition to his SOHC practice, when he knew or ought to have known that he did not have the capacity to do so.

4.3 It was clear from the IOP decision that Dr Hellyar had stopped working at Brixton Prison by the time he was running the SOHC practice in 2006 and his two regular commitments were the SAS scheme (12 patients) and the out of hours service. He also went on clinical attachments on an unpaid basis as and when he was able to fit in but that was not a regular professional commitment.

4.4 Linda Connelly gave evidence at the oral hearing that it was rare they had to phone Dr Hellyar as he always phoned in and if there was a clinical emergency he would tell them where he was so they could get hold of him. But both she and Sarah Lamb complained that he did not set up regular salary payment or contracts for his employees and he did not turn up to meetings they arranged.

4.5 June Mason gave evidence at the oral hearing that Dr Hellyar did not miss clinics without notice or explanation. She confirmed that when she was Practice Manager, if he was ever late because of traffic he would phone in to tell her.

4.6 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 128 to 131. He submitted his workload reflected the activity of an interested doctor who wanted to remain up to date with current medical practice and who derived a considerable professional satisfaction from a variety of medical interests.

4.7 He started doing many of the add-on GP activities before coming to Essex and many of those he started while in Essex, including joining the Basildon Hospital consultants and working with the psychiatrist and with the eye team were unpaid. He rejected and resented Mr Greenwood's allegation that he was preoccupied with making money.

4.8 His clinic duties, for example at Acorns (2 hours daily, 4 days per week), SAS (2 midday or early afternoon clinics or perhaps 30 minutes per week if any of his 10-12 assigned patients needed appointments) and SEEDS (sporadic evening and weekend work sessions) were not onerous and did not erode patient time or administration time at SOHC.

5. Issues of lack of probity

5.1 (i) practitioner was evasive and obstructive with regard to the Performance Advisory Group (PAG) investigation

(ii) practitioner gave false address when registering himself as a patient with Dr Dey

(iii) the use of funding earmarked for particular schemes for acquisition of property, which was personal to the practitioner and the mis-description of that property within records maintained by him

5.2 The PCT upheld the PAG Report findings that Dr Hellyar was evasive and obstructive with regard to the PAG investigation.

5.3 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 125 to 127. He disputed these allegations, submitting that he told Mr Greenwood where he was going to stay and work in Canada. He felt Mr Greenwood repeatedly asked him the same question concerning storing of the patients' case notes in the dental storeroom in several different ways and Mr Greenwood might have felt frustrated at essentially receiving the same answer from him.

5.4 The time difference of 8 hours between Canada and the UK caused delay, as did the referral of some of the questions to Dr Hellyar's medical defence organisation.

5.5 Dr Hellyar believed Mr Greenwood should have interviewed him when he had the opportunity in early October 2006 when he started his investigation and before Dr Hellyar left for Canada. Dr Hellyar had made himself available for investigation and looking at the PAG Report, it was apparent that Mr Greenwood knew the bulk of the allegations in the first few weeks of the investigation (although Dr Hellyar did not).

5.6 In closing submissions Counsel for the PCT submitted Dr Hellyar's argument that he could not answer the questions without sight of the medical records was opportunistic. There were issues of patient confidentiality arising which tended to reduce the enthusiasm of investigators to start disclosing notes and no efforts would be made to obtain that consent until the doctor made a request for them. At no time did Dr Hellyar make such a request and say he wanted sight of the records, yet at the hearing he raised for the first time the suggestion that he wanted records and was deprived of them, although he had had the benefit of legal advice.

5.7 The PCT upheld the PAG Report findings that Dr Hellyar gave a false address when registering himself as a patient with Dr Dey.

5.8 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to this allegation is set out at paragraph 94. He submitted that he had been admitted to Dartford Hospital with a suspected sub-arachnoid haemorrhage and after a CT scan and investigations the hospital needed details of a GP to whom his post-discharge reports could be sent. Like many GPs, he did not have a GP, so he asked Dr Dey to act as his GP, which he agreed to if Dr Hellyar had an accommodation address in his area. He gave Mrs Vincent's address and consulted Dr Dey once after his discharge from hospital. He submitted there was no attempt to deceive and Dr Dey knew the details, the NHS had not been defrauded or deceived and it was an expediency he cancelled long ago, for which he had apologised to Dr Dey.

5.9 This issue was not raised or referred to at the oral hearing.

5.10 The PCT upheld the PAG Report findings that Dr Hellyar failed to observe the criteria of the Prescribing Incentive Scheme (PIS) in applying for furniture and equipment under the scheme and in relation to the use and retention of that furniture and equipment.

5.11 In closing submissions Counsel for Dr Hellyar submitted it was clear that issues of probity related in reality only to the PIS monies (namely, the allegation of the use of funding earmarked for particular schemes for acquisition of property, which was personal to Dr Hellyar and the mis-description of that property within records maintained by him) and that much had been confirmed by witnesses for the PCT.

5.12 The evidence on the PIS monies within the papers and at the oral hearing was extremely lengthy, complex, referred to in numerous places and difficult to collate, developing and evolving during the appeal. The facts and arguments in relation to the PIS monies are perhaps best summarised in respective Counsels' closing submissions.

5.13 Counsel for the PCT summarised the evidence by submitting the criteria governing the scheme were set out clearly in the bundles *(RB p780 for 2003/4 criteria)*. Dr Hellyar's primary position was that: *(RB p867 para 15.4)*:

> *"In relation to the consideration at paragraph 938, it is not admitted or denied by Dr Hellyar that the details provided are correct. No evidence has been provided in the Report of the relevant criteria to be applied. Considering the absence of such criteria, Dr Hellyar requires the PAG to produce satisfactory evidence to the PCT before commenting further on the relevant criteria." (emphasis added)*

Given the published criteria, Dr Hellyar's primary position was untenable.

5.14 Counsel submitted Dr Hellyar provided a "Wish List" (properly so described) *(at page 5 of the small sheaf of papers produced on the last day)*. That Wish List was dated 28th December 2004 and signed by him. It included a wish for a "Laptop eg HP5252 with modem £1000c"

5.15 At the head of that document Dr Hellyar claimed £3,500 of PIS funding;

5.16 By letter dated January 27th 2005 *(RB p786)* Dr Hellyar expressly stated that he had "purchased equipment for the practice…" He then set out a list of the equipment he had allegedly purchased. The single most expensive item on that list was the £799 AppleMac computer;

5.17 Dr Hellyar was paid £3,500;

5.18 Dr Hellyar accepted finally and in his most recent witness statement that the AppleMac had never been purchased *{WS AB p33 para 98}:*

> *"The AppleMac computer .. [was] never purchased … I cannot remember why these items were not purchased. I believe there was not enough money coming from the PIS to pay for everything on my wish list.."*

5.19 He had never given any explanation for including a highly specific amount (£799.00) in respect of a purchase which had not been made;

5.20 He sought in the witness box to construct a new explanation by referring to the fact that he had actually purchased an HP computer for £1,200 and had submitted the invoice to the Trust. There was no evidence of that in the Trust's records;

5.21 Critically, (and the Appeal Authority may consider that this hit hard on the issue of probity or frankness) Dr Hellyar never once mentioned this new explanation in any of his witness statements or responses. He never volunteered it by letter. Despite the obvious significance of an allegation in relation to the computer he waited until he was being cross-examined to reveal it. That was because it was an opportunistic explanation that he thought about on the hoof and gave simply to try and avoid criticism. But it was demonstrably inconsistent with his earlier statement. In the live evidence he suggested that instead of buying the AppleMac for £799 he had in fact purchased an HP computer for £1,200 odd. How could that possibly sit with his earlier explanation that (see above): *"I believe there was not enough money coming from the PIS to pay for everything on my wish list.."*. The two positions were wholly irreconcilable. Dr Hellyar was simply not being honest with the FHSAA.

5.22 In that context Counsel moved on to consider briefly the issue of the Grainetier. Neither Dr Grew (27 years in GP practice) nor Mr Greenwood (rather more years in the health service) had ever seen the PIS criteria interpreted in the way that Dr Hellyar suggested they could be interpreted. In this case the PCT's position was straightforward. This was a doctor who misled and deceived by providing half-truths and inconsistent statements as it suited. He well knew that the purchase of the Grainetier was not appropriate for a practice and it was never intended to place it there. His explanations to the FHSAA would be weak and difficult to maintain even if his integrity was intact and he could be trusted. In light of the evidence above he did not enjoy that advantage.

5.23 The same was true of his interpretation of the criteria that allowed him to remove the items from his practice. This was no genuinely held belief that he could remove items. He bought expensive camera equipment and joked at the appeal about his inadequacy as a photographer. His account that he honestly believed he could remove the camera, associated paraphernalia and Grainetier held no water at all. He wanted the equipment for himself and took it, availing himself of the loose terms of

the criteria later. On his own account he was not even aware of the criteria at the time. On that basis could he honestly have thought there was a loophole? Or was he in fact helping himself to property which he well knew ought to have remained with the practice?

5.24 Finally and again on the issue of opportunism (see paragraph 5.6 above) Counsel mentioned another issue which put into context the approach of the Dr Hellyar and his advisors. With reference to the AppleMac computer and the fact that a total sum of £3,500 was in issue, he submitted that during the course of cross-examination Dr Hellyar's advisors interjected and sought to challenge for the very first time the question of whether or not the sum had actually been received by him. Eventually the point was conceded but this was an issue that had never been raised before. It had never been questioned. The PCT had never been asked to "prove" the payment. None of that prevented the ultimately futile rearguard action being put on Dr Hellyar's behalf.

5.25 By itself the issue was curious and doomed to failure. But in context it defined the way in which Dr Hellyar approached all of his responses to the PCT, to the PAG and ultimately to Counsel for the PCT during cross-examination. He did not appear to be trying to give honest and genuine answers from the witness chair. He was often thinking long and hard of any ways that he could sidestep responsibility; or lay the blame on others even if his efforts were transparently untruthful – see for instance his persistent defence of the systems re filing and the assertion that everything was in a good order when he left. It wasn't. The disarray had not been caused substantially by others coming in but was simply the ongoing position revealed by the evidence of June Mason, Sara Lamb, Linda Connelly, Dr Chauhan, Dr Benavides, Vicki Johnson – and the documentary evidence including that mysterious "bundle" of medical records, notes, referrals and results.

5.26 Counsel for Dr Hellyar summarised the evidence by submitting there had to be seen to be two elements to this charge. The first was that there was some sort of inappropriate behaviour on the part of Dr Hellyar in relation to the information given to the PCT when PIS monies were being "claimed". The second was that the retention of property whose purchase was made in the assurance that PIS monies would fund the purchase, was wrong.

5.27 <u>The obtaining of the funds</u> - the first of these elements, on the evidence, boiled down to the following sub-elements (taking them chronologically):

5.27.1 Dr Hellyar signed a letter *(RB p786)* saying that he had already bought an Apple Mac laptop computer, when he had not done so, and thereby obtained PIS monies, which he would not otherwise have obtained; and

5.27.2 Dr Hellyar stated that a grainetier was a lockable workstation which he was going to use in his practice at SOHC, when that was not true.

5.28 As for the first of these two allegations, Dr Hellyar's evidence was that there were two reasons why the allegation was a bad one. One was that the PCT would, as far as he was aware, not pay money in respect of a computer for which there was no receipt, and the other was that he had in fact bought a laptop computer as a result of whose purchase the PIS funds had been released in full (bearing it in mind that they were limited to £3,500 in total for the relevant year).

5.29 In response to the first of these aspects of Dr Hellyar's evidence, the PCT alleged, without any evidence other than the absence in its records of a receipt for any computer bought by Dr Hellyar, that its own systems had been breached so that the PIS monies had been paid out improperly. That was startling. In order to make good its allegation of a lack of probity on the part of Dr Hellyar in this regard, the PCT had to be

able to satisfy the panel that Dr Hellyar claimed the PIS monies for the Apple Mac computer knowing that he had not bought that or any other computer and knowing (or at least believing) that the payment would be authorised without a receipt for any computer, or at least receipts for appropriate purchases whose total equalled or exceeded £3,500. The panel heard the evidence of Dr Hellyar, and Counsel submitted that it was clear that he did not do that. If he had intended to deceive, then, given the apparent absence of any receipt at all kept by the PCT in respect of a laptop computer, he would surely have said that he had in fact bought an Apple Mac computer. But he did not do that. Honestly and properly, he said that he had not bought an Apple Mac computer. His evidence in his witness statement *(WS AB p33 para 98)* was that he could not remember why the Apple Mac was not bought. However, at the hearing, he remembered that he had in fact bought a Hewlett Packard ("HP") computer.

5.30 The fact that the practice at the SOHC was a very busy one was attested to by June Mason, who, as a former practice manager, could be expected to know what a very busy practice looks like. In addition, it was clear that the claiming process was carried out in a hurry, and that the authorisation of Mr Croager dated 5 February 2005, of which a copy was put before the panel and given to Dr Hellyar only during the hearing, was marked "urgent" because the deadline for claiming the relevant PIS monies had passed. Thus there was a readily comprehensible explanation for Dr Hellyar's signing a letter saying that he had bought an Apple Mac computer, when he had not in fact done so. To his credit, though, Dr Hellyar did not attempt to minimise or explain away the fact that he had thereby made a false statement in a letter claiming PIS monies.

5.31 Dr Hellyar's evidence was that he did in fact receive £3,500 by way of PIS monies. This was evidence which a dishonest person might well not have given in the circumstances, since there was no documentary proof of the payment of that sum to Dr Hellyar as PIS monies. It was asserted in the PCT's closing submissions (see paragraphs 5.24 and 5.25 above) that the fact that it was pointed out by Counsel for Dr Hellyar during the hearing that there was no proof of the payment of the sum of £3,500, indicated the way in which Dr Hellyar approached all of his responses to the PCT. As will be apparent, the absence of documentary proof of the payment of £3,500 was pointed out by that Counsel without instructions, and Dr Hellyar fairly and honestly immediately said that the sum was in fact paid. Thus the attempt to cast doubt on Dr Hellyar's honesty by reason of the late reference to the absence of written proof of the payment of £3,500 was surely both unfair and wrong.

5.32 There were in any event only two possibilities in relation to the claim for funds for a laptop computer. They were these:

5.32.1 there was a receipt for a computer other than an Apple Mac which the PCT had lost, or

5.32.2 Dr Hellyar never did give the PCT a receipt for a computer to support his claim for PIS monies in respect of a computer.

5.33 As for the first of these possibilities, it could not be said that the PCT's systems were so reliable that receipts were never lost by the PCT. In fact, no direct evidence was led by the PCT as to the systems for the retention of receipts for property bought in the anticipation of the receipt of PIS monies, or as to the manner in which payments were authorised in that regard. However, the PCT acknowledged that its usual procedure was not to pay PIS monies in full unless the receipts given to it in support of a claim for such monies firstly were in respect of items whose purchase with PIS monies had been authorised in advance by (so far as relevant) Mr Croager and secondly were for sums which were in total at least the amount of the PIS monies.

5.34 It would have been very unusual indeed for the PCT to have approved the

payment of PIS monies without the necessary receipts to back up such payment. Counsel submitted that the overwhelming likelihood was that there was a receipt for a laptop computer — or at least there were receipts for approved equipment to the value of at least £3,500 — before the PCT when it approved the release to Dr Hellyar of the full amount of £3,500 in 2005 for the 2003-4 PIS scheme. The letter dated January 27th 2005 *(RB p786)* showed only a total expenditure of £3765.64, whereas the "wish list" *(AB AH1 p84)* had a figure for the total of the projected expenditure of £4604, which included expenditure for a "Scanner/printer/copier (laser) with duplex", for £340.

(Incidentally, contrary to the assertion (in paragraph 5.14 above) this document was not put before the panel only on the last day of the hearing. It was regrettable that the PCT did not itself give a copy to the PAG investigators, or if the PCT did give a copy to the PAG investigators, a copy was not put in the appendices to the PAG Report.) Further, Dr Hellyar's letter to John Croager dated 27th January 2005 *(RB p786)* referred to "a printer, inks, paper, leads, manuals and a text on newsletters" which Dr Hellyar wrote that he had bought, but that he had not put receipts for those amounts before the PCT as "the total already goes above £3500". If the sum for the Apple Mac was deducted from the sum of £3765.64, but the sum of £340 was added for the printer, then the total was likely, with the "inks, paper, leads, manuals and a text on newsletters", to be above £3,500 in any event.

5.35 Be that as it may, by the time of the hearing before the panel, Dr Hellyar's recollection was (according to Counsel's unamended notes made during the hearing):

"When the receipts were submitted, before any payment was made; a computer was purchased, and I sent in a receipt with the intention of offsetting the cost of a different computer. I bought the computer; I had a photocopy of a receipt in my diary and no means of following the audit trail myself."

5.36 However, if there was no such receipt, and the payment was not properly authorised, then it was equally likely that Dr Hellyar had no belief that he would receive the full amount of £3,500 without putting a relevant receipt before the PCT. He could have had no reasonable belief that he would receive the full amount of £3,500 if he did not put before the PCT sufficient appropriate receipts to justify the release of that amount. Further, Dr Hellyar's evidence in his witness statement was that he needed to put a receipt before the Respondent in order to "enable payments" *(WS AB p33 para 98)*.

5.37 It was true that that evidence was not in the initial response of Dr Hellyar to the PAG Report. However, it was helpful to consider the manner in which the PAG and the PCT treated Dr Hellyar in relation to responding to the allegations which formed the basis of the PAG Report. First, at no time did Mr Greenwood state in specific terms what the allegations were. Rather, he asked a series of questions about the relevant matters, in at least some respects without saying what his concerns were *(RB pp400-405)*.

5.38 Secondly, Dr Hellyar's evidence as to the speed with which he was required to respond to the PAG Report was not contradicted, and was clear. He was given only a week or two to respond to the voluminous and repetitive report, and he had to do so from Canada, to which he had to return shortly after he (fortuitously) first saw the PAG Report. His solicitor, Mr Wallens, wrote the response *(RB pp821-894)* on Dr Hellyar's instructions and in a hurry. If any evidential matter was missed at that time by Dr Hellyar, then it should not be held against him or seen as evidence that his later evidence was an invention.

5.39 In fact, in relation to the obtaining of PIS monies partly in relation to the laptop computer, Dr Hellyar's initial response was *(RB p803 para 10)* that the PCT had "copies of receipts as well as details of the reward sums involved."

5.40 As for the grainetier, it was described by Dr Hellyar as a "Workstation lockable desks" *(RB p794).* However, even if the PCT in any way misunderstood the nature of the grainetier, its purchase was firmly within criterion number 3 for the relevant year *(RB p782*),

namely: “The purchase of material or equipment which will enhance the comfort or convenience of patients or members of the practice, including furniture ... for the practice” *(emphasis added)*. The fact that the grainetier was not taken to SOHC was explicable by reference to the fact that the room in which it was going to be placed (the intended large consulting room) had not been refurbished by the time that it was delivered. Dr Hellyar’s initial recollection as to the time when the item was delivered was (as he confirmed when giving oral evidence) that it was at the end of 2005. However, the invoice for it *(RB p795)* shows that it was ordered on 26 March 2006, but that the lead time for it was 8 to 10 weeks. Thus, it is likely that it was delivered after Dr Hellyar had decided to leave SOHC. However, it was clearly ordered before he decided to do so (since he decided to do so only in April 2006), and the fact that it was now kept in his garage showed that he did not intend it to be used in his home as part of his normal home furniture.

5.41 For all of these reasons, Counsel submitted that the evidence concerning the alleged lack of probity on the part of Dr Hellyar concerning the obtaining of PIS funds was, on a close examination, insubstantial. The allegation of a lack of probity on the part of Dr Hellyar should be rejected.

5.42 The retention of property bought with PIS funds - the retention of the grainetier and the other items bought with PIS funds was the subject of full submissions in the skeleton argument filed on behalf of Dr Hellyar. The matter was the subject of considerable implicit resiling on the part of Dr Grew in cross-examination. He acknowledged that if PIS monies were used to improve a building used for a surgery (which was firmly within, for example, criterion number 6 of the 2003/2004 PIS *(RB p780)* i.e. Investment in existing practice premises where the improvements or development proposals are consistent with the Primary Care Investment Plan”, then the financial benefit of that improvement accrued to the GP to whom the premises belonged, even though the PCT paid the GP a rent for the premises. Further, payments to staff (criterion number 5 of the 2003/2004 PIS was “Non-recurring staff costs”) could not be recovered. In addition, Dr Grew appeared to accept on reflection that a “practice” was not a person, whether natural or legal, and that so far as relevant it was owned by either a sole practitioner or a partnership. It was worthy of note that the PCT’s closing submissions (see paragraph 5.23 above), continued to assert that property “ought to have remained with the practice”. Counsel reminded the panel of the words at the end of the PCT’s Briefing Note in relation to Dr Hellyar and PIS *(RB p799)*, namely: “This may seem a rather convoluted process but it is to ensure that there is no collusion between the award being made and the payment and authorisation of payment of public funds for appropriate purposes to what is in effect a third party.” *(emphasis added.)*

5.43 Dr Grew acknowledged also that PISs had been in place for only six or seven years, and that he was unaware of a situation in which a sole practitioner had ceased to practise where the practitioner had bought goods on the basis that they would be paid for by PIS monies.

5.44 Certainly, there was no express statement in the relevant documents concerning PIS monies which were before the panel that the property bought with PIS monies was to be held by the “practice” (whoever or whatever that may be) — or anyone else — on trust for the PCT.

5.45 Furthermore, a careful analysis showed that the property must be held by someone as its owner, and that that person can, in the case of a sole practitioner, only be that practitioner.

5.46 Vicki Johnson could not properly claim as she did *(WS RB p236 para16)* that a laptop bought with PIS monies “is the property of the practice now”. In any event, if a partnership was in fact formed, then the property which the parties

brought to it would have had to be dealt with in the partnership agreement.

Perhaps the absence of that and other material matters from the oral agreement to enter into a partnership, which was evidenced by the jointly-signed letter of 4th August 2006 *(RB p324)*, had the effect that there was no such partnership in place. But in any event, Vicki Johnson's evidence was that no such partnership was formed. As a result, she could not say that she and her partners had any claim to property bought by Dr Hellyar with PIS monies.

5.47 For all of these reasons, Counsel submitted that Dr Hellyar's honesty and probity could not properly be questioned, and that the charges in that regard were not made out.

6. Issues of general governance

6.1 (i) practitioner left his practice in a fashion of abandonment in August 2006

(ii) practitioner accessed patient information after leaving practice, culminating in treatment of a former patient

(iii) practitioner failed to recruit adequate staff in the form of a practice nurse

6.2 The PCT upheld the PAG Report findings that Dr Hellyar left his practice in a fashion of abandonment in August 2006.

6.3 Members of the Aveley team, including Dr Chauhan (see paragraphs 1.23 to 1.28 above), Dr Benavides (see paragraphs 1.29 to 1.31 above) and Vicki Johnson (see paragraphs 1.41 to 1.44 above) all attested to the chaotic state in which Dr Hellyar left the practice.

6.4 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 108-110. He submitted that when he started working as Dr Dey's locum in the summer of 2006 he believed the Bluebell practice had taken over a functioning and popular practice. He invited questions, comments and discussion on any problems they encountered but nothing of note was reported to him. Gloria Parnell told him they messed up the notes on the clinic office floor as they were sorting case notes of new patients.

6.5 He firmly denied the practice was chaotic, unfit for purpose or dysfunctional when he left it and submitted it might have been made so by a team used to completely paperless management coming into an essentially non-computerised practice, as Gloria Parnell had suggested (see paragraphs 1.20 to 1.21 above).

6.6 Lizzie Hellyar's evidence supported Dr Hellyar's submissions (see paragraphs 1.75 and 1.78 above).

6.7 The PCT upheld the PAG Report findings that Dr Hellyar accessed patient information after leaving the practice, culminating in treatment of a former patient when he was not entitled to do so and issued a prescription to him.

6.8 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 111 – 120. He submitted that as far as he was concerned he was a partner in the Bluebell practice and entitled to continue seeing patients and assessing their notes.

6.9 One of the patients was large, illiterate, brusque and previously on the Special Allocation Scheme with many serious health problems. Dr Hellyar was aware some of the staff viewed him with disdain or wariness. The patient had called him after visiting the Bluebell surgery because he had been told to write a repeat prescription request form, but was unable to do so. Dr Hellyar telephoned the Bluebell surgery and told them what the patient needed, having accessed his file so he could recall what medication he was on.

6.10 He accessed the other patient's records for his date of birth and address to enable him to complete a report which needed sending immediately.

6.11 The PCT upheld the PAG Report findings that Dr Hellyar failed to recruit adequate staff in the form of a practice nurse.

6.12 Dr Hellyar's evidence *(WS AB pp1.1-41)* specifically relating to these allegations is set out at paragraphs 121 – 124. He submitted that when Sara Lamb left in discontent at the end of December 2005 he did not replace her. He performed all the services that she did with the exception of gynaecology examinations like Pap smears and cervical screening which could be done at a local clinic. When a chaperone was required he used Linda Connelly (who he had sent on a Health Care Assistant course) and in November 2005 he engaged Katrina Laurence, the Community Nurse, to provide immunisations.

6.13 The patients did not suffer by not having a practice nurse. After Sara Lamb left in December 2005 he had seen the trouble which Drs Dey and Bellworthy had experienced in seeking to replace their practice nurses and he decided to go without. After March 2006 he knew he was not staying so it would have been wrong to recruit a nurse for a practice which he then believed was going to disappear.

6.14 At the hearing Dr Hellyar said that after Sara Lamb left he had asked around and tried to poach a nurse; he tried to find one but he couldn't. At the time the rooms were still being refurbished, they weren't computerised and they were still working out of whatever room was available so he couldn't attract anyone. Once he decided to leave it would have been completely unfair to encourage someone to leave their job to join him. He knew Aveley had practice nurses and he believed they would be available for his clinic. In fact, Sara Lamb came to the Bluebell surgery several times.

6.15 In response to questions Dr Hellyar admitted he had not advertised for a new nurse but had relied on word of mouth and phoning particular people and asking nearby practices if he could borrow their practice nurses for sessions. Because of the availability of practice nurse facilities elsewhere (at Purfleet, Orsett and Greys) within easy travelling distance he was able to function without a practice nurse, although he acknowledged it was debateable how well he functioned.

7. Partnership

7.1 One final area of concern on which submissions were made was whether or not a partnership between Dr Hellyar and the partners of Aveley Medical Centre existed.

7.2 Dr Hellyar signed a letter dated 4th August 2006 addressed and delivered to the PCT which stated *"Please accept this letter as confirmation that Dr Leighton, Dr Williams and Dr Khraishi of Aveley Medical Centre have entered into a partnership with Dr Andrew Hellyar"*.

7.3 The PCT upheld the PAG Report finding that Dr Hellyar's action in signing that letter was inappropriate, provided false information to the PCT and was contrary to good medical practice, but did not uphold that it was designed to

mislead the PCT.

7.4 Counsel for the PCT went into the partnership issue in great detail in closing Submissions, summarizing that as a matter of law Dr Hellyar did no more than enter into an agreement to commence a partnership and contending there was insufficient evidence of a joint enterprise to sustain the argument Dr Hellyar advanced that a partnership had come into existence.

7.5 He submitted the legal status of Dr Hellyar's business arrangements were secondary to the critical conclusion arising out of the partnership discussions and that he wholly failed to take any or any sufficient care to ensure the continued welfare of patients on his list. He contended Dr Hellyar was content simply to leave the country ("lock stock and barrel") and hand over the care of his entire list with only the most flimsy of arrangements. That behaviour would be unusual in any other circumstance. In this case though there was ample reason. Since 2005 when he had decided to leave GP practice the state of his practice had deteriorated and by August 2006 was on the point of collapse. The contemplated partnership which in fact would have allowed him to relocate abroad and yet enable him to return to work if he wished for short periods in the UK provided a welcome and convenient escape route for Dr Hellyar

7.6 Counsel for Dr Hellyar did not refer to the partnership issue in closing submissions but in his Skeleton Argument he submitted that a partnership can come into existence informally. An oral agreement will do. What was perhaps more important here was the fact that Dr Hellyar understood that a partnership "at will" could come into existence with no formality, and that such a partnership would suffice for the purposes of the NHS. This was clear from the letter from his accountant *(AB AH1 pp 31-33)*: see in particular the first page, under the headings "Partnership Dispute" and "Your Partnership".

7.7 Accordingly, both in law and as far as Dr Hellyar's objective responsibility was concerned, Dr Hellyar was in a partnership with Drs Leighton and Williams. He had agreed that they would be taking over his practice, in the manner he described in paragraphs 30-34 of his witness statement *(WS AB pp1-41)*.

7.8 These proceedings were concerned with Dr Hellyar's personal culpability and his personal suitability to be on any PCT's performers list. Given his evidence on this issue, it was surely clear that he had been treated wholly unfairly and that the PCT here had acted in an unbalanced and irrational way. Drs Leighton and Williams, who took over de facto and, in fact, shared legal responsibility for Dr Hellyar's practice in August 2006, were truly responsible (at least in personal terms, since Dr Hellyar was entitled to rely on them and their practice staff in the relevant respects) for almost all of the administrative failings which formed the basis of the PCT's decision to remove Dr Hellyar from its Performers List.

8. Closing submissions

8.1 Counsel for the PCT contended that Dr Hellyar's systems for running his practice were grossly inadequate as they placed patients at risk, inconvenienced patients, other healthcare professionals and others involved in the administration of the NHS. Dr Hellyar should have known that the situation had deteriorated to an unacceptable degree. If he did know then it was inexcusable that he took no action which provided an effective remedy. If he did not know about it then that omission was itself inexcusable.

8.2 Whatever his answer, Dr Hellyar placed himself in that position by choosing to employ his own daughter and by failing to ensure that she had enough experience or training to properly run the practice. He failed to produce any evidence until he was being cross-examined of the steps he had taken to find a practice nurse. He knew the

situation on the Immunisations front was unacceptable and allowed that situation to prevail.

8.3 He was frankly dishonest in relation to the PIS funding issues. He was almost certainly dishonest both to the Coroner's officer, to the PAG investigation and to the Appeal Authority in relation to the Coroner's request for assistance. His responses in a number of other regards were revealed to be highly unlikely when more closely analysed.

8.4 His practice was demonstrably inefficient. His lack of probity and inappropriate attitude to both patients and others in the NHS mean that he cannot be considered suitable either now or at any time in the future. The PCT maintains the position that he should be removed from the Performers' List and that the sanction should apply nationwide.

8.5 Counsel for Dr Hellyar submitted that his evidence was truthful and such faults as his practice at SOHC exhibited were faults concerning the administration of his practice. Dr Hellyar was guilty of no impropriety concerning the PIS monies. Such fault as he must bear responsibility for concerned the absence of a filing cabinet, some late immunisation returns, and the apparent putting to one side of a number of documents which were received in the post over a short period of time, when Dr Hellyar was absent from his practice as a result of the serious assault on him in April 2006, after which it was clear from June Mason's evidence that the practice continued to be very busy.

8.6 Nevertheless, it was also clear that Dr Hellyar made all appropriate efforts to remedy the defects in terms of the sufficiency of staff in the second quarter of 2006. He employed Pat Marns to assist with data entry onto the new computers. He employed Gloria Parnell to assist with the administration. He employed also Maureen Midgen and Mike Lenton. He sought to employ a practice nurse but was unable to do so.

8.7 In these circumstances, Counsel submitted that it would be completely inappropriate for Dr Hellyar to be disqualified from being on any Performers' List in the country and that the only kind of restriction which might reasonably be thought to be necessary would be on Dr Hellyar practising as a sole GP.

8.8 However, Dr Hellyar was now in Canada, and performing well (as confirmed by the recent emailed report of Dr Wilson of his visit of 22nd January 2008 to Dr Hellyar's practice in Dawson Creek). That assessment spoke for itself. It included the statement: "I believe he is an asset to his patients and community." The assessment was clearly favourable as far as the administration of his practice is concerned.

8.9 For all of these reasons, Counsel submitted that Dr Hellyar's appeal should succeed.

E. Consideration of the Evidence

1.1 In considering the evidence we were aware of the possibility of the PAG investigation being flawed by the way it had been conducted (for example its failure to give the clinical aspects of the investigation appropriate weight and the discomfort of some of the witnesses at the way in which their statements were obtained) and by the failure of the PAG Report to particularise the allegations. We were also aware of shortcomings in the way in which the PCT conducted its own hearing (for example its failure to fully record its consideration of the evidence).

1.2 Having noted this, we were also aware that we were not tasked to investigate the performances of the PAG and the PCT as this was a rehearing to consider Dr Hellyar's appeal on the evidence now before us. However, we did consider we had the right to comment on the PAG or the PCT's investigation and actions if it would help to explain our consideration of the appeal, how we reached our conclusions and any differences in our findings.

The Partnership Issue

1.3 Given our remit, we first considered the evidence relating to whether or not a partnership had been formed. If so, when it had been formed and its effect on the issues we had been asked to consider.

1.4 Counsels' submissions for both parties in relation to whether or not a partnership had been formed are set out in section D7 above, but we felt it was very difficult to ascertain precisely what happened and when, particularly as no senior partner from the Aveley Medical Centre was called to give evidence.

1.5 It was clear from his letter to the PCT dated 4th August 2006 that at that stage Dr Hellyar believed he had entered into a partnership with the partners at Aveley Medical Centre. We note that the PCT accepted this letter was not designed to mislead it and we are also satisfied that this was an honestly and reasonably held belief at that point.

1.6 However, we consider it is not clear from the evidence precisely when Dr Hellyar realised there was not a partnership. We note from Vicki Johnson's evidence that the partners from the Aveley Practice decided in a partners' meeting they would have no further contact with Dr Hellyar after the PAG was called in on 21st September, but this was not communicated to him and it was left to Dr Hellyar to come to the realisation that what he had believed to be a bona fide partnership was no more than a discussion of a partnership in principle.

1.7 Whilst we understand why the partners from the Aveley Practice became alarmed by the state of Dr Hellyar's practice, we are concerned that they chose not to tell him their intentions with regard to the partnership had changed. Both sides had something to gain by entering into the partnership and accordingly, we do not consider it is fair to apportion blame on this issue. In any event, we do not consider the partnership issue to be crucial to our consideration of the other issues since the evidence points to those issues having arisen to a greater or lesser extent before Aveley came in.

Patient Records

The system (or absence thereof) for the maintenance of accurate records on behalf of patients and whether the shortcomings in Dr Hellyar's system resulted in a failure to make records appropriately in connection with referrals, immunisations etc.

1.8 We note that the PAG investigation commenced some weeks after Dr Hellyar left the surgery and, indeed, some of the witnesses, notably Linda Connelly, Gloria Parnell and Lizzie Hellyar, gave evidence that the state of the surgery and the records were altered by people from the Aveley practice during those weeks. We also note that the photographs of the state and storage of the records taken by the PAG were taken on 29th September 2006, which was five or six weeks after Dr Hellyar left the SOHC.

1.9 Counsel for the PCT submitted that other than from his own family and Gloria Parnell (who failed to attend), there was no support for Dr Hellyar's suggestion that his systems were adequate. He drew attention to June Mason's evidence that on her visit in March 2006 the state of the records in the tea room was having an awful impact on the efficiency of the practice and finding records was taking thirty minutes when usually it takes two minutes. Likewise Sara Lamb's evidence indicated the difficulties she had with locating medical records and both Doctors Chauhan and Benavides provided evidence supporting

the poor state that they found the records in when they came to the practice. Yet Dr Hellyar's only response was that somebody must have put his otherwise orderly records into a poor state after he left, which contradicted the evidence from elsewhere that Dr Hellyar and his practice manager had simply lost control of the records.

1.10 Counsel for the PCT also pointed out that Dr Hellyar and his practice manager were unable to provide any explanation at all for the bundle of papers that appeared. Dr Hellyar was completely unaware of it and only reluctantly in cross-examination did he accept responsibility for that system failure. Counsel contended this issue served to provide independent corroboration of Dr Chauhan's evidence.

1.11 He also contended that further evidence of the state of records and systems was provided by the repeated requests (accompanied by tones of increasing urgency) from Customer Services, but once again, neither Dr Hellyar nor his practice manager had any explanation for their ignorance of these letters.

1.12 Counsel for Dr Hellyar conceded that Dr Hellyar could not give a good reason for failing to purchase additional filing cabinets, although he pointed out Lizzie Hellyar had said it was initially due to lack of space and then down to them not knowing if they wanted a different storage set-up in future. He also pointed out that in April 2006 Dr Hellyar was the victim of a serious assault, and after that he was sure that he would be leaving the SOHC.

1.13 He contended there was a system in place throughout the period up to and including July 2006 for the storage of patients' records and that it worked, at least if the absence of complaints about matters relating to records was taken as a sound indicator of a system that worked. It might not have been aesthetically pleasing, but it was not faulty.

1.14 He also contended there was a system after 4 August 2006, but those who came into Dr Hellyar's rooms at the SOHC were unused to paper files and Gloria Parnell and Linda Connelly had testified to this. He submitted it was significant that at no time before the end of September 2006 did anyone from the Aveley practice approach Dr Hellyar or Lizzie Hellyar to ask for information about the whereabouts of documents or files, or complain to anyone about the whereabouts of documents or files.

1.15 Counsel for Dr Hellyar also questioned Vicki Johnson's evidence that the situation as it was at the end of September 2006 was as it was when she took over the management of Dr Hellyar's practice at the SOHC. He submitted she gave distinctly inaccurate and potentially misleading evidence about the time when the Aveley practice took over Dr Hellyar's practice, whereas he submitted Dr Hellyar's evidence on this was accurate and, as it was on other matters, was given honestly.

1.16 He also submitted that the witness statements of Dr Chauhan and other persons whose statements were appended to the PAG report which recommended Dr Hellyar's removal from the PCT's Performers' List, were all made by an "investigator" whose apparent aim was to prove that the state of affairs witnessed by Dr Grew on 28 September 2006 was the fault of Dr Hellyar and he submitted it was striking that nobody on behalf of the PAG spoke either to Gloria Parnell, Lizzie Hellyar or Dr Dambawinna (who was present in the period before the Aveley doctors started to work at the SOHC), about the situation and, perhaps most strikingly, nobody on behalf of the PAG spoke to Dr Hellyar to see what his recollection of the situation was.

1.17 Counsel conceded that sometimes, as with all paper filing systems, the files went astray temporarily, but not permanently.

1.18 So far as the apparent non-return of medical records for patients who had died or moved was concerned, Counsel submitted that neither Lizzie Hellyar nor Dr Hellyar had seen the first three letters from Customer Services and Lizzie Hellyar said that a number of times Customer Services would not accept that the files which it was requesting had never been at Dr Hellyar's practice.

1.19 Taking into account all of the evidence on this matter it is hard for us to resolve precisely when Aveley took over Dr Hellyar's practice and at what stage the system for maintenance of patient records (which was never particularly satisfactory) deteriorated. Notwithstanding these conflicts, it is clear to us from the evidence relating to the records that Dr Hellyar, as he himself conceded, for a considerable time before Aveley came in had failed to ensure there was an effective system for the maintenance of accurate patient records. There was a system of sorts, but we do not accept the overly rosy picture painted by Counsel for Dr Hellyar that whilst it might not have been aesthetically pleasing, it was not faulty. We consider the evidence clearly points to Dr Hellyar's system being ineffective and requiring improvement in many areas. Several witnesses had given evidence that there was insufficient time and staff to run a safe and effective system.

1.20 It seems to us that Carol Vincent and Sara Lamb had had a better system in place (although it was not necessarily properly overseen by Dr Hellyar) but when Dr Hellyar employed his daughter as Practice Manager, he failed to properly oversee her. The fault lay not in employing his relative but in failing to properly supervise her and accordingly, we consider Dr Hellyar must bear responsibility for failing to ensure Lizzie had enough experience or training to properly run the practice.

1.21 We also consider that Lizzie Hellyar bore responsibility, as Practice Manager, to ensure there was an effective system, but she failed either to implement the necessary improvements or to impress upon Dr Hellyar the need for more staff to achieve this.

1.22 We are of the view that it is a prerequisite of Good Management Practice that doctors ensure their staff are able to fulfil their professional duties so that standards of practice and care are maintained and improved. We note that Dr Hellyar devoted Thursday afternoons to administration and that in 2006 he also employed some additional staff as a result of the QOF Report and recommendations (for example, Pat Marns to assist with data entry on the new computers, Gloria Parnell to assist with administration and Maureen Midgen one morning a week). If Dr Hellyar had properly supervised his staff this might have been sufficient but the evidence indicates he did not, with the result that the practice was unable to follow through the QOF recommendations and ensure reasonable systems were in place.

1.23 Dr Hellyar acknowledged that as well as keeping a referrals file an entry should also have been made in individual patients' records. We considered clear examples of how this could lead to a failure to make records appropriately in connection with referrals, immunisations etc that were illustrated by the problems with the referrals of CL and CS, and the very unsatisfactory handling of the Coroner's case, on which we found Dr Hellyar's evidence far from convincing. In that situation we would have expected him to respond urgently to the Coroner's second request for a report, to urgently contact the Health Authority to return the patient's notes (or if they were unavailable to compile a report based on his personal knowledge) and that he would have ensured that this time his report was promptly and safely received by the Coroner.

1.24 Likewise, on the issue of returning files to Customer Services, we are not persuaded by the evidence of Dr Hellyar or Lizzie Hellyar. We feel Dr Hellyar's reluctance to criticise his daughter, together with his failure to properly supervise her, exacerbated this and other situations (for example the prompt filing of hospital correspondence and laboratory reports) relating to appropriate record-keeping .

The records were handled in such a way that their confidentiality was placed at risk - that is, they were left on the floor of the dental surgery, were left available for access by unauthorised persons and were left in an area known as the tea room

1.25 Linda Connelly's evidence on this issue was that the records were moved over from Dr Bellworthy's surgery in cardboard boxes to the dental waiting room until the two filing cabinets were moved over later that day and that the records may only have been on the floor of the dental waiting room for a day at most, with the older records then going into the dental storage room, which was situated in a corridor inaccessible to the public behind a coded security door and the more recent records being stored in the two filing cabinets in the dental waiting room and later "the broom cupboard" downstairs, which were kept locked outside surgery hours, or where a member of staff was always present if patients were there. She also confirmed the tea room was kept locked and the SOHC kept a master key.

1.26 Dr Hellyar's evidence corroborated this version of events. In addition, he confirmed the dental clinic staff were all trained in patient confidentiality, there was no suggestion they gained access to the notes and when the notes were transferred to the tea room, it was in fact a lockable consulting room with a secure door which was closed when his surgery was in session and patients and non-clinic staff did not access the room.

1.27 We heard evidence that the dental store room and the tea room were disorderly but we consider that evidence relates to the absence of systems rather than confidentiality.

1.28 Although we would not normally like to see patient records being stored away from a doctor's surgery, in this instance, where Dr Hellyar was not initially provided with his own rooms or storage facilities, we consider Linda Connelly to be a credible witness and we accept Dr Hellyar did his best in trying circumstances. There was no evidence of patient complaints or breach of confidentiality and we did not see or hear any evidence from the PCT to contradict this version of events. Accordingly, we are satisfied that patient confidentiality was not compromised. and we do not find the allegations on breach of confidentiality proven.

Failure to maintain records or make accurate or contemporaneous records consistent with good medical practice, including the failure to deal with documentation and incoming mail from hospitals in connection with referrals and failure to record matters in terms of reviews of patients receiving repeat prescriptions.

1.29 The evidence from the staff of Dr Hellyar, and of Dr Hellyar himself, was that there was a separate file in which copies of referral letters were kept. Copies of the letters were not also placed in patients' files, but they were there, and they were readily accessible. Counsel for Dr Hellyar submitted this was a sensible system and there is no written requirement in the relevant GMC guidance that referral letters are kept in patients' files and as long as they are readily accessible, there can be no proper complaint.

1.30 We noted Dr Hellyar's evidence that he often produced a hand-written or word-processed referral letter and photocopies were made of referral letters and kept alphabetically in a large file in the office at the surgery. He admitted that sometimes, but not always, a copy was also given to the patient and sometimes a copy was also put with the patient's records but acknowledged there should also have been an entry in the records as well.

1.31 We also noted Lizzie Hellyar's evidence that their referrals file was sorted alphabetically by surname and enabled them to check the position very quickly if a patient asked for information about a referral and that from the beginning of the

computerised practice referrals were done by Linda Connelly directly onto the patients' notes. They were typed and sent and a copy was saved on the computer system. Prior to this Dr Hellyar would write referrals by hand there and then and they would take a photocopy and send the referral off for processing in the red sacks provided. Alternatively, referrals were typed on Dr Hellyar's or her laptop, printed and sent, copied to the file and sent out.

1.32 On cross-examination Linda Connelly confirmed there was a referrals file, although in her witness statement she submitted patients would always be chasing referrals or results and she wouldn't be able to locate their notes.

1.33 There was also conflicting evidence as to whether Lizzie Hellyar had walked Vicki Johnson around the practice before the Aveley team moved in and shown her the referrals file. Lizzie Hellyar maintained she walked her around twice but Vicki Johnson denied she was shown around.

1.34 So far as Dr Hellyar's alleged failure to deal with documentation and incoming mail from hospitals in connection with referrals is concerned, we noted the evidence of Drs Chauhan and Benavides relating to the big piles of loose papers going back three or four months and that Dr Benavides had spent one morning just going through a black bag that was full of such papers, which included test results, discharge letters, hospital review details and A & E reports and she had followed these letters up where appropriate before summarising the correspondence on the computer. We also noted Brid Johnson's evidence she and Dr Grew had been shown a pile of correspondence which Drs Benavides and Chauhan had started to action.

1.35 Dr Hellyar's evidence was that he had not actively allowed this situation to arise; it may have developed and he accepted it was incumbent upon him to quickly join up incoming results and letters with patient records and it was his responsibility to monitor and do something about the systems in place if they broke down. Although he did not know how the situation had arisen he accepted responsibility for not doing something about it.

1.36 We noted that Lizzie Hellyar also accepted that the bundle of papers should have been actioned, although she submitted some of the information such as duplicated pathology results would already have been on the computer system and minor injuries could have been read and filed, that is a lot of it was information which could have been recorded in other ways.

1.37 With regard to the allegation that Dr Hellyar failed to record matters in terms of reviews of patients receiving repeat prescriptions, we noted Dr Hellyar's admission that he reviewed repeat prescriptions on an ad hoc basis, usually with the patient present. He acknowledged this was not done on a regular basis but he did see patients frequently and would only prescribe short courses of medication and ask patients to return for review if there were mental health issues or the drugs had street value.

1.38 In considering this issue we felt we were hampered by the PCT's failure to adduce any patient records in evidence, either in the form of Lloyd George notes or computer entries. In our view, Counsel for Dr Hellyar was correct in pointing out in closing submissions that the only concrete examples of alleged failures to refer about which evidence was led before the Panel were the cases of CL and CS, but as their medical records were not before the Panel, and Dr Hellyar was given no opportunity to see those records, he was unable to defend himself properly in relation to their cases. Furthermore, it was impossible for us to verify to what, if any, extent referrals were noted onto the patients' notes from the beginning of the computerised practice as Lizzie Hellyar had submitted, although we note Dr Hellyar's admission that prior to that referrals should have been entered on individual patients' notes.

1.39 We accept the existence of a referrals file and, on balance, we think it is likely that this was shown to Vicki Johnson before she took over management of the practice along with the practice protocols, since we consider it is unlikely that Dr Leighton, his partners and their practice manager (who was also a partner) would have contemplated entering into any partnership without first having inspected the practice premises to see how the practice was run.

1.40 We do consider it is possible that the significance of this file was not highlighted to, or realised by, Ms Johnson and that it might have gone unnoticed or been forgotten about during the upheaval of the handover of the practice when Drs Chauhan and Benavides were looking for, and expected to find details of referrals in the individual patients' notes.

1.41 However, we also consider the evidence on this issue again points towards Dr Hellyar failing to follow through the QOF recommendations and ensuring effective and reasonable management systems were in place

1.42 So far as Dr Hellyar's alleged failure to deal with documentation and incoming mail from hospitals in connection with referrals is concerned, we note that he accepted it was incumbent upon him to deal with incoming mail and that although he did not know how the situation had arisen he accepted responsibility for not doing something about it.

1.43 Turning to his alleged failure to record matters in terms of reviews of patients receiving repeat prescriptions, we noted Dr Hellyar's admission that he reviewed repeat prescriptions on an ad hoc, irregular basis.

1.44 Given this evidence and Dr Hellyar's admissions relating to dealing with incoming mail and review of repeat prescriptions, we accept the PAG's findings in this regard. In relation to his system for referrals, we have mentioned our concerns relating to the PCT's failure to provide specific examples of medical records, subject to which we consider his system of keeping a referrals file falls short of the required standards of practice and care

without a back up system of consistently entering details of referrals in individual patients' notes

Immunisations

Systemic failure to adopt any system regulating the preservation, cataloguing and administration of immunisations

(a) failure to destroy old vaccines and keep records with regard to their destruction

2.1 From the evidence of Linda Connelly, Carol Saunders and Vicki Johnson, it appeared to us that there was a system in place to regulate the preservation, cataloguing and administration of immunisations whilst Sara Lamb was the Practice Nurse, but when she left and Lizzie Hellyar took over, the system for immunisations started to break down.

2.2 This seemed to be illustrated by Sara Lamb's evidence at the hearing that when she was at the practice the vaccines were definitely not out of date. Vicki Johnson submitted she had not seen out of date vaccines but Carol Saunders had. Brid Johnson and Dr Grew acknowledged they accepted what the Aveley staff told them. Dr Hellyar told us he had no knowledge of an out of date vaccine left in the fridge when the practice was handed over to Aveley; no one had indicated the vaccine type or patient's name attached to it.

2.3 We were concerned this was an unparticularised allegation with no clear evidence in support. Without more detail we felt unable to uphold such an allegation based only on hearsay evidence.

(b) failure to monitor temperature of fridge in which vaccines stored

2.4 We heard conflicting evidence as to whether there was a thermometer inside or outside the fridge. Sara Lamb gave evidence at the hearing that there was a chart stuck on the fridge and she thought there was a thermometer built into the fridge but she was not completely sure about that. Dr Hellyar confirmed she compiled the fridge temperature log which was kept in clear plastic and stuck on the fridge for easy viewing and that the log was available at each of the nGMS assessment visits and was checked by Brid Johnson at the 2005 visit. Lizzie Hellyar submitted the thermometer was kept outside the fridge; there were two vaccine fridges and one had a LCD display and they also kept a thermometer but she could not recall which fridge they were talking about. Although she never personally took readings they were taken and recorded and she had seen the notebook in which they were recorded. Vicki Johnson said there was no internal thermometer in the fridge, only an external one.

2.5 It was hard for us to be certain whether the thermometer was internal or external and if, and how often the temperature was recorded. We felt confident that Sara Lamb had monitored the temperature and after she left we consider that on the balance of probabilities the temperature was probably monitored from time to time. However, we consider there should have been clear protocols in place for doing this but we are satisfied, on balance, that once Sara Lamb left there was no system in place to ensure the temperature was monitored on a regular basis.

(c) absence of system to regulate batch numbers

2.6 Vicki Johnson's evidence was that batch numbers had not been recorded and if it had been necessary to recall a faulty batch of vaccine, the practice wouldn't have been able to notify anyone as there was no tracking at all

2.7 Lizzie Hellyar contended batch numbers were recorded on the white sheets sent to Child Health and in individual notes so it was not correct, as Vicki Johnson had suggested, that a faulty batch of vaccines could not be recalled.

2.8 We noted that Lizzie Hellyar acknowledged that she did not return the white sheets regularly or on time. Accordingly, we do not accept there was an adequate system in place to regulate batch numbers.

(d) failure to lodge returns with regard to maintenance of vaccination immunisation records

2.9 We have already referred to the system for immunisations breaking down after Sara Lamb left. Dr Hellyar himself submitted evidence of a meeting with Sally at the Child Care Unit in which she told him that "*when Lizzie was doing the returns, the lateness became dire."*

2.10 We note that in September 2006 Sally wrote to Vicky Johnson enclosing a list of dates when no immunisation sheets had been returned under cover of a letter stating: *"As you can see we have not rec. many back and the ones we have received are really out of date. If we (sic) not rec. sheets within 3 months from date we DNA patients. Hope this is useful."*

2.11 We further note Dr Hellyar's evidence that he had undertaken an immunisations audit in November 2006 which did not support the finding in the PAG Report that their system for immunisations was inadequate in either coverage or recording and that he contended his system was not unfit for purpose when considered in the round with other surgeries and their practices.

2.12 However, we also note that both Dr Hellyar and Lizzie acknowledged she failed to return the white forms regularly or on time and Dr Hellyar accepted responsibility for this.

2.13 In the circumstances we consider the system for lodging immunisation returns broke down and was inadequate after Sara Lamb left the practice.

Accommodation

failure to provide seating accommodation and telephone facilities and inadequate provision of any facility for storage of records etc

3.1 We note and concur with the IOP finding that the accommodation provided by Dr Hellyar to his patients was provided for the use of the surgery by the PCT itself and that this encompassed the initial temporary accommodation, the suggested porta-cabin accommodation and the permanent rooms at the SOHC finally allocated to Dr Hellyar.

3.2 We also note Dr Hellyar chose to continue to use the SOHC's waiting room after he was allocated his own rooms for reasons of confidentiality and that he had organised a land-line link to the dental suite for use with a wireless "roving" telephone system because he was not initially given any office space or allowed to install a land-line.

3.3 So far as storage of records was concerned we note Counsel's submission that Dr Hellyar did his best in trying circumstances for two and a half years from May 2003 to December 2006 before he was given adequate space at the SOHC. After then, he had enough space, but failed to buy another filing cabinet, and although he could not explain that failure, his practice manager indicated they were thinking about the best way to keep paper records, and they were considering whether to get rid of the existing two cabinets or simply add to them. Then, only a couple of months later, Dr Hellyar was assaulted and decided to leave the United Kingdom and work abroad.

3.4 Counsel for Dr Hellyar submitted this did not justify Dr Hellyar's exclusion from any PCT's performers' list and we agree. Although we would have expected him to invest in better telephone and storage systems when he was allocated his own rooms (and wondered why he failed to use any of the PIS scheme monies towards doing this), whilst not condoning his lack of motivation, we accept that he was reluctant to make much effort after he decided he was leaving. Prior to that we wondered how the PCT could criticise his telephone system if he was not given adequate office space or allowed to install a land-line.

3.5 We also consider the accommodation issues should have been a matter of co-operation and pragmatism between Dr Hellyar and the PCT. When Dr Hellyar left Dr Bellworthy's practice he had a patient list but no accommodation and we feel the PCT must bear some of the responsibility for his situation. We consider there was a failure on both sides to reach a mutually acceptable solution in a reasonable amount of time and given these circumstances, we do not uphold the PAGs allegations in this regard.

Attendance at the surgery

practitioner over-extended himself by taking on additional responsibilities outside those within his own practice

4.1 We heard evidence that Dr Hellyar had given up some of his extraneous appointments by the time he started running the SOHC practice in 2006 and noted that Linda Connelly gave evidence at the hearing that it was rare they had to phone Dr Hellyar as he always phoned in and if there was an emergency he would tell them where he was so they could get hold of him, and June Mason confirmed that he did not miss clinics without notice or explanation and if he was ever late because of traffic he would phone in to tell her.

4.2 We did not hear any credible evidence that Dr Hellyar failed to attend appropriately at the surgery.

4.3 Although we felt Dr Hellyar was not always there enough to properly supervise his staff, and deal with the administration necessary to run a GMS practice we consider the evidence indicated he attended appropriately at the practice for his clinical duties and whenever he was delayed for any reason he always phoned in to tell the staff. Accordingly, we do not uphold the PAGs allegations in this regard.

Issues of lack of probity

practitioner was evasive and obstructive with regard to the PAG investigation

5.1 We noted that in oral closing submissions Counsel for the PCT claimed Dr Hellyar's argument that he could not answer the questions without sight of the medical records was opportunistic and there were issues of patient confidentiality arising which tended to reduce the enthusiasm of investigators to start disclosing notes and no efforts would be made to obtain that consent until the doctor made a request for them. He also maintained that at no time did Dr Hellyar make such a request and say he wanted sight of the records, yet at the hearing he raised for the first time the suggestion that he wanted records and was deprived of them, although he had had the benefit of legal advice.

5.2 We also noted the written closing response from Counsel for Dr Hellyar that this claim was both adventurous and unfair and that Dr Hellyar had specifically stated in his responses to Mr Greenwood that he could not access the relevant documents and was thus able to give answers only on the basis of limited information. He submitted it was therefore incumbent on the PAG and/or the PCT to give Dr Hellyar access to those documents if it was going to accuse him of wrongdoing and that he did not need to say "please give me access" because any reasonable person who was genuinely interested in arriving at a true understanding of the position would have offered him access to the relevant documents, but no such access was offered then, and no such access was offered subsequently, including during the hearing before the Panel. It was therefore unfair to assert that Dr Hellyar had in some way been less than straight and as open as he could be in his responses to the PAG's requests for information.

5.3 We were also aware that when told of the investigation Dr Hellyar had offered to co-operate and he delayed going to Canada for six weeks in case Mr Greenwood wanted to interview him.

5.4 The principles of good practice in the Department of Health Guidance 'Handling Concerns about the Performance of Healthcare Professionals' make it clear that practitioners should normally be informed immediately about the concerns that have been raised (unless fraud or other criminal activity is suspected) and that an initial meeting will provide an opportunity for the practitioner to hear the concerns and respond, and it will help determine the action to be taken. The Guidance also stipulates that when a case needs to be taken forward, the practitioner must be informed, in writing, of the exact nature of the allegations, the procedure that is to be followed, the possible sanctions that may be applied and the likely timescales.

5.5 We consider the submissions of Counsel for the PCT relating to the provision of medical records to be disingenuous. We note that Dr Hellyar's responses to Mr Greenwood on 5th March *(RB pp802-805*) and 4th April 2007 *(RB pp 810-12)* expressly indicated that he was unable to answer some of his questions without accessing practice documents, that his defence organisation had suggested he invite Mr Greenwood to state any complaints, criticisms or comments, including relevant patient details, so that he could address them properly and fully but that Mr Greenwood had failed to do so and that his paragraph by paragraph response to the PAG Report did in fact repeatedly request the notes *(AB Exhibit AH2 eg paragraphs 14, 576, 577, 584, 589, 604. 618, 654, 747, 752,)*

5.6 We are under no illusions from the evidence he gave that Dr Hellyar found it difficult to accept his deficiencies; he did not always accept he was wrong and he demonstrated a degree of inflexibility in admitting to having and accepting responsibility for the poorly organised and managed systems, practices and protocols at the practice.

5.7 We also acknowledge that his answers could be evasive, for example in relation to the Coroner's report. However, we do not accept the picture was as black and white as was painted by Counsel for the PCT in closing submissions, who contended that his approach to the PAG investigators and the entire enquiry was evasive, opportunistic, comprised of half truths and and that in itself mandated that he be removed from the Performers' List on a national basis.

5.8 Whilst we accept that the performance of the PAG is not the matter under investigation, we do consider that where it might affect the outcome of the appeal, we are entitled to consider same. Given that Dr Hellyar was defending his livelihood, we feel good and fair practice requires a practitioner be provided with particularised details of the exact nature of any allegations against him, together with copies of the relevant medical notes, and a reasonable time to respond to those allegations with that evidence before him. Instead, we note that Mr Greenwood asked questions requiring detailed answers and requested copy documentation knowing Dr Hellyar was abroad and no longer had access to his practice and we feel that Dr Hellyar's frustration at this which came across in some of his answers was understandable in the circumstances

5.9 We do feel the investigation was hampered and complicated by the fact Dr Hellyar was no longer at the practice, but we do not consider that should count against him. Indeed, in those circumstances, we would have expected the PAG investigators to ensure the practitioner had access to the necessary documentation to give him the opportunity to fully and properly respond to the questions put to him. We wondered whether Mr Greenwood's suspicions of Dr Hellyar's possible fraud under the PIS accounted for his failure to fully explain some of the allegations, but even if that was the case, given there was no risk of ongoing fraud and the investigation of use of monies from the PIS could be separated from the other issues, we consider such omission on Mr Greenwood's part was inequitable.

5.10 In these circumstances we do not accept Dr Hellyar was evasive and obstructive with regard to the PAG investigation

practitioner gave false address when registering himself as a patient with Dr Dey

5.11 We note Dr Hellyar's admission in this regard, his reasons for it and his apology. Although we accept he demonstrated a lack of probity in this particular instance we do not consider it is indicative of a consistent pattern of dishonesty.

the use of funding earmarked for particular schemes for acquisition of property, which was personal to the practitioner and the mis-description of that property within records maintained by him

5.12 We note that the probity issue to which the PCT attached by far the most weight was the PIS monies and the submission of Counsel for the PCT that Dr Hellyar's primary position that he could not comment further without evidence being provided of the relevant criteria to be applied was untenable, given the published criteria.

5.13 We also note his contention that Dr Hellyar's explanation relating to the purchase of the HP computer rather than the Apple Mac was opportunistic and thought about on the hoof and that he was being dishonest.

5.14 Counsel for Dr Hellyar submitted that the allegation Dr Hellyar had signed a letter saying that he had already bought an Apple Mac laptop computer, when he had not done so, and thereby obtained PIS monies, which he would not otherwise have obtained, was flawed, since the PCT would not pay money in respect of a computer for which there was no receipt, and Dr Hellyar in fact bought a different computer as a result of which the PIS funds had been released.

5.15 He pointed out that the PCT alleged, without any evidence other than the absence in its records of a receipt for any computer bought by Dr Hellyar, that its own systems had been breached so that the PIS monies had been paid out improperly and he contended it was astonishing that in order to make good its allegation of a lack of probity on Dr Hellyar's part, the PCT had to be able to satisfy the Panel that he claimed the PIS monies for the Apple Mac computer knowing that he had not bought that or any other computer and knowing (or at least believing) that the payment would be authorised without a receipt for any computer, or at least receipts for appropriate purchases whose total equalled or exceeded £3,500. It was clear that he did not do that

5.16 Counsel also pointed out there was a feasible explanation for Dr Hellyar signing a letter saying that he had bought an Apple Mac computer, when he had not in fact done so, because the claiming process was carried out in a hurry since the deadline for claiming the relevant PIS monies had passed.

5.17 We prefer Dr Hellyar's evidence on this issue. The PCT had acknowledged that its usual procedure was not to pay PIS monies without receipts for items whose purchase with PIS monies had been authorised in advance and which were for sums totalling at least the amount of the PIS monies. Accordingly, we find it hard to believe the PCT would have breached its own procedures and approved the payment of PIS monies without the necessary receipts. We also consider it unlikely that Dr Hellyar would believe he would receive the full amount of £3,500 without submitting to the PCT sufficient appropriate receipts to justify the release of that amount

5.18 Turning to the purchase of the grainetier (work station), Counsel for the PCT submitted that neither Dr Grew nor Mr Greenwood, with their many years of experience in the NHS, had ever seen the PIS criteria interpreted in this way and that Dr Hellyar had been misleading and deceitful since he well knew that the purchase of the grainetier was not appropriate for a practice and it was never intended to place it there.

5.19 He further submitted the same was true of Dr Hellyar's interpretation of the criteria that allowed him to retain items from his practice, such as the grainetier and expensive camera equipment, and accused him of helping himself to property which he well knew ought to have remained with the practice.

5.20 Counsel for Dr Hellyar contended that the purchase of the grainetier was firmly within the PIS criteria for the relevant year *(RB p782*), namely: *"The purchase of material or equipment which will enhance the comfort or convenience of patients or members of the practice, including furniture ... for the practice"* and the fact the grainetier was not taken to the SOHC was explicable by reference to the fact that the room in which it was going to be placed had not been refurbished by the time that it was delivered.

5.21 No clear evidence was adduced to us in relation to what should happen to items purchased with PIS monies if a sole practitioner leaves his practice. Barabara Stuttle and Dr Grew opined that Dr Hellyar breached the PIS criteria when he retained the grainetier and camera equipment, but when pressed they were unable to identify any local or national guidelines to confirm this. Our own enquiries also failed to elicit a definitive answer and we note that Dr Grew had acknowledged that PISs had been in place for only six or seven years, and that he was unaware of any other situation in which a sole practitioner had ceased to practise,

where that practitioner had bought goods on the basis that they would be paid for by PIS monies.

5.22 We also note Vicki Johnson's claim that a laptop bought with PIS monies now became the property of the practice but we consider that if a partnership was in fact formed, then the property which the parties brought to it would have had to be dealt with in the partnership agreement. However, she denied any partnership was formed and we therefore accept the submission of Counsel for Dr Hellyar she could not then say that she and her partners had any claim to property bought by Dr Hellyar with PIS monies.

5.23 We question the usefulness and appropriateness of the grainetier and the purchase of such sophisticated camera equipment and whether this was the most judicious use of PIS monies. However, we note PIS monies were awarded for past behaviour in the form of prescribing practices of which the PCT approved, the PIS guidelines made no provision for these circumstances, the PCT had never asked for the property to be returned and Dr Hellyar had never concealed the whereabouts of these items. Accordingly, in the absence of any evidence of concealment and in view of prior PCT approval and the lack of more prescriptive guidelines, we feel it was up to Dr Hellyar to decide what to do with the items purchased by the PIS monies when leaving the practice. We do not consider there is sufficient evidence of a dishonest intention and we do not uphold the allegations of financial impropriety on the part of Dr Hellyar.

<u>Issues of general governance</u>

practitioner left his practice in a fashion of abandonment in August 2006

6.1 Members of the Aveley team, including Dr Chauhan, Dr Benavides and Vicki Johnson all attested to the chaotic state in which Dr Hellyar left the practice, although we note Dr Chauhan's evidence that he did not mention any difficulties to Dr Hellyar or Lizzie Hellyar in the first few weeks as he was trying to get used to the system there and thought it better to communicate any difficulties to Aveley as his employer.

6.2 Dr Hellyar's evidence (supported by and Lizzie Hellyar) that Vicki Johnson was walked around the practice and that he invited questions, comments and discussion on any problems encountered when Aveley took over, but nothing of note was reported to him and that he denied the practice was chaotic when he left it and submitted it might have been made so by a team used to completely paperless management coming into an essentially non-computerised practice, as Gloria Parnell had suggested

6.3 It seems to us that there was fault on both sides; we have already concluded that Dr Hellyar's management of the practice, and some of its procedures and its protocols was deficient and that this was known to the PCT from its most recent QOF visit. On the other hand, it appears no one at Aveley raised their concerns with Dr Hellyar at any stage. We consider that Vicki Johnson should have raised with Dr Hellyar or Lizzie any concerns she had on the initial walk round and that the Aveley partners, as experienced practitioners, should have made it their business to ascertain the state of the practice before going in or as soon as possible thereafter, and to have raised their concerns with Dr Hellyar but again, they failed to do so. In the circumstances, whilst we accept Dr Hellyar left the practice in a certain amount of disarray, we do not accept that he abandoned it in August 2006.

practitioner accessed patient information after leaving practice, culminating in treatment of a former patient

6.4 Dr Hellyar's evidence in relation to this allegation was that he thought he was still a partner in the Bluebell practice and entitled to continue seeing patients and assessing their notes and that he had accessed one patient's file to recall what medication he was on as the patient was illiterate, ex-Special Allocation Service with serious health problems and had telephoned him after visiting the Bluebell surgery because he had been unable to write a repeat prescription request form. He had accessed another patient's records for his date of birth and address to enable him to complete a report which needed sending immediately.

6.5 We note Dr Hellyar did not try to conceal his actions and he asked the receptionist to issue the prescription and we felt he was trying to help where he had a special relationship with a difficult patient. There was no evidence Dr Hellyar was consistently accessing the records or trying to change them or trying to obtain financial gain. We also note that he thought at this stage he was in a partnership and entitled to act as he did and we wondered why, if Aveley did not at that stage consider they were in a partnership with Dr Hellyar, they continued to allow him access to the practice computer.

6.6 Given the above, and the fact Dr Hellyar did not attempt to deny or conceal his actions, we do not consider he acted dishonestly.

practitioner failed to recruit adequate staff in the form of a practice nurse

6.7 Dr Hellyar's evidence in relation to this allegation was that when Sara Lamb left at the end of 2005 he did not replace her, engaging the Community Nurse, to provide immunisations and knowing either he or a local clinic could perform the necessary procedures. He knew Drs Dey and Bellworthy had experienced problems in seeking to replace their practice nurses and he decided to go without, particularly after March 2006 when he knew he was not staying. He also indicated that although he had not advertised, he had asked around and tried to poach a nurse, but he was still working out of whatever room was available so he couldn't attract anyone.

6.8 We note that Dr Hellyar did attempt to recruit a practice nurse although it is debatable how hard he tried. We also note that he was able to function without a practice nurse, although as he himself acknowledged, it was debateable how well he functioned. We do consider this issue highlights once more the shortcomings in management of the practice and its staff by Dr Hellyar and his Practice Manager and we agree that more staff should have been in place to ensure the practice operated satisfactorily and efficiently.

F. Conclusions

1.1 It is clear to us that when the PAG was called in and it decided to investigate his practice, the situation was complicated by the fact Dr Hellyar had left the practice and he then left the country (although we note he delayed his departure in order to co-operate with the investigation), so he was not in situ for assessment or to access records and documents to enable him to fully respond to many of the questions and allegations. Given his willingness to co-operate, the gravity of the allegations against him and the possible consequences of adverse findings against him, whilst we are aware of our remit we nonetheless feel we must place on record our concern that the PAG did not make any realistic attempt, or see any real need, to assess him and the impact this decision had on the outcome of the PAG's investigation of Dr Hellyar. In our view his absence made it more imperative for him to be kept fully informed of the exact nature of the allegations and to be given the opportunity and the means to be able to properly respond to them.

1.2 That having been said, we turn to our detailed consideration of all of the issues and our conclusion that the most important issues were the lack of systems for record-keeping and immunisations and the lack of adequate staff (which we shall collectively refer to as management issues) and the issues of probity. We have upheld the allegations relating to management of the practice (save for the allegation relating to breach of confidentiality), but we have not upheld the allegations relating to probity (save for the giving of a false address when registering with Dr Dey and certain inconsistencies in his evidence)

1.3 It appears to us that the pattern which emerged from the totality of the evidence was that there were a number of key areas in the management and administration of his practice in which Dr Hellyar failed to meet acceptable standards of competence. We note that although Dr Hellyar did have some insight into his shortcomings, he was often reluctant to accept he was in the wrong and he frequently exhibited a degree of inflexibility in admitting to areas of organisational deficiencies, particularly in relation to the supervision of his daughter as the Practice Manager, even though this had been pointed out to him by other employees, June Mason and John Croager at the PCT.

1.4 However, we do not consider these organisational deficiencies were so grave and so incapable of remedy that they made Dr Hellyar unsuitable to be included on the Performers' List and we feel they should more properly be considered in relation to whether his continued inclusion on the Performers' List would be prejudicial to the efficiency of services.

1.5 We are aware that if we uphold the PCT's decision to remove Dr Hellyar from its Performers' List and accede to its request to nationally disqualify him, the effect would be to prevent him from practising his chosen profession as a general practitioner in the UK for the foreseeable future. We understand that it would also impact upon him practising in Canada and would therefore affect his livelihood. In that regard we are aware that he is now performing well there (as confirmed by the recent Canadian assessment dated 22nd January 2008 that he easily meets the standard of care expected of a general practitioner in British Columbia). Accordingly, we feel it is appropriate to weigh the prejudice to Dr Hellyar against the potential prejudice to the efficiency of the NHS should he remain on the Performers' List and in doing so, to consider whether contingent, as opposed to complete, removal would be the an appropriate outcome.

1.6 Section 15(3) of The National Health Service (Performers List) Regulations 2004 allows the FHSAA on appeal to impose any decision which the PCT could have made.

1.7 This allows the FHSAA to remove a practitioner from the Performers List contingently, that is by imposing conditions on his inclusion in the Performers List with a view to removing any prejudice to the efficiency of services.

1.8 We note that the IOP felt it appropriate to impose a condition confining Dr Hellyar's practice to general practice posts in a group practice and that his own Counsel conceded the only restriction which might reasonably be thought to be necessary would be on him practising as a sole GP. Having carefully considered all of the evidence, we are unanimously of the view that contingent removal imposing a condition restricting Dr Hellyar engaging in single-handed practice is indeed the most appropriate way forward.

G Findings

1.1 For all the above reasons we unanimously find that Dr Hellyar is not unsuitable to be included in the PCT's Performers List and we allow his appeal in relation to the unsuitability ground.

1.2 For all the above reasons we unanimously find that in order for DrHellyar's continued inclusion in the Performers List not to be prejudicial to the efficiency of services which those included in the PCT's Performers List perform, he should be contingently removed under Rule 12 of the Performers Lists Regulations on the basis his continued inclusion in the PCT's performers' list is subject to the condition that he shall not engage in single- handed practice. To that extent we allow his appeal in relation to the efficiency grounds.

H Supplementary matters

1.1 We direct that a copy of this decision be sent to the persons and bodies referred to in Regulation 47 of the Rules**.**

1.2 In accordance with Rule 42(5) of the Rules, we hereby notify the parties that they have the right to appeal this decision under and by virtue of section 11 of the Tribunals and Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from receipt of this decision.

Dated this day of 2008

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Debra R Shaw
Chairman of the Appeal Panel