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In the Family Health Services Appeal Authority case no: 14277

Heard at Harrogate	
On 22 and 27 May 2008	

Before

Mr J D Atkinson (Chairman)
Mr I Conquest
Mr R Rhodes

Between

Ascon Projects Management Ltd
t/a
Bell Hall Pharmacy
with Superintendent Pharmacist Mr Mohammad Arif

(formerly listed for hearing as Mohammad Arif)

Appellant

and

Calderdale Primary Care Trust

Respondent

Representation:

For the Appellant: Mr McCartney of Counsel
For the Respondent: Miss Steward of Counsel

DECISION AND REASONS

The Appeal

1. This is an appeal against the decision of the respondent dated 3 January 2008 to remove the appellant from the respondent's pharmaceutical list under the Health Services Act 1977 (as amended) and associated regulations.

The Proceedings

2. Mr Arif is the sole shareholder and director of Ascon Projects Management Ltd which trades as Bell Hall Pharmacy. At all material times Mr Arif was the superintendent pharmacist. Mr Arif has worked at Bell Hall pharmacy for in excess of 20 years. On 1 October 1999 Ascon Projects Management Ltd entered into a contract with the respondent for the provision of pharmaceutical services.

3. In 2006 the respondent began a systematic review of the contract with the appellant which identified a number of concerns. In March 2007 the respondent appointed officers to carry out a formal investigation into the appellant. On 19 December 2007 the respondent conducted a removal hearing attended by Mr Arif.

4. On 3 January 2008 the respondent decided that the appellant should be removed from its pharmaceutical list on the grounds that the appellant's continued inclusion on the list would be prejudicial to the efficiency of the provision of pharmaceutical services. The reasons given for removal may be summarised as follows:

    i. the appellant had breached his duty to disclose information to the respondent on 3 occasions relating to a previous conviction leading to a term of imprisonment, a police caution for failures in the records relating to controlled drugs, and an investigation of the appellant by the Royal Pharmaceutical Society of Great Britain (RPSGB)
    ii. the appellant had over ordered repeat medication, incorrectly dispensed prescriptions and failed to comply with stock integrity procedures
    iii. the appellant had put at risk the public and public finances as a result of excessive dispensing and incorrect claims for medical use reviews
    iv. the appellant had failed to demonstrate adequate compliance with the requirements of clinical governance despite support provided by the respondent

5. On the same date the respondent also decided to apply to the Family Health Services Appeal Authority for a national disqualification of the appellant.

6. On 29 January 2008 the appellant appealed to the Family Health Services Appeal Authority. Appeals to the FHSAA are by way of redetermination.

The Law

7. The relevant law is to be found in the 1977 Health Services Act as amended by the health and Social Care Act 2001 together with associated regulations. Extracts of the relevant law as set out in section 49F of the 19977 Act may be summarised as follows:

    49F… the grounds for removal include…
    (2) … the continued inclusion of the person would be prejudicial to the efficiency of the services…

The documents and evidence considered

8. The appellant and respondent submitted originating documentation which was compiled into bundles marked A and R respectively.

9. For the hearing, the respondent filed 3 volumes of material: vols i and ii indexed and paginated to 873 with further unpaginated folios attached. Vol iii was paginated separately to 59. The Panel notes here that there were some errors in pagination and numbers referred to in this determination refer to page numbers in the bundle provided to the Panel.

10. For the hearing the appellant relied on the bundle marked A.

11. In addition, in the course of the hearing the Panel gave leave to both parties to file further evidence as set out in a schedule marked *documents tendered in the course of hearing* and

indexed 1-17, the contents of which need not be set out here. The Panel note here that the admissibility of a number of those documents was disputed. The Panel admitted them in evidence in the interests of justice and having due regard to the requirements of natural justice.

12. At the end of the hearing the respondent was given leave to prepare a draft of conditions relating to possible contingent removal as at document 17, with leave to the appellant to make further written representations within 7 days on the terms if so advised.

Preliminary matters

13. The appeal was originally set down for substantive hearing on 2 May 2008. The appellant failed to properly instruct a legal representative and the appeal was not ready for hearing by that date. The Panel in consequence issued directions, the full details of which need not be set out here, and the matter was re-listed for hearing on 22 and 27 May 2008.

14. At the outset of the substantive hearing Miss Steward, without the benefit of a skeleton argument made a number of submissions on preliminary matters that may be summarised as follows. Whilst it was accepted that the respondent had made a typographical error in the decision letter of 3 January 2008 by referring to the *removal of Mr M Arif of Bell Hall Pharmacy* instead of *Mr M Arif* and *Bell Hall Pharmacy*, it is undisputed that neither Mr Arif nor Bell Hall pharmacy are on the pharmaceutical list and therefore cannot be removed from it. Mr Arif as the superintendent pharmacist does not appear on the list. Bell Hall Pharmacy is merely a trading name and is not a legal entity and as such cannot be removed from the list.

15. In consequence the respondent's decision, in purporting to remove persons from the list who were not on the list, amounted to a nullity. If it was accepted that the decision was a nullity it followed that the Panel had no jurisdiction to determine an appeal because there was no original decision against which appeal could be brought. Although the Panel were required to proceed by way of redetermination, it could not rectify the error because of want of jurisdiction.

16. Mr McCartney in reply on behalf of the respondent made a number of submissions that may be summarised as follows. The preliminary matter now raised was merely a technical point which gave rise to no prejudice to Mr Arif who is the undisputed shareholder, director and superintendent pharmacist of Ascon Projects Management Ltd (Ascon). The respondent took its decision on the basis that it was dealing with Ascon and Bell Hall where Mr Arif was the superintendent pharmacist. In removing Bell Hall from the list it also removed Ascon.

17. The Panel retired to deliberate and found as follows. The defect complained of in the respondent's decision is a matter of form rather than substance. The respondent has denoted the party's name as Mr Arif and Bell Hall Pharmacy, whereas it is Ascon Projects Management Ltd trading as Bell Hall Pharmacy in respect of which Mr Arif is the superintendent pharmacists. This is a trivial matter in that, in the context of the determination of the issues, it gives rise to no prejudice to Mr Arif: he is the sole director and shareholder in Ascon, trading as Bell Hall Pharmacy and is the superintendent pharmacist. It is not disputed that Mr Arif has received requisite notice of matters in issue and attended the respondent's oral hearing several months ago in December 2007.

18. All these points need to be considered in the context of the Panel's powers and jurisdiction. The Panel conducts these proceedings on the basis of a redetermination of the matter, that is to say it considers matters afresh on the basis of the evidence adduced. This means that the jurisdiction and powers of the Panel relate not to a mere review of the respondent's decision, nor even a consideration of whether the respondent has erred in fact or law; but a consideration of the evidence as if the Panel were the primary decision maker, subject to the usual safeguards of natural justice.

19. It follows that the Panel has jurisdiction to consider the evidence going to the primary issues and as necessary can determine the correct name of the parties subject to questions of natural justice. The Panel is of the view that, given the trivial nature of the respondent's failure to correctly name the party, being one which does not go to the substance of the matter and gives rise to no prejudice to those affected, it has the power to redetermine the matter whilst correcting the name of the party.

20. The Panel further notes that, if Miss Steward be right in her submission as to nullity, it would lead to administrative absurdity: on her contention the decision before the Panel would be void ab initio. In reality the respondent would then simply amend the name of the party without affecting the substance of the decision; and, in consequence the proceedings before the FHSAA, would have to be started again. Such a delay in the administration of justice on those grounds would be unwarranted.

21. Accordingly the name of the appellant is determined to be Ascon Projects Management Ltd trading as Bell Hall Pharmacy with Mr Mohammad Arif as superintendent pharmacist.

Opening submissions on behalf of the Respondent

22. Mr McCartney relied on his opening statement and made further submissions that may be summarised as follows. The appellant should be removed from the pharmaceutical list on efficiency grounds because of his failures in a number of respects

failure in complying with the requirements of clinical governance;

failure to disclose that he had been sentenced to a term of imprisonment, that he had been cautioned by police for failing to properly the records relating to controlled drugs (methadone), and being the subject of a Royal Pharmaceutical Society of Great Britain (RPSGB) investigation

repeatedly over ordering medication leading to either over claiming to the Prescription Pricing Authority (PAA) or oversupplying patients

dispensing drugs which were similar but not the same as those that had been prescribed

and a number of other matters relating to medicine use reviews(MURs) and stock integrity

Oral Evidence on behalf of the Respondent

23. In addition to considering the documentary evidence the Panel heard oral evidence on behalf of the respondent from Ruth Elizabeth Naomi Buchan, community pharmacy facilitator. She adopted her statement of 17 April 2008 as evidence in chief and was examined, cross examined and re-examined. Relevant extracts of her oral evidence may be summarised as follows.

24. Ruth Buchan has a B. Pharm degree from the university of Bradford dated 1994 and is a member of the RPSGB. She has a diploma in medicines management in primary care from the university of Leeds dated 2006. Ms Buchan was employed by the respondent in 2003 and appointed prescribing support pharmacist in January 2006 with responsibility for clinical

governance for community pharmacy. The purpose of clinical governance is to improve patient safety by having procedures in place that underpin the delivery of services under contractual arrangements.

25. On 27 July 2006 Ms Buchan visited Mr Arif to assess compliance with clinical governance requirements. Ms Buchan identified concerns across a range of matters as set out at page 111. The concerns related to issues such as the lack of standard operating procedures, documents which were undated, with no review dates, lack of signatures on records, inadequate recording of details on reports, inadequate procedures for dealing with medication *owing,* disposal of confidential waste, information on data protection and other elements of prescribing. The overall view was that there was poor compliance with clinical governance requirements.

26. An action plan was devised as set out at page 113 and a review date was set for 3 months in November 2006. Mr Arif was required to sign the record showing that he accepted the typed version of the action plan, but failed to do so.

27. On 24 November 2006 Ms Buchan visited Mr Arif as planned. She noted that there had been no progress in implementing the plan save for the provision of a paper shredder for confidential waste.

28. On 15 February 2007 Ms Buchan visited again. She noted at page 198 that progress had been made in 10 areas of the action plan and that further work was needed in completing the high priority areas of action and that a start should be made on the medium priority areas, with preparations to be made for action on low priority areas. Two particular areas of high priority concerns remained relating to the inadequacy of standard operating procedures and repeat dispensing.

29. Ms Buchan visited the appellant again on 27 March 2007 as noted at page 216. It was noted that he had failed to sign the action plans and failed to make any progress since the last visit in implementing the action plan. Mr Arif was warned that lack of improvement would lead to formal disciplinary measures. The warning was included as a note to the action plan. Mr Arif signed a declaration agreeing to the report.

30. Ms Buchan visited again on 28 June 2007 as noted at page 57. In the period between March and June it had come to the respondent's notice that Mr Arif had been subject to a term of imprisonment in 1998-99; had received a police caution in 2006 as a result of his failure in managing controlled drugs; and that there were a number of incident reports relating to the dispensing of out of date medication, over ordering medication and dispensing errors. Those matters were put to Mr Arif and his replies noted. Ms Buchan was of the view that there was very poor compliance by Mr Arif, particularly when compared with her experience with other pharmacists. Ms Buchan arranged to visit again in 2 weeks.

31. Ms Buchan quantified the extent of the problem with over ordering and dispensing in the following terms. Copies of the prescriptions of various patients had been compiled in vol ii and ran from page 417 to over 879. The prescriptions related to anonymised patients PR, SLG, VA, NAA, NCH, BAS, and JB as compiled by the respondent and patients 1-4 as compiled by NHS counter fraud officers. Examination of the prescriptions showed over ordering or dispensing in the following respects.

32. Patient RT at page 417 would normally be expected to require 952 tablets of gaviscon over 17 weeks but 1400 had been ordered, making an excess of 450.

33. Patient RT at page 418 would also normally be expected to require 4 angina sprays over 17 weeks but 13 had been ordered, making an excess of 9.

34. Patient PR at page 442 would normally be expected to require 4 angina sprays over 17 weeks but 22 had been ordered, making an excess of 18.

35. Patient PR at page 442 would also normally be expected to require 5 salbutomol inhalers over the 17 weeks period but 28 had been ordered, making an excess of 23.

36. Patient PR at page 443 would also normally be expected to require up to 3 x 119 tablets of varying strengths of warfarin tablets over the relevant period but 3 x 550 of such tablets had been ordered. Ms Buchan further noted that if such a dosage had been taken then this would be beyond what was considered safe.

37. Patient SLG at page 493 would normally be expected to require 3 inhalers over the relevant period but 14 had been ordered, making an excess of 11.

38. Patient VD at page 522 would normally be expected to require 3 beclazone and 4 salmetrol inhalers over the relevant period but 15 of each had been ordered, making an excess of 23.

39. Patient NAA at page 543 would normally be expected to require 8 bottles of oilatum bath oil over the relevant period but 18 had been ordered, making an excess of 10.

40. Patient NCH at page 569 would normally be expected to require 5 bricanyl and 8 symbicourt inhalers over the relevant period but 14 of each had been ordered, making an excess of 15.

41. Patient BAS at page 592 would normally be expected to require 84 mefenamic tablets over the relevant period, and in extremis may require up to 357 but 500 had been ordered, making an excess of up to 416 .

42. Patient JB at page 604 would normally be expected to require 357 novofine needles over the relevant period but 1400 had been ordered, making an excess of more than 1000.

43. Patient 1 at page 652 had been prescribed 7 tablets of clobazem to be taken over days to be followed by a break of 21 days. However the scripts showed that in July, October, November 2005 and January 2006 a whole months supply of 28 tablets had been dispensed on each occasion. This put the patient at risk. The drug is a benzodiazipine and therefore addictive. It is treatment for epilepsy and anxiety. Its over use may lead to dependency. Some of the scripts were endorsed by Mr Arif with the letters ZD (zero discount) showing that he had applied his mind to individual items and identified as items which did not attract a discount for pricing purposes.

44. Patient 4 at page 677 would normally be expected to require 331 capsules of Lopace over 47 weeks but 644 had been ordered making an excess of 313.

45. Patient 5 at page 803 would normally be expected to require 57 tablets of risedronate, 392 of sertraline and 644 of trazadone over 57 weeks but 116, 728 and 1120 respectively had been ordered.

46. Patient 4 at page 77 would normally be expected to require 331 capsules over 47 weeks but 644 had been ordered making an excess of 313.

47. There were also concerns about the integrity of stock held by the appellant arising from management of the fridge temperature and out of date medication.

48. A further concern related to the appellant supplying a medication other than which was prescribed by the GP. At page 70 the evidence showed that the appellant supplied risedronate when alendronate had been prescribed and had attached an alendronate label to a risedronate box. Similarly at page 194 the record shows that a patient complained that they

had been prescribed bisoprolol yet the appellant had dispensed felodipine.

49. On cross examination and further questioning relevant extracts of Ms Buchan's evidence is as follows. It was accepted that in relation to the risedronate issue at page 70 the original script was not available, however the box (which was produced to the Panel) was supplied by the GP. It was accepted that a GP had reported the issue of bisoprolol/felodipine but there were no details about the circumstances of that complaint.

50. It was not accepted that the prescriptions of the various patients should be viewed in isolation. The pharmacists was under a duty to keep records and this should fall within standard operating procedures.

51. It was accepted that the dosage for taking warfarin varied depending on blood tests.

52. It was accepted, as shown at page 189, that NHS counter fraud officers were having difficulties in finding reliable witnesses [in order to prosecute for fraud], however that was because the patients were vulnerable.

53. Turning to the issues of clinical governance it was accepted that in July 2006 the appellant appeared willing to respond. It was accepted that progress had been made as recorded in the reports of November 2006 and February 2007. The matters noted in those reports did not look at the whole of the pharmacy – there were other indicators as well. It was accepted that the report to the oral hearing as set out at page 48 was inaccurate in stating that there had not been any additional progress after the first follow up visit.

54. It was put to Ms Buchan that the appellant did not recall being given a formal warning that his failure to improve may lead to disciplinary proceedings. Ms Buchan did not accept that. She had given the appellant information about the process, he had signed the report at page 218 which recorded the warning and a typed version of the report had also been sent to him as at page 217.

55. It was accepted that the appellant had shown some comparative improvement in that by the time of the last monitoring visit he was placed 5th worst on the pharmaceutical list as opposed to 3rd worst.

56. The comparison took into account that the pharmaceutical list was comprised about 50:50 independent pharmacists to chain/multiples

Oral evidence on behalf of the appellant

57. The Panel heard oral evidence on behalf of the appellant from Mr Arif, Mr Haider and Mr Hyams. They were examined, cross examined and re-examined. Relevant extracts of the oral evidence may be summarised as follows.

Mr Arif

58. Mr Arif adopted as evidence in chief his two statements of 22 May 2008. He is a member of RPSGB, having obtained his BSc in 1981 and has worked at Bell Hall pharmacy for 23 years having set up his company in 1984.

59. It was not conceivable that he had given medication such as risedronate when alendronate had been prescribed. He would never give a different medication without consultation. Nor would he have swapped felodipine for bisoprolol. Those matters had come about as a result of a labeling error.

60. Mr Arif accepted that he had not returned the signed documents relating to clinical

governance and monitoring to the respondent as requested because he assumed that it was not important to do so. He will do so in the future.

61. It is accepted that he did not meet the required standards, but he had other commitments and he was concentrating on the business side of the pharmacy and working alone. He intended to change in the future. He had not appreciated the degree of extra paperwork that arose as a result of changes in 2005.

62. It was accepted that he had signed the report at page 217 containing the warning about possible disciplinary proceedings but he did not read the document fully and *probably* missed the reference to disciplinary proceedings.

63. The documents showed that there had been over-prescribing, but that was because they had been correlated and set out all together after they had been prescribed.

64. Mr Arif noted that at page 166 there was a record of complaints by anonymised patients relating to repeat prescriptions. There had been problems with the patients prescriptions. They had often run out of medication and asked Mr Arif for emergency medication. In order to avoid such requests Mr Arif had himself ordered prescriptions from the GP. However on one occasion Mr Arif had ordered such a prescription without knowing that the patient was also ordering one; as a result the patient had complained.

65. Mr Arif dispenses the medication that is prescribed on the script. If he did not have an item he would order it and the patient would collect it later. Mr Arif disputes the GP receptionist account of his dealing with repeat prescriptions as set out at page 304. Mr Arif has attempted to sort it out with practice but when he telephoned the practice manager put the phone down on him.

66. When Mr Arif dispenses a prescription he usually has the last dispensing details to hand, however it was impractical to analyse the records. It is accepted that the computer system at the pharmacy needs upgrading. However Mr Arif strongly believes that the GPs have a lot of responsibility for the over-prescribing and the problem is not his over-dispensing. The respondent has acted hastily and has not given him an opportunity to show he could improve. Mr Arif had rung the GPs when he had concerns about over-prescription.

67. Turning to issues about disclosure Mr Arif said that he had not disclosed the fact of his conviction and imprisonment to the respondent because he had been advised by a colleague that he did not need to do so as the conviction had occurred more than 5 years a go. The forms provided by the respondent were not clear about the extent of his duty to disclose.

68. Mr Arif conceded that he should have disclosed the fact that he had accepted a caution from the police about his management of controlled drugs. It was accepted that the records were incomplete, however at the time he had had a student working for him. In hindsight an explanation for the incomplete records might be because the patient did not collect the medication. The system has now been changed. Mr Arif assumed that the police would tell the respondent.

69. Mr Arif odes not accept that he should have told the respondent about his involvement with RPSGB in July 2007. His duty to disclose related to investigations being undertaken by the RPSGB. He was not aware that such an investigation was underway. Mr Arif had been asked to comment on a complaint, but that did not mean there would be an investigation.

70. Mr Arif accepted that he should have responded differently to the issue of the fridge temperature. It was also conceded that he was at fault in his preparation of methadone. It was conceded that he had dispensed an out of date antibiotic, but he had subsequently retained it without harm to anyone. It was accepted that he had retained out of date stock of

palliative medicine, but none had been dispensed. It was conceded that an incorrect claim for MURs had been made, but the £46 in claims had been returned.

71. Turning to the future, Mr Arif planned a number of changes. Mr Hyams through his firm NGS would oversee the physical changes to the business. Mr Haider would oversee the changes to the pharmaceutical side of the business. It was anticipated that such changes may take place over a 2 year period. Mr Arif would keep open the option of selling the pharmacy. Mr Arif would be willing to accept conditions on his practice although he had reservations about being prohibited from providing enhanced services.

72. In cross examination and in answering other questions extracts of Mr Arif's evidence are as follows.

73. In relation to all the matters where it was said that there was over-prescribing, he had dispensed those items.

74. As to the patient who had complained, at page 166, that she had not received inhalers, that was patient SLG whom Mr Arif knew. She had received all 14 inhalers as prescribed. Mr Arif had asked if she had needed the inhalers. Mr Arif disputed her account as set out at page 166. She had retracted her complaint.

75. Referring to patient PR, the records for whom were also filed as patient number 3, it was put to Mr Arif that he had dispensed 150 warfarin tablets in a week amounting to 450 mg, yet the BNF gave an average daily dose of 5-9mg. Mr Arif said that was possible, but he had dispensed what the GP had prescribed and the patients knew their own dosage. Mr Arif was not in a position to decided what the correct dose was and it would be necessary to look at the GP records.

76. [The Panel note at this point that the respondent had afforded the appellant access to the GP records, but they had not been admitted in evidence because Counsel for the appellant had indicated that they did not assist the appellant's case.]

77. Mr Arif accepted that he had been afforded access to the records but was unsure if they supported his point because he had not scrutinized them.

78. Referring to patient 1, it was put to Mr Arif that pages 652 and 653 showed that he had dispensed 28 tablets of clobazem on 31 July 2005 on 4 scripts, yet each prescription stated that one tablet a day should be taken for 7 days with a twenty one day break. Mr Arif said that sometimes patients take more than 7 tablets and it would have been wrong not to dispense. The patient knew their condition as either anxiety or epilepsy. Mr Arif had dispensed 7 tablets for a week and had entered the GP instructions on the label.

79. Referring to patient 5, Mr Arif was taken through pages 802 to 838 showing that 728 sertraline tablets had been dispensed to the patient because of their mental health condition, yet only 392 would normally have been required. Mr Arif said that he had supplied all the medication prescribed and he did not consider that the patient's mental health was put at risk because he could have been taking more medication.

80. Mr Arif was asked whether those pages, and in particular pages 814 and 816 showing that 2 prescriptions for 56 tablets each of sertraline, each equivalent to one months supply, were issued on 21and 23 June 2005 and dispensed, showed that there was something wrong with the prescribing. Mr Arif at first said that he was not sure. Then he said that in hindsight that it was so, but the GP had prescribed them. He suggested that the may be the GP had decided that the dosage should be that high. Mr Arif said that he had not had the opportunity to look at the GP records.

81. Turning to the issue of disclosure of his conviction, Mr Arif said that he had asked a colleague whom he would only refer to as a Dr Q about whether or not he needed to disclose it because the form provided by the respondent was unclear. Mr Arif did not ask the respondent for clarification because he did not want to divulge the information if he did not need to. As to the police caution, Mr Arif did not know that he needed to pass on that information and assumed the respondent would know because of the presence of an inspecting officer from RPSGB. Mr Arif did not mention his further involvement with RPSGB relating to a complaint in July 2007 because the RPSGB involvement did not amount to an investigation.

82. Turning to the future management of the pharmacy Mr Arif said that he would be assisted by Mr Hyams and Mr Haider. Mr Arif had been working on the operating procedures but was not in a position to produce it to the Panel. The refurbishment of the premises was put on hold pending the outcome of these proceedings. Mr Arif had been in contact with Mr Haider in the previous few weeks. Mr Haider had not been in a position to agree to be the superintendent pharmacist at that time because of his other commitments. It is now proposed that he will work at the pharmacy 2 days per week.

83. Mr Arif relied on further evidence adduced in the course of the hearing [documents 9 to 16] to show that there continued to be difficulties with GPs over prescribing and that he had taken action to bring this to their attention.

Mr Haider

84. Mr Haider adopted his statements of 22 and 27 May 2008 as evidence in chief. His further oral evidence may be summarised as follows. Mr Haider qualified in 1998 and is the principal pharmacist at Ealing hospital NHS trust. He has experience in community pharmacy and works one day a fortnight in such a setting in order to maintain his skills. He has knowledge of standard operating procedures as they relate to both primary and secondary care.

85. Mr Haider is aware of the concerns relating to Mr Arif's over prescribing [and with leave of the Panel was in attendance when Mr Arif gave much of his evidence]. From his experience, responsibility for prescribing falls on both the prescriber and the dispenser. Given the main impact of such issues fell on patients and the importance of avoiding risk to them, it was important to liaise with patients and the GPs. The issue could be managed in terms of training so that over prescribing could be identified with clear pathways showing what steps needed to be taken. Mr Haider would identify training that would assist Mr Arif and he would teach Mr Arif and help him develop.

86. Mr Haider works full time at Ealing NHS trust and is responsible for 6 members of staff. He would be able to supervise Mr Arif one evening in the week and at weekends. At other times a locum would be available. If a locum was not available Mr Arif would be the superintendent pharmacist. Mr Haider agreed in principle to act as superintendent pharmacist about one and half to two months ago, but had not mentioned it to his present employer. It is likely that his present employment will be affected in any event by restructuring of services.

87. Mr Haider was asked what he would do if he became aware that a patient was receiving one months worth of medication on a weekly basis. He said that first he would inform the surgery. If it happened again he would raise it with the patient and the GP. He would make endorsements on the script or send it back to the GP. The first duty of care was to the patient but if there were further incidents then it would need to be followed up with the surgery. Mr Haider would not dispense the medication immediately without taking those steps.

88. Mr Haider was asked specifically about his views of circumstances where warfarin was being dispensed as the rate of 150 tablets in a week. He said that such a dose would be exceptional and the issue would be raised with the patient and the GP. The script would be endorsed appropriately. Mr Haider had personally never seen warfarin prescribed at such a

level and it would set alarm bells ringing. He would not supply such a dosage and would follow up matters with the GP.

89. Mr Haider would be able to start working with Mr Arif within the week. Refurbishment of the premises and physical aspects of the pharmacy may take up to 2 years. Mr Haider in his own view has the time and experience to supervise Mr Arif adequately.

Mr Hyams

90. Mr Hyams adopted his statement of 21 May 2008 as evidence in chief. His further oral evidence may be summarized as follows. Mr Hyams is a consultant with NGS Corporate Services Ltd. The company offers a wide range of services relating to mergers, restructuring, dispute resolution, negotiations and providing para legal advice. The firm has between 4 and 6 employees.

91. Mr Hyams has responsibility for the dealing with Mr Arif as a client. Mr Hyams has no experience dealing with pharmacy matters, his expertise lies in retailing. His task is to ensure that the pharmacy meets the physical requirements of the respondent and that management systems are in place. The pharmacy may need to close for 2 to 4 months to implement those changes, but no definite decision had been made about closure. The respondent had not been advised of this because no decision had yet been taken. There is the possibility of using the next door property as part of the refurbishment programme.

The Respondent's submissions

92. Mr McCartney, on behalf of the respondent, relied on his opening statement and made a number of further submissions that may be summarised as follows. The respondent relies on all the matters set out in the documentation but identifies the following four issues as the most serious: over-dispensing, lack of disclosure, dispensing of medication other than as identified on the prescription and the appellant's attitude to clinical governance.

Over-dispensing

93. The evidence shows that the appellant has over dispensed medication. The concerns arise from both the quantity of medication dispensed and the pattern of dispensing. The documentary evidence showed for example the appellant frequently dispensed 28 days of clobazam to patient 1 when only 7 days was required (page 652 onwards) ; and that warfarin was dispensed to patient PR in such quantities (page 443 onwards) that, according to his own witness Mr Haider, alarm bells should have been ringing.

94. The evidence showed that the appellant had endorsed some of the scripts which indicates that he had consciously directed his mind to the relevant items, yet it would be obvious to any pharmacist that the medication levels needed review.

95. The extent of the over prescribing was also reflected in the costs schedule at vol iii page 1 which provided a snapshot of consequential overpayments to the appellant of £2191.81.

Failure to disclose

96. The appellant had failed to disclose matters to the respondent in respect of 3 matters on 3 occasions. In his original declaration he had failed to disclose his previous conviction and removal from the Royal Pharmaceutical Society of Great Britain (pages 83-101). He had failed to disclose the fact of his police caution (page 190). He had failed to disclose the fact that the RPSGB had begun an investigation into a complaint against him in July 2007. The appellant had failed to put forward adequate explanations for such failures.

Mis-dispensing

97. On 2 occasions albeit 2 years apart, the appellant had substituted the drug named on the prescription for a similar type of drug, without authority as referred to at pages 69 (risendroneate dispensed, alendronate prescribed) and at page 194 (felodipine dispensed, bisoprolol prescribed). The Panel were invited to draw the inference that such substitution was a product of a conscious decision to do so and was not a result of a labeling error.

Clinical Governance

98. The appellant by his attitude had failed to show a proper understanding of clinical governance issues and as such there had been specific failings in his practice which fell short of acceptable standards. The appellant had been visited on 5 occasions by the respondent on such matters and whilst showing some improvements over time, the standard of compliance with clinical governance measures was poor. This suggested that the appellant was seeking to comply with clinical governance issues at only the minimal level required to keep the respondent happy.

99. In addition the appellant had showed a failure to exercise his own clinical judgment by suggesting that responsibility for the specific concerns about over dispensing were attributable to the prescriber.

Removal

100. Given the above the respondent took the view that contingent removal was not an appropriate course of action. In particular, the evidence showed that the appellant had consciously decided to take the various courses of action set out in the evidence. Such deliberate decision making on the part of the appellant suggested there were no conditions which could be imposed that would address the respondent's concerns.

National disqualification

101. The concerns of the respondent related to matters that could not be described as local issues and as such the imposition of a national disqualification was appropriate.

The submissions on behalf of the Appellant

102. Miss Steward on behalf of the appellant relied on her skeleton argument on which she elaborated. Her submissions may be summarised as follows. The appellant should not been removed on the list, but is willing to accept the imposition of conditions.

Dispensing errors

103. The evidence relating to incidents prior to July 2005 ought not to be taken into account because they were not taken into account by the respondent in coming to its decision. To the extent that such evidence is taken into account to show a pattern of behaviour, as opposed to a particular incident on which a removal decision may be based, then the evidence, as hearsay, should be treated with caution. In particular the incident in April 2005 relating to the dispensing of risendronate , when Alendronate had been prescribed (page 69) was a genuine error on the appellant's part as was the later dispensing of felodipine instead of bisoprolol (page 194).

104. The appellant's case is that of the 4 incidents claimed by the respondent to be dispensing errors, two have been conceded by the respondent to be labeling errors; the remaining 2 incidents are not sufficient to show a pattern of dealing on the basis contended for by the respondent.

Clinical Governance

105. The appellant's approach to clinical governance issues should be viewed in the context of staffing levels at the pharmacy. The appellant worked alone with occasional support from a trainee or equivalent. It is accepted that perhaps the appellant had not struck the balance right in his practice, but these amounted to failures in respect of simple administrative tasks. He accepts that the individual action points raised by the respondent need to be addressed.

106. The respondent visited the appellant on 6 occasions between July 2006 and August 2007. Over that period he showed that he addressed many of the issues. The respondent had admitted that the report to the oral hearing of December 2007 (page 48) incorrectly stated that visits after the first follow up visit did not see any additional progress. In that context caution should also be exercised in giving weight to comparative statistical data said to show that the appellant had moved from third worst to fifth worst in the rankings of pharmacists on the list.

Over- dispensing

107. The evidence relating to complaints about over dispensing should be treated with caution. The evidence of one of the complainants is said to have been retracted. The appellant has put forward a reasonable explanation for the claimed over prescribing in September 2007, namely that there were difficulties with the repeat ordering procedures with the local GP.

108. As to the documentary evidence in the form of prescriptions, it is accepted that on their face they show an excessive amount being prescribed. However, in assessing the significance of the prescriptions due weight should be given to the fact that they were issued by GPs and that the appellant is not responsible for writing the prescriptions. The evidence shows that the appellant has attempted to address this issue with the local GPs but that there have been communication difficulties between the parties.

109. In addition to considering the context in which such prescriptions were produced, weight should also be given to the fact that the appellant, on dispensing the medication, would not have the full history of a patient's prescriptions. The prescriptions therefore were viewed in isolation and in themselves would not give rise to concern. On occasion the appellant had noted the level of prescribing and had tried to contact GPs.

Disclosure

110. The appellant accepts that he failed to disclose material matters, but such failure was not a dishonest attempt to conceal information. In relation to the failure to disclose his previous conviction he had sought advice and as a result thought it need not be disclosed. As to the police caution, he had assumed that the police would notify the respondent over what was a minor matter. As to the failure to disclose the investigation by the RPSGB, the evidence did not show that there was an investigation, only that a complaint had been made against the appellant and a response had been called. Such circumstances did not require the appellant to notify the r respondent.

Other matters

111. The appellant conceded that he had erred in the manner in which he dealt with regulation of the fridge temperature, and that had now been remedied. The appellant had also put in place a system to monitor when stock became out of date and had repaid the sums of money relating to payments for MURs.

Removal

112. The appropriate disposal of the appeal should be by way of contingent removal. The appellant accepted that conditions should be imposed on his remaining on the list. The respondent had originally considered the possibility of contingent removal as shown at page 7 and by draft conditions at page 20.

113. The appellant accepted that it was not necessary for him to be allowed to provide enhanced services. It was proposed that the appellant be supervised in his practice; that the management of the pharmacy would be supported by Mr Hyams and that additional staff would be employed. Mr Haider, who had shown himself to a knowledgeable and diligent witness who would spend 2 days a week at the pharmacy and provide appropriate supervision and advice.

114. It was accepted that should the Panel find that the appellant be removed from the pharmaceutical list, no reasonable objection could be raised to the imposition of a national disqualification.

Assessment of Evidence and Findings of Fact

115. The Panel considered all the evidence and the submissions of the representatives. The Panel notes that, following directions from the Panel, Miss Steward as Counsel on behalf of the appellant produced handwritten schedules at documents 5a,b and c of respectively those matters that are not in dispute, those matters that are in dispute and those matters in respect of which there are partial admissions. The Panel further notes the amendment to document 5b whereby the only matter said to be wholly in dispute, relating to the investigation by a regulatory body was now admitted as to the occurrence of the events therein described. In drawing up such schedules Miss Steward, as set out above made a number of submissions which sought to put those matters in context. Accordingly the Panel makes findings of fact by reference to those matters as follows.

Over-dispensing

116. At document 5c the appellant accepts that on the basis of the evidence provided and the form in which it is collated, that it would appear that more medication than would have been necessitated by the relevant condition was prescribed and dispensed.

117. The Panel find that appellant has dispensed medications beyond what would normally be expected in the terms as set out in the evidence of Ruth Buchan. The Panel finds her to be a credible witness. Her account was consistent and detailed. She accepted, where appropriate, when she had made an error in summarising her account. Accordingly the appellant has over-dispensed medication in the following terms.

118. Patient RT at page 417 would normally be expected to require 952 tablets of gaviscon over 17 weeks but 1400 had been ordered, making an excess of 450.

119. Patient RT at page 418 would also normally be expected to require 4 angina sprays over 17 weeks but 13 had been ordered, making an excess of 9.

120. Patient PR at page 442 would normally be expected to require 4 angina sprays over 17 weeks but 22 had been ordered, making an excess of 18.

121. Patient PR at page 442 would also normally be expected to require 5 salbutomol inhalers over the 17 weeks period but 28 had been ordered, making an excess of 23.

122. Patient PR at page 443 would also normally be expected to require up to 3 x 119 tablets

of varying strengths of warfarin tablets over the relevant period but 3 x 550 of such tablets had been ordered. Ms Buchan further noted that if such a dosage had been taken then this would be beyond what was considered safe.

123. Patient SLG at page 493 would normally be expected to require 3 inhalers over the relevant period but 14 had been ordered, making an excess of 11.

124. Patient VD at page 522 would normally be expected to require 3 beclazone and 4 salmetrol inhalers over the relevant period but 15 of each had been ordered, making an excess of 23.

125. Patient NAA at page 543 would normally be expected to require 8 bottles of oilatum bath oil over the relevant period but 18 had been ordered, making an excess of 10.

126. Patient NCH at page 569 would normally be expected to require 5 bricanyl and 8 symbicourt inhalers over the relevant period but 14 of each had been ordered, making an excess of 15.

127. Patient BAS at page 592 would normally be expected to require 84 mefenamic tablets over the relevant period, and in extremis may require up to 357 but 500 had been ordered, making an excess of up to 416 .

128. Patient JB at page 604 would normally be expected to require 357 novofine needles over the relevant period but 1400 had been ordered, making an excess of more than 1000.

129. Patient 1 at page 652 had been prescribed 7 tablets of clobazem to be taken over 7 days to be followed by a break of 21 days, but in July, October, November 2005 and January 2006 a whole months supply of 28 tablets had been dispensed. Some of the scripts were endorsed by Mr Arif with the letters ZD (zero discount) showing that he had applied his mind to individual items and identified as items which did not attract a discount for pricing purposes.

130. Patient 4 at page 677 would normally be expected to require 331 capsules of Lopace over 47 weeks but 644 had been ordered making an excess of 313.

131. Patient 5 at page 803 would normally be expected to require 57 tablets of risedronate, 392 of sertraline and 644 of trazadone over 57 weeks but 116, 728 and 1120 respectively had been ordered.

132. Patient 4 at page 77 would normally be expected to require 331 capsules over 47 weeks but 644 had been ordered making an excess of 313.

Failure to disclose

133. In document 5a the appellant accepts and the Panel finds that that Mr Arif failed to disclose in his declaration of 5 October 2005 at page 84 that he had been sentenced to a term of imprisonment and had served such a sentence in 1998-99.

134. The Panel further finds that Mr Arif failed to disclose that in the course of 2006 he had been subject to a police caution for failing to comply with the requirements of record keeping respect of controlled drugs.

135. The Panel notes from the amendment to document 5b that the appellant no longer disputes the occurrence of a complaint made against him to the RPSGB. However, the Panel finds that there is insufficient evidence to show that Mr Arif was subject to a formal investigation by the RPSGB of which he was given formal notice. The respondent relies on

the document at 236 in support of that allegation. The Panel find that the evidence shows only that a complaint against Mr Arif was being looked into and not that he was subject to a formal investigation. Accordingly the Panel find that Mr Arif has not breached his duty of disclosure in this respect.

Mis-dispensing

136. In document 5c the appellant accepts that there were dispensing errors in relation to the use of epilim in April 2005 (page 67) and May 2005 page 74) and bisoprolol for felodipine in February 2007 (page 194) but submits that they were labeling errors.

137. The respondent accepts that the matters relating to epilim were labeling errors but that the incident relating to bisoprolol and the further incident relating to risedronate and alendronate in March 2005 (page 70) show that Mr Arif deliberately dispensed medication that was different from that prescribed.

138. The Panel rejects those submissions of the respondent for the following reasons. The affixing of labels is prone to human error. Mr Arif was working largely on his own and substitution of the medications would not lead to any significant benefit to Mr Arif. Further the matter complained of in relation to risedronate/alendronate is so obvious even on a cursory inspection of the box and label, that it is suggestive of error rather than a deliberate decision which the appellant would have wished to conceal. In the context of this evidence the Panel declines to draw the inference contended for by the respondent and finds it highly implausible, that Mr Arif would have deliberately substituted different medications.

Clinical governance

139. At document 5c the appellant accepts as described the evidence relating to clinical governance, but issue is taken as to the extent of improvement. Accordingly, the Panel finds as follows.

140. On 27 July 2006 Ms Buchan visited Mr Arif to assess compliance with clinical governance requirements. Ms Buchan identified concerns across a range of matters as set out at page 111. The concerns related to issues such as the lack of standard operating procedures, documents which were undated, with no review dates, lack of signatures on records, inadequate recording of details on reports, inadequate procedures for dealing with medication *owing,* disposal of confidential waste, information on data protection and other element so of prescribing.

141. An action plan was devised as set out at page 113 and a review date was set for 3 months in November 2006. Mr Arif was required to sign the record showing that he accepted the typed version of the action plan, but failed to do so.

142. On 24 November 2006 Ms Buchan visited Mr Arif as planned. She noted that there had been no progress in implementing the plan save for the provision of a paper shredder for confidential waste.

143. On 15 February 2007 Ms Buchan visited again. She noted at page 198 that progress had been made in 10 areas of the action plan and that further work was needed in completing the high priority areas of action and that a start should be made on the medium priority areas, with preparations to be made for action on low priority areas. Two particular areas of high priority concerns remained relating to the inadequacy of standard operating procedures and repeat dispensing.

144. Ms Buchan visited the appellant again on 27 March 2007 as noted at page 216. It was noted that he had failed to sign the action plans and failed to make any progress since the

last visit in implementing the action plan.

145. The Panel further finds that Mr Arif, as set out at page 217, was warned that lack of improvement would lead to formal disciplinary measures and that as at page 215 a typed version was sent to him.

Decision and Reasons

146. Looking at the totality of the evidence in the context of the criteria for removal from the pharmaceutical list and in the light of the above findings, the Panel directs that the appellant be removed from the respondent's list because his continued inclusion would be prejudicial to the efficiency of the services which those included in the relevant pharmaceutical list perform for the following reasons.

Dispensing

147. The extent of the over dispensing in relation to eleven patients (RT, PR, SLG, VD, NAA, NCH, BAS, JB, patients1,4 and 5) is striking. The detailed findings are setout above and need not be set out again. The Panel notes that on some occasions, for example patient PR, over a 17 week period received 50 inhalers when one would expect only 9 to be used. This means that Mr Arif, virtually every week, was handing over two inhalers to the same patient when any reasonable pharmacist would know that the inhaler would be expected to last in the region of a month. In other words Mr Arif was dispensing more than 5 times the required amount. The facts relating to patients SLG, VD and NCH could also be expressed in similar terms.

148. Such a profligacy gives rise to grave concerns not only about the financial aspects of the service, but also about patient safety. Most egregious in this respect is Mr Arif's dispensing in relation to patients PR who was on warfarin, and patient 1, who was taking clobezam.

149. Patient PR was being given warfarin by Mr Arif at the rate of 150 tablets a week. As Mr Haider, a witness called on behalf of the appellant said, this was an exceptional amount, the like of which he had never seen prescribed. For Mr Haider, such a level of prescribing would set alarm bells ringing and he would raise matters with the patient, with the GP and endorse the script.

150. By way of contrast to the proper approach adopted by Mr Haider, and although the appellant has introduced evidence to show that in limited circumstances he had tried to raise an issue with the GP, the facts show that Mr Arif continued dispensing at a level of over 4 times the expected level and continued to do so over a 17 week period. The Panel finds that such dispensing gives rise to a real risk of detriment to the health of the patient.

151. Perhaps even more seriously, patient 1, who given the nature of his medication is likely to have a mental health condition, was directed by his GP to take 1 tablet of clobezam a day for 7 days and then take a 21 break. The Panel notes that clobezam is a benzodiapine which is addictive and can lead to dependency. No doubt that is one of the factors that gives rise to the stipulation that the patient should not have more than 7 in one month. However, as a matter of fact, Mr Arif dispensed 28 tablets at a time on a number of consecutive occasions.

152. The Panel's concerns about this level of prescribing are heightened by Mr Arif's response to them. Not only in oral evidence did he attempt to suggest that there could be clinical reasons for such dispensing but Mr Arif also attempted in oral evidence to deflect responsibility for such dispensing, by suggesting that the fault lay with the prescribing GPs. The Panel note that whilst some responsibility may lie with the GPs, the focus of its inquiries is Mr Arif and his role. On the oral evidence of Mr Arif there was a conspicuous lack of acceptance of the part he had played in the over dispensing. Indeed, as noted above, Mr Arif

went as far as to suggest that there might be good clinical reasons for such prescribing and that he had been denied access to the medical records to support this claim. However, when it was put to him that he and his counsel had had access to the records, and his counsel had confirmed to the Panel that the records did not support Mr Arif's contention, Mr Arif's response was that he had not scrutinized the records.

153. The Panel further find that the facts show that Mr Arif failed to comply with the RPSGB's code of ethics (at document 8). This requires a pharmacist to use their professional judgement to decide whether concordance or other problems encountered by a patient may require early reference to the prescriber. The facts show that Mr Arif had failed on many occasions to exercise such professional judgement.

154. In assessing the evidence the Panel have come to the view that a particularly strong element emerges from many of the facts as found and that is of significance, especially when looking to the outcome of this appeal. That element relates to what appears to be a deep seated attitude on the part of Mr Arif in failing to take responsibility for his deliberate and conscious actions and in attempting to cast the blame on others. This aspect of Mr Arif's approach is apparent under each of the further heads of complaint, of failures to disclose and in clinical governance to which the Panel now turns.

Failure to Disclose

155. Mr Arif failed to disclose his criminal conviction and police caution. The Panel finds that Mr Arif has failed to put forward a satisfactory explanation for either of those failures.

156. Mr Arif's excuse for not disclosing his conviction is that the form he was required to fill in was not clear and so he relied on the advice of a colleague who said disclosure was not necessary. The Panel finds that such an explanation both fails to stand up to scrutiny and gives rise to further concerns about accepting responsibility for his actions.

157. The form that Mr Arif was required to fill in is at page 84. The Panel rejects Mr Arif's contention that the form is unclear about whether or not he should disclose his previous convictions. Question 1 on the form asks Mr Arif to tick either a yes or no box in response to the statement *I have a criminal conviction in the UK.* The Panel does not find that to be unclear.

158. Further, on the following page Mr Arif was directed to a number of sources he could refer to, including an email address, if he had any queries. Mr Arif did not chose to take such action. Instead he consulted a Dr Q. Mr Arif has not suggested that Dr Q had any particular expertise relating either to pharmacists or professional regulation. Dr Q is said to have advised him that if the conviction was more than 5 years old he need not declare it. The Panel did not hear evidence from Dr Q as to whether that was said and if it so, why. However, it is clear that Mr Arif's evidence is that he chose to rely on it and that he did not make inquiries of the respondent as to the extent of his duty to disclose. The Panel finds that this in reality amounts to Mr Arif effectively and deliberately closing his mind to the issue of whether or not he should disclose his conviction and of seeking to avoid responsibility for his actions by hiding behind the advice of Dr Q.

159. The Panel finds a similar avoidance of responsibility in respect of the caution for his failures in management of controlled drugs. Mr Arif said that he accepted the caution but presumed that the police would tell the respondent. The Panel finds that to be an answer which does not provide a satisfactory explanation of why he should feel that such an assumption would relieve him of his obligation. Indeed the element of avoiding responsibility is further exacerbated by Mr Arif's suggestion that a possible explanation for the failure in properly managing a controlled drug lay with a trainee. Such a suggestion appears to ignore the fact that he was the superintendent pharmacist.

Clinical Governance

160. The Panel finds that the facts show that Mr Arif has only poorly complied with clinical governance requirements. Whilst noting Miss Steward's concerns about the dangers of comparative statistics and taking account of the areas of improvement, the facts show that there were and remain deficits in the level of compliance. Indeed the specific problems in dispensing as found above would have been dealt with at an early stage if the requirements of clinical governance had been met in the first place.

161. The Panel find that despite a number of visits over a period of a year there were many areas of the practice which required attention. For example, even at the date of this hearing Mr Arif had not produced a satisfactory set of standard operating procedures. Mr Arif also accepts that his computer systems need up dating and that he should take on more staff.

162. Over the period of Ms Buchan's 5 visits, on 2 of those occasions (November 2006 and March 2007) Mr Arif had failed to make significant progress. Throughout the period he failed to sign documents showing that he had accepted the typed action plans and record.

163. Mr Arif's position as expressed in his statement at paragraphs 7 and 8 of his statement suggest that he did not understand the significance of his alleged short coming or of the respondent's oral hearing of December 2007. In oral evidence he suggested that the respondent had acted hastily in not giving him the time to put things right. In oral evidence it was put to him that he had been warned orally and in handwritten and typed notes in March 2007 of the possibility of disciplinary action. In reply Mr Arif said that he had not read the record which he had signed as agreed, and denied receiving a typed version of the warning.

164. The Panel finds Mr Arif's approach to issues of clinical governance, as exemplified by the above, to be symptomatic of his failure to take responsibility.

Disposal

165. The Panel find, given its findings of fact and assessment, that the appellant's being on the list gives rise to an inefficiency in the provision of pharmaceutical services. The Panel next asked itself whether or not such inefficiency could be made good by allowing the appellant to remain on the list subject to conditions amounting to contingent removal.

166. The Panel considered the draft form of conditions that are set out in document 17. They need not be set out in detail here. The Panel also take into account the proposals as put forward by the appellant in the course of evidence. In summary it is suggested by the respondent that amongst other things Mr Arif attend a return to practise course, appoint a mentor, and resign as superintendent pharmacist. In addition Mr Arif has put forward proposals relating to Mr Haider's and NGS involvement in the pharmacy.

167. The Panel finds that the proposed conditions put forward by the respondent, even when taken together with Mr Arif's proposals for support from Mr Haider and NGS, are not sufficient to make good the prejudice to the efficiency of services. This is so because the fundamental difficulty in this case relates to Mr Arif's behaviour and approach.

168. The proposed return to practice course is aimed at those wishing to return after a career break or wishing to refresh their practise. It is not a course that is designed to deal with the deep seated issues the Panel have identified. Nor is it sufficient even when taken in combination with the other proposals.

169. The appointment of a mentor is unlikely to challenge and develop Mr Arif in the manner required. Mr Haider's influence is likely to be limited by both the geographical distance between his work in Ealing and the practice in Calderdale and more significantly, his availability for only 2 days in the week which would necessarily include time spent in intending the pharmacy. The availability of services from Mr Hyams is directed to only the physical aspects of the pharmacy and is unlikely to have much impact on the core issue. The Panel therefore concludes that, in looking at all the proposals and assessing their cumulative effect, they are insufficient.

170. The Panel next considered whether or not removal of the appellant from the list would be the appropriate and proportionate course of action. The Panel finds that the appellant's removal from the list is the minimum necessary step available to achieve the legitimate aim of ensuring that the prejudice to the efficiency of pharmaceutical services is made good.

171. Accordingly the Panel directs that the appellant be removed from the list.

172. The Panel next considered the issue of national disqualification. Miss Steward in her submissions accepted that if the appellant were to be removed from the respondent's list, she would not be able to resist the imposition of a national disqualification.

173. The Panel finds that the core concerns relating to the appellant are not confined to mere local issues involving the present respondent. The Panel finds that on whatever list the appellant might wish to appear, on the facts as found, the inclusion of the appellant on a pharmaceutical list would prejudice the efficiency of pharmaceutical services.

174. Accordingly, the Panel directs that a national disqualification be imposed on the appellant.

Summary

175. The Panel directs that appellant be removed from the Calderdale Primary Care Trust's pharmaceutical list on the grounds that continued inclusion on its list would be prejudicial to the efficiency of the services which such a party on the list performs.

176. The panel directs that the appellant be subject to a national disqualification.

177. In accordance with Rule 42 (5) of the Rules the Panel hereby gives notice that a party to these proceedings can appeal this decision under Sec 11 Tribunals & Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days of receipt of this decision.

Signed Date

Mr J D Atkinson, Chairman