Case No. 15227

FIRST TIER TRIBUNAL PRIMARY HEALTH LISTS

Mr D Pratt	**Tribunal Judge**
Dr R Rathi	**Professional Member**
Mr W Nelson	**Member**

BETWEEN:

DR DINABANDHU SARKAR
(GMC Reg no. 1644032)

Appellant

-and-

NORTH EAST LINCOLNSHIRE CARE TRUST PLUS

Respondent

DECISION WITH REASONS

1. Dr Sarkar is a General Medical Practitioner who appeals against the decision of his Primary Care Trust, North East Lincolnshire Care Trust Plus (the PCT) to remove him from the Performers List pursuant to Regulations 10 (3) and (4) (a) of the NHS (Performers List) Regulations 2004 ("the Regulations"): "an efficiency case"[1]. We use the abbreviation "PCT" for ease of recognition of the body it is, although the Respondent identifies itself as the "CTP".
2. Dr Sarkar was represented by Mr Kenneth Rogers of Counsel, instructed by Britannia Law Practice, Birmingham, and the PCT by Mr Richard Tirrell of Counsel, instructed by Beachcrofts, solicitors.

DECISION

3. The unanimous decision of the Tribunal is to dismiss the appeal and direct the removal of Dr Sarkar from the Performers List of the PCT.

BACKGROUND AND REASONS

Preliminary Matters

4. The appeal was listed but adjourned on 4 May, with further Directions (in particular giving permission to the Appellant to put in expert evidence) as set out in the Tribunal's Order of that date. It was relisted for 5 days starting on 12 July but unfortunately Counsel for the Appellant was unwell on that date and did not become fit to appear until 15 July when the case was opened on

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[1] Regulation 10 …
(3)The [PCT] may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.
(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 relevant performers list perform ("an efficiency case")…..

behalf of the Respondent and evidence received on that and the following day. The hearing resumed on the first available dates suitable to the parties and their witnesses, namely 28 and 29 October, 4 and 5 November and 11 and 12 November. We heard oral evidence from a total of 17 witnesses.

5. The statement of a Dr Misra (see paragraph 18 below under the list of Appellant's documents) was served following the permission given by our Order of 4 May 2010 for the Appellant to serve and rely on expert evidence. However, for the reasons set out in our decision dated 28 October 2010, we dismissed the Appellant's application to be relieved of the consequences of non-compliance with an "unless" order for the service of that evidence and debarred him from reliance on that statement, or an associated bundle comprising 169 pages of records, clinical correspondence and summaries relating to patients identified by letters A – V which would have been produced and referred to by Dr Misra. We allowed some of these patient records to be put to other witnesses for specific purposes. Otherwise we have not taken into account any of the content of this statement or the bundle of patient records, which were in any event objected to (even if the evidence of Dr MIsra had been admitted) on the basis that they did not represent a random sample of patients, but had been selected.
6. At the conclusion of his available witnesses on 12 November 2010, Mr Rogers applied to adjourn the case to a further date to enable him to call some of the witnesses listed at paragraph 19 below, namely Dr Bedi, Ms Robinson, Ms Coulbeck, Ms Smyth and Ms Gardiner, who were not in attendance to give evidence on 12 November. In fact the Respondent was willing to admit the statements of these witnesses on the basis set out at paragraph 19 below, but Mr Rogers nevertheless wished to call them. He submitted that Dr Bedi was Dr Sarkar's GP and that we may have formed the impression that Dr Sarkar appeared vague and there may be reasons why. No explanation was offered for the unavailability of the other witnesses.
7. We refused that application to adjourn to a further date. Almost half a day of time remained available to hear evidence on 12 November and this date (indeed all the hearing dates) had been known since 16 July 2010. The reason advanced for calling live witnesses appeared to be (most strikingly in the case of Dr Bedi) to put forward additional evidence not within their witness statements and thereby raising a new and wholly different case from that advanced throughout the case to date. Dr Sarkar would not be prejudiced if, as agreed, the relevant witness statements were received by us as evidence of their contents, subject to weight and argument. It would not have been proportionate, in our judgement, to allow a further adjournment (with associated costs and delay) for a purpose which is itself impermissible.
8. At the conclusion of the final day the Appellant therefore closed his case and we adjourned for submissions in writing which were received by the Tribunals Service respectively on 21 and 20 December 2010. Dr Sarkar's submissions asked us to receive and take into account some 380 additional pages of evidence, comprising what we were informed was a transcript of part of the oral evidence given in the course of a hearing before the Fitness to Practise Panel of the General Medical Council on 5 dates (out of 18 days of hearing).
9. We reject that application. We had heard oral testimony from the same witnesses in our own hearing and that evidence had been tested by cross-examination, in relation to the issues which we have to determine. We had

formed our own impression of the witnesses. There was no basis on which we could properly consider evidence provided by the same witnesses to another tribunal in different proceedings, very shortly after they had faced questioning before us when giving their evidence about the same events. Even if we were persuaded that there was a basis in principle on which the additional or repeated evidence from the same witnesses could be admitted, we could not do so without causing irremediable unfairness to the PCT, which was not a party to the GMC hearing and could not put its case to those witnesses again, or otherwise test them as it had done before us. No justification for late admission is relied on other than that the evidence before the GMC was taken on oath and may help resolve ambiguity. However the Appellant's submissions do not identify any genuine ambiguity to which this could relate. We unhesitatingly reject the application.

History and Background

10. Dr Sarkar is a 68 year old (born 25 July 1942) General Medical Practitioner in a single-handed practice. His qualifications are MBBS 1970, MSc 1971. He has been included in the Performers List since 1981, when he joined a local GP practice. In 1989 he set up his own practice. He had premises at 142 Grimsby Road, Cleethorpes and in 2007 moved to Stirling Medical Centre, Stirling Street, Grimsby. His practice list was 1895 patients in July 2009 [R 32]. Prior to the events with which this case is concerned there were no adverse regulatory or professional disciplinary findings (or proceedings) against him.
11. In December 2008 the PCT undertook a practice contract performance review in the course of which a meeting was held, attended by Dr Sarkar and the Chief Executive of the PCT. As a result, the Chief Executive and Medical Director, Dr Paul Twomey, subsequently asked the Practice Manager, Ms Karen Thickett, if staff had any concerns about the doctor's performance. They did. On 16 February 2009 the PCT suspended Dr Sarkar under Regulation 13 of the Regulations, confirmed by letter of the following date.
12. The PCT then undertook an investigation, co-ordinated by Mr Christopher Clarke (Assistant Director, Primary Care), including a review of clinical records and systems by Dr Keith Collett, a GP who has extensive experience as a Senior Clinical Medical Education Tutor for North East Lincolnshire and the GP Vocational Training Service. A report was prepared by PCT Investigation Team in July 2009 [R 30 – 55 plus 18 appendices] and hand-delivered to Dr Sarkar at his home by Dr Twomey on 22 July 2009. The PCT's case draws upon this investigation report and Dr Collett's evidence. A panel was convened to consider removing Dr Sarkar from the Performers List. The oral hearing was postponed several times on the application of Dr Sarkar, who was said to have become unwell while visiting India. In due course the Panel considered the case on 9 November 2009 and determined to remove Dr Sarkar from the Performers List under Regulation 10 (3) and (4) [see paragraph 1 above].

The Appeal

13. By his solicitor's letter of 7 December 2009 Dr Sarkar appeals that decision. The case concerns multiple allegations which are grouped broadly under the headings of inadequate service provision, clinical issues, and management of results, hospital letters and referrals. Dr Sarkar has made some limited

admissions, in particular of persistent lateness for surgery, but his case has throughout been that "the entire process was instigated by Karen Thickett [his Practice Manager] and others when the doctor refused to retire" [Appellant's closing submissions paragraph 6] so as to "emulate a modern practice known as Ashwood Surgery … that is in effect operated and controlled by a practice manager" [ditto paragraph 8].

The relevant legal framework

14. This appeal is brought pursuant to regulation 15 of the Regulations, by virtue of which it proceeds by way of a redetermination of the PCT's decision, and this Tribunal may make any decision which the PCT could have made.
15. We have set out above Regulation 10 insofar as it relates to the power to remove Dr Sarkar from the Performers List. Regulation 11 of the Regulations sets out the criteria for removal in cases of efficiency, and we have had regard to those and to the Department of Health Guidance, while not limiting our consideration of factors to those mentioned in the guidance, and we have considered all the factors urged on us in this appeal.
16. Regulation 12 gives us a discretion to remove Dr Sarkar contingently from the Performers List, subjecting him to conditions, because this is an efficiency case under Regulation 10 (4). Contingent removal requires that we impose such conditions as we may decide with a view to "removing any prejudice to the efficiency of the services in question": regulation 12 (2) (a).
17. In our view the burden of satisfying us that the case is proved, lies on the PCT, and we invited the PCT to lead its evidence first.
18. The standard of proof which we have applied is the balance of probabilities, whether a fact or allegation is more likely than not to have occurred, in accordance with the decision of the House of Lords in *Re D* [2008] UKHL 33.
19. The obligations of a GP arising from his provision of services are to be found in Schedule 5 of the NHS (Personal Medical Services Agreements) Regulations 2004, relevant part of which are set out at RB 41A – B, 41H, 45 A, 45 D, 47A, and 49A.

Evidence - Documents

20. The parties lodged bundles of witness statements, reports, clinical records and other documents, and some further documents were put in during the appeal hearing, by agreement, and placed with additional pagination in the Tribunal bundles.

    <u>The Appellant</u>:

    - Case Papers bundle lodged on appeal: A1 to A 24
    - Appellant bundle comprising
        - Submissions on behalf of Appellant
        - Statement of Dr Sarkar (signed but undated)
        - Index of witness statements numbered 1 - 21
        - Witness statements paginated 1- 67 [but see paragraph 19 below as to which of these was received in evidence]
        - [Statement Dr N Misra paginated by Tribunal as 68 – 77 but not received in evidence for failure to comply with directions as to service of expert evidence – see below]
        - Letter 26 March 2010

    - Draft proposal (pursuant to Directions of the Tribunal that any proposed conditions be notified in writing)
    - Index of documents
    - Appellant's medical reports paginated 1 – 11
    - Letters seeking disclosure paginated 12- 17
    - Order 10 March 2010 by Interim Orders Panel of General Medical Council paginated 18-21
- Patient records for patients A – V together with hospital letters and other clinical documents indexed 1- 118 (169 pages) [hereafter A's Patient Records]. The Tribunal ruled during the course of the hearing that although these records were objected to by the Respondent as documents which would have been produced by Dr Misra and were evidently not a random selection, but tainted by selectivity, the bundle could remain available to be put to witnesses subject to the Tribunal further regulating that process in the context of any specific question being put to the witness.

<u>The Respondent</u>

- Case Papers bundle lodged in response to appeal R1 – 23
- Copy letter Mr C Clarke to Dr Sarkar 5 June 2009 requesting the return of the Practice Complaints File - R24
- Colour copies of screen-dump showing patient records relating to the immunisation of an infant, ZK, on 2 January 2008 and associated patient retrieval printout summaries R25 – 31
- Copy letter from Karen Thickett to Dr Sarkar, 27 October 2000 – R32
- Email exchange Karen Thickett and Mr Chris Clarke 1 – 2 February 2008 – R 33-34
- Respondent Bundle [hereafter "RB"] comprising:
    - Index to Respondent's Summary Grounds and Documents
    - Respondent's Summary Grounds in response to appeal against removal from Performers List
    - Chronology and supporting documents paginated 1 – 29
    - PCT Investigation Report and Appendices [including witness statements of Karen Thickett, Helen Noble, Wendy Brookling, Julie Nunns and Dawn Pickett], paginated 30 -314
    - Statement of Dr Keith Collett dated11 Jan 2010 (pp 315-316) and supplementary statement 12 May 2010 (pp 316 A – C)
    - Supporting documents relating to witness statement of Helen Noble – pp 317 – 387
    - Statement of Dr Paul Twomey 19 Jan 2010 – pp 388 – 390
- Patient Records of Patients numbered 1 – 52 (identified by name in the index thereto) paginated 1 - 342
- Complaints File [hereafter "CF"], comprising:
    - Index
    - General complaints file pp 1 – 57 plus page 16A, the se handwritten document concerning documents held on computer
    - Complaint/ litigation documents pp 58 – 200

21. Additional documents were added the Respondent's Bundle during the course of the hearing, including:

- 41 A – H: provisions of the NHS (Personal Medical Services Agreements) Regulations 2004/7, Regs 1 and 72, and excerpt from "Good Clinical Care", pp 1 – 3 and 11 - 12.
- 45 A – G: Ditto Reg 70 and pp 9 - 10 from "Good Clinical Care",
- 47 A: Ditto Reg 60.
- 49A – C: Ditto Reg 86 and p 32 from "Good Clinical Care",
- 198A: Analysis of Log Statistics for period July – Dec 2008 (Dr Sarkar's Extended Hours).
- 278A –B: Email from BMA Adviser to Dr Sarkar 13 Feb 2009
- 293A – R: printouts of patient records relating to patients Mrs J, Mrs K, Mrs L and Mr M.
- 296A – C: examples of stamped report forms of investigations of patients with the surgery stamp for recording action which is referred to in the evidence of surgery staff.

Other evidence

22. We heard evidence from the following witnesses on behalf of the PCT:
    Dr Paul Anthony Twomey
    Ms Helen Noble
    Ms Julie Nunns
    Ms Dawn Pickett
    Ms Wendy Brookling
    Ms Karen Thickett
    Dr Keith Collett
    Mr Christopher Clarke.
23. We heard evidence from the following witnesses on behalf of Dr Sarkar:
    Dr Dinabandhu Sarkar
    Ms Caroline Metcalfe
    Dr Geeta Bhorchi
    Mr Gurmit Singh Aurora
    Dr Kalwant S Koonar
    Dr Ehab Amin
    Ms Anne Clayton
    Dr K S Rajsekhara
    Mr William Sparnon
24. Apart from the oral evidence received by us, the PCT agreed to admit a number of written statements submitted on behalf of the Appellant, as evidence of their content, subject to weight and comment, By reference to the Index of witness statements in the Appellant's bundle (see above) these were:
    Witness 3 – Dr Narinder Pal Singh Bedi [pp 6 – 8]
    Witness 7 – Dr Ramsagar Prasad Singh [pp 20 – 22]
    Witness 10 – Mrs Mandy Coulbeck [pp 29 – 32]
    Witness 12 – Mrs Margaret Gardiner [pp 36 – 38]
    Witness 15 – Mrs Kay Robinson [pp 48 – 51]
    Witness 16 – Mrs Shahina N Smyth [pp 52 – 54]

    The remaining statements within the Appellant's witness bundle in respect of which we neither heard evidence from the makers nor were admitted by agreement, were not received in evidence by us and have not been taken into account, namely:
    Witness 1 – Dr S N Adhikaree
    Witness 9 – Mrs Carla Clyburn

Witness 11 – Mrs Anita Dixon
Witness 13 – Mrs Gillian Linford
Witness 17 – Mrs Angela Waters
Witness 20 – Mrs Christine Wright
Witness 21 - Dr Sean Thrippleton (letter).

Oral Evidence

25. Generally. The evidence was both extensive and detailed, with cross-reference to documents such as patient records. We set out a summary in the Appendix to this decision. Save where objection had been raised, the Tribunal read the statements of the witnesses, and treated them as read when each gave his or her evidence.

Consideration and findings

26. The allegations in this case cover a wide spectrum of General Practice competences. Some are founded in the documents we have seen. Others rely, wholly or in part, on the witness evidence. The case advanced by Dr Sarkar raised serious allegations against the witnesses who were relied on by the PCT. Firstly that Karen Thickett, supported by Helen Noble and other staff, had conspired to get him out of the Practice so that they could introduce a different administration model, in which the Practice Manager and senior staff ran the Practice and employed the doctors who provided medical services there; he alleged they therefore had a commercial interest in giving evidence against him. Second that he was a victim of discriminatory treatment by the PCT and that the investigation it conducted was unfair and one-sided. We have therefore considered carefully our impression of the reliability of witnesses who gave evidence.
27. In general we found the witnesses for the PCT to be genuine and reliable, trying their best to give accurate evidence and in varying degrees distressed by the fact that they were called upon to give evidence in this case at all, and by the fact that Dr Sarkar was a man whom they had genuinely liked as a person. Where that evidence could be tested against documents it was supported. The attack against them focused on the general points we summarise above, and not much on the specific deficiencies about which they were giving evidence, save where we have identified those challenges above.
28. Dr Twomey was a careful, low-key witness, who gave thought to his answers, and regarded his primary function (as we accept) to support doctors and help them to overcome poor performance, rather than pursue disciplinary measures for that poor performance. He appeared to have reached the view that Dr Sarkar should be removed from the List more in sorrow than in anger. We do not accept that he intended to be, or was in fact, discriminatory or unfair in the way he went about things following the initial meeting with Dr Sarkar in December 2008. He may regret having gone to Dr Sarkar's house to deliver the investigation report so that he had time to submit comments before the PCT Panel met to consider it, but we understand and accept the reasons why he did so. We found him to be reliable and accept his account of meetings and events. We reject the suggestion that he told Dr Sarkar that if he did not accept the suggestion of retirement there would be adverse publicity. On the contrary, he tried his best to ensure that Dr Sarkar did not create the risk of adverse publicity by talking to his staff about the matters of concern which the PCT were looking at. Sadly, Dr Sarkar did exactly the

opposite of what he was advised to do, and held two meetings in January 2009 the purpose of which was (we are satisfied) to deter his staff from providing information to or the PCT which might be adverse to Dr Sarkar. He also involved other GPs from the area in one of those meetings and in so doing spread within his professional community sensitive information (not all of it accurate) about the allegations and the investigation.

29. The Tribunal found Ms Helen Noble to be an impressive witness. She is a very experienced nurse within the Health Service. She was down-to-earth. She had plainly been very fond of Dr Sarkar, worked with him for a very long time and had done a great deal to try and patch up the systems to help the Practice keep functioning, when Dr Sarkar was not giving the amount or quality of clinical input that system required. She was, and remains, one of the corner stones of that team. We accept her evidence.
30. Ms Julie Nunns and Ms Dawn Pickett had at different times carried out similar functions in processing blood and other pathology results and hospital correspondence. Their experiences of Dr Sarkar's input, or lack of input, in reading and acting on these documents, were strikingly similar. Although Mr Rogers explored with Ms Pickett whether she was aware of and alleged plan by Karen Thickett that the Practice should be run by her and that Dr Sarkar should be got rid of (she denied ever hearing of such a plan) it was not directly suggested to either of these witnesses that they had a motive for making up the evidence they gave, nor can we imagine any credible reason for doing so. Neither were medically qualified yet both felt compelled to screen out the normal results and other letters which did not obviously call for action, and make a reduced or more manageable pile of results or letters to take to Dr Sarkar; even then they were highlighting small portions of the letters or explaining to the doctor orally what they appeared to require, so as to obtain his response and then undertake whatever was required themselves. They did so because (as we accept) the alternative was to leave the reports and letters on Dr Sarkar's desk for him to read and action, in which case nothing was done, or was done with unacceptable delay.
31. Karen Thickett was apparently baffled and distressed by the allegation made against her. Like other staff members she said she had not been aware of it until she attended the first (abortive) Tribunal hearing in May 2010. She appeared to feel the stress of giving evidence against this background and was more hesitant than some of the other staff witnesses. It appeared to the Tribunal that she was making a genuine effort to be as accurate as she could about how things had been, and was moderate in her expression. In our view her distress and anxiety that she might be thought to "have it in for" Dr Sarkar accounted for occasional hesitation. Where her evidence overlapped with that of other witnesses it was supported. Where documents existed they were supportive. We accept her evidence.
32. Wendy Brookling was a mature sensible person who impressed us. We accept her evidence without hesitation. It was clear that her involvement in the case of administering the wrong drug at a baby immunisation had made a big impression on her and shaken her. She retained a very clear memory of events.
33. Dr Keith Collett was clearly independent and objective. We reject the suggestion at paragraph 34 (7) of Dr Sarkar's statement that he was not independent. In the course of cross-examination we asked if it was being

suggested that his conclusions were influenced by extraneous factors and if so what they were. It was then put to him that they were influenced by a desire from the staff to replace Dr Sarkar. Dr Collett's answer was that he was overwhelmed by the affection that the staff had for Dr Sarkar and his role was simply to look for systems within the records. He was not improperly influenced. He is a practising GP (26 years in the Grimsby area) and senior partner in a local group practice. He is an examiner for the RCGP, a senior clinical medical education tutor for North East Lincolnshire (the regional Deanery), and undertakes quality assessments for GP Vocational Training Schemes and GP Appraisals. He was well qualified to undertake a review of Dr Sarkar's medical records and processing of hospital letters and reports. He was willing and able to justify his methodology (conveniently described at R316 B) which he described as "tried and tested" and "shown scientifically to work". We noted that he examined almost 4 times as many patient records than the initial 10 used by the RCGP in its assessment of practitioners for Membership. He stressed, very fairly, that he was simply looking at the processes within the record keeping of Dr Sarkar, and not at the clinical care which was the subject matter of the records. He gave examples of good medical practice which he had encountered during this exercise. He was so anxious not to be judgemental that at times he leaned over backwards in the opposite direction. We accept his evidence and his findings.

34. Mr Christopher Clarke was also low-key and down to earth in manner. Our impression of him was of a very open and sincere man, whom we found entirely credible. He made concessions where appropriate and was considered in his replies. In the view of the PCT, and in our judgement also, an enquiry had to be conducted because of the concerns raised. He was the person who was charged with the conduct of the investigation. We find there is no effective criticism of the way he had conducted that investigation and we accept his evidence.
35. We found the PCT's witnesses to be credible and except where we specifically set out anything to the contrary we accept the evidence submitted on behalf of the PCT.
36. Dr Sarkar was a very poor witness, whose evidence compounded the concerns raised by the evidence we heard from the PCT. Throughout the hearing he maintained an attitude of disengagement from the proceedings, which was in contrast to the allegations raised on his behalf in this appeal. He was late on 3 mornings of the hearing by 20 minutes (twice) and 8 minutes (once) and several times after the lunch adjournment. From time to time he closed his eyes and appeared to be asleep.
37. It was extremely difficult to make a coherent note of Dr Sarkar's evidence. His answers rapidly flew away from the subject matter of the questions and he sometimes contradicted his first answer within a sentence or two. Most questions were met with a response which was not an answer to the question but to some other question. He sometimes met questions with a long silence, even when the question was reformulated. At other times he spoke rapidly and was difficult to stop. He found it very difficult to focus on a question or on a document he was asked to look at. Within a few minutes he would have turned to a different page and had to be referred back to the original page number. He said he could remember nothing about some key documents

such as those which minuted crucial meetings he had attended and which had been the subject of cross-examination on his instructions.

38. Dr Sarkar either had a significant difficulty in understanding straightforward questions, even when they concerned matters to which he must have given anxious thought over many months, and in expressing himself, or was being deliberately evasive. His presentation in the witness box was at times hopeless. At these times he met any damaging allegation by asserting it was a lie (even when independently supported) and that there was a conspiracy against him involving most of the staff members of his Practice, and (although this was first raised by him in the course of his evidence) senior members of the PCT. Often these allegations had not been put to PCT witnesses and this reinforced the impression that they had been made up on the spot. We did not find him persuasive or credible where he disputed allegations or criticisms. Where Dr Sarkar's evidence conflicts with that of the witnesses put forward by the PCT we prefer the evidence of those other witnesses.
39. A number of local GPs attended to give evidence on Dr Sarkar's behalf. Those who participated in the Locum Rota with Dr Sarkar were in the difficulty that they adopted the same system of covering his surgery and their own, within the same 2 hour slot, as was criticised in the case of Dr Sarkar. They were not prepared to acknowledge that the service to patients was inevitably compromised. This caused Dr Amin, for example, to try and justify the proposition that a 2 hour surgery (as required by contractual arrangements and advertised to patients) did not have to have a doctor present, which was a hopeless and disingenuous proposition. The exception to the somewhat self-serving impression we found, was Dr Koonar, whom we found to be impressive and a doctor who was prepared to go the extra mile for patients and the staff at Locums he undertook.
40. Caroline Metcalf's alleged support for the allegation that Karen Thickett had hatched a conspiracy against Dr Sarkar evaporated in the course of her evidence. Ms Metcalf had heard a conversation a couple of years before, when the Practice was in its former premises, which was simply speculation about when Dr Sarkar might retire, and that if he did locums might have to be hired. She told the Tribunal that it seemed like a normal conversation and did not strike her as wrong. After talking to a lot of people she had a different impression. This contrasts with the different and more serious allegation in her statement (A 43 paragraph 7) that she had heard Karen Thickett discuss her ambition to run the Practice by herself and hire a locum. We prefer the version given in oral evidence. In our judgement it was an innocent conversation among staff of the kind which is not surprising when a single-handed practitioner is at normal retirement age. We find no support in it for the allegation made against Ms Thickett or other staff members.
41. Mr William Sparnon is an experienced and reliable witness, who gave evidence in a spirit of offering the Tribunal all the assistance he could while emphasising the limits of what he could and could not say about Dr Sarkar (namely that his only contact was in the field of forensic work and from police records of the call-outs and attendances by Dr Sarkar for his police force. He had taken the trouble to look up these records before coming to the Tribunal and we accept the evidence he presented, including that Dr Sarkar was "right up in the top quarter" of the 22 doctors available for forensic work, in the frequency with which he undertook work as a police surgeon. He was candid

in telling us that the assessment system operated for the police when selecting its Forensic Medical Examiners was outdated, no good, and soon to be replaced, but the difficulty in recruiting doctors to do it had made recruitment by word of mouth the usual way. Only a week of training was offered and then "they fly solo". There is currently no reassessment of doctors following their appointment. We accept Mr Sparnon's evidence.

42. The PCT presented the multiple areas of concern and criticism under three broad categories: inadequate service provision and surgery arrangements; management of results, letters and referrals; and clinical and record-keeping issues. While there is significant overlap between these categories it may be convenient to adopt the same approach.

1. <u>Inadequate Service provision/ surgery arrangements</u>

43. Dr Sarkar, like other GPs, had general obligations arising from his provision of services under paragraph 1 of Part 1 of Schedule 5 of the NHS (Personal Medical Services Agreements) Regulations 2004, which are set out at RB 41A – B. Relevant parts of those Regulations and the Royal College of General Practitioners guidance "Good Practice for General Practitioners" were handed in and appear at RB 41A – RB 49C, The GP contractor must provide essential services at such times within the core hours as are appropriate to meet the reasonable needs of the patients and to have in place arrangements for patients to access such services throughout the core hours in case of emergency. Core hours are defined as "the period beginning at 8 am and ending at 6.30 pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays." RCGP guidance on providing adequate access (RB 41G-H) emphasises the importance of being able to get through to the GP by telephone, having an appointment system which meets the needs of patients and a practice leaflet which says clearly when the surgery is open. A doctor must also ensure he can be contacted easily while he is on call.

A. <u>Restricted availability of surgery</u>

44. Dr Sarkar's Practice leaflet (which he is bound by the terms of his contract to compile and to include specified information, reviewed every 12 months) is at RB 96-100. The surgery hours specified are:

    Mon- Fri mornings 9.30 – 11.30 am
    Mon and Tuesday afternoon 4.30 – 6.30 pm
    Wednesday and Friday afternoon 4.30 – 6 pm
    Thursday afternoon 1.30 – 2.30 pm.

    We heard evidence, which we accept, that the 9.30 starting time was introduced in order to accommodate Dr Sarkar's former habit of turning up nearer to 9.30 when the starting time (for which patients had been booked) was 9.00 am.

45. When Dr Sarkar described his surgery opening hours to Dr Twomey on 9 December 2008 he specified shorter hours than this (RB 307): 9.30 – 11 am on Monday, Wednesday and Friday, 6 patients on a Tuesday morning, and 4.30 – 6 pm each weekday afternoon. This record of his account was not challenged in cross-examination but was said by Dr Sarkar to be wrong when he gave evidence. He then suggested the "surgery hours" included time to go and see patients at home, and later told the Tribunal in answer to questions that if the doctor was available on the telephone, staff could manage. We accept that Dr Twomey accurately recorded what Dr Sarkar told him and do

not accept that the reasons subsequently given to us by Dr Sarkar in any way amount to providing the surgery hours he advertised and was obliged to fulfil. Indeed they demonstrate a cavalier attitude to fulfilling his clinical obligations.

46. We note that in December 2008 Dr Sarkar told Dr Twomey he ran a surgery on Tuesday mornings (albeit limited to 6 patients). We find this to be untrue. We accept the evidence of Dr Twomey, and several staff members, supported by the surgery records from his own Practice computer (eg at RB 82-83), that with the exception of a handful of Tuesdays in 2008 and 3 in 2005-6, he did not in fact operate a surgery on Tuesday mornings, and this was the case both while he attended the local hospital as a clinical assistant to Dr Adhikaree, and after that appointment came to an end in April 2007 when Dr Adhikaree retired. There was no reason why he should not have resumed normal GP duties in his own surgery after the end of his clinical job at the local hospital. Even before that, adequate Locum arrangements should have been put in place to enable patients to be seen on a Tuesday morning. Instead, they had to be squeezed into the afternoon session or seen the next day.
47. No attempt was made to provide adequate cover, or to inform the PCT that no patients would be seen on a Tuesday morning. Dr Twomey told us, and we accept, that Locum cover was in place for Tuesday mornings only when Dr Sarkar was on holiday. Dr Sarkar suggested that the PCT was aware he was not offering a Tuesday morning surgery. PCT witnesses such as Mr Clarke, who would have been in a position to know if this had happened, said it was not true. We accept Mr Clarke's evidence and reject Dr Sarkar's evidence about this. At best, Dr Sarkar's position was based on wishful thinking. At worst, he was trying to mislead us. Dr Sarkar also suggested for the first time in re-examination that he had had locum cover on Tuesday mornings. When this was challenged he said this only applied to when he was on holiday. We found this to be an example of his recklessness with assertions which, on examination, were untrue or exaggerations,
48. Witnesses such as Dawn Pickett told us that Dr Sarkar was not willing to stay late on a Tuesday afternoon surgery to accommodate patients who could not be seen on Tuesday morning. If staff put more patients into the Tuesday afternoon surgery, Dr Sarkar would complain (see eg Karen Thickett's statement paragraphs 15 and 19, RB 282). We saw screen prints for surgery bookings which showed (eg RB 83) that the "slots" for patient appointments had been reduced from 10 to 5 minutes so as to fit in more patients on a Tuesday afternoon.
49. In written submissions on behalf of Dr Sarkar (para 19 (ii)) it is argued that there was a "deemed acceptance" of his non-attendance at Tuesday morning surgeries because Dr Sarkar had a long-standing commitment to an elderly care clinic at Queen Elizabeth Hospital, which was known to his Practice Manager and to the PCT. We are unable to accept that Ms Thickett's knowledge of his absence creates a "deemed acceptance" of what is presumably suggested to be a variation of Dr Sarkar's contract with the PCT, and we are not satisfied that the PCT did have such knowledge, or if it did, that should be deemed to have known that there was no full locum cover, or that they were intending to agree any variation. The only evidence as to cover came from Dr Bedi who referred to covering for emergencies. That is not locum cover in the proper sense.

50. We accept the evidence of Dr Twomey, who telephoned his surgery at 6.10 pm on Wednesday 10 December but got only an answering machine with an "Out of Hours" message. He rang again the following morning at 8.10 and 8.35 and got only the same recorded message. It follows that the answering machine was switched on 20 minutes earlier than it should have been on the evening of 10 December and was still on the following morning half an hour after it should have been switched off when the practice should be open for patient contacts. There is no other evidence of truncated opening hours, and we therefore attach little weight to this as a stand-alone failure, but this evidence is of a piece with the casual attitude we have found to have existed at that time about availability of GP services to the patients on Dr Sarkar's list.
51. We find that Dr Sarkar did not provide the full surgery hours set out in his Practice leaflet: at most he operated the more restricted hours he mentioned to Dr Twomey, but often he would leave the surgery well before the end of this more limited surgery and if a patient did turn up he would expect his staff to deal with it. Often they were unable to contact him, as we accept. In consequence the expected capacity of the Practice to meet patient demand was compromised.

B. <u>Lateness.</u>

52. The witness evidence from all staff who gave evidence before us (which we accept), supported by the computer login data we have been shown (RB 58-69), satisfies us that Dr Sarkar was habitually and substantially late for the start of his advertised surgery times. We reject the evidence given by Dr Sarkar that the computer printouts, showing late logins by him, are accounted for by his having been present but attending to other things in the surgery before logging on, or that it took him up to (but not beyond) 15 minutes to log in after his arrival, as he suggested in his evidence in chief. While the extent of his lateness varied from day to day, we are satisfied that is was often 20-30 minutes, and in particular that it delayed patients being seen for booked appointments in both the morning and afternoon surgeries. We find that some were unable or unwilling to wait to be seen. If all waited to be seen, they would have to be seen in a shorter period than should have been allocated to each, in order to finish in good time. We were told (see eg statements of Ms Thickett at paragraph 9 and of Ms Pickett and paragraph 10) and accept, that Dr Sarkar did not stay late if he arrived late. Ms Noble told us (and we so find) that his lateness also impacted on her own ability to start immunisation clinics on time, because two qualified staff had to be on hand in order to before these clinics could be started.
53. We were referred to the Waiting Times Report for February 2008 to January 2009 (RB 70-81) and note that between 64% and 93% of patient appointments for Dr Sarkar were delayed during that 12 month period. That contrasts unfavourably with delays on other clinics within the Practice. The <u>average</u> wait for those who were delayed varied by month between 13 and 19 minutes. Only when cross-examined on this document did Dr Sarkar suggest for the first time that the figures were not accurate. We reject that late challenge and find that they are substantially accurate. In his evidence in chief Dr Sarkar also raised for the first time that he might be log in on late because of talking to patients or looking at letters brought in by staff (though why he could properly consider letters about patients without logging on to the computer is not clear). As we have already indicated, we reject that

explanation. It is of concern to the Tribunal that Dr Sarkar's case on lateness has been so variable and he shows little if any insight into the mischief that it causes.

54. The mischief of his habitual lateness therefore ranges from discourtesy to patients in putting their needs second to his own whims about time-keeping, to giving inadequate time and attention to their needs or deferring a consultation which might potentially be time-sensitive, or wasting resources fixing further appointments. In addition, staff were placed in the embarrassing position of covering for his absence or being on the receiving end of complaints by irritated patients.
55. We were referred to many minutes of Practice Meetings where the problem of lateness was raised by staff. We were told and accept that in general Dr Sarkar would improve for a few days after this, then slip back into his old timekeeping habits.
56. Dr Sarkar's poor timekeeping was reflected by his lateness for sessions of this hearing. He was late on 3 mornings of the hearing: twice by 20 minutes (including once when he was in the middle of his cross-examination) and once by 8 minutes, and several times after the lunch adjournment. The reasons given on his behalf included "checking out of his hotel". His lateness was all the more surprising in view of the fact that timekeeping was an issue in this case.
57. Dr Sarkar did accept, in evidence in chief, that his timekeeping was not good, but said he was doing administrative tasks (see above) and patients had not complained. We think it likely that the reception staff took the brunt of this level of complaint and in any event patient complaints about lateness are to be found in the Complaints File at pp 4, 21 and 22, He also contended in his witness statement that "patient care was not compromised" but for the reasons set out above we reject that contention.

C. Inadequate Locum cover

58. A GP's absence from his Practice must be covered by an adequate Locum arrangement to provide the services to NHS patients which he is obliged by his terms and conditions to provide. Dr Sarkar is aware of this obligation, making the point in his witness statement that whenever he is on holiday he ensures that the locum cover is adequate. He and 5 other local GPs, mainly those who, like him, worked in a single-handed Practice, operated a Rota by which they would cover absences for others within the Rota, while also running their own surgery commitments.
59. The consequence of this arrangement was that, at times when Dr Sarkar was absent from his Practice, instead of having access to a GP-run surgery for the advertised hours, patients could be seen for only a short period of around one hour, morning and afternoon, by the Locum, who would then depart to see his own patients in his own Practice (see eg witness statement of Karen Thickett, RB 283).
60. There was apparently an agreement among the Locums that they would not see more than 6 patients per surgery, while providing Locum cover: this equates to 6 appointments each of 10 minutes. However we heard evidence from staff, which we accept, that quite commonly Locums would rush through the patients and leave before a full hour expired. In the case of Locums performed by Dr Amin, he sometimes arranged to see Dr Sarkar's patients at

his own surgery. On other occasions he told staff to send the patients, who had arrived after his departure, down to A & E.

61. The corollary of this Locum Rota was that Dr Sarkar also provided cover for the other GPs on the Rota while they were absent, and therefore truncated the surgery hours in his own Practice while attending a Surgery for a colleague elsewhere. Analysis of the Locum Holiday Rota (RB 103) shows that Dr Sarkar provided Locum cover for 6 days a year for each of 5 other GPs, making a total of 30 days a year.
62. Locum cover through the Rota was intended to be available to Dr Sarkar and the others involved for 6 weeks each a year. Dr Sarkar was on holiday from his Practice for considerably more than that. In the first 9 months of 2008 he took 60.5 days leave. This equates to over 12 working weeks or 23.27% of the available working days in the year. Dr Sarkar did not dispute the figures but said that part of it was due to his having exercised his option to take superannuation retirement in January 2008, as a result of which he had to perform no services for a short period. Mr Clarke confirmed that this was so, and the doctor had to stay away for 24 hours, performing no services, but could then come back under the superannuation retirement arrangements. In fact Dr Sarkar was on leave for 10.5 days during January-February 2008. He contended that patient care was not compromised and no patient had complained about his taking leave. Among the patient complaints in the file are several raising complaints about the quality of Locum cover (CF 1, 3, 4 and 49) of which one (CF 4) complains about locum coverage when Dr Sarkar booked “one of your numerous holidays”. Ms Thickett said that surgery times had to be adjusted to accommodate the Rota, and in answer to the Tribunal said that during the periods of limited Locum provision there was an increase in Accident and Emergency attendances and use of the Out of Hours service. She said the Chief Executive of the PCT wanted to know about it but Ms Thickett did not know what to say because it had been going on for 3 to 4 years. As we have indicated, we accept her account.
63. The sample screen prints from the Practice computer which we have seen support the evidence we heard and read about the limited availability of a doctor’s surgery during periods of Locum cover. (RB 91-94 covering random dates in April, October and November 2008 when Dr Sarkar was providing Locum cover to other Practices, RB 104-7 covering the month of June 2008, and 108-120 showing Mondays and Tuesdays in September 2008). Even on a Monday morning, the busiest morning in a GP week, the cover was only for one hour. These screen prints also demonstrate the limitation on the number of patients seen, and that when 7 patients were seen on one occasion, two of them were allocated only 5 minute appointments (RB 109 – Dr Amin). They also show that on these Mondays and Tuesdays in September 2008, no Extended Hours cover from 6.30 to 7 pm was provided, although Dr Sarkar had by then signed up to provide such extra hours, and received payment for it.
64. The impact on patients in Dr Sarkar’s Practice when he was covering elsewhere was also significant as demonstrated by the screen prints at RB 91-94. On Monday 14 April 2008 Dr Sarkar covered Dr Bedi’s practice at 8.45 am, then Dr Amin’s practice some 5 miles away at 9.30 am, and his own patient appointments (6 only) were booked from 10.45 to 11.45. In the afternoon his own patients were booked for appointments from 3.30 to 4.45

pm (Surgery hours are 4.30 to 6.30 pm) and at 5 pm he was covering for Dr Amin again. On 8 October Dr Sarkar started his own surgery 35 minutes late and finished at 11.50. Some of the 13 patients seen were allocated only 5 minute appointments. The same is the case in the shortened afternoon surgery from 3.30 to 4.50 pm.

65. In addition to the 60.5 days holiday absence in 2008, Dr Sarkar was providing cover for other local GPs for 30 days in the year under the Rota they operated (see above) this meant that his patients were exposed to the reduced service described for more than 90 working days (18 weeks) in that year.
66. We accept the evidence from staff members that they experienced problems running the Practice because of what they regarded as inadequate Locum arrangements, and would raise these on their annual Appraisals. Examples may be found at RB 134, RB 148, RB 152 and RB 135. We are satisfied that staff raised these concerns at times before they were aware that the PCT was undertaking an investigation of Dr Sarkar. We also accept that other consequences were that from time to time two patients were booked for one 10 minutes appointment slot.
67. In addition to holiday arrangements Dr Sarkar undertook other work which affected his availability for surgery duties. Foremost among these was his work for Humberside Police as a Forensic Medical Examiner. We accept the evidence we heard from Mr Sparnon, that Dr Sarkar's commitment to this police work was considerable: "right up there in the top quarter" of the 22 doctors who did this work for the police.
68. Mr Sparnon was able to give us figures, which we also accept:
    In 2003 Dr Sarkar had dealt with 314 cases in cells (fitness for detention) and another 70 examinations, and a further 9 examinations in sexual assault cases;
    In 2006 he dealt with 350 cases in the cells and 6 sexual assault examinations;
    In 2008 he dealt with 450 cases in the cells and 9 sex assault examinations.
    Dr Sarkar was entrusted to prepare the rota for police doctors (including himself) in Grimsby. This meant being on call for 24 hours one or two days a week. This did not mean necessarily being away from his own Practice, so long as he was available to be called out. Dr Sarkar spread his availability on the police rota over weekdays and weekends.
69. Dawn Pickett's evidence was that it caused problems with running the surgery if Dr Sarkar was called out to see someone in police custody, as pressure was put on staff and Dr Sarkar was not available for clinical input. Karen Thickett's evidence was that Dr Sarkar prioritised his work for the police and (when it was available) the hospital. He would simply ring up to say he was doing a police job before coming in to surgery (RB 282). We accept this evidence.
70. Of less importance in this context was the evidence we heard from Dr Bhorchi who told us that Dr Sarkar had also provided Locum cover to her during periods of leave, but she did not reciprocate by providing cover in his Practice. She was perfectly well satisfied with the quality of the cover provided, but it represents another conflicting commitment for Dr Sarkar in the provision of the service to his own patients.
71. We were invited to consider evidence from Mr Clarke about the relationship between the size of a patient list and the number of patients a GP would expect to see per week, as one means of measuring the number of patients

Dr Sarkar should have been seeing, compared to the number he actually saw. The Tower Hamlets study shows 72 patient appointments per week, per thousand patients on a GP List. Mr Clarke would therefore have expected Dr Sarkar's Practice of nearly 2000 patients to generate about 140 appointments per week, or 28 per day. Locum cover which was able to deal with only about 12 patients each day, or 60 a week, is less than half of the average which should be expected, based on that study. Dr Sarkar told us that 10 to 12 patients could be seen in an hour, and therefore if Locum cover had been provided for two hours in the day it was sufficient to get near the Tower Hamlets level. In any event most patients were happy to wait until he had returned from holiday.

72. While we treat the findings of one study with great caution, we find nothing in it to contradict the conclusion that the Locum cover provided by Dr Sarkar was wholly inadequate. We take into account that there may be benefits in local GPs, who know the local patient population and the local services, being involved in the provision of Locum cover, but Dr Sarkar's Locum arrangements created significant detriments for patients. It did not take, or should not have taken, representations from staff to let him know that what patients were being offered was a significantly reduced service. It was reduced in terms of the availability of surgery time and often in terms of the sufficiency of appointment times or contact with a doctor. The consequences in patient service were simply unacceptable in our view, and any GP concerned to put the interests of his patients first, or simply to comply with the basic obligations of his contract with the PCT, would know that.
73. We are also satisfied that the impact of some of these arrangements was that on occasion up to 17 patients were squeezed into appointments over one hour. This offers a wholly inadequate opportunity to listen properly to patients or give them the extra time which, in a proportion of such cases, will be required.
74. We therefore conclude that against the background of this inadequate Locum cover, the effect of Dr Sarkar's persistent lateness, his Tuesday absenteeism, his lengthy holiday absences, combined with his police Forensic Medical Examiner absences, to which he gave priority, and his provision of reciprocal Locum cover to other local GPs on the Rota (on one day we saw he was covering 3 practices) meant that his patients had access to an unacceptable level of GP surgery availability.
75. It was of concern to us that Dr Sarkar continued to defend the adequacy of provision, and to rely on increasingly strained justifications, such as that a Surgery was available for the whole advertised period despite the absence of a doctor if there were staff present who could contact him. We put on one side the fact that (as we find) he was not always contactable after he left the surgery. Surgery hours are surgery hours and save in exceptional (and usually unforeseeable) circumstances a doctor should be available. Dr Sarkar showed no sense of awareness of the problems created when he was questioned about the various consequences we have outlined above.
76. Extended Hours. On 2 June 2008 Dr Sarkar signed up to provide Extended Hours of surgery opening on top of his normal hours. This was part of an NHS-wide initiative at the time. It amounted to an extra half hour on Monday and Tuesday evenings 6.30 pm – 7 pm and on a Thursday afternoon (RB 195). Strictly speaking the Thursday afternoon session was not "extended

hours" because it fell within the core contractual hours of 8.30 – 18.30 Monday to Friday. However, Dr Sarkar was entitled to receive extra payment from the PCT for this additional evening service. A confirmation sheet had to be submitted each quarter, verifying that the service had been provided. For the first quarter, this was signed and submitted by Karen Thickett (RB 196), stating that 52 extra hours of GP sessions had been provided for the period July – September 2008. For the next quarter, Dr Sarkar signed and submitted the confirmation sheet for the period October - December 2008. We accept the evidence of Karen Thickett about this issue. She said that she signed the first quarter's form because it had to be submitted by a cut-off date and she could not find Dr Sarkar to sign it. She said she was unwilling to sign the second confirmation sheet herself, as she was aware that the service was not in fact being provided, and therefore left it for Dr Sarkar to sign. This happened after she saw an email dated 13 October 2008 (RB 216) which stated that Dr Sarkar did not want any more appointments after 6 pm. Plainly his instruction could not be reconciled with providing the Extended Hours service to which he had signed up.

77. The log-on data at RB 198A analyses log-on times for July to December 2008 and shows that during the first quarter there were 4 log-in times within the 6.30 to 7 pm slot, 10 log-in times outside that slot and 7 where no log-in time is available. During the second quarter there were 3 log-in times within the 6.30 to 7 slot, 6 were leave days, 8 were outside the relevant slot, and 9 show no log-in times. The screen prints for Monday and Tuesday evenings on random dates from July to December 2008 (RB 199-214) show that no extended hours were provided on those dates.

78. Dr Sarkar's case in his witness statement (para 38) was that the first confirmation form had been filled in by the Practice Manager, and signed by her without his knowledge or authority. He was asked why, having signed up for the scheme, he was unaware of the first claim being made. He said that just because he had signed up for the service did not mean he had to undertake it. He said that the second quarter's form which he signed himself was a valid claim and he would not have signed it if he had not believed it to be true. Indeed he claimed in re-examination that he had looked at the computer himself before signing the form. He could not explain why he had said (as set out in the email of 13 October 2008) that he did not want any appointments after 6 pm, or why there were only a few log-in times after 6.30 pm. He then suggested for the first time that he sometimes covered a colleague for that GP's extended hours and vice versa and that Dr Bedi covered his hours. None of that had been put to PCT witnesses, in particular his staff.

79. The PCT has been at pains to emphasise that it does not allege fraud against Dr Sarkar, arising from this situation, but points to it as an example of his chaotic and careless approach to provision of services and his failure to grasp necessary administration such as the impact of QOF. We are satisfied that Dr Sarkar was chaotic about providing the services for which he was being paid, to the point of being reckless as to whether they were in fact being provided. He seems to have regarded the Extended Hours agreement which he signed and the quarterly returns which were subsequently submitted to confirm that the additional service had been provided, as "box-ticking" exercises. It is impossible to square the instruction, given in October 2008, not to book

appointments after 6 pm, with the obligation he had taken on, only 4 months earlier, to provide Extended Hours. We also note that when he explained his surgery opening hours to Dr Twomey in December 2008, the hours he described did not cover the Extended Hours commitment.

80. It is submitted on behalf of Dr Sarkar [para 19 (x)] that the wrongdoing in respect of submitting claims for extended hours which were not provided was that of Karen Thickett, who then used "her own wrongs to disgrace Dr". We reject this submission in light of the evidence we have accepted. In any event, the plain fact is that for 2 quarters immediately after signing a commitment to provide extra hours in return for payment, Dr Sarkar substantially failed to do so, whoever submitted the quarterly return, and on one of the occasions signed off the return himself. He has not suggested that it slipped his mind that he had recently taken on this commitment, and his instruction to staff not to book patients after 6 pm made it impossible for him to honour it. The attempt to blame Karen Thickett (even if she should not have signed off the first quarterly return) wholly misses the point about this underlying failure and is merely seeking to blame others where the opportunity presents.
81. In our view Dr Sarkar did not have any appreciation that the simple additional obligation he had taken on, and for which he was being paid, required him to provide the service. We reject his evidence about how the forms came to be signed and submitted, insofar as it conflicts with that of Ms Thickett. We found that his explanations, including the one advanced only in cross-examination that his extended hours were covered by Dr Bedi, were not credible, and we are left with the unhappy conclusion that he was trying to mislead the Tribunal.

2. <u>Management of results, letters and referrals</u>

82. The manner in which Dr Sarkar reviewed, or failed to review, results of blood tests and other pathology investigations, or hospital letters, and the standard of his record keeping, was in the forefront of the PCT's case. We were referred to the PMS Regulations (para 70, Schedule 5, Part 5, at RB 45A) concerning the contractual terms, the RCGP guidance (RB 45B-C) and paragraph 67 of Schedule 5, Part 4 of the PMS Regulations which requires the GP to carry out his obligations with reasonable skill and care, and RCGP guidance on providing good clinical care (RB 45 E – H). We were also referred to paragraph 60 of Schedule 5 Part 4 of the PMS Regulations (RB 47A) concerning the GP's obligation to rake reasonable care to satisfy himself that a person employed to assist in the provision of services is both suitably qualified and competent to discharge those duties. The RCGP guidance includes bullet points describing features of "the unacceptable GP".
83. <u>Reviewing results and letters.</u> We accept the evidence we have heard and read from members of Dr Sarkar's staff about the system for reviewing blood and other pathology results and hospital letters as they were received. They are consistent one with another and describe a state of affairs which existed over a number of years. Essentially this involved the delegation of scrutiny of these documents to medically unqualified personnel.
84. Staff were dealing with a situation in which Dr Sarkar did not attend to clinical correspondence and reports which came into the surgery. We heard that if patients came in to enquire about their results, staff had to look through a huge pile on Dr Sarkar's desk to find the relevant one. We saw minutes of Practice Meetings which raised the problem of not attending to this incoming

documentation: on 13 March 1995 [RB 164] Dr Sarkar is minuted as agreeing to check the incoming results and letters and to initial them before they were filed. On 26 September 2008 [RB166] the post tray was getting very full again, causing the filing to pile up and patients' letters were not getting filed away, so it was decided to put clinical letters in a folder and placed on Dr Sarkar's desk daily to be read through by him.

85. A different system had to be adopted because Dr Sarkar could not adhere to this discipline. Dawn Pickett said "Dr Sarkar would not read letters". As described by Julie Nunns and Dawn Pickett, who operated it successively, this involved one of them reading all the incoming hospital letters and making a pile of standard clinical letters "where nothing needed doing" which were filed away, and another pile of hospital letters which suggested changes [in the medication or management of the patient]. These were then taken to Dr Sarkar by the staff member. Dawn Pickett told us she would say "the hospital is suggesting this" and Dr Sarkar would say "OK let's go with that". He did not read the full letter, but only the bits which had been highlighted for him by staff. Ms Pickett said it had been brought up at a Practice Meeting that he should initial letters "to cover me, because I was doing the changes". This reflects an understandable level of concern that Dawn Pickett (who has no medical qualification or training) was effectively actioning hospital suggestions with minimal if any real input from Dr Sarkar. Even this very limited input proved difficult to obtain during the extensive periods of Locum cover and in consequence Ms Pickett complained during her Appraisal in December 2008 (RB 135).
86. So far as blood results were concerned Helen Noble' statement, which we accept, explains that Dr Sarkar did not usually review them and would simply recall patients for further tests and did not do anything about abnormal results. They would be ticked by him even if they were abnormal. In addition in 2000 Julie Nunns had come across several abnormal blood results which were simply filed away. After discussion with Karen Thickett Ms Nunns started writing on the abnormal results, and had then devised a stamp (examples of which we saw) to act as a prompt for action.
87. Shortly after the introduction of the stamp, Dawn Pickett took over Julie Nunns "screening" function. In relation to the abnormal blood results she took to Dr Sarkar she said he never asked to see the patient's history. She would prompt him to say what he wanted to do. He would frequently reply "review in 3 months' time". He did not see, or ask to see, the "normal" results. But Dawn Pickett's confidence in his clinical judgement became low, so she sometimes used to ask a second opinion from Helen Noble. Dawn Pickett was not claiming medical expertise herself, but simply going on Dr Sarkar's inconsistent responses.
88. In his statement, Dr Sarkar accepted he did not look at the normal results but went through the abnormal results with a member of staff and actioned them appropriately (para 34 (1)) and during his evidence in chief said that the staff knew what was normal and what was abnormal and it was all marked for them on the results and he did not need to see normal ones. It follows that he accepted the basic system described by staff. However during cross-examination he changed this evidence and said he saw all the results, the abnormal ones being seen first. He claimed he looked at the normal ones in his own time. He was unable to reconcile his new evidence to the evidence he

had given in his witness statement or in chief. We are satisfied that the admission in his statement is nearer the truth and his change of evidence may reflect a belated awareness that there was a serious criticism to be met.

89. Dr Sarkar did not claim in his statement that he consulted patients' history or records before sanctioning action on a hospital letter or a result.

90. Although it was suggested to Dr Collett in cross-examination that GPs could and did delegate to administrative staff the sifting of hospital letters and results, he said it was terribly unusual. This was not a system which was robust or worked. Although staff might open and stamp post, it was for the doctor to read every letter. He said "The thing that alarmed me and that was too big for me was that I did not see a system which worked safely for patients". There was no daily routine and queries often occurred when there was no doctor to ask. Among other things, the decision whether to present a letter or result to the doctor was not being taken by suitably qualified staff. There was also no system for coding queries with the doctor. The doctor needed to see all the letters and results, and review suggestions for altered management. Dr Collett said by way of example that he had stopped actions advised by the hospital because of something known to him as the GP which was not known to the hospital. A hospital letter (A's Patient Records bundle p. 49) was put to him in cross-examination and Dr Collett pointed out that it was a non-medical member of staff who had picked up that the medication prescribed by Dr Sarkar following receipt of this letter was in fact contra-indicated. That was fortuitous. It was also important to review normal results as well as abnormal ones, so as to consider what if any further investigations were necessary, or to establish patterns (such as progress or deterioration). Dr Collett's approach, methodology and conclusions were not in our judgement effectively undermined. These are set out at RB 315 (paras 7-11) RB 316 B (paras 5-7) and RB 248 (paras 2 (i) – (ix) and were amplified and tested in evidence. We accept his opinion.

91. In Dr Collett's review of randomly selected hospital letters, only 16 of 50 letters had been initialled by Dr Sarkar (although 48 were marked for action) and none had annotations on by him. On the basis of the system described by staff and initially agreed by him, this suggests only those 16 letters were seen by him. However in cross examination Dr Sarkar explained that only 16 were found to be initialled because it was a recent practice for him to initial them. It was then put to him that the letters were from 2008 (shortly before his suspension). He then told the Tribunal that sometimes he forgot to initial them although he had seen them. We did not find this evidence credible and are satisfied that he only initialled those letters which were seen by him as a result of being brought by Julie Nunns or Dawn Pickett, and that the proportion of 16 letters out of 50 selected by Dr Collett is a fair reflection of the number of letters he actually saw. Dr Collett also reviewed 50 random pathology reports; Dr Sarkar's initials appeared on only 17 of them, and there were no annotations by him. There was no evidence that Dr Sarkar had reviewed the contents of the pathology reports which were not initialled by him. We have concluded that this fairly reflects the proportion of pathology results which he actually saw and considered.

92. It was of considerable concern to the Tribunal that the initial sorting of letters and blood results into "standard/normal" (therefore not to be referred to the doctor) and others requiring his attention, was done by non-qualified staff. Ms

Nunns and Ms Pickett appear to have done this mainly on the basis of what was a hospital letter not making suggestions for changed management, or what was a blood result which was within the normal range (printed on the proforma result document). Not every selection could be made on a straightforward basis. Some required input from a person with clinical knowledge. That input did not come from Dr Sarkar. Eventually, Nurse Helen Noble had to block off the last appointment slot for her own patients in order to help Dawn Pickett to sort the blood results.

93. Ms Thickett accepted that in devising systems to support Dr Sarkar, staff had been over-protective of him.
94. We are wholly satisfied that this was an inadequate system which potentially put patients at risk. Results of tests which are ordered by a GP should be seen and considered by that GP or another doctor able to monitor their significance. It may be as important to know that the results were within the normal range as that they were outside that range, since further or different investigations may then need to be undertaken to explain the patient's symptoms. In addition, even within the normal range, there may be progressive change in successive results which can indicate a disease process or deteriorating levels of important components of the blood or other physiological features.
95. Delegation to unqualified staff of the scrutiny of results which necessarily involves some degree of clinical decision-making is unacceptable. There was no evidence that Dr Sarkar supervised this part of the process. Quite the reverse; there was evidence that staff had to pursue him for decisions or input which they needed to action.
96. <u>Referral letters</u> (to hospital Consultants for opinion or investigation by their respective teams) were prepared by Wendy Brookling. It is alleged that the system described by her necessarily involved inadequate input of clinical or historical information and/or inadequate workup by preliminary investigations of the patient's condition. We accept Ms Brookling's evidence, in particular: (i) that the information provided to her by Dr Sarkar was sparse, and necessitated her extracting details from the (often brief) Journal entry he put on the computer; (ii) that he sometimes referred patients to a Consultant as if it was a fresh referral when in fact the patient was already referred to that Consultant, leading to the inference that Dr Sarkar did not normally refer to the patient's history or records (even to the extent of scrolling down the screen available to him on his computer) when deciding whether to refer or not; and (iii) that no blood tests had been undertaken even when the proforma referral for a particular clinic required that information to be entered. In order to draft a referral letter for Dr Sarkar's signature, Ms Brookling had to seek out a patient history herself from the records, and insert it in the letter. She said that in her position (namely an unqualified person) she did not really know what was necessary to be included in the history. We agree that this is an inescapable consequence of the system adopted by Dr Sarkar. It was not appropriate and might foreseeably compromise the effective investigation of a patient's condition.
97. We accept and find that at one stage referrals for cancer clinics which had been put into the 2 week wait track (for expeditious investigation) were being audited and returned by the PCT because there was no indication as to why they qualified as 2 week cases. Ms Brookling did not have the knowledge or

qualification to respond so the letters were referred to Dr Sarkar, but he failed to respond. Her concerns about this are reflected in the Practice Meeting minute dated 6 November 2007 (RB 174-5) which states: "all referrals that are passed to Wendy must indicate whether they are a 2 ww or not, It is NOT the responsibility of staff to make this decision. It must be a CLINICAL decision. Also all referrals are being audited by the PCT. IT is very important for the clinical staff to follow the correct pathways. If they are not followed, maximum QOF points will not be achieved, which in turn will [cost] the doctor money".

98. Dr Sarkar's case is that he provided Ms Brookling with the clinical content for all referral letters including the reason for referral, clinical findings, investigations and results. In answer to question from the Tribunal he said that all that was left for the staff to do was put on a "Dear….". We reject this account. No draft letters of that character have been produced, or mentioned by any witness. Dr Sarkar has not explained how he transmitted to Ms Brookling the full information he contends he gave her. We find that her account is credible and supported by other witnesses (eg Ms Noble) and contemporaneous documents such as the Practice Meeting Minute of November 2007 and Ms Brookling's Appraisal on 23 December 2008, which among other things refers to the difficulty of getting clinical information for inclusion in the referral letters.

3. Record keeping and related clinical issues

99. Three separate exercises were undertaken by Dr Collett: (1) a review of the records of 13 patients from a routine surgery held by Dr Sarkar on Monday 3 November 2008 (a date chosen at random); (2) a review of records relating to 15 patients who were prescribed Diazepam (a benzodiazepine); and (3) records relating to 9 patients with anaemia. The reason for the first review was to assess a random sample of records from a typical surgery. The reason for the second review was that benzodiazepines are addictive and it is a priority for PCTs to reduce the number of patients prescribed such drugs and to control and carefully follow up any continued use. The reason for the third review was that investigation and follow up of anaemic patients is "crucial" (RB 316 B); it is a treatable condition but can also be associated with sinister conditions.

100. The normal RCGP practice is to take 10 records, and if there is cause for concern revealed, to take another 10. Dr Collett therefore felt able to say that the sample he reviewed equalled or exceeded this statistically reliable model. Having been informed in cross-examination that the list size was about 1900 patients, Dr Collett said that the sample represented a bigger proportion of this list than the average list for which the method had been found statistically accurate. He considered each of the patient records under headings for working diagnosis, appropriate history, appropriate examination (negative or positive findings), prescription issues, follow-up arranged and opportunistic intervention/management of overdue issues. If there was an entry in the records he would tick the appropriate box in a standard grid which recorded his findings and are to be found as follows:

a. Surgery 3/11/08 – RB 263-4
b. Diazepam patients – RB 261-2
c. Anaemia patients – RB 265-6

101. Surgery 3/11/08. There was a diagnosis in all but one of the 13 cases and in that case there was no record at all, so that patient may not have

turned up. However, a history was recorded in only 6 cases. An examination of any sort was noted in only 5 cases and in the remaining cases, 3 examinations were described as "cursory". A prescription was noted in 7 of the 13 cases with no follow-up or opportunistic diary entry noted in any of the cases. The data was often limited to a single read code and a prescription. In Dr Collett's view a locum looking at these records would have insufficient basic information on which to act, and would have to "clerk" the patients (elicit and record that information) afresh. He amplified this point, saying that when following up cases, a GP needed to refer to baseline findings to see if a change had occurred (this meant negative as well as positive findings). A Locum could not have taken over these patients where there was no history or examination without starting afresh. Meanwhile there may in fact have been some change in the intervening period.

102. Dr Collett made clear that he was not making a judgement on the quality of the information in the records, merely measuring whether *something* was recorded under each of the standard headings. However, having regard to what he had seen in these records and those relating to anaemia and Diazepam patients, he was sufficiently concerned to consult the Medical Defence Union and his Local Practitioner Committee about his personal responsibilities to patients whose management he had seen in the records (see RB 245).

103. In cross-examination Dr Collett rejected the suggestion that these records were brief but adequate. He said they were brief *and inadequate*. Additional patient records were put to Dr Collett from the Appellant's Bundle of Patient Records, which he had never seen before. He was critical of all them.

104. Diazepam patients. Dr Collett identified 15 cases at random. There was a recorded diagnosis in 10 cases, no history or examination recorded in any of the cases, but a prescription was issued in all 15 cases (in 4 of which the patient was not seen), with no follow-up noted and no opportunistic diary entry. It was of concern that there was no record in any of these cases over the previous year that there was any indication for the continuing use of this addictive drug. Dr Collett told the Tribunal that a history was also important because sometimes an inference could be drawn from a single case of a panic attack.

105. Anaemia patients. 9 patients with anaemia (excluding pregnancy-related anaemia) were identified. A diagnosis was recorded in only 3 of those cases. A history was recorded in 1 case only. An examination was noted in the same case but no others: in that case the patient was admitted to hospital. A prescription was issued in 4 cases. An opportunistic diary entry was made in 1 case. In 2 cases the patients had not been seen and there was no record of a blood count. In another 3 cases the patient had not been seen but there was a low blood count recorded which showed that those patients were at risk. These should have been followed up. One of the patients had been seen for depression but anaemia was not addressed in the records. Dr Collett therefore had cause for concern. There was a need for appropriate treatment and review of these patients and you would expect appropriate follow up.

106. One measure of the inadequacy of this record keeping (and by inference, management) was that on this analysis Dr Sarkar would not have been allowed to pass the Vocational Training Scheme for GPs.

107. We were impressed by the care and rigour of Dr Collett's investigation of records. Cross-examination achieved no impression on the conclusions. We accept Dr Collett's findings and conclusions. It is of considerable concern to the Tribunal that Dr Sarkar's record keeping does not satisfy the basic standard for Vocational Training. These are not fancy modern developments but basic tools long required to be used by GPs (reinforced by the requirements of bodies such as the RCGP and GMC).

108. We are also satisfied on a balance of probabilities that in most if not all cases where matters were not recorded by Dr Sarkar, it was because he did not take the history, or do the examination, or form a plan for follow-up, or consider opportunistic matters, as the case may be. Whatever his background knowledge of the individual patients, that is an unacceptable clinical standard.

109. <u>QOF and computer literacy</u>. While the QOF system for achieving points and therefore payment affects the question of giving 10 minute appointments when booking patients (which was not followed in order to accommodate the timetabling which Dr Sarkar or his Locums required from time to time) and the Extended Hours, we also heard and read evidence, which we accept (eg Julie Nunns' Appraisal 22 December 2008 RB 132), that Dr Sarkar did not action QOF alerts or that he would sometimes input a diabetes diagnosis twice and this would produce duplicate alerts. Karen Thickett told us, as we accept, that Dr Sarkar did not put the read codes into the computer so the information was not fed into QOF. The staff shouldered a larger share of the burden of operating the QOF system than would normally be the case.

110. We are satisfied that Dr Sarkar had little aptitude for operating the computer system which had become more and more central to the management of a GP practice and the wellbeing of its patients. We heard no evidence that he recognised this or at least that if he did, attended courses to update his skills in this regard. If he did, he does not appear to have been able to put into practice any skills he was taught, to the extent that it is reasonable to expect.

111. This is not simply a matter of administrative efficiency but of patient welfare. Dr Sarkar agreed when questioned by the Tribunal that a GP must be competent in using the Practice computer, and assured us he could manage it. We do not think his computer competence was as good as is necessary and was at a more basic level.

112. Helen Noble's Appraisals of February 2006 and December 2008 also raise concerns about Dr Sarkar's approach to QOF. This raises again the issue of Dr Sarkar's engagement with the audit designed to reduce the prescribing of benzodiazepines. Many of the patients were on high doses. The figures came down dramatically between 2001 and 2004, stayed low in 2005 and 2006, but then rose again, as a result of prescribing by Dr Sarkar. Similarly, a programme to reduce the use of proton pump inhibitors (PPI's) in response to an action plan from the PCT resulted in 23 of 39 patients identified in 2002 being stepped down or discontinued and 15 switched to a different brand. However in 2008 a review showed that figures were going back up and the prescribing of PPIs was too high (RB 319-320). We are inclined to think this is as a consequence of Dr Sarkar adopting management which was familiar to him in order to meet patient pressure or expectation. Whether that is so or not, he could not have been unaware of the strenuous efforts which had recently taken place to reduce this prescribing.

113. Our findings on this area of record keeping and associated clinical issues represent extremely inadequate standards of record keeping and poor clinical practice. We consider the absence of follow-up in the anaemia cases to be significant, having regard to the fact that it can be an indicator for serious health problems. In the Diazepam cases the lack of a history or evidence that the patient was questioned about how they were feeling is also of concern. These are addictive drugs, and we heard (and accept) powerful evidence from Helen Noble about efforts she and other staff had made to reduce the high number of patients in the practice who were receiving them, in response to a PCT initiative, only for that reduction to be reversed when Dr Sarkar agreed to put patients back on them. We also note that 5 of the 15 patients whose records were considered by Dr Collett had been prescribed Diazepam without being seen.

114. When considered in conjunction with our findings of an unacceptable practice of not reviewing all pathology results and hospital letters, but delegating to staff the selection of some letters for his attention, a picture of lax and unacceptable clinical practice emerges, of which the records are a reflection.

115. Other clinical issues. Dr Sarkar administered an adult dose of Pneumovax to a baby, instead of Prevenar (for infants) as a result of an error by one of his staff getting out the wrong box of vaccine. We accept the evidence we heard from Helen Noble, and Wendy Brookling about this. Ms Brookling was clearly very affected by the experience and felt responsible for what might have been happened. The resolution in a subsequent Practice Meeting Minute (RB177) that a named staff member would get out immunisations for Dr Sarkar if Helen Noble was off work for any reason, but the responsibility lay with the doctor to ensure there were correct, is plainly right. It is remarkable, in our view, that staff felt obliged to spell this out at a Practice Meeting. However, errors can happen. We are more concerned by Dr Sarkar's subsequent behaviour than by that error. The error was discovered the next day by Ms Noble. He showed no concern so far as we can detect, and it was left to staff to contact the manufacturer of their own initiative and obtain reassurance. We reject the evidence, given by Dr Sarkar in his evidence in chief for the first time, that he had contacted the manufacturer himself. Nor did he contact the baby's parents about it, because he took the view that there was no adverse effect so no need to inform them. When the RCGP guidance about being honest with patients and declaring mistakes was put to him, Dr Sarkar said the family was alright. The baby's mother subsequently changed to a different doctor and Dr Sarkar responded to her letter of complaint (Complaints File p. 15). In our judgement Dr Sarkar's approach was "least said, soonest mended", but we do not believe he can have been confident that no adverse effect would ensue, and nevertheless did nothing to discover what might happen, and therefore put himself in a properly informed position to give information, guidance or reassurance to the baby's mother.

116. Several cases of concerns about clinical management of patients were put before us. Each of these had been discovered or flagged up by members of Dr Sarkar's staff. Mrs D (records at RB 351-353) concerned a female patient who presented complaining of chest pain which was diagnosed by Dr Sarkar as musculo-skeletal. We accept the evidence of Helen Noble about

this and find that Dr Sarkar did not question her adequately to discover (as was the case and as Helen Noble discovered) that the patient had been woken by the pain in the night. Ms Noble thought it was more serious and so spoke to Dr Sarkar who said she could "do an ECG if I wanted". He suggested a referral to the Rapid Access Chest Pain Clinic but Ms Noble thought it was more urgent that the 2 weeks this might take, so spoke to the hospital who advised emergency admission by ambulance to hospital where an ECG was performed. This was reported as showing that the patient was in fact having a myocardial infarct of the anterior wall of the heart. It is of concern that even when the additional information was put to Dr Sarkar by Ms Noble, his response was that she could arrange an ECG "if she wanted", and he had a poor sense of urgency in getting his patient to specialist care.

117. Mr E was an insulin dependent diabetic patient who presented with a bandaged and oozing toe. Dr Sarkar prescribed antibiotics but when pressed by Ms Noble agreed to refer him to hospital where he was found to have a staphylococcus aureus infection and received in-patient treatment for about a week. While Dr Sarkar may be commended for accepting Ms Noble's suggestion, it is of concern that given the patient's known diabetic condition he did not examine him with the degree of care which would have caused him to reach that conclusion himself.

118. Two patients (Ms F whose records are at RB 372-4 and Mrs G whose records are at RB 375-382)) had over-active thyroids, as blood results clearly showed, but Dr Sarkar prescribed medication for an under-active thyroid. In the case of Ms F it was the patient who thought something was amiss and rang the surgery. Miss Noble then arranged for Carbimazole to be prescribed in substitution. In Mrs G's case a Locum asked for a repeat test and prescribed the correct drug.

119. Dr Sarkar did not comment on either of the above cases, nor was Ms Noble's evidence challenged on this subject.

120. Mrs H was a patient (records at RB 383-7) whose chronic kidney disease (CKD) was not diagnosed by Dr Sarkar. This is against the background that Dr Sarkar's practice had an unusually low number of CKD patients (below 4% on the CKD register) compared to the average of 6 – 8%. It was raised by the PCT at a PMS review. Following Dr Sarkar's suspension and a lot of work by a Locum, the number of patients on the CKD register rose from 6 in 2008 to 104 by March 2010. In the case of Mrs H, a Locum made a note on 16 July 2009 (RB 283) backdated to 1 September 2006 that this patient had CKD. Dr Sarkar did not dispute the basic facts but said in cross-examination that tings had moved forward a lot in medicine since he was suspended in February 2009, an explanation which we are unable to accept in relation to the maintenance of a CKD register and proper management of such patients. We are satisfied that Dr Sarkar was less alert to diagnose CKD than he should have been or to arrange adequate monitoring and follow up by ensuring the patient was placed on the CKD register.

121. The documents within the Complaints File (at 2.1, 2.2 and 2.3) contain correspondence files relating to 3 medico-legal complaints against Dr Sarkar. The first concerns the death of a child from sepsis (Group A Streptococcal infection) following a consultation with Dr Sarkar in December 2004. The second concerns a male patient who complained that he presented in October/November 2005 with shortness of breath on exertion and was

prescribed a week's course of antibiotics, which achieved no improvement, and then was prescribed Frusimide and subsequently referred to a Cardiology Consultant. On examination in hospital he was found to have a collapsed right lung. The third (a complaint dealt with through the PCT complaints procedure) concerns a female patient who initially presented with hip pain in January 2008, but developed a range of other symptoms, including urinary infections, altered bowel movements, mouth ulcers, thrush and Bell's palsy and died in July 2008. We do not have information about how these complaints were disposed of or indeed whether they were pursued, and we attach no weight to the detail of the complaints, other than to note that a common thread was an alleged failure to examine the patient on several opportunities to do so. But it is clear that in at least the second of these cases the Medical Protection Society had significant difficulties in obtaining any response or instructions from Dr Sarkar, without which it was difficult for them to represent his interests. Dr Sarkar does seem to have had difficulty in dealing with correspondence even where his own vital interests were involved and this reinforces the impression we have formed that he did not care to deal with correspondence concerning his patients if he could avoid or delay doing so.

122. The Tribunal reminded itself that these cases involving individual patients were not put before us as a result of an audit of Dr Sarkar's clinical practice and were anecdotal in the sense that they were brought to light when they came to the attention of staff, in particular Ms Noble. We cannot therefore know what proportion of his patient contacts were characterised by error or omission. But these are worrying incidents surfacing over a relatively short time period, However we also noted that the basic facts concerning the patients other than the negligence claims were not disputed and we were therefore concerned about Dr Sarkar's response, or lack of response to the incidents. He showed no awareness that regrettable mistakes had been made, or that there was anything potentially damaging to patient welfare arising from them. Nor did he show any evidence of reflecting on these cases and drawing lessons for the conduct of his future practice or continuing education. We also find these cases tend to support the impression we have formed from the evidence generally as to Dr Sarkar's conduct of his practice that he increasingly did the minimum that he could and patient welfare could and did suffer in consequence.

123. Ms Brookling illustrated this in the context of clinical investigations since locums started doing the clinical work after February 2009. She said that in 2007-8 the Practice had asked for zero MRI scans, in 2008-9 there was one at the specific request of an A & E Consultant, and in 2009-10 there were 8 referrals for MRI scans, which characterised the work-up investigations now being done. Likewise, over 100 ultrasound scans were done in 2009-10 compared to around 30 in previous years under Dr Sarkar.

124. Complaints and satisfaction levels. We were reminded that the PMS Regulations require a contractor to establish and operate a complaints procedure. We are satisfied from the evidence of Practice staff that they frequently received oral complaints about Dr Sarkar's lateness and consequent effect upon appointments, and about the difficulties of getting appointments and seeing a doctor during Dr Sarkar's abnormal level of absences from his practice. Although these problems were (as we accept) raised at Practice Meetings from time to time, nothing was done to address

and improve them in the long run. Written complaints were rarer. Several concern the problems set out above. One complains Dr Sarkar fell asleep during a consultation (but he says he was merely closing his eyes in thought). Another concerns the immunisation error discussed above. One concerns a failure to attend a patient. The system does not appear to have operated well. We could not always trace replies, or timely replies, in the complaints file.

125. It is submitted in writing on behalf of Dr Sarkar that many of the complaints "have the flavour of invited complaints". To the extent that many complainants will do so initially by telephone, and may then be invited to put it in writing, that would not be surprising if it were true. This was not explored in evidence and there is no basis on which we could find adequate support for this allegation. We reject the suggestion that staff were encouraging or putting up patients to lodge complaints, a suggestion which was never put to them and is wholly at odds with the impression we have formed that staff were markedly loyal to Dr Sarkar and liked him on a personal level very much.

126. It was suggested by Dr Sarkar that his level of complaints was below average. Dr Twomey did not know what was the national average but regarded 3 medico-legal complaints in 5 years as significantly higher than average. We do not have an evidential basis on which to reach a conclusion either way on this issue. What is clear is that there were complaints, including medico-legal complaints.

127. The investigation found that the complaints file was unavailable within the surgery. It is common ground that it had in fact been handed to Dr Sarkar by Julie Nunns, at his request, during the absence from work of Karen Thickett. It turned up at reception within a week of a letter dated 6 June 2009 being sent by Mr Christopher Clarke to Dr Sarkar at his home address requesting its return and warning of the consequences of not co-operating in its return (R 24). However Dr Sarkar says he did not have it in his possession and had merely copied the contents and returned it. Karen Thickett cannot say whether contents were missing from the complaints file when she next saw it but it was disarranged. There is therefore no evidence that Dr Sarkar removed written complaints from the file, and it is therefore puzzling why he gave such unsatisfactory evidence about this episode. He told us that he did this photocopying personally in the Practice premises, without removing the file. He said he did not ask his staff to photocopy it although they were present within the Practice at the time, because he was free to do it and regarded it as personal photocopying. We found this explanation unlikely. We think it more probable that he did in fact remove the file and return it following receipt of Mr Clarke's letter. We must therefore conclude that Dr Sarkar's credibility on a contested issue is impugned.

128. The PCT conducts patient surveys on a regular basis to determine satisfaction levels. We were referred to several of these at RB 222-226 (the comparative summary is at RB 222), covering the years 2005-2008. There are 15 "indicators", the first 6 of which concern the operations of surgery generally and the remainder with the performance of the doctor himself. Of the former, all but "waiting times at the practice" achieved higher satisfaction rates than the benchmark throughout the whole period. Of the 9 indicators reflecting the doctor's own performance, all satisfaction levels were below the benchmark level throughout the period. While the nadir of patient satisfaction was 2005, and improved in the following year, it remained below the benchmark and

showed no sustained improvement in the 3 years to 2008. Indeed 2008 was a poorer outcome in general than the previous year. Mr Clarke confirmed that the scores reflecting patient experience of the doctor himself were those which were below the benchmark and below other areas. It was suggested on Dr Sarkar's behalf that the indicator "How quickly the patient was able to see the doctor" referred to patient waiting times at the surgery and that the scores were above the benchmark and had improved year on year. It is clear to us that this indicator does not refer to surgery waiting times, but to the interval between seeking and getting an appointment.

129. Thus the perception of patients broadly reflected the evidence we heard and findings we have made above.

Some issues raised by Dr Sarkar.

130. Conspiracy. As we have indicated at the outset of our consideration, Dr Sarkar alleged that there was a staff conspiracy organised by Karen Thickett, to get him out of the Practice so that they could introduce a different administration model, in which the Practice Manager and senior staff ran the Practice and employed the doctors who provided medical services there; he alleged they therefore had a commercial interest in giving evidence against him.

131. We find there was no such conspiracy, nor (for completeness) was there a plan by Karen Thickett to get Dr Sarkar out of the practice and run it herself.

132. We have considered with care the submissions on this point given to us in writing on behalf of Dr Sarkar, which we find not to be supported by the evidence we have accepted. The high point of this argument for Dr Sarkar is an email exchange between Karen Thickett and Mr Clarke on 1 February 2006 (R 33-34) in which Ms Thickett says she is keeping him informed about some concerns about running of the practice, in particular that Dr Sarkar had little or no input into the implementation of the new contract, that he had cut staff hours, and had asked a member of staff from Dr Bedi's practice to come in and do some work on his behalf. This had caused some bad feeling and resentment amongst staff. Mr Clarke's response was to suggest this be included in the report for the next PMS review. Mr Clarke told us he referred it to the lead director responsible. We are unable to spell out of this either a budding conspiracy or a motive for ousting Dr Sarkar. These are operational concerns properly raised.

133. When first interviewed in December 2009 Dr Sarkar did not suggest that he was the victim of a conspiracy of this kind. However his statement suggests at paragraph 31 (1) that the genuineness of appraisals was disputed because they were inspired by the intentions of Karen Thickett and Helen Noble to emulate the model of another surgery to allow a private company to take over the doctor's surgery. At paragraph 31 (2) it was suggested that further staff are "interested" and that Karen Thickett and Helen Noble had a "commercial interest" supported by Dr Paul Twomey, as the appraisal was done after Dr Sarkar had met with Dr Twomey. At 31 (3) and (4) it is again suggested that Helen Noble has a vested commercial interest in the preparation of critical appraisals. When these allegations were put to Helen Noble in cross examination she denied them vehemently. She said none of this was what they wanted to happen and it had been the most stressful time of their entire lives. If Dr Sarkar could have improved and worked efficiently

staff would have been happy to work for him “until the cows came home”, but by December 2008 it was out of their hands. Mr Rogers put to Ms Noble that another local Practice (Ashwood) had a practice model where it was run by the Practice Manager. He suggested that this is what she and Karen Thickett were planning to do, and so to get Dr Sarkar out. She said she was not aware of that Ashwood situation until she first came to this Tribunal on 5 May, and had never heard of anything so ridiculous as the suggestion put to her, which she found quite insulting. She had hoped to be able to retire at the same time as Dr Sarkar and had just wanted him to improve. Mr Rogers then said he did not want to pursue paragraphs 31-32 and 34 (the allegations of improper motive against Ms Noble) of his client’s statement with this witness.

134. We are wholly unable to find a commercial benefit to either Ms Thickett or Ms Noble from the change in arrangements following on Dr Sarkar’s suspension, or prospectively if he were to be removed from the Performers List. Both Ms Thickett and Mr Clarke explained the arrangements as being payments made by the PCT into the practice bank account, which required two signatories, Ms Thickett and Ms Noble, who therefore operated the account but were accountable for the disbursement of money for the proper purposes of the Practice. There is no change in their own benefits. The allegations of conspiracy or commercial interest were not put to Julie Nunns or Dawn Pickett. Mr Rogers was circumspect in what he suggested to Wendy Brookling, asking if she was aware of a new model for running the practice (which she was not) but the Tribunal asked her directly if she was aware of a plan by staff to take over and manage the Practice. She said it had never been mentioned and was not even a rumour so far as she was concerned. We accept this was the case.

135. Dr Sarkar also placed reliance on the evidence of Ms Caroline Metcalf, whose statement says (para 7 A’s witness bundle p. 43) “I have heard Karen Thickett speaking to other members of staff and discussing the probability of Dr Sarkar retiring in the near future, but the reality of Dr Sarkar retiring was never truly foreseen. I have also heard her discuss her ambition to run the Practice by herself and hire a locum. I did not at the time realise what her personal gain would be if she was to run the Practice by herself.” This version evaporated in the course of her evidence. Ms Metcalf had heard a conversation a couple of years before, when the Practice was in its former premises, which was simply speculation about when Dr Sarkar might retire, and that if he did locums might have to be hired. She told the Tribunal that it seemed like a normal conversation and did not strike her as wrong. After talking to a lot of people she had a different impression. We do not know what other people she is referring to. However her oral evidence contrasts with the different and more serious allegation in her statement, and we prefer the version given in evidence.

136. We were unable to establish from Dr Sarkar what evidence had been given which, but for the conspiracy he alleged, would not have been given. Indeed since many of the factual matters were not specifically challenged, we were left with the impression that the only difference that might be alleged was some exaggeration or “spin”. On occasion the scope of the conspiracy appeared to be widened. It was suggested to Mr Clarke that he and Ms Thickett had started compiling evidence against Dr Sarkar in late 2005 or early 2006 to get rid of him. This was denied by Mr Clarke and had never

been put to Ms Thickett. When the Tribunal pointed out that serious allegations of (at least) bias appeared to be being made against the PCT without fully identifying the individuals, Mr Rogers apologised for using the word conspiracy and said it was the ethos of the investigation which he was exploring. Since neither Mr Clarke nor any other PCT official was involved in conducting the Appraisals we are unable to see how they can be complicit in some improper conduct of those Appraisals. Mr Clarke was questioned about the email exchange of 1 February 2006 and when we sought clarification, asking if his approach to the investigation of Dr Sarkar on behalf of the PCT had been tainted by that email exchange he said no and indeed had difficulty remembering the email when questioned about it.

137. We are driven to the conclusion that the allegations of conspiracy by Dr Sarkar, to which much time has been devoted, were fanciful and baseless. In our judgement deploying this explanation was an alternative to admitting error and acknowledging shortcomings. Dr Sarkar's professional misfortunes are in his view almost all somebody else's fault.

138. Bias or lack of independence in the investigation. Mr Clarke was questioned extensively. We accept his evidence. We do not accept that the investigation he was charged with conducting was tainted by bias or lack of independence. There was and is a practical limit to the investigations which can be undertaken. It is not a telling criticism that the Locums were not asked for comment, indeed there is good reason for a PCT investigating one local practitioner not to divulge professional or confidential concerns to other local practitioners.

139. In any event, the investigation merely produced the report which was considered by the PCT. We have heard the evidence of witnesses for ourselves, and formed our own view, independently of the views expressed in the report. We have also looked at documentary material some of which was produced in appendices to that investigation report, but they are factual matters often contained in or analyses of contemporaneous documents. Dr Sarkar has been at liberty to adduce his own evidence to seek to modify or contradict that evidence, and has done so, as this appeal is a rehearing. Even if (which we reject) Mr Clarke's investigation was looking for damaging evidence rather than a truly independent investigation of concerns raised, the mischief of that would be spent by reason of the redetermination process of this appeal.

140. Lack of support. The written submissions on behalf of Dr Sarkar concede that at the date of the exchange of emails in February 2006 "It was abundantly clear that Dr [Sarkar] was struggling with the new contract and this was the trigger for any responsible trust to step in and assist." Dr Twomey told us that his primary role was to support doctors who got into difficulties. The difficulties identified were mainly those of commitment and application. The first impression of senior PCT officers when they met Dr Sarkar in December 2008 was that there may be something wrong with him as he seemed so disengaged. It was not put to a PCT witness, nor suggested in submissions, what kind of support should have been made available which was not made available. We are in some difficulties in seeing what could or should have been done by the PCT, in the absence of any awareness whatsoever by Dr Sarkar that he had shortcomings, or that he was seriously committed to effective re-education.

Conclusions on "efficiency"

141. We are satisfied that there is prejudice to patient care, which in the respects we identify above, has been totally inadequate over a period of years leading up to Dr Sarkar's suspension in February 2009. We are satisfied that there has been prejudice to the proper use of NHS resources, and to the conduct of a properly and efficiently run Practice. These are not one-off inadequacies but part of a pattern persisting over several years. The failures persisted despite warning bells sounded by staff members (for example at Practice Meetings) who may not have had a medical background but could see the evident effect on patient care and Practice efficiency. There had been some promises to improve, for example in the matter of timekeeping, but on each occasion Dr Sarkar slipped back into unacceptable practices even in this straightforward matter. This can be set in the context of what we find to be a complete lack of insight into his deficiencies or where there was any scope for improvement. For example he replied to Dr Rathi to the effect that he did not attend development courses because he had no need of improvement.

142. We are driven to the conclusion that in light of the range of deficiencies we have found proved, their persistence, and their seriousness, Dr Sarkar's continued inclusion on the Performers List would be prejudicial to the services which those on the List perform.

Conditions

143. We were told at the outset of this case that Dr Sarkar would argue for contingent removal in the event we found or he admitted deficiencies. We therefore directed that he put in writing, in advance, any conditions he might wish to argue for. The only one proposed was "Appellant takes on Partner/Partners in his Surgery; and/or takes on Salaried Partner in his Surgery." Dr Twomey responded in his oral evidence. He said that doctors sit in their own consulting rooms (meaning they are physically present to review each other's consultations) and he did not see what difference it would make to take on a partner. Referring to Dr Sarkar's proposal to take on a salaried partner he said that on a list of 1800 patients a full-time salaried doctor alongside a full-time principal was not viable. In any event from the professional perspective the investigations revealed significant clinical and professional deficiencies and having discussed them with the NCAS his view was that Dr Sarkar should not practise. He said that in recent years the patient satisfaction levels with the practice had gone backwards and it had become apparent that the staff were covering the deficiencies as best they could. Dr Sarkar was no longer motivated and his practice standards were not consistent with the GMC guidance in Good Medical Practice. He had no confidence that Dr Sarkar would undertake an education programme and in previous years when issues were raised he did not do so. He had no insight into his poor practice or any willingness to move on, and it was necessary to take into account his age and whether he was able to move on. Dr Twomey had significant concerns about his Out of Hours work (which he could continue to do if on the Performers List) as well as his own practice.

144. Mr Clarke replied to a similar effect when we raised this issue with him.

145. Dr Sarkar told us in his own evidence that he would be willing to take on a partner. He did not seem to know what Mr Tirrell was talking about when

he asked him whether that person would be supervising his consultations or who would supervise his locum work or out of hours calls.

146. When it was suggested to him that he had a problem with insight he said he had no illness. He confirmed he was not willing to go on an education programme. When pressed on this further by the Tribunal he said he could manage without those. In further questioning from his own Counsel he said "I am bright and alert why should I go to medical school again?". When asked by the Tribunal what faults he would rectify he said he would rectify his lateness. When asked if there was anything else he said: "Staff management: I would keep them comfortable and give them reasonable job description so that everything is done in perfect order. There would be better patient care and they would be seen on time and all investigations and hospital referrals, I would do everything". He also said "Most of the concerns are theoretical and not practical". Referring to the allegations of lateness Dr Sarkar said nobody was without fault and if he got the chance to rectify them everything would be right and perfect. He was therefore asked by us if he had reflected on what went wrong and what was his fault, but he replied that he was discriminated against and was told he was 67 and could not practise any more. Then regarding the staff there was a commercial interest and fictitious complaint and he had been humiliated. He had intended to retire but after this humiliation he would not retire and would do so later with respect and dignity. We detected no acknowledgement in any of this of deficiency or shortcoming or shortcoming on his part, with the limited exception of some lateness.

147. Dr Sarkar later told the Tribunal "I have not got deficiencies but if the Tribunal decides I have deficiencies I will go upon that and I shall do my best to remedy them". This was against the background of his refusal to contemplate a need for any remedial education. He had not even considered speaking to the Deanery about available help. It was pointed out to him that he had now been away from practice for nearly 2 years. He said he was attending lunch time courses offered by British International Doctors and had last done a course (nephrology) in Birmingham in April 2010. He did not produce any documents relating to continuing education. In our view attendance at some local practitioner lectures is not enough in a case such as this. An education programme directed to Dr Sarkar's particular needs is required, not a general education programme.

148. We asked him how he contemplated restoring working professional relationships with his staff after the allegations which had been ventilated about them. He said "My staff will rectify their fault and I will rectify my fault, I will go back to work with these staff and PCT officers. I have not thought about it yet – nothing is impossible. I want justice first".

149. In our view Dr Sarkar has a near complete lack of insight into his deficiencies and shortcomings. He has overlaid this with an unfounded but deep conviction that he is the victim of a conspiracy and discrimination. He is unable to look beyond this sense of grievance to consider the primary interests of his patients.

150. The condition proposed by Dr Sarkar is unworkable and inappropriate for the reasons advanced by Dr Twomey. We are not satisfied that Dr Sarkar would change in his essential approach to GP practice and the presence of a Partner would make no significant difference to that. Nor is employing a salaried GP viable in this Practice. In any event without a radical change in his

insight and effective steps to remedy his deficiencies, it would not be practicable for some other GP within the Practice to be asked, effectively, to supervise the day to day conduct of Dr Sarkar's clinical practice.

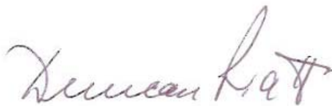
151. Nor can we identify any alternative conditions which would effectively address the deficiencies in the absence of any willingness to acknowledge them. These include the conditions belatedly suggested in written submissions on behalf of Dr Sarkar (para 33) of (i) a course of computer literacy; (ii) regular appraisals as to surgery times; (iii) Dr to be mentored by a suitable colleague; and (iv) Dr's clinical notes and practices to be reviewed from time to time. The time for Dr Sarkar to address these points and persuade us of his open-ness to implementing them was in his evidence. We remained satisfied that he would not participate, learn or apply any learning effectively, in view of his intransigent attitude and underlying convictions mentioned above.

152. The policing of these newly proposed conditions, in particular (ii) and (iv) would be an unreasonable and probably impractical burden on the PCT, in our view.

153. We are therefore driven to the conclusion that a contingent removal , with conditions, is not appropriate in this case, nor would conditions be likely to "remove any prejudice to the efficiency of the services in question": regulation 12 (2) (a). We are mindful of the submissions made in writing by Mr Rogers as to the consequences of a removal from the Performers List for Dr Sarkar. We do not accept that a consequence of such an order is to deny him his livelihood, and note that he continues to do police forensic examiner work. But in any event we consider that having regard to the impact on patient welfare and the proper use of NHS resources, removal is proportionate when weighed against the effect on Dr Sarkar. We do not derive any assistance on this issue from the GMC case of *Enrique Mateu Lopez [Privy Council Appeal No 96 of* 2002] upon which Mr Rogers relied.

Decision

154. We therefore dismiss the appeal and direct the removal of the Appellant's name from the Performers List.



Mr Duncan Pratt
Tribunal Judge

17 May 2011