TRIBUNALS SERVICE
PRIMARY HEALTH LISTS – FIRST TIER

Case Number: 15214

Listed at:	**Manchester.**
On:	**26th, 27th April 2010 and 8th July 2010**

Mr T Jones	**Judge of the First-tier**
Dr G Sharma	**Professional Member**
Mrs Greene	**Member**

BETWEEN

Dr Raghavendra Prasad Sinha
(GMC Professional Registration Number: 2398806)

Appellant

and

Salford Primary Care Trust ("The PCT")

Respondent

Appearances:

The Appellant appeared in person.
Mr Anderson of Counsel appeared for the PCT.

APPEAL AGAINST REMOVAL OF THE APPELLANT FROM THE PCT'S PERFORMERS LIST

The hearing and the appeal

1. On the date and times appointed for the hearing, we convened a hearing with a quorate Panel. The Appellant appeared and was assisted by a friend Dr Gupta. Mr Anderson of Counsel appeared for the PCT.

2. On 7th October 2009 the PCT decided to remove the Appellant from its performance list pursuant to Regulation 10 of the Performers List Regulations. This was because; it is said that continued inclusion of the performers list would be prejudicial to the efficiency of the service.

3. An appeal was submitted by the Appellant and the matter set down for an appeal hearing that took place over a number of days as outlined above. Both parties to the appeal submitted a large number of documents, which ran to in excess of five lever arch files; we found, whilst considering the whole of them, there was repetition in some parts, and whilst noting and following all representations to reference pages in submissions and evidence, that the core bundle here is in fact lever arch file number five.

4. The Respondents case was outlined by Counsel and a case summary was provided. This is a document of record and can be read further and in full by the parties. In summary the PCT case was that there have been ongoing performance and prescribing concerns since 1996. There had been improvements in some areas of practice, but the improvements were not maintained over time. Eventually, following support and guidance given to the Appellant by the PCT, the PCT referred matters to the National Clinical Advisory Service for guidance. An interim report was issued by NCAS on 19th December 2008 (A187) suggesting one to one supervision of the Appellants practise, as alarm was expressed as to the poor nature of the Appellants performance and basic skills. The PCT considered the practicalities of the same, the Appellant is a single handed GP, and resolved to suspend him from its performers list following a meeting on 23rd December 2008. Steps were taken as outlined below to enquire into and action remediation. It is said this was not practicable, as notwithstanding medical enquiry as to whether the Appellant may have cognitive impairment problems (which was considered fully and none were diagnosed), he could not later, as part of the remediation programme entered into by him pass a preliminary Deanery Assessment of his capacity to enter practice without risk to patients – this was taken, unsuccessfully, on two occasions. The Deanery, reporting back to the PCT was not satisfied the Appellant was safe to be allowed to enter a training practice at the Respondents expense, estimated to be in the region of £100,000. The Respondent then resolved to remove the Appellant from its Performers List as noted above, and in the submissions before the Tribunal, seeks an order for National Disqualification.

5. The PCT called a number of witnesses at the appeal hearing. They included Dr Talbot the PCT's Associate medical Director at the times of these events, Dr B Lewis Director of postgraduate GP Education at the North Western Deanery, Mr A Berry Associate Director for Professional Support at the PCT, and Dr Clough Executive Director of the PCT. All adopted their witness statements and exhibited documents as their evidence; all were cross examined and asked additional clarifications questions by the Panel. A note of the same is set out in the record of proceedings.

6. The Appellants case was set out in his grounds of appeal. He gave evidence at length in support of the same. He outlined his career history, qualifying in 1974, providing care as a GP since 1988, and as to the development of his sole practice. He told us of his efforts to improve the fabric of his premises with little help from the PCT as he saw it. He obtained good QOF outcomes and regarded them as highly significant and thanks Dr Talbot for his support and assistance in that regard. He initially submitted that the NCAS assessment was unnecessary and he found at that time he was stressed, and that it should not be fully relied upon. He thought he should have been allowed to build on a proposed action plan earlier devised with the PCT. He should be contingently removed and work upon conditions not dissimilar to those imposed by the Interim Orders Panel of the General Medical Council. He is willing to abide by the GMC publication Good Medical Practice and any conditions that are thought necessary.

7. The Appellant said he felt that the referral to the Deanery was a form of "short circuiting" by the PCT and ignored the NCAS suggestion he should be closely supervised in his own surgery for a period of time. The first Deanery MCQ assessment was not validated, it ignored his claim he was suffering anxiety and may have had a form of cognitive impairment, and whilst he re took the assessment and failed with a better score, it ignores his good MCQ test in 1986.

8. He told the Panel he acknowledged there were prescribing issues and he had gone some way to address them. He had merely sought to give his patients his best care and responded to their needs. He has a good rapport with patients, a good number of whom attended and attested to this. He has had no patient complaints. He acknowledged there were concerns to be addressed as to his level of referrals to secondary care; he denied they were deficient, saying his computer system was linked to his local hospital, and by reason of this link, they would ordinarily have his patient records annexed to any referral for the benefit of the Consultant. He requested that his appeal be allowed in the terms of contingent removal and that there be no order for national disqualification.

Our findings.

9. Applying the appropriate civil standard, (Re B [2008] UK HL 35) we found the witnesses called by the PCT, and the evidence given by the many patients called by the Appellant to be entirely credible and reliable. The PCT witnesses were all closely cross examined by the Appellant and we found them entirely consistent and credible, open to agree with some propositions put by the Appellant; but it remained the case that sound and resolute as to concerns for patient safety were made out. This is based in no small part upon the NCAS assessment, and in ability of the Appellant to pass the Deanery assessment, based on nationally accredited assessment programme, and having taken account of his anxiety at taking such and having ruled out cognitive impairment as a concern, his failure then to pass either one of the two available assessments undertaken. We find that the PCT has in line with their outline, evidence and submissions to have acted appropriately at all times and to have engaged with the Appellant openly and constructively with many earlier concerns, over some years, but that in line particularly with the evidence of Dr Talbot that there were improvements on the part of the Appellant, but they were not sustained across the board. The PCT engaged NCAS as a way forward, and as a result of the same, and was then obliged to act; suspending the Appellant upon receipt of the urgent concerns expressed by NCAS in the interim report of 19th December 2008 due to patient safety concerns. We do not accept the submission that the PCT was obliged to place the Appellant under close 1:1 supervision in his own practice without the input or advice of the Deanery. We accept the PCT submission they became concerned as to the basic competencies of the Appellant, and were properly mindful of the need to ensure patient safety. It was entirely reasonable, and we find, responsible for the PCT to engage the Deanery – a process which we find the Appellant then agreed to. In the course of cross examination the Appellant said he now agreed with the NCAS findings, and that he had agreed to the Deanery referral, thereby contradicting what he may have written or said earlier in that regard.

10. We found no evidence to suggest the PCT acted in bad faith as to the recommendations of NCAS in their full report. We found that the Appellant had in fact entered into an open agreement to engage with the Deanery as a central part of a potentially very expensive remediation plan to be paid for by the PCT (R80, R331-2). It is indeed unfortunate this came to nothing, but we find the evidence of Dr Lewis as to the national standards behind the assessments, his evidence as to the component parts, and methodology of the same to be entirely understandable and credible. We attach weight to his evidence as to the intention of the Deanery to support the Appellant in conjunction with the PCT, taking account of any anxiety on the part of the Appellant undertaking these assessments, twice without success, exhausting all the national assessment papers in so doing. We accepted Dr Lewis' evidence that these assessments are intended

to test the capacity of a fairly junior (FY2) doctor. We find the assessments were carried out properly, as outlined by Dr Lewis and that they were undertaken in good faith and in order to demonstrate the Appellants ability to enter a training practice without properly held concerns as to patient safety remaining. Indeed, in reply to questions put by the Appellant we noted that Dr Lewis said, "Two fails – two written papers show poor, so low core knowledge that I couldn't safely place you in a training practice. I cannot place you if you score so low, patient safety would be compromised". We accept this to be the case.

11. It is indeed unfortunate, and in some measure understandable, that the Appellant feels aggrieved at his inability to pass beyond this obstacle to remediation. This in itself, we find, shows a lack of insight into his own abilities when he has had to make a number of concessions when cross examined, as to his wide ranging deficiencies as noted in the record of proceedings. He has pointed to some good QOF outcomes. It is the case he is well liked by patients, has no recorded patient complaints, and many patients joined him at the hearing having travelled to the hearing venue together in a mini bus; all attesting to how much they like him, and of the regard they have for him as their GP. However, none of them knew of the detail of the NCAS concerns or the Deanery assessments being failed, giving rise to concerns as to the Appellants core competences as a GP. We regrettably can set little weight by their evidence as to the essential issues in this appeal. The Appellant has given many years service to the NHS, he is liked and respected by patients, and that is not overlooked by us; but that unfortunately, is not the yardstick upon which we must reach our decisions. There was reference to a good MCQ score in 1986 by the Appellant; we thought this to be misplaced, and spoke of a lack of insight on the part of the Appellant, as to the need on his part to demonstrate current competence. We noted the Appellant brought forth no professional testimonials. In cross examination he had to concede he had earlier agreed with the deficiencies outlined, grave as they are when linked to the NCAS report and Dr Lewis' evidence, as to basic core GP skills and knowledge. There were also replies made to questions put by the Panel which occasioned us concern. They related, amongst other things, to a poor potential outcome for a young patient which was conceded by the Appellant when questions were put to the Appellant by our Professional member. In reply to Mrs Greene, a Panel member, there were also concessions by the Appellant, as to a very poor referral letter "please see this lady", addressed to another hospital (not his local one) - which the Appellant conceded would not have been accompanied by the patients records. The Panel also expressed concern as to the CPD schedule produced without advanced warning at the hearing by the Appellant (thereby disallowing full consideration by the PCT), which our medical member, in open session, said was lacking in meaningful and relevant content, when considering the Appellants efforts; he said he had made to keep his medical knowledge current.

12. The Appellant said at the conclusion of the proceedings, in reply to Mr Anderson's closing submissions, amongst other things, "I don't seek to deny the NCAS report – I have to accept my deficiencies, I am not 100% Doctor – I have inclination to move forward". Whilst we do not doubt the latter part of that submission, we found the submissions made by Mr Anderson in closing, based on his document "Respondent's Case Summary" compelling, and in looking at the appeal in the round, we subscribe to the same for like reasons ourselves.

13. It follows that as a consequence of our conclusions we dismiss the appeal. We find it would be unrealistic and inappropriate for the Panel to contingently remove the Appellant as he might wish. We find he should be removed from the Performers List for like reasons as put forward by the Respondent. As to the request for an order for National Disqualification, it is clear the inefficiencies revolve, as they do, about the Appellant. As such they cannot be said to be "local" and we find are such that the Appellant ought not to be able to seek inclusion on another PCT/Local Health Board Performers List at this time; his inclusion on any such Performers List we find, at this time, would be prejudicial to the efficiency of the service.

Decision

1) **The Appeal is dismissed.**
2) **The application for national disqualification is allowed**

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Judge of the First-tier Tribunal
Mr T Jones
Dated 12th September 2010