First-tier Tribunal Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

2025-01384.PHL

IN THE MATTER OF THE NATIONAL HEALTH SERVICE (PERFORMERS LISTS) (ENGLAND) REGULATIONS 2013

Heard at Birmingham Court Centre
On 29 and 30 July 2025
Panel deliberations on 15 August 2025

BEFORE
Judge S Goodrich
Mrs L Jacobs
Dr D Cochran

BETWEEN:

Dr Amoolya Prasad

Appellant

-v-

NHS England

Respondent

DECISION AND REASONS

Representation

The Appellant represented himself and was supported by his wife, Mrs Prasad. The Respondent was represented by Mr Simon Cridland, of counsel, instructed by Hill Dickinson.

The Appeal

1. This is an appeal by Dr Prasad against the decision made by the Performer List Decision Panel (the "PLDP" or “the panel”) on 13 January 2025. The decision made was to refuse to include his name in the Medical Performers List (MPL) by reference to regulation 7 (2) (g) of the National Health Service (Performers List) (England) Regulations 2013 (“the regulations”) on the grounds that there were

reasonable grounds for concluding that the inclusion of Dr Prasad in the performers list would be prejudicial to the efficiency of the services which those on the list perform.

The Decision

2. The decision letter dated 13 January 2025 included an account of Dr Prasad's regulatory history since 2002, setting out the broad chronology regarding regulatory action taken by the General Medical Council (the GMC), the Medical Practitioners Tribunal Service (the MPTS or MPT - which is the adjudication body for the GMC), and the Respondent's PLDP, as well as the GMC performance assessments undertaken in 2012, 2016, 2018, 2023.

3. The PLDP considered that there was a long and relevant regulatory history. As a result of its review the panel concluded that to include Dr Prasad on the MPL would be prejudicial to the efficiency of services. The rationale for the decision included that there is a 20-year history of performance issues which remain unaddressed with no evidence of significant remediation, learning or development. Dr Prasad had been known to breach suspensions and conditions. The outcome of the performance assessments was that his performance remained below an acceptable standard in several domains. The panel was concerned about the potential risk to patient safety. Dr Prasad was not eligible for a supported return to NHS general practice due to his performance related conditions and would require a substantial amount of support to assist with a safe return to practice, including having a high level of supervision for a long period which could be seen as unworkable and impractical.

The Hearing

4. We had received and read in advance of the hearing two paginated and indexed bundles consisting of 592 and 607 pages (pdf) respectively. We had also read the Respondent's skeleton argument. Dr Prasad confirmed that he had access to, and had considered, the bundles and the skeleton argument. The appeal had been case managed throughout with the last order on 2 July 2025 having permitted the Respondent to rely on a supplementary statement from Ms Appleby dated 11 June 2025, producing further source documents regarding the regulatory history. The Appellant was permitted to respond by way of a statement by 9 July 2025. No supplement statement was then lodged.

5. There were no preliminary issues raised. Mr Cridland handed up copies of the publicly available document on the GMC website regarding the conditions imposed by the MPTS at its most recent hearing on 16 July 2025. He explained that the MPT determination is not yet public given that the appeal period has not yet expired.

6. At the outset of the hearing the judge explained the hearing process, the nature of a redetermination and the issues in the appeal. It was directed that the evidence of witnesses, once adopted, would stand as their evidence in chief. In particular the judge explained that our task is not that of review: this panel can make any decision the PDLP could have made and takes into account evidence as at today's

date. As this is an appeal against a refusal to include, the burden is on the Appellant to satisfy us that the application for inclusion should today be granted, rather than refused. It was clear that the core issue to be determined is whether Dr Prasad should today be included in the MPL with conditions, and, if so, what conditions, and in particular regarding supervision. In so far as human rights issue under Article 8 (private life) has been raised it was for the Respondent to satisfy us that a decision to refuse inclusion to the list was in accordance with the law, and was necessary, justified and proportionate to the public interests engaged.

7. In effect, Dr Prasad said that his human rights argument was not so much Article 8 of the ECHR but, rather, whether there had been a fair adjudication by the PLDP. He contended that the Respondent had not followed the proper process under the "Policy on managing the NHS Performers Lists (England)" published in July 2024. The judge explained again that this appeal process requires a redetermination which effectively means we stand in the shoes of the PDLP and decide everything afresh. This includes interpreting and applying the policy.

8. We ascertained that there was no request for any reasonable adjustments. The judge informed Dr Prasad that if he needed a break or any assistance at any time he need only ask. Dr Prasad was supported by his wife who sat alongside him. In addition to usual mid-morning and afternoon breaks we agreed to all further breaks requested by Dr Prasad.

9. Dr Prasad made an application that the Respondent's witnesses should not give evidence in the presence of the other. His concern was that the oral evidence of one may be affected by the other. The panel decided that the issues in this appeal were not such as to merit or require a departure from the usual practice in civil proceedings where witnesses are able to be present when another gives evidence.

10. We heard oral evidence on oath from the Respondent's witnesses:
    - Ms Appleby, Senior Case Manager of NHS England London Region
    - Dr Jamil Rahman, Senior Clinical Advisor, NHS England London Region.

    Although the Respondent's evidence was completed at 3.30pm on the first day we decided to rise early so that Dr Prasad's evidence would be given in one piece and at the start of the next day. Dr Prasad chose to give evidence on oath. With his agreement, the judge assisted Dr Prasad to provide his evidence in chief so as to confirm his background and his case.

11. We do not intend to set out herein all the oral evidence given by either side but will refer to parts of it when making our findings below.

12. Both parties conducted themselves throughout with patience, respect and courtesy. Dr Prasad was able to explain his position very fully. We were also assisted by oral submissions from both parties which we have taken fully into account. We will not refer to every point taken. We will focus on those matters which have most bearing on our decision making. Whilst the allocated hearing time was such that the evidence and oral submissions were comfortably concluded, there was insufficient time for panel deliberations, for which a date was then set.

The Appellant's case

13. In section H of the application form Dr Prasad explained why he considered the decision was wrong. The main point is that he has conditions on his registration imposed by the GMC by reason of the fitness to practice decisions made by the MPT. The Respondent should have considered the MPT determination on sanction in June 2024 and should have used this to mirror, or possibly strengthen, the conditions. The Respondent was wrong to summarily dismiss his application without looking further into the conditions. He has not held appointments outside the NHS for over a decade, has worked only as an NHS GP and wants to work in the NHS, as per his training, where there is a shortage of trained staff and long waiting times.

14. In his witness statement dated 1 May 2025 Dr Prasad made the following points which we summarise. He places emphasis on the five-day MPT hearing in 2023/2024 at the end of which conditions were placed on his registration, including a requirement for close supervision (i.e. reduced from direct supervision). His case includes the following points. The GMC is the senior regulator in the matter of the registration of GPs and licensing to practise and is above NHS England and its regulatory capacity. Being on the GMC list of licensed medical practitioners should be enough to gain conditional inclusion onto the MPL. MPT panel hearings may take days or weeks whereas a PLDP decision is taken in the course of a few hours. Patient safety is exhaustively covered by the MPT as it is their prime consideration and the main reason for their existence. The NHS has monopolistic powers which can infringe on a person's right to work in the field or speciality of his training and thereby infringes on human rights, as embodied under the Human Rights Act 1998. The cost of close supervision which he said "in principle, may be of the order or an hour or so a week "would be much less than the service he would render to the NHS. There is a shortage of GPs.

15. As referred to above at the beginning of the hearing Dr Prasad explained that his position was that the Respondent had not followed its own policy. His case was advanced on the basis that he should have had the benefit of a structured conversation with the senior clinical advisor in order to consider the support and assistance required for his return to practice.

16. On the start of the second day of the hearing Dr Prasad provided a second witness statement dated 30 July 2025. This was in the nature of a skeleton argument. The Respondent did not object to this and we duly received it.

The Respondent's case

17. The Respondent's case was set out in the response to the appeal, the matters identified in the SS and in its skeleton argument. We need not repeat here all the points made. In summary, the Respondent does not consider that conditions could be formulated to mitigate the risk to patient safety, and without undermining the efficiency of NHS primary care. The decision was appropriate and refusal of the application was the only appropriate action in the interests of patient safety, and in the public interest.

The National Health Service (Performers Lists) (England) Regulations 2013

18. The main provisions are as follows:

Decisions and grounds for refusal

7.—(1) NHS England—

(a) may refuse to include a Practitioner in a performers list on the grounds set out in paragraph (2);

…..

(2) The grounds on which NHS England may refuse to include a Practitioner in a performers list are, in addition to those prescribed in the relevant Part, that—

…..

(g) it considers that there are reasonable grounds for concluding that including the Practitioner in a performers list would be prejudicial to the efficiency of the services which those included in that list perform.

(3) Where NHS England is considering a refusal of a Practitioner's application under a ground contained in paragraph (2) it must, in particular, take into consideration—

(a) the nature of any matter in question;

(b) the length of time since that matter and the events giving rise to it occurred;

(c) any action or penalty imposed by any regulatory or other body as a result of that matter;

(d) the relevance of that matter to the Practitioner's performance of the services which those included in the relevant performers list perform, and any likely risk to the Practitioner's patients or to public finances;

…..

(f) whether, in respect of any list, the Practitioner—

(i) was refused inclusion in it,

(ii) was included in it subject to conditions,

(iii) was removed from it, or

(iv) is currently suspended from it,

and, if so, the facts relating to the matter which led to such action together with the reasons given by the holder of the list;….”

Conditions

10.—(1) Where NHS England considers it appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in a performers list perform…it may impose conditions on a Practitioner's—

(a) initial inclusion in a performers list; or

(b) continued inclusion in such a list.

…….

(5) Where NHS England decides to impose conditions under paragraph (1)(a), the Practitioner must, within 28 days of the date of notification of the decision—

(a) notify NHS England whether the Practitioner wishes to be included in the performers list subject to those conditions; and

(b) if the Practitioner does so wish, provide an undertaking that the Practitioner will comply with the conditions specified.

Additional grounds for refusal

27.—(1) In addition to the grounds in regulation 7(2), NHS England may refuse to include a medical practitioner in the medical performers list if—

(a) the medical practitioner's registration in the register of medical practitioners is subject to conditions by virtue of an order made by an Interim Orders Panel, a Fitness to Practise Panel or a court under section 41A of the Medical Act 1983 (interim orders);

(b) the medical practitioner's registration in that register is subject to conditions by virtue of a direction of a Fitness to Practise Panel under section 35D of the Medical Act 1983 (functions of a fitness to practise panel) or

(c) the medical practitioner's registration in that register is subject to conditions by virtue of a direction of a Fitness to Practise Panel pursuant to rules made under paragraph 5A(3) of Schedule 4 to the Medical Act 1983 (professional performance assessments).

Our Consideration and Findings

19. Dr Prasad brings this appeal under Regulation 17 (2) (a). Regulation 17 (1) provides that the appeal is by way of redetermination. Regulation 17(4) also provides that on appeal the First-tier Tribunal may make any decision which the PLDP could have made.

20. We are required to make a de novo (i.e. fresh) decision. This may be informed by new information or material that was not available to/considered by the PLDP. The

redetermination of the appeal includes consideration of the evidence provided by both sides in this appeal, the oral evidence and submissions before us.

21. In his oral evidence Dr Prasad told us about the main elements of his career and employment history. Dr Prasad qualified as a doctor in 1982 at the University of Manchester. He trained as a GP from 1986 and in 1988 entered practice as an NHS principal within the lists maintained by two local Family Practice Committees, (FPCs as they were then). He thereafter worked as an NHS GP Principal (in a partnership), and also as a single-handed practitioner having responsibility for over 4400 patients. He has also worked as a police surgeon, clinical associate, assistant and hospital practitioner for several years during his career as an NHS GP. Dr Prasad agreed that the last time he had worked as a GP was in July 2018.

22. Dr Prasad acknowledged that in 2022 he had made an application to NHS England in the Walsall region which had been refused in January 2024. We note that the reasons for that refusal were very similar to those under appeal before us. Dr Prasad said that he did not appeal the Walsall region decision because he was too tired to protest and did not want to protest too much. Asked by Mr Cridland why he had then applied for inclusion to the London region when he lived in Birmingham, he said he has sons living in or near London and it would be good for his family if he was able to work in London. This does not make a great deal of sense given that, as Dr Prasad said, everyone knows that the list is national i.e. if admitted via the London region he could work in either London or Birmingham, (or even elsewhere). In our view there was nothing to prevent Dr Prasad from making an application in London but the fact that he did so may be relevant to the assessment of his approach to his return to practice. We will return to consider this.

23. Under Regulation 7 (2) (g) the grounds for refusing inclusion include prejudice to the efficiency of the services which those included in that list perform. Broadly speaking, efficiency grounds include competence and quality of performance. The grounds may relate to everyday work, inadequate capability, poor clinical performance, bad practice, repeated wasteful use of resources that local mechanisms have been unable to address, or actions or activities that have added significantly to the burdens of others in the NHS (including other performers) - see the Respondent's guidance *"Policy on managing the NHS Performers Lists (England)"* published in July 2024. Under the Regulations consideration of efficiency includes any likely risk to the Practitioner's patients or to public finances – see Regulation 7 (3)(d).

24. When considering the application for inclusion, we must take account of the matters referred to in Regulation 7 (3) (a) to (d) – in other words the regulatory history which includes the evidence before us regarding the performance assessments undertaken in the GMC/MPT proceedings and the action taken by the GMC.

25. In short, Dr Prasad's practice has been the subject of regulatory action for many years with multiple findings by the MPT, following a hearing, that his fitness to practice is impaired. The overall history includes the following:

i. In 2002, the Appellant was suspended from the Walsall Performers List for an interim period of time.

ii. In 2004, after returning to practise, he was suspended again and also referred to the GMC who placed conditions on his registration. In 2005, whilst suspended, the Appellant worked a locum shift in a different area.

iii. On 21 December 2005, the Appellant was removed from the Walsall PCT's performers list.

iv. From 2006 to 14 August 2009 the Appellant was subject to contingent removal from the Walsall PCT's performers list.

v. It appears the Appellant had been subject to GMC undertakings for a period of time because, on 14 August 2009, Walsall PCT wrote to the Appellant notifying him that, because the GMC had removed his undertakings, it would lift its conditions.

vi. In 2007, the Appellant underwent a GMC performance assessment.

vii. In April 2012, the GMC Interim Orders Panel (IOP) imposed an interim order of conditions against the Appellant's registration. Condition 12 provided:

> "*You must confine your medical practice to general practice posts, where your work will be supervised by a named GP*."

viii. In October 2012, the Appellant underwent a GMC Performance Assessment in which his professional performance was found to be deficient:

(1) The Appellant's professional performance was considered to be unacceptable in the domains of:
    (a) Assessment of the patient's condition
    (b) Providing or arranging treatment.
    (c) Other good clinical care.
    (d) Maintaining Good Medical Practice.
    (e) Relationships with patients.
(2) The Appellant's professional performance was considered to be acceptable in the domains of:
    (a) Providing or arranging investigations.
(3) The Appellant's professional performance was considered to be cause for concern in the domains of:
    (a) Record keeping.
    (b) Working with colleagues.
(4) In the simulated surgeries the Appellant's overall score was 41.67% against a standard set mark of 50% and significantly below the bell curve of practising GPs.
(5) In 11 of the 12 OSCE stations, the Appellant scored below the median score and below the 25th percentile.
(6) Despite his very poor performance, the assessors found Dr Prasad's medical knowledge to be good.
(7) The conclusion was:

"*The team felt Dr Prasad's performance is impaired. We feel he requires extensive clinical retraining to overcome his poor clinical skills…"*[1] and recommended:
"*Intensive Deanery support including a Refresher Course. Single supportive workplace with active workplace supervision. GMC restrictions on practice.*"

(8) The performance assessors felt the need to express the following reservation:

"*However, the Team note that similar problems to those identified in this report have been identified previously. In the circumstances, the Team question if Dr Prasad is receptive to improvement and if this cannot be clearly demonstrated, then his registration should be reviewed*."

ix. In January 2013, the Appellant was suspended by the GMC's Interim Orders Panel (IOP).

x. In October 2013, the Appellant was subject to a Medical Practitioners Tribunal hearing (MPT):

(1) The MPT found the Appellant to have worked as a locum between 2/8/12 and 5/12/12 and, in doing so, to have breached his IOP conditions in that his work was not supervised by a GP.
(2) The MPT rejected the performance assessors' "unacceptable" judgment in the domain of Other Clinical Care.
(3) The MPT found the Appellant's fitness to practise to be impaired by reason of misconduct and deficient professional performance.
(4) The MPT imposed conditions on the Appellant's GMC registration.

xi. On 5 December 2014, the Respondent received notification from the GMC enclosing a complaint received following attendance at Immigration Tribunal: this alleged working as a doctor (August 2013) whilst an interim suspension was in place.

xii. On 16 January 2014, the GMC IOP suspended the Appellant for 8 Months.

xiii. In June 2014, the IOP lifted the interim order of suspension and replaced it with one of conditions.

xiv. On 16 January 2015, following an unsuccessful appeal by the Appellant to the High Court, the conditions against his GMC registration were imposed.

xv. On 28 October 2015, the Respondent's PLDP determined to impose conditions on the Appellant which mirrored those imposed by the MPT.

xvi. In January 2016, the Appellant underwent a further GMC performance assessment. His standard of professional performance was deemed to be deficient:

(1) The overall assessment of the performances assessors was that "*Dr Prasad is fit to practise on a limited basis under direct supervision.*"
(2) His professional performance was assessed by the performance assessors as being unacceptable in the domains of:
    (i) Maintaining professional performance.
    (ii) Assessment of the patient's condition.
    (iii) Record keeping.
    (iv) Safety and quality.
    (v) Relationships with patients.
(3) His professional performance was considered to give rise to cause for concern in the domain of clinical management.
(4) His professional performance was considered acceptable in the domain of working with colleagues.
(5) The Appellant's medical knowledge score was satisfactory (71.67% against a standard set of 63.94%).
(6) The Appellant scored beneath the 25th centile in 10 out of the 12 OSCE stations.
(7) The Appellant's overall score on the simulated surgery test was 56%, with him scoring below the 25th centile in 9 out of the 10 cases.
(8) The assessors identified safety issues:

"*Safety issues have also been identified in that Dr Prasad does not feel it necessary to highlight concerns saying 'highlighting deficiencies is not done too much – is part of GMP but most practises don't take it too kindly.' And he did not feel 'it would be helpful to his employment to make a fuss about it'….*
Clinical safety issues have also been identified, Dr Prasad had limited awareness of common guidelines and multiple examples of unsafe practice were identified.

(9) The performance assessors recommended inter alia:

"*Dr Prasad should only practise in a GP training practice under the direct supervision of a GP trainer.*
He should undertake a period of retraining at the level of an ST3.
He should not undertake locum duties."

xvii. On 18 March 2016, the Appellant was suspended by the GMC IOT.

xviii. On 30 March 2016, the Appellant was suspended by the Respondent's PLDP because of the suspension of his registration by the GMC.

xix. On hearing dates between 20 June 2016 and 23 June 2016, 3 October 2016 and 11 October 2016 and 16 November 2016 and 17 November 2016 the MPT considered the Appellant's case:

(1) The MPT concluded that the Appellant had breached conditions 13 and 14 by working in an A&E department. The determination is unclear as to whether this occurred on one or more occasions on 3 October 2013, 3 October 2014 and/or 3 January 2014. The Respondent made clear

that it proceeded on the basis there was 1 breach of the 2 conditions lasting 6 hours and noted that the MPT did not consider this amounted to misconduct.

(2) The MPT rejected the performance assessors' judgments of 'unacceptable' in the domains of: "assessment of patients' condition" and 'safety and quality' and replaced them with 'cause for concern'.

(3) The MPT considered there remained 3 domains which were unsatisfactory: maintaining professional performance, record keeping and relationships with patients. The MPT concluded the Appellant had improved in the domain of assessment but had deteriorated in the domain of record keeping.

(4) The MPT determined that the Appellant's fitness to practise was impaired on the ground of deficient professional performance.

(5) A sanction of conditions was imposed which included, amongst other matters, requirement for: a professional development plan (PDP); a mentor; and that a performance assessment be undertaken. In the sanction decision the MPT stressed that it was Dr Prasad's responsibility to improve his performance. The conditions were imposed for 24 months taking into account the time needed to remediate the failings.

xx. On 15 January 2017, the Respondent gave notice to the Appellant that it was considering revoking his suspension and replacing it with conditions.

xxi. Between April and May 2018, the Claimant underwent a further GMC Performance Assessment. The standard of his professional performance was again deemed to be deficient:

(1) The Appellant's professional performance was considered to be unacceptable in the domains of:
   (i) Assessment of the patients' condition.
   (ii) Clinical management.
   (iii) Record keeping.

(2) The Appellant's professional performance was considered to be cause for concern in respect of the domains of:
   (i) Maintaining professional performance.
   (ii) Relationships with patients.
   (iii) Working with colleagues.

(3) The Appellant's performance in the OSCEs was below the median and 25th centile in 9 out of 12 cases.

(4) In the 10 simulated surgeries the Appellant performed at or above the median in 2 cases, 3 cases were below the median but in the interquartile range and 5 cases were below the median and 25th centile.

(5) The performance assessors' recommendations included, amongst other matters, that the Appellant be closely supervised.

xxii. On 15 July 2018, the Respondent received a complaint from a patient relating to the prescription provided by the Appellant of Carbamazepine. This resulted in an investigation. Also on 24 July 2018, the GMC IOT imposed conditions on the Appellant's registration.

xxiii. On 26 November 2018, the NHS England's investigation report into the Appellant's prescribing of Carbamazepine (in 2017/2018) was completed:

(1) Under findings this noted:

"*In all cases the note keeping was brief and of a poor standard with no narrative to explain in detail how Dr P arrived at the diagnosis.*
All cases were prescribed between 56 and 84 tablets of Carbamazepine.
No warnings were issued in any cases.
No safety netting appears to have taken place.
No monitoring or follow up was recorded. No mention of attending for bloods was recorded.
No formal mental health assessment using a scoring system for depression was used.
There were no referrals on to secondary care for assessment, though several cases had been in the system at some time."

(2) The prescribing of Carbamazepine was considered to be inappropriate in every case.

(3) The review also reviewed 20 records relating to rectal bleeding, raised PSA and post-menopausal bleeding and commented:

"*In the majority of cases note keeping was below standard, with no diagnostic reasoning to support some of the diagnoses.*
A number of cases demonstrated failure to record or carry out an appropriate examination.
Referrals were of a poor quality with little supportive information to aid our secondary care colleagues. Many patients were not appropriately assessed in primary care by Dr P before referring on.
I am not convinced Dr Prasad assessed or manages depression to any recognised standard set for Primary Care. His notes are poor, his reasoning non-existent, his prescribing does not conform to guidelines in terms of numbers of days of initial medication and then arranged follow-up.
2 cases should have been considered for a 2- week referral (i.e. for consideration of possible cancer)"

xxiv. On 28 November 2018, the Respondent received a complaint from the partner of a patient in respect of Dr Prasad prescribing of Uniphyllin. As a result, a search of the GP practice's records of all patients prescribed Uniphyllin in the last 12 months was carried out. 29 of the 36 patients had been prescribed the medication by Dr Prasad (the remaining 7 were on repeat prescription initiated by a respiratory physician in secondary care). According to the PLDP:

"*It was noted that 17 of the patients did not have a history of respiratory disease, all of the 36 records reviewed were considered to have inadequate standards of note keeping and the records demonstrated you had prescribed outside of normal primary care management of acute respiratory presentation.*"

xxv. On 11 May 2020, the MPT suspended the Appellant's registration for 12 months. In doing so the MPT:

(1) accepted the judgments of the performance assessors with the exception of their grading of cause for concern in respect of the domain of working with colleagues, which the MPT revised to acceptable.
(2) determined that the Appellant's fitness to practise was impaired by reason of his deficient professional performance in the light of the 2018 performance assessment.
(3) considered there was no evidence placed before it by the Appellant that he had put the advice of his mentor or educational supervisor into practice, or that their advice had "*any significant impact on his performance*" nor that the Appellant had "*provided any evidence of successfully implementing the plan [PDP] to remedy his deficiencies.*"
(4) considered that despite being subject to GMC conditions for 7 years the Appellant had not undertaken any retraining. The MPT considered the Appellant's lacked insight into the deficiencies in his professional performance.
(5) considered that the Appellant posed a real risk of harm to patients.[2]
(6) considered suspension the appropriate sanction and in doing so, concluded in respect of a possible sanction of further conditions: "*The Tribunal has noted that [the Appellant's] registration has been subject to conditions since 2013 and, in view of his limited insight and lack of progress over a considerable period of time, a further period of conditional registration would not be appropriate or workable in the current circumstances. The Tribunal has also taken into account that previous periods of conditional registration have not served to improve [the Appellant's] deficient professional performance. It has considered the PAT's conclusion that [the Appellant] may be fit to practise under close supervision. However, in view of Dr Prasad's limited insight and failure to address his serious and long-standing deficiencies, the Tribunal has concluded that patients may be at serious risk should [the Appellant] be allowed to practise at all at the present time."*

xxvi. On 16 June 2020, given his suspension by the GMC the Respondent removed the Appellant's from its MPL pursuant to Regulation 28(1)(b) of the NHS (Performers Lists) Regulations 2013 (as amended).

xxvii. In May 2021at a review hearing, the MPT considered the Appellant to have limited insight and continued his suspension for a further period of 6 months.

xxviii. In May 2022, at a further review, the MPT lifted the suspension and imposed an order for conditions, which included, amongst other matters:
(1) A workplace reporter (condition 4).
(2) A PDP addressing the following areas of practice: maintaining professional performance, assessment of patients' condition, clinical management, record keeping, safety and quality, relationships with patients (condition 5).
(3) An educational supervisor (condition 6).
(4) Only working in a group practice setting of at least 2 GPs (condition 10).

(5) Close supervision for the first 3 months and then supervision thereafter (condition 13).

xxix. In June 2024, the MPT further considered the Appellant's case:
(1) The MPT noted the Appellant had undergone a further GMC Performance Assessment in April 2023, the outcome of which was that the Appellant's professional performance was deemed deficient in the domains of: Maintaining Professional Performance; Assessment of Patients' Condition; Clinical Management and Relationships with Patients.[3]
(2) The MPT determined the Appellant's fitness to practise remained impaired on the ground of deficient professional performance.
(3) Conditions were imposed. Condition 11 a required close supervision for not less than three months and, thereafter supervision.

xxx. The Appellant requested an MPT review hearing which was listed for 14 to 17 July 2025. It is common ground that the decision made on review was to essentially maintain conditions including close supervision with some adjustments re approval. As noted above the reasons are not yet published.

26. We turn to consider the history of the application for inclusion to the MPL and the policy /process argument. In short Dr Prasad considers that the "Policy for Managing Applications to join the England Performer List" (the policy) published in 2024 was not followed and that a Stage 3 structured conversation should have been conducted by Dr Rahman in order to ascertain his learning and support needs.

27. Dr Prasad's argument was largely based on the flow diagram in relation to Stage 2: Gathering Performer List requirements - see C107. The sequence demonstrated in the flow chart is that if there are current fitness to practice concerns which led to an adverse outcome this leads to a box "Record issue of note-PLDP to consider." Dr Prasad relies on the fact that the flowchart shows a directional line that leads from that point to the "end" box: "progress to Stage 3".

28. Dr Prasad submits that the evidence of Ms Appleby and Dr Rahman was inconsistent and irreconcilable, that both witnesses lacked knowledge of the policy and did not apply the rules and distanced themselves from the policy. He submits that Dr Rahman was under a duty to investigate in Stage 3.

29. We found Ms Appleby be a reliable witness. Her role included that of the management of the application process at stage 1 and she then sought the advice of Dr Rahman regarding stage 2. So far as stage 1 is concerned we find that on 26 November 2024 Ms Appleby informed Dr Prasad that his application would need to be reviewed by the PLDP and advised him of the date by which any reflections he wished to provide should be submitted. On 26 November Dr Prasad provided a very short statement for the PLDP stating: "The current matter is a new and totally separate application with new, updated and revised information with barely a

tenuous connection with the application considered between 2022 and 2024 and which is being put forward on its own merits." Ms Appleby emailed Dr Prasad encouraging him to provide a more detailed statement. She included weblinks to the Return to Practice scheme and advised him that it may need to be self-funded. On 16 December 2024 Dr Prasad confirmed by email that he had no further reflections to include in the PDLP pack.

30. In cross-examination Dr Rahman said that his remit was to consider at Stage 2 if Dr Prasad was automatically eligible to join the list based on the information provided to him. He did not consider that this was the case because of the previous history with clinical practice and the GMC. For that reason he referred the application to the PDLP for decision. There was enough information available for him to decide that it was necessary to refer the application to the PLDP. It was not his remit to look at Dr Prasad's support needs. He repeatedly explained that he was not involved in the decision making of the PLDP.

31. We consider that Dr Rahman was a reliable and conscientious witness. We also consider that Dr Rahman was correct in his view that, in the context of this application, his role was limited to deciding whether there was an issue of note that needed to be decided by the PLDP. The text of the policy states (C101 and 102):

> *"The purpose of the assessment for inclusion is to assure NHS England that the performer is not only fit to practice (included in the professional register) but fit for purpose (suitable to perform primary care services)"*
>
> *"Where the assessment of the application reveals information of note or identifies concerns, the application must be considered by the PDLP for a decision as to whether to include, include with probationary status and agreement terms, or impose conditions, refuse or defer the application."*

32. A point was raised during the evidence about the power to defer an application. The power to defer is set out in Regulation 8 and relates to the situations therein closely described, none of which are applicable. However, as set out in the paper before the PLDP, the first task is for the PLDP (and thus this panel in remaking the decision) is to consider whether it has sufficient information to make an informed decision as to what further action to take with the application.

33. Dr Prasad said that a structured conversation, as envisaged by the process, would have included the same questions the judge had asked that morning. We noted that this referred to when the judge had assisted Dr Prasad by asking questions about his general background by way of introduction to his evidence. In our view, all of the information given in response to these questions was already apparent in the evidence before us. When asked the specific question as to what other information would have been gleaned in a structured conversation, Dr Prasad gave a lengthy answer about the London Region disowning its own policy. He then said that Dr Rahman could have asked him what work he had done and what knowledge he had gained. He said Dr Rahman should have assessed if he needed educational or clinical support and when Dr Rahman realised that he did, then this would have led to referral to HEE (now Workforce Training and Education "WTE") to decide on his participation in a Return to Practice programme (RtP) which is

heavily subsidised. Dr Prasad believes that Dr Rahman was in a rush because he got the file on 26 November and made his decision to refer to the PLDP the next day. Dr Prasad also said Dr Rahman might have re-profiled his PDP and he could have drawn up a risk matrix. The PLDP should have noticed that there had not been a structured conversation.

34. In our view there was no requirement or need for a structured conversation/investigation. Dr Prasad's view is that this would have led to him being considered for a RtP programme. He is mistaken in this. He is ineligible for the (funded) RtP programme because he is subject to GMC conditions. The programme is designed for return to work in general practice after a career break, raising a family or after working overseas - see Return to Practice/Medical Hub published by Workforce, Training and Education (formerly HEE). The reality is that his application raised an "issue of note" and this had to be considered by the PLDP.

35. In remaking the decision of the PLDP, our first step is to consider whether we have sufficient information. Both parties have had a full opportunity to provide the evidence they wish us to consider prior to the hearing. We consider that we have ample information before us in order to make an informed and fair decision.

36. Given Dr Prasad's views as expressed in his first witness statement it is appropriate to draw out the similarities and differences between the overall objectives of the GMC/MPT and that of NHS England. Both are governed by different statutes and regulations. There are differences between the roles and functions of the GMC/MPT and that of the Respondent - although the need to protect patient safety is central for both bodies. The MPT make decisions on allegations of impairment of "fitness to practise" for all registered medical practitioners (whether they provide care on a private basis or under the NHS) on the grounds of impairment of fitness to practice due to serious deficient performance, misconduct, or health. The Respondent, is, however, the body responsible for maintaining the MPL in the context of the provision of NHS primary care services. It is aptly described as a process that concerns "fitness for purpose". Both regimes are concerned with risk to patient safety. However, risk to public finances and efficiency of services are not regulatory objectives under the Medical Acts 1983. The Respondent is, of course, required to consider the action taken by the GMC/MPT – see regulation 7, but is not bound by it.

37. As set out above, we noted that Regulation 27 provides discretionary additional grounds to refuse to include a practitioner to the list if he/she is subject to GMC conditions. In our view it is appropriate to focus on Regulation 7 (2) (g) because the efficiency ground is relevant to the exercise of discretion and proportionality.

38. We are satisfied that regulation 7 (2) (g) applies because there are reasonable grounds for concluding that the inclusion of Dr Prasad in the performers list would be prejudicial to the efficiency of the services which those on the list perform. This gives rise to a discretionary decision as to whether to include, include with agreement terms, include with conditions or refuse the application. In our view the parties have correctly identified that realistically the issue is whether to include with conditions or to refuse the application.

39. The exercise of discretion must be informed by the purpose of the Regulations. As we have said, the Respondent is responsible for admission to, or removal from, the list of primary care performers, and has regulatory oversight of the performers of primary care services whose names are included in the list maintained and published. In short, the continued inclusion of a practitioner's name on the relevant list objectively conveys to the public an assurance of the competence and quality of performance of a primary care practitioner, and that the practitioner's inclusion in the MPL and that he is subject to governance and oversight by the Respondent.

40. We have carefully considered all the evidence. We consider that the long regulatory history shows that there are serious and enduring deficiencies in Dr Prasad's practice and his ability to perform the services required of a practitioner on the MPL. Dr Prasad's case is that such concerns can and should be proportionately met by conditions which mirror, or could even strengthen, those imposed by the MPT in June 2024.

41. The MPT review hearing in June 2024 was to consider whether Dr Prasad's fitness to practise "is impaired" by reason of deficient professional performance and/or adverse physical or mental health. The hearing began in November 2023, was adjourned on day 4 and resumed on 4 June 2024 when fitness to practise was found to be impaired by reason of deficient performance only. In the determination on impairment the MPT *"acknowledged that it was difficult to demonstrate remediation in cases of deficient professional performance other than in another performance assessment. While Dr Prasad had clearly developed his insight further and was working hard to address the areas of deficiencies in his practice, all his remediation had been done in the context of not seeing patients. The Tribunal could not disregard the fact that some of the deficiencies identified in the performance assessment process had the potential to put patients at unwarranted risk of harm. The Tribunal was of the view that although Dr Prasad is addressing the shortfalls in his performance (evidenced in his 2023-2024 Appraisal) he still needs to achieve satisfactory scores in all the relevant domains in a performance assessment to demonstrate practically that the concerns have been addressed."*

42. We note that Dr Prasad gave oral evidence at the sanctions stage. We noted from the MPT determination that he *"addressed the recommendations of the performance assessors, highlighting the areas he believed to be too restrictive and provided the Tribunal with alternatives to these. Dr Prasad told the Tribunal that he found the performance assessment process too subjective: what one assessor could mark as "correct", another could mark as "wrong". He did not believe the assessment process allowed him to fully bring out his abilities. He suggested that an appraisal within six months of starting work would be a better option. Dr Prasad agreed that he needed supervision but not 'close' supervision. He did not object to having an educational supervisor and preferred a mentor to being closely supervised. Dr Prasad addressed the assessors' recommendation that he only work as a salaried GP. He told the Tribunal this was too restrictive as there was a tendency for employers not to employ salaried GPs. Dr Prasad reminded the Tribunal of the hundreds of hours of learning that had gone into his appraisal, and had included attending clinical seminars and meetings. He also said that he was open to further learning and training."*

43. In its determination on sanction the MPT referred to Dr Prasad's *"developing level of insight and understanding of the deficiencies in his performance and that he "has addressed the concerns of the GMC through his 2023-2024 Appraisal and through his CPD."* We noted that the rationale of the MPT in June 2024 was that the MPT was satisfied Dr Prasad was making good progress towards full insight and complete remediation. The MPT considered that a revised set of conditions would assist Dr Prasad to find employment and continue his remediation in a stable, structured and safe environment. However, it rejected Dr Prasad's request for "supervision", rather than "close" supervision and a "lighter touch regime", because this would not provide the level of reassurance and protection required.

44. It is common ground that close supervision as defined in the glossary to the GMC Sanctions guidance includes the requirement that the clinical supervisor:
    - Be available to give advice and/or assistance to the doctor at all times
    - Meet with the doctor formally, at least once a fortnight, for a case-based discussion
    - Meet with the doctor at least once a week for a feedback session

    Dr Prasad's observation in his first witness statement in this appeal was that close supervision may, in principle, involve an hour or so a week. We noted that in his oral evidence Dr Prasad said that the time involved in close supervision might be greater than one to two hours and said that it would be for the supervisor to decide. Having considered the full history we find that Dr Prasad has little or no insight into the extent and seriousness of the deficiencies in his practice. We accept Dr Rahman's view that, in the circumstances of this case, close supervision would probably involve considerably more input than is envisaged by Dr Prasad, and not least in the context that Dr Prasad has not worked as a GP for seven years.

45. We should explain at this stage that we have not been provided with the full 2023 performance assessment. It has not been provided to the Respondent by the GMC because Dr Prasad is no longer on the MPL, and GDPR issues arise. We do, however, have the summary conclusions. Dr Prasad agreed in cross examination that the areas in which Dr Prasad's performance was considered unacceptable in the 2023 performance assessment were in the domains of: Maintaining Professional Performance; Assessment of Patients' Condition; Clinical Management and Relationships with Patients. It was, of course, open to Dr Prasad to have included the full 2023 assessment with his application so as to demonstrate the detail supporting the assessment outcomes above and/or the extent to which he had improved in other domains.

46. In our view the serious nature and extent of the risks posed by Dr Prasad's practice are clear from the history of the performance assessments. Leaving aside the broad outcomes reached, consideration of the details of the OSCEs (Objective Structured Clinical Examinations) and SS (simulated surgeries) in the 2016 and 2018 full assessment reports illustrate clearly the likely risks to patient safety, as well as the inefficiencies involved, if Dr Prasad were to be included in the MPL. We noted that his practice in the specific domains of Maintaining Professional Performance, Assessment of Patients' Condition and Relationships with Patients was considered deficient in 2016 and 2018, and also that the deficiencies in practice in 2012 included Assessment of Patients' Condition, Providing or arranging treatment, Other good clinical care and Relationships with Patients. We

find that Dr Prasad's practice has been deficient in core domains since (at least) 2012. We recognise, of course, the difficulties in remediation given Dr Prasad had not been able to find suitable employment as a GP since 2018. The fact that Dr Prasad has not worked since 2018 carries its own risks i.e. not being up to date, or up to speed.

47. We noted that the events regarding the treatment of patients prescribed Uniphyllin and/or Carbamazepine occurred whilst Dr Prasad was working under conditions, albeit with no level of supervision imposed.

48. We have considered all the evidence regarding Dr Prasad's insight. It was apparent from Dr Prasad's evidence regarding the policy that he sees himself as in the similar position to a doctor who is returning to practice after a career break or coming to work as a GP in the NHS from abroad. In our view this shows a startling lack of insight regarding the significance of his regulatory history, and the extent and seriousness of the enduring deficiencies in his practice.

49. As noted above Dr Prasad's policy arguments embraced, amongst other matters, that Dr Rahman could/should have re-profiled his PDP. We reject this. In our view it is significant that Dr Prasad has not taken the opportunity to provide a current PDP i.e. one that shows his current view as to the areas of practice he considers he needs to address, and how he will do so. We acknowledge that Dr Prasad submitted with his application the positive appraisals undertaken in 2022/23 and 2023/24 but a PDP is an essential tool and one that was required under the MPT conditions. We noted also that Dr Prasad has not undertaken any shadowing in a GP practice. This is startling given that he last practiced in 2018.

50. We acknowledge that Dr Prasad has said that he will meet all the costs of the conditions imposed by the MPT, and also the cost of supervision at any level that we might consider appropriate to address the risk to patient safety and the impact of the deficiencies in his practice on NHS primary cares services.

51. We acknowledge also Dr Prasad said that he has continued to undertake a great deal of CPD. Although he did not produce recent CPD records before us, we are prepared to assume for present purposes that Dr Prasad has undertaken recent CPD. We noted, in his favour, that there has never been an issue with his medical knowledge. There is, however, a difference between undertaking CPD and putting what has been learnt into practice in a consultation.

52. We noted that, as set out in para 25 above, Dr Prasad has a past history of breaching the terms of suspension and/or conditions. Dr Prasad has provided explanations for the context of some of these historic breaches. The Respondent's point is that the simple fact that there have ever been breaches of suspension and conditions in the past is not reassuring. In our view the past history regarding compliance does not require further examination in order to make an informed decision regarding the Dr Prasad's application to be included in the MPL.

53. In our view the nature and extent of the deficiencies in Dr Prasad's practice are such that close supervision would not be adequate to address the risks to patient safety and the efficiency of services. As shown by the performance assessments

one of the deficiencies in Dr Prasad's practice is that he does not always undertake an adequate assessment of patients' condition. In our view this raises a serious issue regarding the adequacy of close supervision as a safeguard against risk to patient safety. Further, the efficacy of close supervision is dependent upon the practitioner having enough insight to recognise when he needs to seek the view of his supervisor.

54. Direct supervision involves that all aspects of the doctor's clinical care are subject to oversight by the supervising GP. In summary, an approved GP principal has to supervise all contact with patents, and monitor prescribing. Irrespective of who pays the costs, the intensity of direct supervision is a drain to the work force resource that might otherwise be available to the NHS. In practical terms direct supervision can only realistically be undertaken in suitable cases for short periods.

55. We have no confidence that <u>any</u> period of direct supervision will address the deficiencies in Dr Prasad's practice such that he will, after a period, be able to progress to close supervision, or "simple" supervision thereafter. In our view Dr Prasad lacks insight/understanding into the consequences of the deficiencies in his approach to patients. We consider that a significant underlying issue is that Dr Prasad has a particular style of consultation. Mr Cridland asked Dr Prasad in the context of the 20 years history, including 5 performance assessments, what he could say to reassure the panel that today he is able to (i.e. comply with acceptable standards) going forward. His initial response was that if he does not do it, he will be subject to action. He then said: *"I've changed but probably not enough. What some people think is a better standard is a modern style of consultation. my consultation style is different there is some degree of "affordability" (i.e. "accommodation") given to different styles. In many practices patients are drawn to my old style rather than the so-called modern style. I am not saying that it has been proven that the old style does not produce better results."* When Mr Cridland suggested to him that his answer suggested that he does not really accept the areas of criticism of his practice as per the performance assessment, Dr Prasad said that he was ready and had moved on. He was not saying that the new style was not superior but he maintained that there is a group of patients who want to approach a doctor who is more succinct.

56. In our view the evidence overall indicates very strongly that Dr Prasad's approach to aspects of fundamental practice is very deeply engrained. In our view he has not moved on.

57. Dr Prasad has not worked as a primary care medical performer since 2018. In our view this, in and of itself, poses an obvious risk to patient safety. In our view the long history of Dr Prasad's inability to fully remediate his deficient performance over so many years is such that his inclusion on the list would be contrary to the efficiency of services in NHS primary care.

58. Having carefully considered all the evidence before us we have decided that no conditions could be devised that would adequately address or reasonably mitigate the risk to patient safety and to the efficiency of services that is involved in Dr Prasad's practice.

59. For the purposes of this decision, we are prepared to assume that the decision to refuse to include Dr Prasad on the MPL under Regulation 7 (2) (g) represents an interference with his private life rights under Article 8 (1) of the ECHR which is sufficient to engage protection under Article 8 (2).

60. The Respondent has satisfied us that the decision made is in accordance with the law and is necessary in pursuit of a legitimate public interest aims, namely, the protection of the health and safety of patients and the efficiency of services in primary care.

61. In terms of proportionality, our task is to weigh the impact of the interference involved in the decision upon Dr Prasad's private life interests against the public interests engaged.

62. We recognise that Dr Prasad wants to work again and practise in his chosen specialty. We recognise how very important this is to him. A decision that will prevent him working as a GP, and that may well bring his career in medicine to an end, is one that is never to be taken lightly. We recognise the impact of our decision upon his private life interests is likely to be profound. We are, however, entirely satisfied the private life interests of Dr Prasad are far outweighed by the public interests of patient safety and efficiency in NHS primary care services.

Decision

63. We have decided to refuse to include Dr Prasad's name on the medical performers list. We dismiss the appeal.

Judge S Goodrich

Primary Health Lists First-tier Tribunal
(Health Education and Social Care)

Date Issued: 29 August 2025