Care Standards

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

[2018] 3321. EA-MoU

Heard on: 19, 20 and 21 June 2018 and 19 and 20 September 2018.

Panel deliberations 29 October 2018

Heard at: Tribunals Hearing Centre, Leicester

BETWEEN

LEICESTER MEDICAL GROUP

Appellant

-v-

CARE QUALITY COMMISSION

Respondent

BEFORE

Tribunal Judge -Melanie Lewis
Ms Maxine Harris -Specialist Member
Ms. Wendy Stafford –Specialist Member

Representation and Witnesses

Mr Malik QC counsel represented the Appellants. We heard oral evidence and read witness statements from Dr Singh and his partner Dr Minhas.

The Respondent was represented by Mr Graham Solicitor. We heard oral evidence from the following witnesses:-

i. Melanie Whittal CQC Primary Care inspector
ii. Vanessa Twigg CQC Inspector
iii. Dr Janet Hall CQC G P specialist adviser
iv. Michelle Hurst CQC inspection manager

v. Michele Golden -CQC Head of Inspection
vi. Ian Potter director of Primary Care, West Leicestershire
viii. Deborah Caroline Dodge CQC Pharmacist Specialist

We additionally read witness statements from:-

i. Christopher Jarvis CQC Inspector
Ii Kay Bestall Contract Support Manage
iii Laura Norton Head of GP contracts.
vi. Ian Potter director of Primary Care, West Leicestershire
viii. Deborah Caroline Dodge CQC Pharmacist Specialist

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ii. Christopher Jarvis CQC Inspector
Ii Kay Bestall Contract Support Manage
iii Laura Norton Head of GP contracts.

Reporting Order

The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the service users in this case so as to protect their private lives.

The Appeal.

This is an appeal by Leicester Medical Group against a decision dated 11 April 2018 pursuant to Section 31 of the Health and Social Care Act 2008 ('H&SCA 2008') , to impose conditions on the registration as a service provider. No regulated activities were to be carried out at Leicester Medical group, Thurmaston Health Centre, Leicester LE4 8EA.

1. The Leicester Medical group was a partnership of Dr Harjit Minhas and Dr Kamaljit Singh but Dr Minhas ran the Aylestone Practice (the other location) and was not involved in Thurmaston Practice at the relevant time. They operated independently of each other. There have been no concerns about the Aylestone surgery, which has recently been inspected by CQC and received an overall rating of 'Good', as it did on the previous inspection.

Background

2. On day three of the hearing on 20 June 2018 at the point of being re-examined, Dr Singh conceded the appeal. Consequently, the Notice issued pursuant to s.31 H & SCA 2008 was no longer challenged. The only issue was whether the imposition of the conditions remained proportionate and reasonable.

3. Accordingly, we need only set out the background in summary.

4. On 18 June 2005 a CQC comprehensive inspection at Leicester Medical Group rated the practice as 'Good in all key questions and population groups.

5. On 14 December 2017, there was an unannounced comprehensive inspection at Thurmaston Group. On this visit the inspection team found a number of breaches of the Health and Social Care Regulations 2014. These in particular related to the care and treatment of patients (Regulation 12), good governance (Regulation 17), and safeguarding service users from abuse and improper treatment (Regulation 13). It was also evident that the service was undertaking the regulated activity of family planning, although it was not registered to do so. The findings of that inspection were published on 27 March 2018. The practice was rated as 'Inadequate' in the safe and effective key questions, 'Requires Improvement' in the effective key question and 'Good' for the caring and response key questions. Overall the practice was rated as Inadequate.

6. On 18 December 2017 a Management Review Meeting was held in the decision was taken to issue a Warning Notice under Regulation 13, the imposition of urgent conditions in respect of the breaches and Regulations 12 and 17.

7. On 19 December 2017, the CQC revised that position and issued Warning Notices only for breaches under regulation 12, 13 and 17. The reason was that they had received assurances from NHS West Leicestershire Clinical Commissioning Group that they would support Leicester Medical Group.

8. Representations to the three warning notices were made by Dr Singh and consequently the warning notice relating to get regulation 13 was withdrawn and the warning notices for Regulations 12 and 17 revised and reissued on 13 February 2018 with a date to be compliance of 14 March 2018. The Practice was placed in special measures on 27 March 2018.

9. On 5 February 2018 there was a Risk Review Meeting to consider the risks and concerns and how they were being addressed by whom. The partners Dr Singh and Dr Minhas were present and the practice manager. Dr Singh did not wish to close the list temporarily, although he moved away from that position at the first hearing.

10. At a further meeting attended by Dr Singh and Dr Minhas on 28 March, Dr Singh advised that final work to address concerns had been completed and that what was now needed was for CQC to 'back off'. He said that he *'felt ready for reinspection'*. Dr Minhas felt that Dr Singh was a *'victim of his own success'.* Professor Lakhani who attended welcome the commitment shown by both Dr Singh and Dr Minhas but shared with them the perception of that the situation was not being taken seriously. This was denied. The meeting was told that Dr.Bapodra would join the practice

The Notice of decision

11. An unannounced focused inspection of Thurmaston Health Centre was carried out on 10 April 2018. Inspection had been brought forward because of

concerns raised during a meeting with the Clinical Commissioning Group on 15 March 2018 about the level of risk at the practice due to a reduction in progress against identified actions, a failure to meet deadlines and their capacity to make the required changes.

12. The inspection determined that there were serious concerns identified with regard to the safe care and treatment of patients. The Respondent had previously inspected the service on 14 December 2017 and identified areas of inadequate care and treatment. As a result the service had been in special measures since 27 March 2018. Following the inspection in December 2017, two Warning Notices were issued. The inspection on 10 April 2018 evidenced a failure on the part of the Appellant to comply with the terms of those Warning Notices

13. The Notice of decision dated 11 April 2018 sets out the main areas of concern, which centered on

i) Medication reviews not being undertaken

ii) Prescriptions not being collected and only being cleared every three months

iii) National guidelines not being followed in respect of patients taking high risk drugs.

iv) Healthcare assistants giving B12 injections lawfully given if authorised by a patient specific direction.

v) Examples of poor clinical care

vi) Missed diagnoses, in particular a child with onset diabetes was not seen on 15 February 2018, the day their parents rang asking for a blood test even though symptoms were recorded. Child not seen by Dr Singh until 7 March 2018 as not processed in timely manner by reception team.

vii) A total of 356 patient records were found not summarised.

viii) safeguarding registered and not up-to-date examples of poor medicine management.

ix) Expired equipment in use, namely out of date winged infusion needles. Out-of-date equipment medications in unlocked rooms, which inspection team were told related to a private practice of body sculpture which could be accessed by patients and members of the public.

x) No documented process or protocol in place relating to INR monitoring

xi) Lack of investigation and analysis of significant events.

14. By agreement the case was adjourned to allow Dr Singh to put together a further Action Plan of any proposed conditions by 2 July 2018, with a response by 16 July 2018 and listed for further directions on 17 July 2018. An action plan was submitted.

15. The Respondent was not satisfied with the proposed action plan as it lacked detail and substance and failed to address the issues raised by CQC following their inspection in April 2018. It was a concern that Dr MInhas, Dr Singh's partner formed no part of the proposed plan and that the action plan failed to adopt the good practices of Ayslestone Surgery. The unchallenged evidence at the first hearing was that 40 sessions was the minimum number to safely manage the patient list, whereas the action plan only proposed 27 clinical sections as a baseline, with an extra three being provided by locums 'when required.'

16. Pursuant to an agreed further directions order dated 24 July 2018, the West Leicester Clinical Commissioning group set out their response and what future role and input they could have. Their position was and remained at the final hearing, that they had put in a significant input into the practice in December 2017 to March 2018, particularly the Safeguarding and Medicines Management teams but it had not brought about change. In particular, when Mr Potter had met with Dr Singh on 28 March 2018, he stated that all required actions have been completed and the practice was ready for CQC reinspection, which the April 2018 inspection showed was not the case and that little progress had been made. There was continued concern that the action plan was *'not a systematic response to the issues highlighted by CQC'.* Again, the concern was expressed that 40 GP sessions would be required to serve the patient list. Again, the role of Dr Minhas was queried. Whilst other GPs were referenced, there was no written evidence of commitment from them, which the CCG with an overview of local practice had concerns about. There was limited reference to the role and importance of the practice manager.

Order pursuant to Rule 26 Tribunal Procedure Rules, restricting attendance at hearing on 19 September 2018.

17. At the adjourned hearing on 19 September 2018 Mr Malik QC applied to exclude Dr Panaseer from the hearing room. Dr Panaseer has been in dispute with the Appellants for some years, a fact that Dr Panaseer had volunteered to our clerk before the hearing when asking whether he would be permitted to remain in the hearing. Balancing that this was a hearing open to all members of the public and that justice must be seen to be done, we weighed against that, that his presence in a small hearing room, where it was not possible to make any adjustments could adversely affect both Dr Singh and Dr. Minhas giving evidence. Under the rules, we may exclude a person from the hearing and we balanced the competing factors in favour of excluding Dr Panaseer, who did not wish to leave voluntarily. We explained that if he had an interest in the outcome, the decision will be up on the public website.

Summary of evidence heard on 19 and 20 September 2018

18. in the light of the concession made on 20 June 2018, we do not set out the considerable volume of written and oral evidence considered by the Tribunal, which ultimately was not challenged on behalf the Appellants.

19. We do record however that CQC's witnesses had been subject to full cross-examination by Mr Malik QC. While still under oath and giving evidence, so not after consultation with his counsel, Dr Singh had reflected over the lunch adjournment before he was re -examined. He recognised that he could not challenge, in particular the detailed medical evidence given by Dr Janet Hall. He said as much. Her evidence was not a matter of subjective opinion but clinical evaluation and practice. Dr. Singh rightly in our view, acknowledged that her evidence was thorough, balanced and well prepared.

20. At the adjourned hearing, none of the three witnesses who gave evidence on behalf of CQC had made further witness statements. The witnesses recalled were Dr Janet Hall and Ms Melanie Whittal and Mr Potter and we were mindful that the concerns they had, were new to the Appellants.

21. By that point the action plan was at version 7 and the position of the Appellants that emerged was that they would implement any further recommendations or suggestions for the plan. None of the three witnesses thought that the action plan version 7 went far enough in addressing continued concerns, particularly around safeguarding, management of medicines and clinical supervision and that GPs would actually be available to cover the 37clinical sessions now offered.

22. Dr Hall assisted us that a clinical session would usually be four hours, so half a day. She remained concerned about the Significant Events 'SEA' policy, which in the policy document appended to the action plan stated that there would be monthly meetings unless the issue was urgent, whereas the action plan was saying it would be seven days.

23. The management of test results had been a major issue at the first hearing. She had considered the Protocol annexed to the Action Plan (D527 SB) not specific enough as it didn't assist on how things would be done, that is setting things out in a way that all staff could clearly understand and follow. In her view seven days was too long for a definitive decision recorded by a practice clinician on all test results

24. . A further issue was medication reviews set out in a Medication Review Policy and Risk Stratification Tool (D 583). Whilst the guidance appended to the action plan was satisfactory in itself, the issue was around capacity and how the medication review policy, peer review and checks would all be carried out in practice. The policies on these things appeared to contradict each other.

25. Miss Whittal was concerned that the organisational chart was not workable. The leadership showed a lack of insight and lack of fitness who could not meet the requirements of the Health and Social Care Act regulations, the plan was not sustainable and the policies and processes attached to working action plan version 7 were contradictory, inaccurate or had insufficient detail.

26. The position of the Clinical Commissioning group was that they had provided a high level of support. Their position remained that set out in their position statement of 30 July 2018, even if more recent email exchanges between Mr Potter and Dr Singh had seemed to express support for the then action plan. They could be no expectation that this would continue. The CCG would offer a monitoring level of involvement, not the weekly meetings envisaged by the action plan.

27. On instructions Mr Smith refused the request from Mr Malik QC that the CQC witnesses sit with Dr Singh and Dr Minhas to make amendments to the action plan, based on their evidence. Mr Malik's reasoning was that they were prepared to do whatever was required and it was easier to hear from them than rely on a note of their evidence.

28. A compromise was reached and a summary of the concerns was prepared, which Dr Minhas and Dr Singh took away overnight and prepared Action Plan Version 8 and Staff Organisational Chart. Version 9 followed post hearing but that was colour coded for ease of reference.

29. In summary, there was concern that the policies contained within the action plan was generic, rather than robust and specific to the practice. There was still concern over the capacity and capability regarding implementation of the action plan including: overall clinical governance, culture, leadership, engagement and involvement in a vision for the practice. A further issue was how the plan would be implemented and put in place in a timely manner.

30. Dr Singh gave evidence and told us that he and Dr Minhas were up until 4 am preparing the new action plan version 8. He stated that he accepted the criticisms of Dr Janet Hall were '*astute, perceptive and valid'*. He would continue to make changes. Dr Bhopadra had agreed to be his GP supervisor. Dr Selvakumar had agreed to do seven sessions at Thurmaston, evidence which was contradicted very shortly after the hearing as we will set out.

31. Dr Singh was willing to comply with any guidance or requirement. He would accept any conditions imposed upon him and there was some discussion about what those might be. Through his representatives he suggested that they would be to:- a) remedy the Clinical Commissioning group notices from August 2018, b). Carry out the proposed amended action plan, c), carry out any further changes in compliance required by the Clinical Commissioning Group and d) any other changes that in the view of the Care Quality Commission elevated the action plan to a satisfactory standard. The expectation was that CQC would inspect after a reasonable period. The practice would remain in special measures, so Dr Singh and Dr Minhas understood that CQC could come in at any time.

32. When cross-examined by Mr Graham, Dr Singh accepted that on *'thorough reflection'*, there had been issues within the practice which placed patients at serious risk. He agreed that the actions of CQC were proportionate and required an initial greater response from him. He agreed that the higher the risk the greater his response needed to be.

33. He agreed that version 1 of the action plan wasn't sufficient and needed to be improved. His priority list would be around medicine management, significant events and safeguarding. He thought it would take one year for this to be embedded.

34. He was prepared to invest funds including paying a consultancy whom he provided evidence that he had already approached and to join the Royal College support group, although they would not provide support whilst the Practice was in special measures.

35. A key issue was the role of Dr Minhas. Dr Minhas did not attend the first hearing, because he was covering his surgery and told it was not necessary. He prepared a witness statement on 1 August 2018 in which he stated the then action plan was *'comprehensive and adequate'*. We were concerned that it was thin on the detail of what input he would have.

36. In a letter dated 11 September 2011 the Programme Manager NHS England stated that before Dr Briggs could approve Dr Bopodra as a clinical supervisor, clarification was required why Dr Minhas had been put down as the approved clinical supervisor, when this had not been approved. Further, they were unable to reconcile the contradictions between the action plan and that Dr Minhas had informed NHS England that he had no role or responsibility regarding clinical leadership and governance of the Thurmaston practice. However, his name was on the front page under purpose of the plan. This was causing them considerable concern.

37. In response, Dr Minhas wrote to Dr Briggs on 17 September 2018. He clarified that he had no role in the running of the Thurmaston Health Centre in the past four years. He acknowledged that he remained a partner contract holder for the Thurmaston Health Centre and that as a consequence of that he would be referred to the Performance Committee. He stated he wished to make it clear that he was fully involved with the appeal, the action plan and was more than happy to work alongside Dr Singh to improve the services at Thurmaston and was able to take over complete clinical leadership and clinical governance at Thurmaston, if that was required.

38. At the adjourned hearing he was able to confirm that he could backfill the surgery at Aylestone, as he was taking on a new GP, who he hoped would move to partner status. That would enable him to be freed up for up to 8 sessions a week and work as long as it took to get systems and processes at Thurmaston to the same high standards that had proved that he could achieve by the CQC following two in-depth inspections in the past 13 months at Aylestone. His time estimate for that was about 6 months.

The Law.

39. The relevant requirements for present purposes are to be found in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ("the 2014 Regs."). The Appellant has conceded that the regulated activity was not carried out in accordance with the Regulations.

40. The powers of the Tribunal are set out in section 32 of the H & SCA Act. The Tribunal has the power to confirm the decision of the Respondent, direct the decision of the Respondent to have no effect and to direct the imposition of any such discretionary condition as it thinks fit. The Tribunal considers the appeal on the basis of the available evidence at the time of the hearing.

41. In relation to any conditions, we must ask ourselves whether the conditions are reasonable and proportionate. We look at the least restrictive option, placing patient safety as first priority. We have looked at how specific, manageable and achievable time-limited proposed conditions are.

Closing submissions

42. Both representatives made summary oral submissions.

43. On behalf of CQC, Mr. Graham submitted that there have been significant risks within the practice in December 2017. That risk remained despite warning notices in March 2018. The focused April 2018 inspection, found the highest risk, namely death. This was in relation to the child who had diabetes. The mindset of the partners was of concern. Even now, the action plans were reactive. The suggested conditions could not be endorsed as they were neither reasonable or proportionate. There could be no assurance given by the Action Plan V 8 as it was not workable since Dr Singh could not be the practice manager as he had no clinical supervisor. Dr Mihas was coming on as a late addition and his role was not sustainable. The partnership had showed no real insight into the risk and the need to prioritise change. Dr Minhas had categorised CQC's involvement as *'over picky'* and this remained a concern. Dr Singh could still work but at Aylestone Practice.

44. Mr Malik QC on the other hand submitted that the action plan had been amended, after listening to the evidence from CQC and accepting guidance and criticism which was reasonable and proportionate. As at the date of the hearing it could not be said that the risk was so great that it would be proportionate to impose the condition restricting practice. He maintained that we could be confident that Dr Singh would comply with the action plan and level of risk will be reduced if Dr Minhas came in. Dr Singh had acknowledged his failures in the past, accepted his responsibility and demonstrated his intention to take steps to put in place clear systems in collaboration with an outside partner. There was no belligerence or adversarial stance taken and Dr Singh could listen to the criticism made and act on it.

Conclusion and Reasons.

45. In reaching our conclusions, we have had regard to all the evidence, both written and oral and the oral submissions of both parties. This was a hearing that evolved and we have recorded the changes that took place.

46. We must look at whether the condition to comply with Action Plan version 9 (colour-coded version) is both proportionate and reasonable. Other conditions were also suggested and we bear in mind that we could also

impose any conditions we saw fit. We have asked ourselves what conditions would be appropriate, achievable and assessable. In short, bearing in mind that neither CQC, the Clinical Commissioning Group or the Tribunal has a monitoring role, will what is currently on paper be put into practice within the timeframe identified.

47. The case for CQC was detailed and cross-referenced to contemporaneous notes and the relevant Policy and Guidance.

46. The case for the Appellants evolved. This was a partnership, but the reality was that Dr Singh was the day-to-day service provider. We have contrasted his initial Witness Statement which provides a detailed and adversarial defence of his position, with the position that he took when conceding that CQC's actions had been evidence-based and proportionate.

47. Having heard and read the evidence, we conclude that Dr Minhas at the risk assessment meeting in March 2018 was right to state that Dr Singh was *'a victim of his own success'.* He was popular with patients and did not want to shut his list, even temporarily. The Tribunal asked Dr Singh to reflect, where with hindsight, he would have done things differently. He identified that, that he been working too much: in excess of 60 to 70 hours per week at a time when he had suffered bereavements in his immediate family.

48. Overall, we formed the view that Dr Singh intended well, tried hard and put enormous energy into trying to put things right. However, the history shows that he did not have the capacity to understand what was required to make the practice compliant with the regulations. Nor did he have the resources and personnel in place.

49. Overall, we had some concerns about the role of Dr Minhas. Whilst, the two practices were running separately, he was nevertheless a registered partner. We conclude that Mr Graham's submission, that '*whatever happened on his watch'* was accurate. He needed to do more and for the good practice at Ayslestone to carry over to Thurmaston. He had known Dr Singh since they were children and they had worked together professionally for many years, running a group of compliant practices. He would have been ideally placed to be a 'critical friend '. His evidence was supportive of his colleague but we conclude smoothed over the serious concerns raised.

50. We must look at the evidence at the date of the hearing but the history is relevant in weighing how achievable and realistic the proposed action plan is.

51. The ultimately unchallenged history leads us to conclude that neither Dr Singh or Dr Minhas in 2017, going towards the December inspection had understood the level of non-compliance. They did not show that they understood that the Warning Notice procedure and meetings thereafter, meant that things needed to change and change quickly. We have recorded the concerns discussed at the meeting in March 2018, where

their seeming lack of understanding of the need for change was specifically raised.

52. We have very carefully analysed the changes that were made through the various action plans. We do not accept the submission on behalf of the Appellants that the practice was showing an open mind and responding to the *'helpful critique'* by in particular Dr Janet Hall, who as the national GP lead has considerable expertise and oversight. We concluded that Dr Hall was a compelling witness but that there were still major omissions in the plans and that each of the concerns she and Ms Whittal raised, must be given considerable weight. The fact that the Appellants did not pick them up themselves weighs against them.

53. We focus on what were the major issues of concern. Concerns such as rooms used for private practice, not being locked can be easily remedied and Dr Singh told us that his private practice has stopped in any event.

54. We are not persuaded that on balance the key medical and other personnel are in place. Dr Selvakumar was to offer 7 clinical sessions but given that he wanted to be registered as the manager of his own practice that was questioned. Dr Singh's view is that Dr Selvakumar was put under pressure by CQC but as 7 sessions would take up 3.5 days, we see nothing sinister in questioning that and the impact it would have elsewhere. Anyone working in a practice in special measures must be aware and ready for the fact that an inspection could take place at any time, so might be reasonably expected to be able to take a robust view and to be committed to working towards change. It is a concern that Mrs Lipkin did not agree to be a Practice Manager and was concerned that her name had been put forward. Dr Singh by way of explanation said that the caretaker practice meant that he had not been able to talk to her but he had been led to believe their staff would stay. That is not secure enough to satisfy us that they would. Again, we were not satisfied on the late assertion that it would happen, that it would be sustainable for the Practice manager at Aylestone to come every day.

55. In March 2018, both Dr Minhas and Dr Singh thought they had put forward a sustainable action plan, when the April 2018 inspection which Dr Singh now accepts turned up concerns at the most serious level, namely the significant risk of death of a child through lack of monitoring of diabetes, medication review issues and safeguarding.

56. However, even by the adjourned hearing it had to be pointed out by CQC that there were still issues that needed addressing. On our careful consideration and analysis these were not minor amendments but more major insertions, which on our analysis should have been worked through by the partners.

57. This included that the safeguarding audit tool needs to be used in conjunction with most recent CCG Safeguarding lead approved policy.

58. Medication review was another major issue. The April 2018 inspection found a cursory reactive review to their concerns had been carried out by

Dr Singh with large numbers being done in a short period. Dr Hall had to point out that whilst review could be by a nurse, pharmacist or doctor this then had to be detailed using the appropriate 'read code'. This would ensure that patients on a repeat medication have a review within a 12 month period.

59. Another area requiring major review, as identified by Dr Hall, was the monitoring of high-risk drugs. The title was changed to 'High Risk Shared Medication *Proactive* Monitoring' processes. Dr Singh was to be the lead clinician on this but a pharmacist would carry out the review. Her evidence included that this would be better done in a timescale appropriate to the Leicestershire medicine strategy group guidance and also specialist direction, rather than the model inserted and this was inserted.

60. Overall, action plan version 7 had not made clear the process that would take the policy from paper to actual practice. The detail was not there until Dr Hall pointed it out. In the final version 9 the receptionist would attach the most recent blood test result and clinical review to any prescription before the prescription was signed. Disease modifying drugs would only be issued for one month at a time.

61. A further omission was the absence of a procedure to follow up non-attendance at a booked appointment. Again, the detail had to be inserted after Dr Hall's evidence. The detail then went in that there would be telephone contact or a letter if that didn't work which be actioned the same day. A second appointment should be given within one week and if that was not taken up and the medication would be stopped and the patient referred to the Doctor.

62.. The Prescription protocol also needed revising to give the finer detail to state that if the prescription hadn't been collected within seven days, there will be contact by reception then if it had not been collected after another three days it would be marked up and passed to Dr Singh. Any scripts not collected after four weeks would be destroyed. All contacts with patients were to be recorded in the notes.

63. Initially Dr Singh had put forward that there would be manual recording for home visits. Dr Singh had taken on board what in this instance what we would characterise as advice not a major revision. The visiting Doctor on return to practice would insert the prescription by the digital system to ensure safe prescribing protocol. This could be then sent digitally to a local pharmacist. Handwritten prescriptions would no longer be used.

64. Medicines prescribed elsewhere would be entered onto the patient's notes and clinician could limit the number of medication reviews according to the drug in the circumstances. There would then be no further issue of the drugs without clinical authorisation. That we regard as a more significant issue.

65. The Significant Event Management Pathway was significantly updated in Version 9, but we find the level of new detail required again demonstrates the weaknesses of what was put forward. The significant event lead was

Dr Singh with Dr Minhas deputising in his absence. One of them would be available at all times to ensure compliance with the policy. Timescales were tightened up. An urgent meeting would be held within 24 hours and it would then be decided whether urgent further investigation was needed and also look at training requirements

66. The summarising notes protocol was also significantly amended including that Dr Singh would randomly check note summarisation by appropriately trained staff. Further, each new patient on repeat medication would be invited to the surgery for a detailed consultation at which point the summarised note would be checked, discussed and amended if necessary to allow for medication to be reviewed and rationalised. In short, we characterise the evidence before us at the hearing as 'too little, too late'.

67. Accordingly, the decision of the Respondent dated 11 April 2018 is confirmed. We do not therefore, as at the date of the final hearing, find there are any conditions which might be applied and consequently persuade us that risk to patients would be sufficiently mitigated and the practice could move could move into full compliance within 3 months which we judge as a reasonable time frame.

Decision

The decision of the Respondent dated 11 April 2018 is confirmed.

Melanie Lewis
Tribunal Judge

Date: 02 November 2018