IN THE UPPER TRIBUNAL **Appeal No. UA-2020-001611-HPHL**
ADMINISTRATIVE APPEALS CHAMBER

On appeal from: First-tier Tribunal (Health, Education and Social Care Chamber)

Between:

Dr H

Appellant

- v –

NHS Commissioning Board
(known as NHS England) Respondent

Before: Upper Tribunal Judge Hemingway

Decision date: 19 January 2023
Decided following a hearing of 29 November 2022

DECISION

The decision of the Upper Tribunal is to dismiss the appeal.

REASONS FOR DECISION

Introduction

1. This appeal to the Upper Tribunal has been brought, with my permission given on limited grounds on 27 February 2020, by a Doctor of Medicine whom I shall simply call Dr H. But I make clear, in referring to him in that way, that I was not invited to consider making and I have not made an anonymity order with respect to him. The appeal is directed towards a decision of the First-tier Tribunal (F-tT) which it made following a substantive hearing which took place on 26 November, 27 November,10 December and 12 December 2019, to dismiss his appeal to it. His appeal to the F-tT had, in turn, been directed towards a decision of the NHS Commissioning Board (which I shall from now on refer to as "NHS England") to remove him from the National Health Service Performers List.

2. I held an oral hearing of the appeal, which was conducted remotely, utilising Cloud Video Platform. Dr H was represented before me by Mr M Evans KC of Counsel and NHS England was represented by Mr G Irwin, of Counsel. I am grateful to each of them for their clear, straightforward and helpful submissions. No technical difficulties were encountered during the course of the remote hearing and I am satisfied that each representative was able to make the same points with the same

force and clarity as would have been the case had there been a more traditional face to face hearing.

3. At the hearing I had before me the F-tT bundle (though I was not asked to look at it), the Upper Tribunal bundle which ran to 139 pages, and a skeleton argument from each side. I have given careful consideration to the written material and the oral submissions prior to deciding this appeal.

Some legislative provisions

4. The National Health Service (Performers Lists) (England) Regulations 2013 ("the 2013 Regulations") were made under authority conferred by provisions of the National Health Service Act 2006.

5. Regulation 14 of the 2013 regulations relevantly provides:

> "**14. - Removal from a performers list**
>
> (1) ……..
>
> (3) The Board may remove a Practitioner from a performers list where any one of the following is satisfied-
>
> (a) …….
>
> (b) the Practitioner's continued inclusion in that performers list would be prejudicial to the efficiency of the services which those included in that performers list perform ("an efficiency case");
>
> (c)…
>
> (d) the Practitioner is unsuitable to be included in that performers list ("an unsuitability case")……"

6. As to action short of removal regulation 10 of the 2013 Regulations relevantly provides:

> "**10. - Conditions**
>
> (1) Where the Board considers it appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in performers list perform or for the purposes of preventing fraud, it may impose conditions on a Practitioner's-
>
> (a) initial inclusion in a performers list; or
>
> (b) continued inclusion in such a list……"

7. As to appeal rights, regulation 17 of the 2013 Regulations relevantly provides:

> "**17. - Appeals**
>
> (a) a Practitioner may appeal (by way of redetermination) to the First-tier Tribunal against the decision of the Board mentioned in paragraph (2). This is subject to paragraph (3).
>
> (2) a decision of the Board referred to in paragraph (1) is a decision to –
>
> (a) ……
>
> (b) ……
>
> (c) remove a Practitioner from a performers list under regulation 11(1)(1)

…

(4) on appeal, the First-tier Tribunal may make any decision which the Board could have made."

The background circumstances and the way in which the case came before the F-tT

8. Dr H fell foul of the applicable regulatory regime. In August 2016 the General Medical Council (GMC), which according to its website has the role of protecting patients and improving medical education and practice across the UK, informed NHS England that it had received a complaint from a member of the public which raised concerns about Dr H's fitness to practice. That concern related to his management of a 16-month-old child who had subsequently passed away. The provision of that information led to NHS England checking to ascertain if there had been other complaints made against Dr H. It found that there had been 3 such complaints. There followed a meeting between representatives of NHS England and Dr H which took place on 5 December 2016 and which was said to have given rise to some concerns regarding his clinical practice and insight. So, NHS England decided to commission a "records review" in order to evaluate the standard of care he was providing.

9. As a key component of the above process, a doctor whom I shall simply call Dr N (an independent GP with no previous connection to Dr H) reviewed a random sample of 30 patient records from his practice. The review resulted in the identification of concerns regarding the standard of clinical care provided by Dr H which included deficiencies in record keeping. Dr H's written response to the review was deemed inadequate, with the consequence that, on 7 September 2017, he was required to and did attend a meeting with the Head of Practitioner Performance and Revalidation at NHS England and with a person I shall refer to as Dr B. Dr B is an associate medical director at NHS England and a practicing GP. It is said that Dr H was unable, at the meeting, to demonstrate that he understood the nature of the concerns or the extent it was said the issues raised placed patients at risk. It was also said that he did not demonstrate an understanding as to how a supervisor could support any necessary remediation and he was not able to explain how he had learnt from previous complaints.

10. During the period in which NHS England was carrying out its investigations the GMC was conducting its own investigation. That resulted in Dr H being made subject to an Interim Conditions of Practice Order an element of which was a condition requiring him to work with a supervisor approved by NHS England. However, given NHS England's own concerns it declined to approve the appointment of a supervisor with the consequence that Dr H was unable to continue in practice. The GMC conducted a performance assessment between October and December 2017 which identified deficiencies in relation to Dr H's clinical assessments of patients, his record keeping, and his insight. The performance assessment conclusion was to the effect that he was fit to practice on a limited basis. Some issues were also raised in 2017 by a person I shall call Dr S who had covered his patient list whilst he was unable to work. She raised concerns with NHS England regarding the standard of care she felt he had been offering to his patients.

11. Since NHS England had taken the view that a supervisor would not sufficiently mitigate the risk it thought had arisen with respect to patient safety, it referred Dr H to

its Performers List Decision Panel ("PLDP"). The PLDP is authorised, amongst other things, to take decision under the 2013 Regulations. It convened on 7 December 2017 to consider whether Dr H ought to remain on the Performers List. However, the proceedings were adjourned. Other avenues were explored which included the obtaining of an occupational health assessment which appeared on the face of it to indicate some concerns regarding potential cognitive decline. There followed further assessment by a consultant clinical neuropsychologist on 19 December 2017, who thought that Dr H's pattern of performance was suggestive, as the F-tT went on to put it "of a weaker performance on tasks reliant on language skills". On 17 April 2018 (presumably as a result of the expression of that view) Dr H sat an International English Language Testing System ("IELTS") test and obtained a score of 6. That was below the level now required of a doctor making a new application for inclusion within the Performers List. For that, a score of 7.5 is required. The higher the score the more competent a user of the English language is. Merely to give an indication as to what a score of 6 indicates, the British Council website describes the skill level attained by a person who achieves a score of 6 as being that of a "Competent user" and adds by way of description "Generally you have an effective command of the language despite some inaccuracies, inappropriate usage and misunderstandings. You can use and understand fairly complex language, particularly in familiar situations."

12. According to the F-tT, Dr H had sat the test on several other occasions "but had been unable to attain the requisite score".

13. The PDLP reconvened on 5 June 2018. It decided that Dr H should be removed from the Performers List pursuant to paragraph 14(3)(b) of the 2013 Regulations, on the basis that his continued inclusion would be prejudicial to the efficiency of the services that those included in the Performers List perform.

The proceedings before the F-tT and its decision

14. Dr H appealed to the F-tT. The case first came before it on 25 February 2019 when, according to the F-tT's written reasons for dismissing the appeal which were issued on 31 December 2019 ("the written reasons") "there was a discussion as to whether the case being presented to the F-tT was purely an efficiency case, or whether it also encompassed suitability". But the F-tT went on to say in its written reasons that by the time the appeal was finally heard it had been made clear by counsel for NHS England (different counsel to the one who had attended before it on 25 February 2019) that it was relying on efficiency grounds only. Directions were given at the hearing of 25 February 2019 or shortly afterwards requiring that Dr H be given access to relevant medical records and affording him an opportunity to provide a witness statement. It was intended that the substantive hearing would commence on 1 July 2019. However, Dr H's then representative sought an adjournment on the grounds of illness and such application was granted. The case was then relisted for a substantive hearing commencing on 26 November 2017. That went ahead although a person whom Dr H had been expecting to represent him withdrew at short notice and at a very late stage, with the upshot that he ended up representing himself. The hearing took place over 4 days. Evidence was given to the F-tT by Dr H himself, and by Dr B (mentioned above). NHS England was represented at that hearing (as before me) by Mr G Irwin.

15. The F-tT, in its written reasons, set out the steps it had taken to seek to ensure that Dr H, as a litigant in person, was not disadvantaged. It relevantly said this:

> "24. Throughout, the F-tT sought to accommodate [Dr H's] status as litigant in person by giving clear indications before any breaks in the hearing as to what would be expected/required of him when the hearing resumed, and by regularly checking to ensure that he understood the F-tT's procedures and the issues and evidence that were being raised. It ensured that regular breaks were taken, that additional breaks were taken when it appeared that [Dr H] needed a little more time to prepare and/or consider any issues, and allowed him to submit and rely on late evidence. Mr Irwin was also very helpful in assisting [Dr H] at the substantive hearing, e.g., by ensuring that up to date copy bundles were available to him during the hearing, by helping him to find the relevant page numbers in the evidence bundles, in arranging for copies of his late evidence to be made, and in seeking permission from the F-tT to explain to, and assist [Dr H] with, procedure during the course of the hearing and in any breaks".

16. As to any issues regarding Dr H's standard of written and oral English, the F-tT noted that part of NHS England's case had been to the effect that he had deficiencies in both spoken and written English and that his standard was insufficient to enable him to provide GP services as a performer without restriction (see paragraph 25 of the written reasons). As to those concerns the F-tT said this:

> "28. Turning to the issue of Dr H's standard of English, we did struggle at times to understand what he was saying, and wondered how a patient might manage during a consultation. However, we note and accept that a Practitioners knowledge of the English language is only a criterion for inclusion in the PL, as opposed to reinstatement to the PL. We also note that there was no mention of his English Language skills in the GMC's PA (although it did refer to lack of content in some of his referral letters), and that his English was not the cause of any complaints against him. Accordingly, we have not attached any weight to [Dr H's] standard of English, and only considered his communication skills in relation to his record keeping. ie. if and how any failure to record information in the medical notes could effect his communication with other health professionals who might need to access those notes and treat those patients, e.g. locum doctors or consultants to whom he has made referrals".

17. The F-tT went on to note that NHS England had not sought to rely, before it, upon the views of Dr S (see above) nor upon what the F-tT described as "*the index case*" (the one involving the child who had sadly passed away- again see above) and, accordingly, did not reach any adverse view with respect to those matters.

18. Having recorded the evidence, both oral and written, which it had received the F-tT went on to say what it had made of it. It relevantly said this:

> "**Consideration of the Evidence**
>
> 117. We reiterate that simply because we have not referred to all of the evidence does not mean that we have not considered it. We have chosen to concentrate on the 7 examples of the records reviewed by [Dr

N] which NHSE relied on at the hearing, and the 2 further examples put forward by [Dr H], as we also heard oral evidence for these examples and were able to ask questions about them. We have collated and set out in detail the written and oral evidence relating to those examples above.

118. We note there were a few instances where [Dr H] was able to explain to us the rationale for his prescribing and actions, even though he had failed to record it, and that there were one or two examples of just acceptable practice and record keeping, e.g. recording a history, examination and prescribed medication, requesting investigations, with review and reasonable safety netting documented, followed by referral for Patient R09, and prescribing Atorvastatin for Patient R03, although he did not document his rationale for doing so.

119. We further note that although [Dr H] disputed [Dr N's] and [Dr B's] analyses in so far as they related to his clinical practice and management, he agreed with them, in part, in relation to their analysis of his record keeping, and accepted there were deficiencies in the quality of the content and brevity of his notes.

120. However, we are sorry to say that there we were not persuaded by any of [Dr H's] excuses for these deficiencies, e.g. he repeatedly used the excuse that lack of time meant he had not made a note of what he was sure he had done, or he had overlooked doing what he should have done, or he had missed something, claiming this can sometimes happen with any busy GP, or he thought other busy GPs would have similar practice. And he thought it was discriminatory when the majority of over-burdened GPs do this.

121. Looking at these examples in the round, we find there are repeated incidences of [Dr H's] failure to document his actions, so it is impossible to know whether, for example, he took a full history, or properly examined, or what was the diagnosis/working diagnosis, or the rationale for his prescribing, or the management plan, or whether he had discussed follow up and/or safety netting. Even when [Dr H] attempted to point us to evidence of good practice (e.g. patients R27 and R30), we find there is evidence of him placing those patients at risk (e.g. when he failed to re-order a CRP test for patient R30). He was unable to persuade us that the overall conclusions reached by [Dr N] and [Dr B] in any single one of these consultations was incorrect, or that a similar amount of deficiencies would be found in a similar sample from an average GP.

122. We did not think it was a knowledge issue; when [Dr H] was asked, or it was put to him, what he should have done, he could say or understand what action he should have taken (e.g. he accepted patient R30's raised CRP level could be indicative of a hidden heart or cancer issue), but he would repeatedly make excuses and say that the patient had looked okay, or had not indicated any new problem, or it was a time issue.

123. Nor was [Dr H] able to demonstrate that he understood the nature of the concerns, or the impact that his actions or lack of action had, and

that he was thereby placing patients at risk, e.g. he would use the fact that, on hindsight, a patient had not come to any harm (e.g. patient R28 for whom he prescribed OTC medication for itchy scalp), or he would claim it was a time issue or, as [Dr B] had noted, he would repeatedly say "If you tell me, I will know". And seemed to think a supervisor would be able to highlight the issues and tell him what to do and enable him to return to safe and efficient practice.

124. We also consider that [Dr H's] failure to make detailed notes and/or document his actions could adversely affect his communication with other health professionals who might need to access those notes and treat those patients. We note, for example, that the Cardiologist to whom [Dr H] referred patient R09 commented that the information received was too limited for him to be able to offer much advice. Furthermore, [Dr H] repeatedly tried to justify his actions or lack of action to us by saying he knew a patient well, so he would be able to assess if the situation had changed by looking at the patient, i.e. he implied he could assess the situation without making detailed notes or having to refer to the notes, without understanding the risk this might pose if the patient saw another doctor. We are not sure that he appreciates the need for detailed notes so that any practitioner who views them can see the past history, especially in London where there is such a mobile population. We find that [Dr H's] communication skills in relation to his record keeping are inadequate.

125. In considering prejudice to the efficiency of the services, we have also taken account of [Dr H's] response to the undertakings imposed by the GMC in October 2018. We consider his failure to start designing a PDP within the required time period and in breach of the GMC undertakings he had agreed to, show a remarkable lack of insight and inability to reflect on his own practice and shortcomings".

19. The F-tT then went on to consider whether it might be appropriate to impose conditions upon Dr H rather than to uphold the decision to remove him from the Performers List. As to that issue, it said this:

"**Consideration of the Imposition of Conditions**

126. We then turned to consider whether it would be appropriate to impose conditions on [Dr H] to enable him to continue to be included in the PL, rather than to uphold NHSE's decision to remove him.

127. We note that [Dr H] has made allegations against almost every professional who has investigated him. This was explored by NHSE's representative at the hearing. For example, in his response dated 30.06.17 to [Dr N's] review, [Dr H] questioned [Dr N's] experience. At the hearing he submitted a more qualified, more experienced doctor should have been appointed to undertake the records review, claiming there were many silly mistakes in her review, her style of examination was not good enough to be a real examiner, and she should not be reviewing GPs with so much experience.

128. He further submitted that, as NHSE employees, [Dr N] and [Dr B's] evidence was influenced by that employment and they were not independent.

129. He also alleged in an e-mail to the F-tT dated 26.10.18, that [Dr A] (doctor appointed by NHSE to undertake OH assessment of Dr H) was part of the orchestrated team in collaboration with NHSE to undermine him and fulfil their own interests, and he submitted at the hearing that he had reported Dr A to the GMC "for the nation's interest" (although the GMC had subsequently confirmed to him that his complaint was not within its remit).

130. [Dr H] also claimed at the hearing that the father of the 16-month-old child that subsequently died of sepsis (in the index case) made up the story to get him into trouble, and he repeated both his allegation of dishonest conduct against [Dr S], and his allegation that NHSE officers had imposed the requirement for him to pass an English Language test by deception and in collaboration with [Dr A].

131. NHSE's representative submitted that these allegations of misconduct against those professionals who were investigating [Dr H] were disgraceful and raised questions about his probity, and we concur.

132. We also grave concerns in relation to [Dr H's] evidence as to what information he disclosed to his appraisers and when (see paragraph 115 above).

133. Dr [H's] allegations and submissions in relation to those investigating him, and the information he provided to his appraisers led us to question his probity. We also had concerns relating to his credibility, and repeatedly had to remind him he was under oath. For example, when being taken through patient records, he would frequently claim to remember facts that he had not documented. Given the consultations in question took place over 3 years ago, we do not believe he could have direct memory (always in his favour) of those consultations, e.g. in his email dated 30.04.19 he stated he was not sure whether or not patient R28 had said at the index consultation that she did not want to see Dr S, but at the hearing he submitted the patient had been adamant that she did not want to see [Dr S]. He also told us he thought he had ordered a further CRP test for patient R30 not long before the index consultation, but when offered time to look through the records to confirm this, he retracted this submission.

134. We were also concerned by [Dr H's] lack of insight into his deficiencies. He only accepted some deficiencies in his record keeping and failed to demonstrate any genuine or lasting understanding of the wide-ranging deficiencies in his practice, e.g. assessment, clinical management and treatment of patients, and safety. As already mentioned above, we consider his failure to start designing a PDP within the required time period and in breach of the GMC undertakings he had agreed to, also show a remarkable lack of insight and inability to reflect on his own practice and shortcomings.

135. Given our concerns relating to [Dr H's] probity, credibility, and woefully inadequate insight, we do not consider there are any appropriate conditions which could be imposed that would prevent prejudice to the efficiency of the services counter his meet that inefficiency that those included in the Performers List perform".

20. Finally, the F-tT set out its overall conclusion in this way:

> "136. We are satisfied as to the accuracy of NHSE's submission that the evidence overwhelmingly points towards current deficiencies in a number of areas of [Dr H's] service provision, including assessment, clinical management and treatment of patients, medical record keeping, safety, and insight and remediation. In light of [Dr H's] inability to self-evaluate and reflect on his practice and shortcomings, his lack of insight into the issues and learning needs, and his lack of understanding of the role of a supervisor, we concur with NHSE's conclusion that it would not be an efficient use of resources to implement a remediation plan or appoint a supervisor.
>
> 137. Given the above, together with our concerns relating to [Dr H's] probity, credibility, and overall lack of insight, we conclude that the continued inclusion of [Dr H's] name on the Medical Performers List would be prejudicial to the efficiency of the services that those included in the Performers List perform, and that no conditions could be imposed that would prevent such prejudice. We dismiss [Dr H's] appeal and confirm NHSE's decision to remove him from the that NHS Performers List."

21. Thus, the F-tT dismissed Dr H's appeal.

The Permission Stage

22. Dr H now represented by Mr Evans, sought permission to appeal to the Upper Tribunal. As required by the Rules of Procedure, permission was sought, first of all, from the F-tT. However, such was refused. The application was renewed to the Upper Tribunal and 11 grounds of appeal were put forward. I held an oral hearing of the application for permission, after which I gave permission with respect to one ground and a part of another ground. But I expressly refused permission on all other grounds. My decision to refuse permission on nine separate grounds and part of one of the remaining grounds has not been the subject of any subsequent challenge and I need not say anything further about the unsuccessful (at that stage) grounds.

23. As to the grounds in respect of which I did give permission, ground 1 was a contention that the F-tT had erred in law and had acted unfairly in failing to make preliminary determinations regarding the appellant's possible cognitive impairment and regarding the level of his language skills (with respect to any possible need he might have for the services of a professional interpreter) prior to proceeding, on the basis that he would be represented himself. What was originally ground 6 of the 11 grounds put forward (but which I shall now call ground 2) amounted to a contention that whilst the F-tT had, at the outset of the hearing, established that the case against Dr H was to be considered on the basis of "efficiency" only rather than on grounds of "suitability" had erred through taking into account matters relevant to suitability being the appellant's probity, his level of insight, and his credibility. In explaining why I was giving permission with respect to an element of what was contained in ground 1, I said this:

> "18. That single consideration relates to interpretation. I accept what Mr Evans has to say about it being difficult for a litigant in person to effectively pursue cross-examination or to provide detailed evidence during the course of a lengthy hearing. Any such difficulties might be

> compounded if a litigant in person is not able to speak English with a sufficient degree of fluency. It appears that the respondent entertained concerns regarding the appellant's level of English and indeed the F-tT itself observed, at paragraph 28 of its written reasons, (as is pointed out in the grounds of appeal) that it did, at times, struggle to understand what the appellant was saying. But the F-tT does not indicate that it gave any specific consideration to the question of whether the appellant might need an interpreter, nor does it appear, from its written reasons, that it made any enquiry of him as to that. It is arguable that it was obliged to either offer the provision of an interpreter or, at least, to explain in its written reasons why it did not think it necessary or appropriate to do so. On the other hand, the appellant had obtained an IELTS score of 6 which does appear to indicate a degree of proficiency in English which might have been sufficient for him to adequately represent himself and ask questions of witnesses. It has not been said (unless I have missed it) on behalf of the appellant that he asked the F-tT to supply him with an interpreter. The fact he did not make such a request either prior to or during the course of the hearing might be a significant indicator that he did not need one. So, the arguments even on this discrete part of this ground are not all one way. Nevertheless, I have concluded that it is appropriate to give permission on the basis that the F-tT might have erred in law through failing to properly consider and deal with the possible need for a professional interpreter. That is the single point in ground 1 in respect of which I give permission. I refuse permission with respect to all other arguments contained within ground 1".

24. In explaining why I was giving permission on ground 2 (originally ground 6) I said this:

> "19. Turning then to ground 6, the content of the relevant regulations has not been set out, in terms, in the written submissions which have been provided. But regulation 14 of the National Health Service (Performers List) (England) Regulations 2013 does distinguish between what is called an "*efficiency case*" and what is called an "*unsuitability case*". It seems to me that the content of the Regulations is then quite limited in setting out or explaining the distinction. I do note that Mr Irwin, in his written submissions of 21 June 2021 opposing permission, has observed that "*the authorities recognise the overlap between, or the difficulty in some cases distinguishing between, inefficiency and suitability - efficiency is not narrowly defined or exclusionary*". But no decided case of the Upper Tribunal or the Superior Courts has been cited in support of those propositions. He goes on to point out that Department of Health Advice suggest that efficiency relates to "*everyday work, inadequate capability, poor clinical performance, bad practice, repeated wasteful use of resources or activities which add significantly to the burden of others… out of date clinical practice; inappropriate clinical practice that puts patients at risk; incompetent clinical practice; inability to communicate effectively; inappropriate delegation of clinical skills and ineffective teamworking*". If that is right, then it seems to become very difficult for the appellant to succeed on this ground. But is it right?

> 20. Having regard to the above I have concluded, on the material currently before me, that the F-tT might have erred in a way which might have impacted upon the outcome through straying into areas relevant to suitability rather than efficiency (which it had expressly limited itself to) when reaching its decision. That being so the relatively low threshold for the giving of permission on this ground is reached and, accordingly, I do give permission".

25. Permission given, on that limited basis, matters went on to be considered at the full hearing of 29 November 2022.

The arguments of the parties

26. Mr Evans, in his skeleton argument and oral submissions, pointed out (insofar as it was relevant to the question of whether the grounds were made out) that much of the original case against Dr H had fallen away. What remained he said, only had to do with record keeping. As to language and interpretation, the appellant did not have the assistance of a professional representative. NHS England had asserted his ability to communicate and understand English was limited and that had been part of his case against him. There was, therefore, now an inconsistency in NHS England arguing that his abilities in English had been sufficient to enable him to properly participate as a litigant in person. The case had been a complex and substantial one involving a great deal of documentation. It had been necessary for him not only to give evidence and put forward his own case but to cross-examine and be cross-examined. The F-tT ought to have adjourned on its own motion with a view to an interpreter being obtained for reconvened hearing.

27. As to ground 2, there is a distinction between an efficiency and an unsuitability case even if the distinction can sometimes become blurred and even if there may in some cases (though not in this one argued Mr Evans) be an overlap. Probity goes to unsuitability rather than to efficiency. Accordingly, the F-tT had strayed beyond the accepted limits of the hearing and, in resolving matters against Dr H, had relied on matters which had not been specifically raised with him in advance of the hearing. That was unfair. Further, considerations as to probity were entirely irrelevant to considerations concerning efficiency in the way in which Dr H dealt with his patients and to his ability to function as a GP. Further still, the way in which he had expressed his disagreement with the views of those who had assessed him might have owed something to language deficiency and was anyway understandable when matters were looked at through his eyes. He had been upset by the suggestion (no longer pursued) that he had some degree of cognitive impairment and he had understandably thought his record keeping would be reviewed by a doctor more senior than Dr N. I was urged to allow the appeal.

28. Mr Irwin, in his oral submissions and skeleton argument, argued that the F-tT's decision had been thorough and careful. There is an overlap between the concept of efficiency and that of unsuitability. Probity is relevant to efficiency. The overlap between the two is considerable. There is no need to create an artificial distinction or barrier between them. Issues regarding probity stemmed from Dr H's inappropriate challenges to all of those who had said something against him during the assessments. Probity was relevant to Dr H's ability to work with others. As to language difficulties and any need for an interpreter, the appellant has a track record of having been able to make himself understood during the course of the regulatory

investigations. At the hearing the F-tT had afforded him every courtesy. There was no suggestion that he had been misunderstood.

My reasoning

29. I shall deal with ground 1. First of all. I acknowledge that this case was one of some complexity and was a case which had generated much in terms of documentation. I acknowledge that most litigants in person would be likely to find the task of representing themselves, over the course of a 4-day substantive hearing, demanding. I accept that the F-tT itself, at paragraph 28 of its written reasons (see above) did indicate that it had struggled at times to understand what Dr H had been saying. Mr Irwin has suggested that there are a number of reasons as to why someone might not always be understood which are not linked to an ability to communicate in English. At one point he suggested that an accent might lead to such difficulties. But I do think the F-tT must have had in mind actual language difficulties because it prefaced its observation that it had struggled at times to understand him by first saying "turning to the issue of [Dr H's] standard of English" (my underlining).

30. Having made the above points, it is right to say that Dr H appears to have been able to express himself without an apparent need for an interpreter or without ever seeking one, through quite extensive review and investigation procedures prior to the matter coming before the F-tT. I have in mind, for example, the PLDP proceedings.

31. There had been two hearings (both adjourned) prior to the substantive hearing taking place. There is nothing to suggest (and it was not suggested on his behalf) that Dr H had either required the services of an interpreter at those hearings or had requested one.

32. Dr H did not request an interpreter, nor seemingly did he express any concerns about his ability to represent himself, give oral evidence, or conduct cross-examination, at the substantive hearing. He is an intelligent man and would, I am sure, have discerned his need for one if, indeed, he did need one in order to effectively participate in the proceedings. There is nothing to suggest he would, had he perceived such a need, have been unassertive in making his need clear to the F-tT. Nor has any proper explanation been offered as to why, if he did need an interpreter, he did not say so. The fact he did not, at any stage during or prior to the commencement of the substantive hearing or the earlier proceedings, indicate any need for or wish for an interpreter is, I think, a powerful indicator to the effect that he did not need one in order to properly participate.

33. The F-tT was clearly alert to and sympathetic to the difficulties Dr H might have as a litigant in person. That is apparent from what it had to say at paragraph 24 of the written reasons (see above). Given that it was alert to such difficulties I am of the view that it would have been alert to any possible language difficulties of substance (notwithstanding what it had to say at paragraph 28 of the written reasons) which would have interfered with Dr H's ability to adequately follow or participate in the proceedings. The fact that a F-tT sympathetic to the needs of a litigant in person did not detect a need for an interpreter is another indicator pointing to there not being a need for one.

34. Although Mr Evans criticises NHS England for being inconsistent with respect to the question of whether Dr H has limitations with respect to his use of English, it does not necessarily follow that the standard required to enable a doctor to properly and

effectively treat patients is the standard needed to understand and participate when assisted by a sympathetic F-tT in inquisitorial proceedings. In any event, whether the stance of NHS England can be characterised as inconsistent or not, that is not the point. The question is simply whether Dr H was able to effectively participate or not.

35. The appellant has attained an IELTS score of 6. Mr Evans was quick to point out that he had other test failures behind him but it seems to me that what the F-tT was saying at paragraph 15 of its written reasons was not (as I think Mr Evans seemed to be suggesting) that he had taken the test and failed to achieve a score of 6 on previous occasions but, rather, he had made a number of unsuccessful attempts to attain a score of 7.5. Be that as it may, his ability to attain a score of 6 does suggest a reasonable level of competence which would, at least, be sufficient to participate in proceedings in circumstances where there was, as here, a F-tT seeking to ensure there were no disadvantage on his part.

36. It has not been said by or on behalf of Dr H in these proceedings before the Upper Tribunal, that he would have sought to put any particular points in cross-examination or would have said something in his evidence or submissions, which he did not put or say because he did not have the assistance of an interpreter.

37. Putting everything together I am satisfied that Dr H was able to and did effectively participate in the proceedings with the result that there was no unfairness in consequence of the F-tT proceeding as it did. I am satisfied that the F-tT was not required to, of its motion, stop the proceedings and either take steps to secure an interpreter or enquire of Dr H (who as I say has never asked for one) whether he would like one. I have concluded, therefore, that ground 1 is not made out.

38. I now come on to ground 2. By way of reminder, Mr Evans contended on behalf of Dr H that the F-tT had erred through dealing with and taking into account matters relevant to a suitability case rather than limiting itself to matters relevant to efficiency in circumstances where it had been agreed that only matters relevant to efficiency were to be relied upon, and that there had been unfairness as a result.

39. It appears that, historically, the differentiation between factors which might be relevant to efficiency and factors which might be relevant to suitability has been an ongoing concern at least to some degree, for the F-tT. But both representatives accepted that there was some degree of overlap between the two albeit that Mr Irwin suggested that there was a greater degree of overlap than did Mr Evans.

40. A flavour of what sort of considerations might be relevant in a suitability case is apparent from what was said in *East Lancashire Primary Care Trust v Pawar [2009] EWHC 3762 (Admin).* Mr Irwin argues that a careful reading of the judgement in Pawar "establishes that the efficiency of services covers all aspects of the service provided by performers; - it is only narrow to the extent that it does not extend to matters outside that remit". He relies upon paragraph 22 of the judgement. I will quote from the salient part of the judgement:

> "22. The third ground of challenge is that the panel failed to give full effect to Regulation 12 on its proper interpretation. Mr McCartney submits that the efficiency of the services in question in Regulation 12 must be given a wide meaning so as to include the efficiency of the use of NHS resources. In my judgement that submission is not consistent with the language of the regulation. The reference in Regulation 12 to

the services in question is plainly a reference to the services identified in regulation 10(4)(a), namely the services which those included in the relevant performers list perform. Those services are specific, and do not refer to the general management and administration including financial performance of the NHS generally. The Department of Health Guidance, Primary Medical Performers Lists, supports this natural interpretation of Regulation 10 and 12. Under the heading "efficiency" the following appears at paragraph 7.4 of the guidance.

> "These grounds may be used when the inclusion of the doctor on the PCT's first list could be "prejudicial to the efficiency of the service" that is performed. Broadly speaking, these are issues of competence and the quality of performance. They may relate to everyday work, to inadequate capability, to poor clinical performance, bad practice, repeated waste or use of resources that local mechanisms have been unable to address, or actions or activities that have added significantly to the burden of others in the NHS (including other doctors)."

23. Similarly, at paragraph 17.16, it said that:

> "In efficiency cases the conditions imposed might address poor performance or clinical shortcomings by requiring additional training or supervision in a particular area of practice. Where there has been a previous fraud or dishonesty, the conditions might limit the doctor's direct access to public funds or require the making of additional checks on claims. These examples are not of course exhaustive."

24. In those paragraphs of the guidance, the focus is plainly on the individual performance of services by those on the list and on matters relating to performer's competence and quality of performance. There is no suggestion that the efficient management and administration of the NHS more generally is intended to be included within the ambit of those regulations. Furthermore, I see no warrant of policy for extending the remit of FHSAA to consider efficiency in the wider sense advanced by Mr McCartney. It is doubtful whether the FHSAA has the resources to undertake such a wide-ranging review and whether its procedures are designed for such a purpose. The implications would be potentially far-reaching, and I do not consider that such an extending remit could have been intended".

41. It is clear that, in the above passages, the High Court was dealing with, and indeed rejecting a submission to the effect that the regulations then in place (but substantially similar to those in place at the time the F-tT decided the appeal before it in this case) permitted a consideration of matters wider than those relating to the level, nature and quality of performance of an individual performer, such as the efficient management and administration of the National Health Service generally. Nevertheless, it is clear that the High Court took the view that matters such as everyday work, inadequate capability, poor clinical performance, bad practice, poor record keeping and other related failings, would comfortably come within the ambit of an assessment as to efficiency. I have concluded that that must be right.

42. That being so, it seems to me beyond doubt that the F-tT was entitled to take into account, under the umbrella of efficiency, the bulk of the matters it did do from paragraph 117 to paragraph 135 of its written reasons.

43. Mr Evans though, at the oral hearing of the appeal, strongly argued that matters of probity could not fall within the ambit of an efficiency case. He had also suggested at an earlier stage that the same was true of credibility (though that I suppose is part and parcel of the same thing) and insight. I do accept that the F-tT took into account its view regarding what it found to be a comprehensive lack of insight on the part of Dr H, as well as its negative view as to his probity. The F-tT referred to its concerns regarding insight at a number of points in the written reasons (examples are at paragraphs 123, 124, 125, 134, and 135 all of which are reproduced above). With respect to what it identified as Dr H's tendency to attack or criticise those who had taken an adverse view of his performance, it initially set out its observations and concerns from paragraph 127 to 130 of the written reasons (again reproduced above)

44. In bringing the threads of all of those concerns together, and to repeat, the F-tT said this:

> "135. Given our concerns relating to Dr H's probity, credibility, and woefully inadequate insight, we do not consider there are any appropriate conditions which could be imposed that would prevent prejudice to the efficiency of the services counter his meet that efficiency. that those included in that Performers List perform."

45. There are some grammatical errors in the above passage, but the meaning is entirely clear.

46. It is apparent, as Mr Evans submits and as is clear from what I have already said above, that the F-tT did take into account its concerns regarding probity, credibility and insight in reaching the outcome it did. I have concluded that it was entitled to take all of them into account and that, in so doing, it did not, in the circumstances of this case, stray into territory which was located exclusively within the province of suitability. It had identified concerns regarding Dr H's performance which fell squarely within the ambit of efficiency. It had to ask itself, not least for the purposes of deciding whether there was any viable alternative to the outcome it eventually reached, whether there might, perhaps aided by training, supervision, self-reflection, the likelihood of a change in practice, and a willingness to learn from others, be scope for improvement. That is largely why it specifically undertook an evaluation as to whether it would be appropriate to impose conditions thus enabling Dr H to continue to be included in the performers list (see paragraph 126 of the written reasons) as an alternative to the outcome it ended up reaching. It had to do that before it could make a proper and informed decision as to that matter and, indeed, as to whether the continued inclusion of Dr H on the Performers List would be prejudicial to the efficiency of the services that those included in the Performers List perform.

47. The F-tT clearly concluded, and was entitled to so conclude on the evidence, that due to the concerns regarding insight and probity, Dr H's capacity to improve was very limited. So, the concerns which Mr Evans said were solely within the province of suitability, were actually relevant to an overall assessment of efficiency

too. They were capable of falling within either category and in the circumstances of this case, did do.

48. Mr Evans, during the course of the oral hearing, suggested that there had been unfairness in that Dr H had been taken by surprise when matters touching on probity and insight (especially probity) had been raised, or that he had not had a proper opportunity to deal with those concerns before the F-tT reached its decision. But It was Dr H who had effectively put those issues in to the arena by making the allegations and complaints against others which he had, and by making assertions before the F-tT which it found unconvincing. There was no unfairness in the F-tT reaching findings and conclusions on the basis of material put before it by Dr H himself. In the circumstances I have concluded that the F-tT did not err in law in the way in which it has been argued it did in support of Ground 2.

49. Finally, in a written submission of 5 May 2022 Mr Irwin had suggested "The appellant should pay any costs reasonably incurred by the Respondent in responding to this appeal". He did not, though, say anything specific about costs at the hearing of the appeal. The costs regime in the Upper Tribunal may be found at rule 10 of the Tribunal Procedure (Upper Tribunal) Rules 2008. No proper explanation has been given as to why any costs order ought to be made in this case. Dr H did secure a grant of permission (albeit limited). He did not always respond in time to directions issued by the Upper Tribunal, but his representative had difficulties which at least partially explained that. I can find no proper basis for the making of an order for costs (which in truth was far from vigorously pursued) and I do not make such an order.

50. This appeal is to the Upper Tribunal is dismissed.

M R Hemingway
Judge of the Upper Tribunal
Authorised for issue on 19 January 2023