# Care Standards

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

**[2019] 3776.EA-MoU**
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Judge G K Sinclair
Specialist Member M Cann
Specialist Member W Stafford

*Between:–*

**THE MONTEIRO CLINIC LTD** *Appellant*

*and*

**CARE QUALITY COMMISSION** *Respondent*

## DECISION

Before the tribunal sitting at the Royal Court of Justice on 2nd & 3rd October 2019

*Representation*

Appellant : Lee Gledhill (counsel, Doctors Defence Service)
Respondent : Stephen Graham (solicitor, Ward Hadaway LLP)



### The appeals

1. The appellant company (co reg no 05021856) provides independent medical services, primarily to the resident Portuguese, Brazilian and Spanish communities in London, at two locations: 2 Clapham Road, Oval, SW9 0JG

("the Clapham clinic") and 7 Craven Park Road, NW10 8SE ("the North clinic").

2. By application dated 1st August 2019 it appeals against a notice of decision by the Care Quality Commission dated 5th July 2019 to impose upon its registration a condition that "the registered person must only provide dental services at [the North clinic]", with the result that it cannot provide medical services from that location.

3. By a second application dated 2nd August 2019 the company appeals against a notice of decision by the Care Quality Commission dated 12th July 2019 to vary a condition on its registration by deleting the Clapham clinic location, thus preventing it from providing medical services from that address.

**Background**

4. The appellant company was incorporated on 21st January 2004 and, save for a period in 2013 when a second director was appointed, Dr Monteiro has at all material times been its sole director and, with Mr Dennis Todd, joint owner.

5. It is noteworthy, but appears to have escaped everyone's attention, that on 24th August 2011 a separate company, The Monteiro Dental Clinic Ltd (co reg no 07751957) of 28a Clapham Road SW9 0JQ was incorporated, again with Dr Monteiro as sole director. For the sake of completeness, a third company, The Monteiro Beauty Clinic Ltd (co reg no 08838439) of 34 Clapham Road SW9 0JQ, was later incorporated on 9th January 2014.

6. Despite the incorporation of an entirely separate company to provide dental services less than two weeks earlier, on 2nd September 2011 The Monteiro Clinic Ltd was registered by the CQC as a service provider. Dr Monteiro is the registered manager. In the version of its certificate dated 10th May 2019 (which can be found at pages H100–H104 in the hearing bundle) the regulated activities for which the appellant company is registered are as follows:
   a. *Diagnostic and screening procedures*, from 28A Clapham Road (the dental clinic), 2 Clapham Road (the Clapham clinic) and 7 Craven Park Road (the North clinic)
   b. *Surgical procedures*, from the dental clinic and the North clinic
   c. *Treatment of disease, disorder or injury*, from the dental clinic, the beauty clinic, the Clapham clinic and the North clinic.

7. The appellant was the subject of various inspections since registration, but as a result of those conducted in 2018 warning notices were issued, but to little effect. Following yet another inspection in April 2019 a section 31 notice was served imposing a condition on the registration at both the Clapham and North clinics that:

   > The registered person must ensure that clinical staff only carry out procedures when trained and competency checked.

8. The notice explained that the decision was made because nursing staff were carrying out a range of activities (which were listed) without being trained or competency checked to do so, and that until they were the CQC had reasonable cause to believe that persons may or will be exposed to the risk of harm. The

decision was to have immediate effect and the appellant was warned that it must thereafter carry on its regulated activities in a way which complied with the conditions of its registration, including this imposition.

9. That section 31 notice was not appealed.

10. Following a further inspection of the North clinic on 4th July 2019 CQC inspectors were seriously concerned by the management of patients on high risk medicines and, yet again, by the activities of the practice nurses (resulting in four being referred to the Nursing & Midwifery Council). As a direct consequence decisions were taken:
    a. To issue the section 31 notice dated 5th July 2019 imposing a condition on the North clinic; and
    b. Urgently to inspect the Clapham clinic to see if conditions there were equally bad.

11. An inspection at the Clapham clinic on 10th July 2019 raised serious concerns about the prescribing of high risk medicines for prolonged periods yet without adequate testing of patients. Clinical records did not accord with best practice guidance, and the clinical database was inadequate. The section 31 notice dated 12th July followed.

12. But for the muddling of both medical and dental services in the minds of Dr Monteiro and the CQC, and an inaccurate global registration of both (plus the beauty clinic) under the same registration in the name of the appellant company, the action taken by the CQC could have been much simpler. In order to avoid closing down the dental services as well the CQC had to adopt the course of imposing conditions causing *de facto* closure of the two GP practices, instead of taking the more straightforward step of cancellation of registration of the GP practices under section 17 (or urgent cancellation under section 30). This led to the rather rushed preparation for the appeals, which were consolidated.

**Material legal provisions**

13. The material statutory provisions are to be found in the Health and Social Care Act 2008. The first Part of the Act deals with the establishment and role of the Care Quality Commission as regulator. This is divided into a number of Chapters and, in Chapter 2, section 8 defines “Regulated activity” as follows:
    (1) In this Part “regulated activity” means an activity of a prescribed kind.
    (2) An activity may be prescribed for the purposes of subsection (1) only if–
        (a) the activity involves, or is connected with, the provision of health or social care in, or in relation to, England, and
        (b) the activity does not involve the carrying on of any establishment or agency, within the meaning of the Care Standards Act 2000 ©. 14), for which Her Majesty's Chief Inspector of Education, Children's Services and Skills is the registration authority under that Act.
    (3) For the purposes of subsection (2), activities connected with the provision of health or social care include, in particular–
        (a) the supply of staff who are to provide such care;

(b) the provision of transport or accommodation for those who require such care;
(c) the provision of advice in respect of such care.

14. By section 10 any person who carries on a regulated activity without being registered under Chapter 2 of the Act in respect of the carrying on of that activity is guilty of an offence, and section 11 provides that a person seeking to be registered as a service provider must make an application to the Commission (the CQC).

15. Also pertinent in the instant case is section 13, which provides that:
(1) The registration under this Chapter of a person ("S") as a service provider in respect of a regulated activity must in prescribed cases be subject to a registered manager condition.
(2) In deciding whether to impose a registered manager condition under section 12(3) or (5), in a case where subsection (1) does not require such a condition to be imposed, the Commission must have regard to prescribed matters.
(3) For the purposes of this Chapter, a registered manager condition is a condition that the activity as carried on by S, or the activity as carried on by S at or from particular premises, must be managed by an individual who is registered under this Chapter as a manager in respect of the activity, or the activity as carried on at or from those premises.

16. By section 31:
(1) If the Commission has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm, the Commission may, by giving notice in writing under this section to a person registered as a service provider or manager in respect of a regulated activity, provide for any decision of the Commission that is mentioned in subsection (2) to take effect from the time when the notice is given.
(2) Those decisions are–
(a) a decision under section 12(5) or 15(5) to vary or remove a condition for the time being in force in relation to the registration or to impose an additional condition;
(b) a decision under section 18 to suspend the registration or extend a period of suspension.
(3) The notice must–
(a) state that it is given under this section,
(b) state the Commission's reasons for believing that the circumstances fall within subsection (1),
(c) specify the condition as varied, removed or imposed or the period (or extended period) of suspension, and
(d) explain the right of appeal conferred by section 32.

17. By section 32(5), on an appeal against a decision to which a notice under section 31 relates, the tribunal may confirm the decision or direct that it is to cease to have effect. Additionally, by subsection (6), the tribunal also has the power:

(a) to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates,
(b) to direct that any such discretionary condition is to cease to have effect,
(c) to direct that any such discretionary condition as the First-tier Tribunal thinks fit shall have effect in respect of the regulated activity, or
(d) to vary the period of any suspension.

18. Subsection (7) defines "discretionary condition", in relation to registration under Chapter 2, as meaning any condition other than a registered manager condition required by section 13(1).

19. In seeking to impose fresh conditions the respondent has sought to rely upon a number of regulatory breaches found at the various inspections. These can be found in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[1], of which the respondent alleged breaches of regulations 12 (safe care and treatment) and 17 (good governance).

**Hearing and evidence**

20. The tribunal was presented with a bundle comprising one lever arch file, to which (with the tribunal's consent granted at the outset of the hearing) the appellant added a file of updating evidence. In addition the tribunal had a short Scott Schedule, detailing each allegation. As the appellant's approach was to admit the allegations almost in their entirety, while arguing that due to its proposed remediation measures the conditions imposed by the CQC were no longer necessary, this schedule was of limited use.

21. As the appellant had conceded the appropriateness of the conditions at the date they were made, but argued that subsequent events and its proposals for the future justified taking an alternative course, it was agreed that the appellant should call its evidence first, and the CQC would then follow by focussing on events since the July inspections, including an announced inspection of the Clapham clinic on 24th September 2019. The tribunal enquired exactly what new conditions on its registration the appellant invited it to impose, but these were forthcoming only in final submissions.

22. The appellant filed witness statements by, and called to give oral evidence:
a. Dr Justino Monteiro: 1st statement (21.ix.19) in bundle 1 at I3; 2nd (20.ix.19) in bundle 2 at tab 4
b. Domingos Santos: 1st statement (13.ix.19) in bundle 1 at I8; 2nd (20.ix.19) in bundle 2 at tab 3
c. Dr Sudip Dutta: 1st statement (17.ix.19) in bundle 1 at I13; 2nd (22.ix.19) in bundle 2 at tab 1.

23. Dr Monteiro took seriously, and personal responsibility for, the failings identified by the CQC. After analysis he saw where he had failed and confirmed that, as stated in his second statement, he had resigned as clinical lead in favour of Dr Dutta. He considered him to be a sound and capable leader, who had successfully managed not only a nearby NHS GP practice but had also set up

[1]SI 2014/2936

his own independent clinic as well. Although in the independent sector the Monteiro Clinic needed to be working with NHS standards, in prescribing, and in culture. He admitted that it will take time for the doctors to change culture; quite a long road. He had explained to Dr Dutta that he would give him his full financial support. Dr Monteiro wants the clinic to run properly, and any investment to improve it is ultimately to his own benefit as co-owner.

24. On the issue of the clinic's bespoke clinical database Dr Monteiro agreed that since the first inspection Mr Millington had drawn attention to the IT problem. He accepted that the clinic needed to make a cultural shift, and an important example of such a change would be to install a different IT system. Dr Monteiro had started the bespoke system in 2004 and updated it from time to time, but the CQC is concerned that it does not flag up some problems. It was now arranged that the EMIS IT system, as used in the NHS and also in private practice, would be installed. The first visit for training, etc will be on 11th October, and installation and the transfer of data is planned to start on the 22nd. The first year cost is £25 000, and after that the annual cost will be £18 000 ongoing.

25. As for his role, he said that he would continue to be the responsible officer, maintaining links with NHS London. It was his intention to support his doctors and, so far as appraisals were concerned, regarded it as his role to refer them for validation. If he were to work as a doctor in the clinic it would be very little, as the other role is very time-consuming.

26. It was pointed out in cross-examination that Dr Monteiro was the registered manager and had not apparently thought of giving up that role as well. He replied that, if it were necessary, he was willing to resign as registered manager – he is 65, not 40 – and has other things to do.

27. Mr Santos, deputy practice manager, had obtained a degree in physical education at university in Portugal, followed by a further qualification in rehabilitation. Moving to the UK in 2012, he found that the clinic needed dispensing staff, studied and obtained the required qualification, and joined the dispensary in 2013. Later, when Dr Monteiro needed additional administrative help, he became deputy manager of the practice and had remained in that role for several years.

28. He said that the action plan appearing at I175 was designed within days of the CQC's inspection. It raised some matters that are no longer applicable, as the appellant had decided not to start without EMIS. He had made improvements on the clinic's training protocols. He observed that, although it is said that the appellant's approach is reactive, when the CQC criticise then something has to be done.

29. On 19th July 2019, one week after the Clapham clinic inspection, the appellant had signed an agreement with the Royal College of General Practitioners ("the RCGP"). Its first visit was intended just to understand how the clinic operates, the audits, etc. He said that the RCGP work very similarly to the CQC. They just shape the document and see the protocols in place, and check doctors'

work. They did not have time to go through the database.

30. Amongst the documents exhibited by Mr Santos were new management documents that he had created, a *pro forma* Memorandum of Understanding between the RCGP and a GP Practice for the provision by the former of assistance to the latter and, helpfully, a Primary Care Development Summary Report dated 17th August 2019 and produced by Dr Michael Heber, clinical deputy lead, and Andrew Sarek, practice support adviser.

31. This latter document noted that the practice has a staff of 32, including seven doctors, practice nurses, a phlebotomist, managerial and administrative staff and IT support. At I165–166 the authors included the following feedback from staff:

> We were aware of a strong sense of caring for the patients and loyalty to the practice, as well as dismay at the possibility of closure – partly due to concerns about the particular population the practice serves being unable to access care. They felt that the doctors were kind and caring and practised holistically. The ability to speak in Portugese and Spanish was vital for many of the local population...
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> They felt they would be able to whistle blow and would report to the owner or Deputy Manager. There was however a sense that management was a top down style and that the current management regime had been somewhat overwhelmed by the regulation required for a satisfactory CQC outcome...
>
> The staff agreed with the negative findings of the CQC but were keen to point out caveats. For example, the difficulty of seeing foreign visitors as a one off and then being held responsible for on-going care, and the concept of prescribing a large amount of drugs for a patient who was unable to obtain that drug in his own country was intended to be a charitable act.
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> Staff felt that the in-house clinical system had contributed to some of the failings found by CQC with information not always available to everyone that needed it.

32. When the tribunal put these last comments to Dr Dutta he commented that if a patient was seen only once then the treatment given would be for seven days only, and that it was not charitable to give drugs to someone unable to obtain them in his own country. What was going to happen in a few months when the supply ran out?

33. Mr Santos said that it is not easy to say at this stage what help the RCGP will provide in future, as it is not sure if the appellant can reopen its doors. What was intended was a maximum of one RCGP visit every 3 months, with comprehensive analysis of the work being done. The appellant wants them in before a soft opening, and would not open the doors until everything is in place, until Dr Dutta is happy with the training, and the RCGP is also happy. The training definitely needs to be in place. Dr Dutta and Dr Ashish Chadha

(referred to throughout the hearing as “Dr Ash”) need to work as one. They will need to know how to control the doctors and nurses.

34. Under cross-examination Mr Santos confirmed that Mr Todd, co-owner of the business, was the actual practice manager and did some work, but that as he (Mr Santos) dealt with “sickness inspections, and staff training” he was the more appropriate person to answer questions. He confirmed that the concerns raised by CQC inspectors on 24th September had influenced the decision also to involve Dr Ash in revised proposals. He had already been involved with the appellant, having carried out formal appraisals of the doctors for the last three years.

35. Although he had filed no witness statement nor attended to give evidence Mr Gledhill was able to hand up a curriculum vitae for Dr Ashish Chadha, and also an email dated 1st October 2019 from Dr Heber confirming that:

> ...any ongoing support package from the RCGP would specifically include clinical support to both doctors and practice nurses, aiming to improve standards to the level expected by the CQC, or indeed that of good NHS general practice.

36. Dr Dutta’s first witness statement was quite short, but his second set out in some detail the proposals he had for a three day per week soft opening of the Clapham clinic only for the first three months, following satisfactory training of the medical staff, installation of and training on the new EMIS program, and monitoring – either by him in person for one day per week or remotely on-line for the rest of the time – of doctors’ diagnoses and prescribing decisions. During this time doctors would see patients for 30 minutes each in two 4-hour shifts per day.

37. He said that at his own practice he only hires the most experienced staff. All work in the NHS as well as in his own private clinic. It is not easy to retrain GPs, so there needs to be a bedding-in period of about one month before opening the doors. That is the weak point of the practice. If there were a weakly performing doctor he would have to go (including if it were Dr Monteiro, with no exceptions).

38. He explained that he has used EMIS in his practice for thirteen years. What would be installed at the Clapham clinic would be the same software as in use at his own practice. He said EMIS does have a very good audit function, and is good for the patients anyway. If a prescription is contra-indicated EMIS is much better than the existing system. It will bring up large warnings, and flag up drugs for 2nd line use. Warnings are there, and in the corner of the screen it does say if the patient has not had a check for X or Y since a certain date, just as reminders. He would not expect doctors to ignore these. If they did, the flags would still be visible.

39. However, in discussion with CQC inspectors on 24th September 2019 it became clear that they regarded the proposed level of supervision as inadequate, given the serious failings identified in July. The proposal advanced by Dr Dutta and by counsel at the hearing was very different. Dr Dutta would be physically

present for one whole day per week but Dr Ash would be there for the other two. After each 30 minute consultation whoever was on duty would, in the patient's absence but before s/he had left the clinic, discuss with the doctor his or her diagnosis and decisions taken. In this way treatment and prescribing habits could be monitored. In addition, Dr Dutta would drive the 15 minutes from his surgery to the clinic each lunchtime for informal feedback and discussion with the staff. Other work would be undertaken remotely on-line.

40. The intention now was to open in between one and two months, after initial retraining of the doctors. Dr Dutta's senior practice nurse, Sarah Maguire, would also attend one day per week to train/supervise the practice nurses, with additional support provided by the RCGP. After a gradual increase from three days per week to full opening the decision would then be taken, but only if Dr Dutta were satisfied and in consultation with the CQC, to re-commence work at the North clinic with a similar soft opening.

41. Cross-examined about the limited time he had available to provide support and act as clinical director, Dr Dutta said that he is self-employed, can control his diary, and had already virtually given up his weekend slots at his private clinic. While having a full-time clinical director was preferable, it was simply impractical in the circumstances of adverse CQC reports and closure to expect someone to risk their own reputation by applying for such a role just now. He was not planning to be in this position long-term; simply to turn it around. He would then hope to bring in a new clinical director full-time.

42. He agreed on the importance of conducting a root cause analysis. It was important to go through prescribing patterns; however it was clear that what was behind this is a lack of understanding of prescribing in the UK and NHS. The doctors are used to practising as they did outside the UK, which is unacceptable. He believes in giving everyone a chance, but weaklings will have to go.

43. He confirmed that he had only spoken with Dr Ash a couple of times, and met him only once. He was not involved in appointing him. He has worked with the clinic in the past. From talking with him, they were both singing from the same hymn sheet and agree on where the flaws lay. The longest they had spoken for was for about half an hour on the telephone.

44. On the subject of the appraisal of doctors he commented that there is a huge flaw in the appraisal system. Unless going through records, etc the accuracy of the outcome would be poor. He is not an appraiser, but had been appraised.

45. Asked by the tribunal, on the subject of training, how these doctors would learn about expectations, Dr Dutta responded that he would want them to become familiar with guidelines. At present, there was no evidence that there is any such awareness. They would need to be fully aware, and confident that they can defend their prescribing. Secondly, there needs to be a change in mind set, as they are the doctor signing off on a course of treatment. It does not matter whether the patient has been prescribed a particular drug elsewhere. There needs to be a complete culture change.

46. The respondent filed witness statements by:
    a. Emma Dove (9.viii.19), at H1
    b. Ben Millington (12.viii.19), at H31
    c. Anthony Hall (12.viii.19), at H83
    d. Brenda Lawrence (9.viii.19), at H109
    e. Bethanie Woolfson (9.viii.19), at H361
    f. Brian Brown (12.viii.19), at H366
    g. Beverley Cole (9.viii.19), at H378.

47. All these witnesses dealt with the July inspections of the North clinic, the Clapham clinic, or both. Their evidence was almost entirely uncontested. The appellant said that their evidence contained only a few minor errors or misunderstandings, but the very damning picture that the evidence created was accepted as being accurate as at the dates of the two notices.

48. Mr Millington and Ms Lawrence were the only witnesses for the respondent to give oral evidence, concentrating (at the tribunal's request) on developments since the July inspections. Importantly, this evidence included an early draft report of a further inspection of the Clapham clinic that took place as recently as 24th September, and a discussion between the inspectors, Dr Monteiro, Dr Dutta, and Mr Santos as to their plans for remediation and reopening.

49. Both remained dissatisfied with the proposals now advanced, and which had changed since their discussions on 24th September. Now a role was being proposed for Dr Ash, who was an unknown quantity, and the start date and possible length of a soft opening (which they regarded as unusual) were now being extended. They did not regard either one month or two as sufficient time in which to retrain seven doctors. Mr Millington, who had practical experience in the past of trying to support failing doctors, said that it was a long, slow process. Further, there was no evidence that Dr Dutta – while able to run a good practice – had any experience of remediating a failing one. Ms Lawrence also drew attention to the observed behaviour of the nurses as recently as the September inspection, which she regarded not only as being in breach of the condition imposed in April 2019 but also (in writing up the doctors' notes) as being an offence potentially affecting their personal registration with the NMC. They too would require rather more substantial input and supervision than envisaged in the appellant's current proposals.

50. In consequence, despite the planned introduction of the EMIS program (the warnings in which could still be bypassed if a doctor wished) and the involvement of Dr Dutta and Dr Ash, the CQC maintained that the conditions imposed by it in July that effectively stopped the provision of medical services from the Clapham and North locations should be upheld, and that the appeals be dismissed.

51. In his closing submissions Mr Graham for the CQC argued that the appellant's response to the very serious findings was fragmented, insufficient and reactive rather than proactive. It kept changing its proposals in response to every objection raised, with the latest version only appearing since 24th September.

The CQC's role was that of regulator, not the provider of advice and guidance. Faced with no definite worked out proposal, or a document from the RCGP setting out exactly what support it is prepared to offer, the task facing Dr Dutta is so large that it cannot be achieved in the timescale suggested.

52. By contrast, Mr Gledhill argued that the appellant accepted that the practice was not run well, and it had reacted to the CQC, and especially to what had been said more recently. Why would Dr Monteiro invest so much in IT, support from the RCGP, etc if not in it for the long term? He argued that Dr Dutta makes a credible witness, with confidence and bona fides. It was clear that he would not tolerate incompetence. He proposed mock sessions with doctors to test their skills. If not sure about moving on, there would be no soft opening. He is well respected, and is on the NHS performer list. Dr Dutta is the gatekeeper for training.

53. Concerning the proposed gradual increase in the number of opening days and sessions, it is a question of risk against quality, as per the NHS and private sector; a matter of capability and risk. He urged that the appellant not be forced to run before it can walk. If it takes six months to move on from three days per week, then they would do it.

54. Mr Gledhill proposed five conditions, but the first and last (a stay on the North clinic appeal, and liberty to apply) are elements of the tribunal's order, not conditions on the appellant's registration. That left three:
    a. That the registered person must ensure that clinical staff only carry out procedures when trained and competency tested
    b. Until the EMIS system has been installed and users trained and competency tested Clapham Clinic shall not provide the regulated activity of treatment of disease, disorder and screening procedures[2]
    c. The Clapham Clinic shall not open before [a date no more than two months hence].

    Mr Gledhill later, following argument, offered a fourth condition:
    d. That for the first three months the clinic is not to open more than three days per week, and each doctor is not to see more than 16 patients per day.

55. None of these was acceptable to the CQC, the representatives present being reluctant to concede anything either in argument or proposed outcome.

**Discussion**

56. This decision has set out in some detail the evidence given on behalf of the appellant, as it is common ground that the situation observed by the CQC in 2018, in April 2019 and finally in July created a serious risk of harm to patients justifying the conditions imposed. It was therefore for the appellant to demonstrate that an alternative course of action was both possible and preferable, and unlikely to cause harm to service users.

[2]Presumably a reference to the two regulated activities of 1) Treatment of disease, disorder and injury, and 2) Diagnostic and screening procedures

57. The tribunal has considered all the evidence, written and oral, and applied such weight to it as it considers appropriate. It notes the complete absence of any evidence by the practice manager, Mr Todd, and the submission only of a c.v. for Dr Ashish Chadha. As the latter would, under the appellant's latest proposal, take on two thirds of the actual supervision of medical staff following patient appointments this was perhaps surprising.

58. Dr Dutta is confident in his views, but perhaps too confident. He is a good doctor, but has no history of remediation of failing doctors, or even of being an official or registered NHS trainer. The appellant's plans kept changing, even throughout the hearing. It will take a lot longer to retrain seven failing doctors, and all the nurses, than the planned one or two months. Whilst the focus of the evidence was on clinical practice, it should also be borne in mind that there are considerable demands on the appellant with regard to documenting all aspects of the service, in order to meet NHS and CQC regulations and guidelines.

59. As a result of the way the appellant has presented its case the tribunal knows little about "Dr Ash", who became involved in the plans only in the last few days, and the actual practice manager (and co-owner of the business), Mr Todd, has remained firmly in the background. He does not feature in the evidence at all, leaving the actual work to young, unqualified and inexperienced Domingos Santos.

60. The tribunal also wishes to express its disappointment that the RCGP was unwilling to permit its staff to assist even by providing straightforward factual evidence, especially about how long it considers proper remediation might take where – in this case – seven doctors need to be brought up to speed. Without the RCGP appearing to take sides (for there is no property in a witness) that would have helped the tribunal (and probably the appellant), and it might even have been able to provide knowledgeable assistance in the selection of essential conditions that should be imposed on the appellant's registration. Those proposed by the appellant were rather too few and too vague.

61. Dr Dutta is an experienced and successful general practitioner but does not appear to have experience of managing the turn round of a seriously failing practice. With proper training and experience obtained in NHS settings Mr Santos is capable of becoming a successful practice manager. Regrettably, however, the tribunal considers that the task of remediation not only of the entire medical and nursing staff but also – and perhaps more significantly – the setting up of far more comprehensive management and audit systems very much from scratch (and not only the EMIS program) will simply be too much to undertake in the time proposed. Dr Dutta mentioned, several times in his evidence, the difficulty in employing someone full-time as clinical director or in persuading someone else to come in to the clinic and take on the role of registered manager because of the potential for damage to their professional reputations.

62. Initially tempting though it may be to try and ensure that a service regarded as valuable by a discrete section of the London Portuguese and Spanish-speaking community is given the chance to recover, in the absence of any concrete

evidence from the RCGP (which is experienced in turning round failing practices) the tribunal regrets that it cannot have confidence that a very part-time clinical director (even with outside help – the exact nature of which is unknown) can achieve what the appellant wants.

63. Had Dr Monteiro, on behalf of the appellant, involved the RCGP much earlier and obtained the services of an experienced registered manager and clinical director then he might have demonstrated some grounds for confidence that this provider could have been turned around. Not having done so, a fresh start is probably required, starting with competent staff rather than a service being held back by the drag of an entire medical and nursing staff requiring retraining, and where ultimate control remains with those who have led to the current and historic failures.

64. Formal warnings from the CQC have been ignored by the appellant and conditions probably broken. In all the circumstances its effective cancellation by imposition of the conditions removing these two locations from the registration appears the only viable option at present.

FOR THE ABOVE REASONS IT IS DETERMINED THAT:

The appeal be dismissed and the Care Quality Commission's two notices of decision dated 5th July 2019 and 12th July 2019 to impose or vary the conditions on the appellant's registration as a provider of medical services be confirmed.

Graham Sinclair
First-tier Tribunal Judge
Dated 10th October 2019