First-tier Tribunal Care Standards

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

NCN: [2022] UKFTT 482 (HESC)
[2021] 4449.EA

Hearing held on 16, 17, 18 August 2022 and 10 November 2022 at North Staffordshire Justice Centre
Deliberation held on 28 November 2022

Before
Ms S Brownlee (Tribunal Judge)
Mr Roger Graham (Specialist Member)
Ms Maxine Harris (Specialist Member)

BETWEEN:

Dr Rajan Jaiswal

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. This is Dr Rajan Jaiswal's ('the Appellant') appeal against a decision of the Care Quality Commission ('CQC' and 'Respondent') to refuse his application to register as a service provider at Broadway Medical, Lysander Road, Stoke-on-Trent, Staffordshire ST3 7TW in relation to the following regulated activities: 'diagnostic and screening procedures', 'treatment of disease, disorder or injury', 'surgical procedures' and 'maternity and midwifery services'. He appeals the Respondent's decision of 13 October 2021 pursuant to section 32 of the Health and Social Care Act 2008 ('the Act') to the First-tier Tribunal.

The Hearing

2. The hearing took place on 16, 17, 18 August 2022 and 10 November 2022 as a face-to-face hearing at North Staffordshire Justice Centre. The parties and all witnesses attended to provide oral evidence. The hearing had to adjourn, part-heard, on the afternoon of 18 August 2022 as it was clear Dr Jaiswal would not be able to complete his oral evidence in one sitting. The parties agreed it was preferable to return on a later date to hear Dr Jaiswal's oral evidence in one complete session. On 10 November 2022, a number of the Respondent's witnesses attended the hearing remotely, to observe, using the CVP platform.

3. At the close of the hearing, on 10 November 2022, the parties were directed to

provide written closing submissions to the Tribunal. The Tribunal deliberated on 28 November 2022, having considered the written closing submissions from the parties, as well as one additional undated two-page document from the Appellant 'Organisation structure V1'. The Respondent did not object to the inclusion of the document. We took it into account as further evidence in the appeal but attached little weight to it on the basis that it had been sent to the Tribunal after the close of the appeal hearing.

4. The documents that we were referred to are in the electronic hearing bundle provided in advance of the hearing (1117 digital pages). Some participants were working from hard copy bundles and some from digital bundles. We received further tranches of late evidence, which are referred to later in the decision. By way of background, Dr Jaiswal engaged legal representation later in the appeal process, which led to the instruction of counsel close to the appeal hearing dates in August. We also considered skeleton arguments and, as previously indicated, written closing submissions from both parties.

Attendance

5. Dr Jaiswal was represented by Mr Oliver Renton of counsel, instructed by Stephensons Solicitors LLP. Dr Jaiswal engaged legal representation on 7 August 2022. Dr Jaiswal gave oral evidence and called one witness, Mrs Lesley Kirk, lead clinical nurse at Broadway Medical. Mr Ryan Donoghue of counsel, instructed by Mr James Lester at the CCQ, represented the Respondent. The Respondent called five witnesses from the CQC: Mr Jaecheol Shin, registration inspector, Mrs Carrolle Hancox, inspector, Mrs Julie O'Neill, registration manager, Mrs Emma Boger, head of registration, Mr Ajit Singh, medicines inspector. The Respondent called one witness from the then Clinical Commissioning Group (replaced with Integrated Care Boards): Mrs Lynn Millar, executive director of Primary Care and Medicines Optimisation.

6. At various points over the course of the public hearing, there were attendees from the parties' legal teams. Dr Jaiswal's sister attended throughout in support.

Preliminary Issues

7. Mr Graham, Specialist Member on the Tribunal panel, provided a written summary (dated 13 August 2022) to the parties of his previous professional involvement with the CCG concerned in the appeal. Mr Graham worked as an interim and salaried manager for all Staffordshire CCGs from 2018-19 but based only in the South Staffordshire area. He indicated that he knew Ms Millar in a limited professional capacity only. The parties considered Mr Graham's summary and raised no objection to Mr Graham continuing as a Specialist Member. The Tribunal panel considered the issue and concluded there was no apparent or actual bias caused by Mr Graham's previous professional role.

8. At various points during the hearing, the Appellant applied to admit late evidence. For ease of reference, the applications are summarised at this point. On 3 August 2022, Dr Jaiswal sent the Tribunal a number of documents with an application to admit them as late evidence. The Respondent's definitive views were not available at that point and given the proximity to the hearing, Dr

Jaiswal was advised to make the application orally at the hearing. The documents consisted of documentary exhibits, as follows:

- RJ24: witness statement dated 29 July 2022 from Karen Bowen Jones, receptionist at Meir Park and Weston Coyney Surgery;
- RJ25: Meir Park and Weston Coyney Surgery Warfarin policy v 2.0 dated 14 October 2020;
- RJ26: redacted email dated 14 June 2021 from Dr Narashimha Rao, consultant neonatologist at Royal Stoke University Hospital;
- RJ27: meeting minutes from a confidential session of the North Staffordshire and Stoke on Trent CCGs Primary Care Commissioning Committee from 3 November 2020;
- RJ28: redacted email exchange between the CQC and the CCG dated March 2021;
- RJ29: confidential briefing notes dated 21 July 2021 following an extraordinary meeting of the Primary Care Commissioning Committee concerning Meir Park and Weston Coyney Surgery;
- RJ30: duty of care when test results and drugs are ordered by secondary care – extract from the British Medical Association guidance last reviewed on 7 September 2020; and
- RJ31: redacted guidance from NHS England on clinical responsibility and the prescribing of medicines, undated.

9. On the morning of the hearing, Mr Renton provided four additional documents to be considered as part of the late evidence application. They were:

   - NHS England patient survey report for both surgeries dated August 2021;
   - Risk control register for both surgeries, undated;
   - Safety netting system document, published on 2 June 2021;
   - A news article from Stoke Sentinel, undated, entitled 'Stoke-on-Trent and North Staffordshire GP surgeries ranked best to worst'; and
   - 'Dr Sarin examples of misconduct' Word document, undated.

10. The Respondent did not specifically object to the admission of any of the documents, seeking to highlight the limited relevance of RJ25 and RJ26, but taking a pragmatic view. The Tribunal decided to admit the documents. Dr Jaiswal had collated them on 1 August 2022 with notice given since that stage. Furthermore, Mr Renton persuaded the Tribunal that all of the documents, including RJ25 and RJ26 would be relevant to Dr Jaiswal's case. We took into account that Mr Renton was instructed to represent Dr Jaiswal at a late stage in the life of the appeal and in the interests of fairness to Dr Jaiswal, we decided to admit all of the documents.

11. During the hearing, there were two further applications to admit late evidence, made by the Appellant. The first application concerned two professional references relating to Dr Jaiswal's work as a locum and sessional GP, confirmation of completion of Dr Jaiswal's appraisal from 28 January 2022 and confirmation of completion of three courses relating to continuing professional development. The second application concerned an extract from the British National Formulary ('BNF') regarding Tramadol Hydrochloride and a letter dated 5 July 2006, sent to Dr Sarin from Dr Matthews, a consultant in pain

management, concerning Tramadol for a patient. All of these documents were admitted as late evidence. Again, the Respondent did not object to their inclusion, noting only the lateness of the applications.

12. Finally, at the close of the Respondent's case, Mr Renton applied for the admission of a two-page letter from Ms Annie Heckels, chair of the Appeal Panel of the CCGs informal meeting of 27 April 2022. The Tribunal did not admit this document. It had been notified to the Appellant and the Tribunal too late in the process. The Tribunal did not consider it fair to admit the document at the point when the Respondent's witnesses had completed their evidence.

Background

13. Dr Jaiswal was first registered with the Respondent as a partner of a GP practice known as 'Weston Coyney Medical Practice' in April 2013. That partnership dissolved and the Appellant then became a sole registered provider at Weston Coyney Medical Practice in April 2016. On or around July 2017, Weston Coyney Medical Practice merged with Meir Park Surgery and Dr Jaiswal went into partnership with Dr Rakesh Sarin who was the registered provider for Meir Park Surgery. The merged partnership's name was changed to 'Meir Park & Weston Coyney Medical Practice ('MPWC'). Dr Jaiswal acted as the clinical lead at Weston Coyney and Dr Sarin acted as the clinical lead at Meir Park. Dr Jaiswal accepted that he was responsible for the regulatory compliance of the practice, along with Dr Sarin as the other registered provider.

14. On 6 March 2019, the CQC conducted an announced comprehensive inspection of Meir Park Surgery. The overall rating was 'inadequate', the service was placed into special measures and a warning notice was issued in relation to safe care and treatment. On 30 April 2019, the CQC conducted an announced focused inspection of Meir Park Surgery to ensure the issues in the warning notice has been adequately addressed. It found that the issues identified in the warning notice had been partially addressed. On 16 September 2019, the CQC conducted an announced comprehensive inspection of Meir Park Surgery and received an overall rating of 'requires improvement' and was taken out of special measures. On 26 May 2020, a short notice announced responsive inspection was carried out at Meir Park Surgery as a result of concerns raised by the CCG. No rating was given but concerns were found in relation to safe care and treatment of patients and governance. The Respondent imposed conditions on the registration of the service because of concerns relating to Regulations 12 and 17 of the Health and Social Care Act (Regulated Activity) Regulations 2014 ('the Regulations').

15. On 9 September 2020, Meir Park Surgery received an announced pilot inspection. The CQC found that there had been some improvement to the management structure and management of medicines, but it remained concerned about the proposed timescale for completion of the review of hospital letters and that the safety of patients continued to be a risk.

16. On 7 December 2020, the CQC received an application from Dr Jaiswal to register as the sole provider at Broadway Medical (Meir Park and Weston Coyney Medical Practice) due to Dr Sarin's impending retirement on 31 December 2020. From 29 January 2021 to 12 March 2021, Dr Jaiswal took a leave of absence from work. On 9 February 2021, the CQC received a statutory

notification regarding an incident relating to a staff grievance raised against Dr Jaiswal.

17. On 23 July 2021, the CCG notified the CQC that it was terminating Dr Jaiswal's NHS contract.

18. On 2 September 2021, the CQC issued a notice of proposal refusing Dr Jaiswal's application on the basis that it did not consider Dr Jaiswal would ensure compliance with Regulations 12 and 17 of the Regulations. Dr Jaiswal did not send any written representations and a notice of decision was issued on 13 October 2021.

Legal Framework

19. Section 2 of the Health and Social Care Act 2008 ('the 2008 Act') invests in the Respondent registration and review and investigation functions. By virtue of section 3(1) of the 2008 Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.

20. Section 4 of the 2008 Act sets out the matters to which the Respondent must have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.

21. Section 12 of the 2008 Act obligates the Respondent to grant an application as a service provider where the Respondent is satisfied that the requirements of the Regulations (amongst other things) are being and will continue to be complied with in relation to the regulated activities. If it is not satisfied, it must refuse it.

22. Under section 20 of the 2008 Act, the Secretary of State is empowered to make regulations in relation to the regulated activities by way of regulations. The Regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ('the Regulations') and The CQC (Registration) Regulations 2009.

23. Sections 26, 27 and 28 of the Act set out the procedural requirements in relation to notification of the Respondent's decision.

24. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to refuse the registration of a service provider in relation to a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect. Under section 32(6), the Tribunal also has power to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates. A 'discretionary condition' means any condition other than a register manager condition required by section 13(1).

25. Part 3 of the Regulations sets out the Fundamental Standards that registered providers must comply with when carrying on a regulated activity, which

includes Regulations 12 (safe care and treatment) and 17 (good governance).

26. The Appellant bears the burden of persuading the Tribunal that the Regulations have been complied with at the date of the hearing, including 'by having regard to' guidance issued under section 23 of the 2008 Act. The findings of fact are made on the basis of whether or not the Tribunal is satisfied as to the facts on the balance of probabilities.

27. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing. Subject only to relevance and fairness, this can include new information that was not available or presented at the time when the decision under appeal was made. The fresh determination in this appeal includes consideration of the detailed documentary evidence provided by both parties, as well as the oral evidence, subject to questioning over the four-day hearing. We have considered all of the evidence and the written submissions before us, even if we do not mention every point of it in our decision. We refer only to the parts of the evidence which were of particular importance in reaching our findings.

The Decision under Appeal

28. The CQC adopted the notice of proposal and refused the application on the basis that the manner in which the regulated activity would be provided, were the application granted, would not be compliant with the requirements of the Regulations, in terms of Regulations 12 and 17.

29. From the notice of proposal, Regulation 12 (1) and (2)(a),(b) and (c) states:

'Safe care and treatment

12(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

   a. *assessing the risks to the health and safety of service users of receiving the care or treatment;*
   b. *doing all that is reasonably practicable to mitigate any such risks;*
   c. *the proper and safe management of medicines;'*

30. Regulation 17(1) states:

'Good governance

17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.'

Issues

31. The key question for the Tribunal is whether, as of today's date, the decision to refuse Dr Jaiswal's application to register as the sole registered provider of a number of regulated activities at Broadway Medical Practice should be confirmed or directed to cease to have effect. Does it remain a reasonable,

proportionate and justified decision?

32. We had helpful skeleton arguments from both parties, which we considered in advance of the hearing and as part of our deliberation, as well as the written closing submissions.

The Appellant's position

33. The Appellant's initial grounds of appeal were not pursued by the time of the appeal hearing. At the point of making the appeal, Dr Jaiswal contended that the CQC:

- failed to follow due process;
- carried out an unethical, factually wrong, poorly define and inappropriate investigation;
- communicated poorly and without transparency, leading to the refusal;
- demonstrated prejudice, discrimination and institutional abuse; and
- engaged in victimisation.

34. From the Appellant's skeleton argument, he contended that the CQC:

- failed properly to take into account evidence pointing towards safe practice on the part of the Appellant, as well as steps taken by and or on behalf of the Appellant to remediate issues around medicines management, to identify ongoing risks to the health and safety of service users and to present ongoing risks to the health and safety of service users;
- took into account material which was not capable of supporting the refusal; and
- the decision was unreasonable and disproportionate to the risk of harm made out on the evidence.

The Respondent's position

35. The Respondent contends that the decision to refuse registration was reasonable, proportionate and justified due to the serious concerns regarding the safety of the service and the medicine management practices under the leadership of Dr Jaiswal. The Respondent relies upon the CQC inspections from March 2019 to September 2020 and the inadequacy of steps taken by Dr Jaiswal to demonstrate sufficient improvements.

36. The Respondent submits that Dr Jaiswal demonstrates a lack of insight and accountability by seeking to blame others for the service's failures. In addition, the CQC does not consider that the evidence presented by the Appellant since the decision was made in October 2021 does not show that the Respondent's concerns have been satisfactorily addressed.

Evidence

37. We considered all the evidence that was presented in the hearing bundle and during the hearing. We have summarised the evidence insofar as it relates to the relevant issues for the Tribunal. What is set out below is not a reflection of

everything that was said or presented at the hearing or in the documentary evidence. Each witness who attended to give oral evidence adopted their witness statements and provided further oral evidence. We also had written witness statements from Ms Karen Bowen-Jones, receptionist at both surgeries and Dr Melody Bradley, a locum GP who worked at Weston Coyney and Meir Park from September 2018 until an unknown date.

38. **Mr Shin** explained that he became involved in Dr Jaiswal's application on 18 February 2021. The assessment process uses a range of information, including the applicant's regulatory history (and services associated with the applicant). He stated that the CQC does not recognise 'branch' surgeries and by registering a partnership, the partners do so as a single entity with a single patient list. When Meir Park Surgery was inspected by the CQC, the CQC was assessing both surgeries. Mr Shin held an assessment interview with Dr Jaiswal on 31 March 2021 and confirmed there were no notes from the meeting. The assessment interview is a routine part of the registration assessment which allows the CQC to establish that all of the details on the application are correct and, if there are previous regulatory issues, to understand what is being done about them. During the interview with Dr Jaiswal, he acknowledged there were concerns with the practice, but they had been Dr Sarin's problems. Dr Jaiswal wanted to start afresh. Mr Shin stated that he did not know, at that point, if the CQC considered the conditions imposed as a result of a previous inspection, had been met. He knew the CQC wanted to inspect the services as soon as possible. From his understanding, Mr Shin explained that if the conditions were being met, the CQC would not have been in a hurry to inspect the services. Mr Shin reflected that a key thing that he found quite concerning was Dr Jaiswal's lack of understanding that he, as well as Dr Sarin, was responsible for regulatory activities at both surgeries. He found it strange that Dr Jaiswal was blaming a recently retired partner.

39. Mr Shin stated that Dr Jaiswal was contacted by email and every time Mr Sarin (Dr Sarin's son) would respond on his behalf. The only matters that Dr Jaiswal responded on were that staff grievance and the GMC investigation from 2020. A management review meeting took place on 30 June 2021 and at that stage, the registration team was inclined to approve Dr Jaiswal's application subject to confirmation from the inspection team that the service was improving. The team did not see the GMC matter as having a bearing on its decision nor the grievance matter, as neither matter presented a high risk to patient safety. On 1 July 2021, Mr Shin asked Ms Hancox for her views on service improvement and on 2 July 2021, she sent Mr Shin the incident report from Tesco Pharmacy with regards to ongoing issues with prescription errors from the surgeries. As a result of the incident report, Mr Shin decided, along with his manager, that specialist input was required from the medicines optimisation team. Mr Singh became involved at this point, attending a follow up management review meeting and a follow up meeting with Dr Jaiswal. The inspection team was of the view that the incident report from Tesco Pharmacy demonstrated increased risk from the surgeries and as a result, plans were being considered to carry out a focused inspection in August 2021.

40. Mr Shin decided to hold a focused registration assessment meeting with Dr Jaiswal to give him an opportunity to comment on the incidents. This was considered a necessary step as there was a consensus, from the management review meeting of 9 July 2021, that the service's risk to patient safety had

increased and the potential consequences of the incidents were quite severe. One prescribing incident involved a 13-week-old infant, which could have resulted in a significant overdose/fatality. As a result of this incident, Mr Shin considered that the CQC needed to be assured on the medicines management. Mr Sarin sent documents to Mr Shin, after the set deadline, but before the second registration meeting. Mr Sarin provided documents on 19 July 2021, including the practice's risk control register – which had no changes made to it since it was last provided in April 2021. This was in spite of the incidents raised by Tesco Pharmacy. Mr Sarin confirmed that there had been recruitment in the form of a clinical pharmacist. However, Mr Shin observed that there had been no changes made to the medicines management plan despite the clinical pharmacist being in place. It was difficult to understand what progress had been made. The most recent date Mr Shin had been able to identify was November 2020 and some actions were still ongoing, but there was no sense as to what updates had taken place. As the prescribing issues had been a known concern for a number of years, he considered that they should have been top of the risk register, but there was no information relating to prescribing issues on the risk register. From Mr Shin's perspective, Dr Jaiswal as the clinical lead and now the only clinical lead, should have had oversight of clinical risk and how the service was implementing actions.

41. The second assessment meeting took place on 21 July 2021. The meetings are only recorded with the consent of the applicant. Dr Jaiswal did not consent and provided no basis for not consenting. From the limited information provided by Dr Jaiswal and Mr Sarin at the meeting, Mr Shin did not consider there was an initial assurance measure to minimise prescribing errors. After the meeting, on 23 July 2021, further documents were provided by Mr Sarin. During the meeting, Dr Jaiswal did not appreciate that GP practices required a risk register, which Mr Shin found quite odd. He was baffled that Dr Jaiswal seemed to think that risk registers were not applicable to GP practices. At the time of the meeting, the policies were out of date. Mr Sarin and Dr Jaiswal said they would be updating their policies. Mr Shin was concerned that they did not appreciate that the documentation was out of date and the issues had to be pointed out to them. Mr Sarin explained that there was an improvement plan for the service, but it was managed by an improvement manager who had left and Dr Jaiswal wanted to create a new improvement plan. Mr Shin was concerned that the issues needed to be pointed out to Dr Jaiswal and he did not appear proactive. Mr Sarin provided further documents after the meeting and they did not reassure Mr Shin as he could not be assured that incidents were being followed up with changes to practice and learning and communication with the wider team. There was no record of the actions taking place and changes being made to policy and practice, which led Mr Shin to be concerned about how staff would know about changes to practice. Discussions were not recorded in the documentation.

42. At the meeting, Dr Jaiswal indicated that there had been only one prescribing incident, involving the 13-week-old infant, between April and June 2021. Mr Shin had information that there had been eight incidents as noted in the incidents log. He considered that to be quite a big discrepancy. There was no evidence as to what actions have been taken to improve the situation, including reviewing the incidents and conducting an audit to measure improvement. Overall, Mr Shin was not assured on Dr Jaiswal's level of oversight and his ability to identify and address issues in a proactive manner. He did not consider

that Dr Jaiswal appreciated the risks. As an example, Dr Jaiswal considered the incident involving the infant to be been a 'typo'. Mr Shin did not get a sense of reflection or learning, which he considered said a lot about the approach to improving the service. After the second meeting with Dr Jaiswal and Mr Sarin, Mr Shin did not consider that Dr Jaiswal had the ability to identify concerns and oversee improvements. This concern was compounded by the fact that Dr Jaiswal was applying as an individual, rather than a partnership so Mr Shin had to be assured of his fitness and suitability. Mr Shin confirmed that he had reviewed all of the evidence Dr Jaiswal provided as part of the appeal and it reinforced his view that the service would not be safe.

43. Mr Shin did not accept that the GMC referral formed part of the CQC's consideration of Dr Jaiswal's application. If it had have, it would have been referenced in the notice of proposal. It was the breaches of Regulations 12 and 17 which formed the basis of the decision to refuse. Mr Shin did not recall Dr Jaiswal telling him of a Warfarin audit being undertaken at the time of the assessment meetings. He accepted that the step of employing a clinical pharmacist was a positive step which significantly reduced risk and that is why all GPs are encouraged to employ them. Mr Shin noted that the version of the risk register sent to him by Mr Sarin had a more recent date on it than the version which was exhibited to Dr Jaiswal's statement for the purposes of the appeal. Mr Shin observed that if Dr Jaiswal had so much concern for the competency of Mr Sarin, it was Dr Jaiswal's responsibility to be proactive and act on it.

44. **Mrs Hancox** first became involved with Meir Park and Weston Coyney Surgeries in November 2020, when both Dr Jaiswal and Dr Sarin were still registered providers. Breaches of regulations 12 and 17 had been recorded as of 30 April 2019. Mrs Hancox observed that there was a trend in governance – the provider was not assuring the CQC that all had been done for safe care and treatment within the timescale. By the time of the inspection on 26 May 2020, there was a backlog at the practice as documents had not been tasked and coded onto patients' records to allow health practitioners to access contemporaneous and accurate records for medications and safeguarding. As of May 2020, the pace of the updates to the patients' records and the level of risk required careful monitoring to ensure the CQC could be assured that the systems and processes were in place to review patient care and delivery of care. The CQC was receiving assurances about improvements in risk and had planned to conduct a follow up inspection in January 2021. A condition was in place that Dr Sarin would retire, and Dr Jaiswal would then provide an application to become a sole provider. The CQC understood that Dr Sarin retired on 1 January 2021. Mrs Hancox was not aware of any concerns about Dr Sarin raised by Dr Jaiswal. The CQC was kept updated about caretaker arrangements from the point when Dr Jaiswal was on leave in early 2021, from the CCG, which was providing support to Mr Sarin, while Dr Jaiswal was on leave. Mrs Hancox confirmed that any decision of the CCG to terminate a contract with a provider would impact on their application for registration to the CQC as it would mean that the location would require updating.

45. From Mrs Hancox's perspective, there were trends in the breaches of regulations 12 and 17 – there was insufficient assurance to the CQC about significant event analysis and why continuous errors happened. The key concern was that there continued to be prescribing errors, including one from

Dr Jaiswal, which were not picked up by the practice, but by Tesco Pharmacy and communication between the pharmacy and the CCG that led to errors being picked up.

46. Mrs Hancox confirmed that the CQC was minded to approve the application for registration up until the concerns being raised by Tesco Pharmacy as to concerns with prescribing, which came to the attention of the CQC in June 2021.

47. **Mrs O'Neill** was involved in the decision as to Dr Jaiswal's application in 2021. She explained that she was part of the team that made the final decision. She was invited to make the decision as she was a head of registration. As she is not from a primary medical background and she wanted to ensure that the decision was robust, she invited Dr Boger, as a qualified nurse. Mrs O'Neill wanted to make sure that the CQC was asking the right questions and making the right decision. She explained that once the application comes in, it is validated and then the registration inspector starts the process of gathering information in a fair and propionate way to demonstrate compliance with the Regulations. If information demonstrated a lack of compliance, then the applicant needed to be given an opportunity to respond. She explained that the team became aware of new information after the management review meeting on 30 June 2021. From the information which came in June 2021 (the Tesco Pharmacy incidents), Mrs O'Neill stated that she asked herself – is the governance working? From the new information, it was reflective of the previous regulatory breaches from the previous five inspections. She was concerned that the information came from the CCG and Tesco Pharmacy, rather than from Dr Jaiswal as the applicant, as it would have demonstrated that he was being proactive and he could have provided assurances that action was being taken and that Dr Jaiswal had understood the risks and impacts. Mrs O'Neill observed that the CQC had to request information, setting out what it wanted to review.

48. Mrs O'Neill explained that as a result of the medications errors and the significant event involving an infant, the focused assessment meeting from Mr Shin and Mr Singh was the opportunity to provide assurance. The information that came back, from the meeting, was that no sufficient audits had taken place and the medicines policy had not been reviewed since 2020, even though there had been a significant event from the prescribing error to an infant.

49. Mrs O'Neill did not consider that Dr Jaiswal's Freedom of Information Act request should have held up his ability to respond to the notice of proposal. He could have notified the CQC of the outstanding FoIA request in a holding response, but the CQC did not receive any response at all to the notice of proposal.

50. **Mrs Millar** explained that CCG contracts were issued to practices and in this case, it as a partnership. She stated that quality safety of practices was part of her role at the time in question. The CCG held monthly meetings with the CQC to go through data with them. The CCG had a GP support team, which was a floating practice team that would go into practices and support them. From March 2019 onwards, the CCG had been closely involved with Meir Park and Weston Coyney Surgeries. The CCG's used a clinical director and senior team to review the practice's action plans before submission to the CQC, in light of

the fact that the practice had received ratings of 'inadequate' on two occasions and 'requires improvement' on the third. She considered the relationship between the CCG and the practice to be long term. The GP support team supported the practice between January and March 2021 when Dr Jaiswal was on leave. At that point, the GP in the support team, Dr Neil Saunders, continued to pick up prescribing errors. Mrs Millar's view was that there continued to be issues despite support and she had concerns about the practice's ability to sustain changes and improvements.

51. Mrs Millar stated that governance was very poor. The CCG had provided support to the practice since 2017, as the practice had been listed as a 'red flag' practice and there was a view that the CCG had to support the practice continually as nothing was getting embedded into the practice. A continuous area of feedback was that Dr Jaiswal failed to realise that the issues being raised were his issues as the clinical lead, partner and registered provider. The feedback to the CCG was a lack of accountability from Dr Jaiswal. The clinical recommendation was that the prescribing concerns were so severe that the CCG needed to take immediate action. She explained that it was a very significant decision and observed that in the past eight years of her experience in role, this was the first time the CCG had decided to remove a contract. Dr Jaiswal's appealed the decision, which was upheld at stage 1. He had decided to appeal it to stage 2.

52. Mrs Millar reviewed Dr Jaiswal's incidents of misconduct document relating to Dr Sarin's errors. She explained that a recurring theme of the practice was that they operated as two single practices and so there was no ownership of prescribing errors happening at the other site. She explained that Ms Karen Cartilage, a pharmacy technician, was sent in the practice in 2020 by the CCG. Ms Cartilage was asked to leave because of a disagreement. It was Mrs Millar's understanding that Ms Cartilage was asked to leave as she was carrying out audits and discovering more errors. Ms Cartilage reported her concerns under the duty of candour. Dr James Gilby, another support team GP from the CCG, had concerns about both practices. Until the federation took over, after the CCG decided to cease its contract with the practice, the practice had the highest A and E attendances from patients in the area.

53. **Mrs Boger** confirmed that she is part of the decision-making team where the scheme of delegation denotes that she should be, in her role as head of registration. She was asked to attend the management review meeting by Mrs O'Neill. She was not aware of why she had been asked to attend the meeting until she was in it. She explained that by the time of the meeting on 30 June 2021, there had been a concern about a GMC referral for which more clarity was needed and there was new information regarding prescribing, oversight and leadership. At that point, the CQC wished to gain assurance and to make sure the applicant could demonstrate compliance, which was why a decision was made to hold a second registration assessment meeting with Dr Jaiswal. Mrs Boger stated that she was not part of that meeting, but attended the subsequent management review meeting at which a decision was made to refuse registration due to the lack of assurance about compliance.

54. Mrs Boger explained that the fact of a live referral to the GMC was not a reason to refuse Dr Jaiswal's application. She accepted that there had been delay with Dr Jaiswal's application and some of that delay was in the gift of the CQC to

control. She explained that there were pressures on the CQC at that time and it was difficult to predict as the prioritisation was demand-led. Mrs Boger stated that the CQC would only register services that will deliver safe and competent care. After the focused assessment interview with Dr Jaiswal, there were factors coming out of it which impacted on the final decision. She clarified that if Dr Jaiswal had been subject to interim conditional practice from the GMC, the CQC still would have considered registering him. The GMC referral did not impact on the decision making with regards to the registration application.

55. **Mr Singh** confirmed that he is a pharmacy technician and medicines inspector who works as part of the medicines optimisation team at the CQC. He will often attend inspection, if the support of the medicine optimisation team is requested, which can happen in GP practices depending on the presence of a GP dispenser. From a registration perspective, if there are risks identified relating to medicines, once an application is assessed, then input and advice will be sought from his team. Mr Singh became involved in Dr Jaiswal's application to assist the inspector (Mr Shin) at an assessment interview which took place on 21 July 2021. In preparing for the interview, Mr Singh analysed the previous inspection reports and based the risks on the reports' findings. A key document for the purposes of the interview was the medicines improvement plan, which Mr Shin provided to Mr Singh.

56. The interview meeting took place on Microsoft Teams as a virtual meeting. Mr Singh asked questions of Dr Jaiswal, but Mr Sarin answered most of the questions. It was Mr Singh's expectation that Dr Jaiswal would answer the questions as it was his application. Mr Sarin commented that the medicines improvement plan was put in place by a previous manager and they would like to make a new one. Mr Singh was concerned with that as the medicines improvement plan contained particular actions relating to medicines, including high risk medications and controlled drugs. He was concerned that the medicines improvement plan was being redone, as it did not assure him that Dr Jaiswal would be on track to meet the requirements in the plan. Not since that meeting had Mr Singh received an updated medicines improvement plan. Medicine reviews have to be carried out clinically. In 2019-20, it was identified that there was a lack of pace to the reviews. Mr Singh asked about progress and was informed that there were about 1440 patients who were outstanding of the total of 1600. The patient population for the practices was 6000, so he deduced that about 24% of the patient population had outstanding reviews. He considered that to be a big proportion of the total population.

57. Dr Jaiswal told Mr Singh and Mr Shin that he had employed a clinical pharmacist, working 55 to 60 hours per month. Mr Singh considered that at that pace, it would still take a long time to get through all of the medication reviews, which had been identified as an issue as far back as the 2019 CQC inspection. He explained that the clinical lead and registered provider of the practice must ensure there are appropriate measures in place to offer and conduct the reviews in a timely manner.

58. As to significant events, the expectation was that there would be a thorough root cause analysis and the learning would be shared with the person who made the error and fellow clinicians. There had been an incident of a patient being prescribed 450 mg of Tramadol for more than 30 days. The learning failed to identify that Dr Jaiswal had conducted a conversation with the patient

about the significance of such a prescription, the offer of other options for pain relief and a record of that discussion. This was not recorded in the learning and was not shared with other clinicians. Mr Singh was informed that it was discussed at clinical meetings, but there was no record of it. Mr Singh observed that oversight of controlled drug prescriptions had been identified in previous inspections and formed part of the medicines improvement plan.

59. In May 2020, the inspection report had noted that hospital correspondence was not being actioned appropriately. This continued to be an action in 2021 and the local pharmacy had identified it as an issue. Mr Singh pointed to the incident involving a 13-week-old infant being prescribed 50 times the recommended dose of a medication. He explained that the safety meeting worked, in that the pharmacy picked up on the error, but it would make him very nervous if he had to be hypervigilant in reviewing prescriptions. He noted that the issue had been identified in previous inspections. He explained that in a GP practice, it is the GP or prescriber who is responsible for prescribing and the prescription can then go to any pharmacy, including an online one, to be dispensed. He considered it was not the best possible scenario to rely upon the pharmacist dispensing to check all prescriptions. He explained that from a medicines management point of view, there should be a log of near misses and they should be shared for learning purposes.

60. Mr Singh was concerned to review the risk register provided by Mr Sarin as it made no reference to the medication errors identified by Tesco Pharmacy. Mr Singh asked the question of Dr Jaiswal – do you think the prescribing and medicines management should be on the risk register. He noted there was a pause, the question was then answered by Mr Sarin who said they should be on the risk register. Mr Singh asked him if there was a policy in place in relation to the risk register and Mr Sarin responded that there was no policy. Mr Singh observed that the CQC relies on registered providers to assure it that they can meet the regulatory requirement. He had concerns that there was a risk register in place, but no policy. From his perspective, it would be very difficult for staff to use the risk register without a policy. Mr Singh had seen the updated risk register provided by Dr Jaiswal as part of his appeal. He still considered it to be ineffective without a policy as to how it would operate. Furthermore, he had concerns that Dr Jaiswal's repeat prescription, medicines management and medicines review protocols had not been updated since 21 October 2020. The version he had seen had references to Dr Sarin, who no longer worked at the practices. At the point of the focused interview on 21 July 2021, he asked Dr Jaiswal and Mr Sarin if the staff had read the policies or had them made available and he was told that everything was being revamped and then the staff would be required to read them.

61. Mr Singh was asked about the letter of 5 July 2006 relating to a patient with a chronic pain issue. In his view, as of 2021, 15 years down the line, the patient should have been evaluated again by a consultant and the prescriber should have conducted a review to change the dose or consider other options.

62. **Mrs Kirk** explained that she had worked in primary care and then took on a role learning teams in doctors' surgeries. She explained that she has a degree in practice management and saw her role as supporting staff on a personal level as a manager and in making sure that surgeries are compliant and functional. Mrs Kirk was approached to help Dr Jaiswal with his surgeries. In preparing for

the role, which she started on 16 May 2021, she read the recent CQC reports. She attended a clinical supervision group meeting and said that feedback from the nurses was that they would not work at Meir Park as it was unsafe. She met with Mr Sarin and Mr Ross Harrison at Meir Park. They thought she could help to make things safe. At that point, Mrs Kirk did have slight reservations about Mr Sarin. He explained to her that there was an ongoing investigation and he felt that an independent person coming in would help. By May 2021, there were no nurses working at the practice and they were not able to deliver their contract requirements. Mrs Kirk spoke to Dr Jaiswal after the meeting and decided she would take on a role for three months to see if she could make a difference. She noted that there was a huge variation between the two sites. She went into the practice to run a clinic on the Friday and wanted to know about the emergency drugs. She could not gain access to the emergency drugs cupboard at Meir Park. Eventually, the key to the cupboard was provided and she noted that several items were out of date. She did a full drug check and asked to see the policies in place. Dr Jaiswal had ensured there was a policy in place. He asked her to review the policy and see if anything had to change. She noted that Meir Park's management of drugs was quite unsafe and at Weston Coyney all was present and correct.

63. Mrs Kirk managed to recruit an advanced nurse practitioner to start within one month of coming on board. She discovered that staff did not have the right qualifications at Meir Park, mandatory training was not up to date, there was a need for a new policy for emergency drugs and improved safety netting. She discovered that a health care assistant was working outside of her area of competence. She was able to see that Dr Sarin had prescribed medications and not reviewed them when he said he would. Mrs Kirk found Dr Jaiswal to be very proactive in making sure the surgery was safe and effective as he wanted things done correctly. She explained that she met once a week with Dr Jaiswal. Mrs Kirk agreed with Dr Jaiswal to approach a nurse who had previously worked at Meir Park to see if she would come back. She had agreed to return, but then withdrew her offer. When she started, there were no meetings and Mrs Kirk put monthly meetings in place. She explained that there was a business manager in place in Mr Sarin, but he was never on site and was never available. Mr Sam Dowling started in June 2021 and by then processes were being run safely, but Mr Dowling was removed when the CCG contract was terminated. Once the federation was put in place to run the surgeries, Mrs Kirk tendered her resignation as she did not think it was safe. Mrs Kirk observed that Dr Jaiswal put his trust in people when he shouldn't have. She cited Mr Sarin and said he did not have the skills to run the practice. Her final day was 26 July 2021.

64. Mrs Kirk confirmed that Dr Jaiswal focused her work on Meir Park, which she thought was unsafe and clearly in need of help. Dr Jaiswal never attended Meir Park. She thought that Mr Sarin was not capable and could not be contacted when he was needed. It was apparent to her from her short time at the practice – the issues with Mr Sarin and his performance were quite clear. There also appeared to be a relationship between Mr Sarin and the healthcare assistant who had been working outside of her competence. It appeared to Mrs Kirk that Mr Sarin was letting the healthcare assistant do things which she wasn't qualified to do. She updated policies and sent them to Dr Jaiswal to be cascaded to staff. Mrs Kirk was not aware of the details with the Tesco Pharmacy incidents, but was aware that Tesco Pharmacy had raised concerns.

She was aware of an event with a drug, but that it had not been dispensed. She explained that the population at Meir Park was quite elderly and it was a big task to start to review them. As an example, she found one female patient who was over the age of 70 and still receiving HRT medication. A legacy of issues were still coming to the fore during her time. She also noted that patients were receiving opiates for long periods of time, which caused her concern.

65. **Dr Jaiswal** observed that there was a lot of pressure for smaller practices to merge with bigger practices. For a time, Dr Jaiswal was working as a sole registered provider. Dr Sarin was also working as a sole registered provider at Meir Park as his partner had left the practice, as had Dr Jaiswal's (upon retiring in around 2016). Dr Jaiswal explained that he applied with Dr Sarin for permission to merge the practices. He didn't realise the extent of the issues at Meir Park. Dr Sarin never divulged anything and kept it really quiet. He said that he knew now that when you have a good practice and a bad practice, you should never allow a merger to go ahead. Dr Jaiswal felt that Meir Park should have been made to come up to scratch before the merger was approved. He said that he looked at the finances of Meir Park and its previous CQC inspections. At the beginning, Dr Sarin said not to worry and he promised everything. Looking back on it, Dr Jaiswal felt that he was desperate to find someone to merge with his practice. Every time Dr Jaiswal came across a concern, he explained 'we' would try to highlight it with Dr Sarin and he would always get angry about it, become defensive and make excuses. He explained that there was a bizarre system of seeing patients at Meir Park – there were not pre booked appointments and patients had to queue every morning. Dr Jaiswal found it difficult to look in the notes of patients at Meir Park as there were no codes and a lot of controlled drugs were being prescribed – such as Zopiclone and Diazepam. Dr Jaiswal understood that he was also legally accountable for Meir Park but Dr Sarin was not listening and not implementing changes. He observed that staff at Weston Coyney often asked why they had merged with Meir Park. We explained that Weston Coyney was trying its best to instigate changes but was met with resistance from Dr Sarin and Mr Sarin. In 2019, Dr Jaiswal discovered that Mr Sarin was logging on to complete mandatory training – as his father and other members of staff.

66. Dr Jaiswal saw whistleblowing as a last resort. He thought that the CCG was so inept and thought that the CQC would pick things up and stimulate change. Dr Jaiswal collected a lot of data on Dr Sarin and emailed it to the CCG – in May 2020. The CQC found general concerns about prescribing, which Dr Jaiswal said he accepted as there was no process in place for medication reviews. Dr Jaiswal met with the CQC in May 2020 to highlight the issued with Meir Park. Meir Park received breach notices, but nothing changed. The issues were flagged with NHS England – this was taken forward by Dr Jaiswal, Dr Saunders and Mr Sarin. As a result of NHS England's concerns with Dr Sarin, a decision was made that Dr Sarin would retire from the Medical Performers List at the end of 2020.

67. Dr Jaiswal made his application to register Broadway Medical on 9 December 2020, as a sole registered provider. His plan was to make the practices more stable and then to bring in another partner, but he understood it would be a challenge and he made this clear with the other doctors on the staff. He agreed with Mrs Kirk's observation that to a certain extent Meir Park had been 'blacklisted' by potential staff. From his point of view, he was forced to be a

sole provider for a period of time. In his previous experience, the application process had taken two to three weeks and he thought he would have sufficient time in putting it in on 9 December, in time for Dr Sarin's retirement at the end of December. Dr Jaiswal did not think that the legacy planning had been robust – to make it robust, there was a need for salaried doctors and another partner.

68. At the beginning of 2021, Dr Jaiswal stated that he contracted Covid-19. He had a meeting with the CCG when he returned, later in January 2021 and he felt that the CCG hijacked the meeting by asking him about a grievance raised by a staff member. The CCG wanted Dr Jaiswal to step back until the grievance was resolved and it also wanted Dr Jaiswal to undergo a health assessment. It transpired that the grievance involved a healthcare assistant who had been at the surgery for a number of years. Mr Sarin had approach Dr Jaiswal about Mr Sarin becoming a non-clinical partner and Dr Jaiswal refused as he did not consider Mr Sarin to be reliable. The grievance was duly investigated and not upheld. Dr Jaiswal considered that Mr Sarin had provided misleading information as part of the grievance. The healthcare assistant appealed the decision, but it was upheld. Dr Jaiswal was also dealing with a further allegation made to the GMC by his ex-wife, as well as divorce proceedings. Ultimately, Dr Jaiswal completed an occupational therapy assessment and returned to work at the practices on 10 March 2021.

69. He wanted to progress things quite rapidly and wanted to identify all of the legacy issues which needed to be tackled. He brough in a clinical pharmacist but she only stayed for three weeks and left at the end of 2020. He had brought in Ross Harrison as a practice management consultant in February 2021. He employed Ms Ruby Sandhu in May/June 2021 as a clinical pharmacist to help with the medication reviews. Dr Jaiswal wanted to recruit an operations manager to train up as a business manager to work across both sites, instead of Mr Sarin. He employed Ms Sam Dowling, with a view to her taking on that role with training from Mr Harrison and hoped that Mr Sarin might get a role elsewhere. Dr Jaiswal managed to bring in other staff members, including three/four doctors as locum/salaried GPs, as well as Mrs Kirk and an ANP, brought in by Mrs Kirk. As Dr Jaiswal saw things, he had so much support in place and he was reassured that something was going to get done. Dr Saunders, from NHS England, appeared quite happy with the progress being made.

70. Dr Jaiswal explained that the CCG was forcing him to use its pharmacy technician (Ms Cartilage) and GP (Dr Saunders). He felt that it was to catch the practice out. Dr Jaiswal stated that the risk register was a work in progress, and he considered it to be a basic task for Mr Sarin to do in his area of competence. Dr Jaiswal said he took responsibility for the issues with the risk register as he should have inspected it and checked it. Dr Jaiswal pointed to the number of policies created and signed off in 2020.

71. He explained that he had no concerns with the way in which medications were prescribed at the practices. He explained that the neonate (13-week-old infant) had been subject to a typo error, but the medication was never dispensed. He explained that it was an error on his part and he spoke to the infant's mother who was sympathetic. He asked all admin staff to check the medications. He explained that he held a meeting with the clinical staff too. He held a meeting with the lead clinician of Tesco Pharmacy and they agreed to hold a teaching

day. It was an issue of communication.

72. By the time the CCG removed the contract, the level of safety between the two practices was very good. He considered the practices to be pretty well run by the time Mrs Kirk had arrived and made further changes.

73. Dr Jaiswal explained that he thought it was sufficient to look at the overviews for three CQC inspection reports concerning Meir Park before the merger. He noted the ratings of 'good' then 'requires improvement' and then 'good'. He thought it was more about the people you work with as things would crop up at every practice. Dr Sarin was a friend of Dr Jaiswal's father He had no idea of the extent of the issues before entering the merger. He had seen the queue of people outside the practice as his parents lived nearby and he would see the queue when he drove by, but he did not ask about it. He accepted that in retrospect, his due diligence should have been better. He accepted he was jointly responsible for both practices and accepted that Meir Park had been inspected five times within an eighteen-month period.

74. Dr Jaiswal recalled that when the inspection report of March 2019 (with a rating of 'inadequate') was published, the practice was placed into special measures at that point and he recalled, as far as he could remember, going through the report with Dr Sarin, Mr Sarin and Ms Julie Shaw. He accepted that at the time of the inspection of 4 November 2019, the rating was 'requires improvement and the practice was in breach of Regulations 12 and 17. He felt that he kept on meeting resistance from Meir Park and that is why he raise his concerns with the CCG in May 2020 – the examples of misconduct.

75. Dr Jaiswal attended the CQC inspection in May 2020, at the beginning, and then went back to his practice, as he decided to leave it in Dr Sarin's hands. He accepted that the concerns in the CQC inspection reports went deeper than the examples of misconduct Dr Jaiswal raised with the CCG in May 2020. He explained that there was no single document which pulled all of the actions and improvements together after the May 2020 CQC inspection. Dr Jaiswal said that he detached himself from Meir Park as he was getting shouted at by Dr Sarin. When Dr Sarin retried, the practice was less risky and in Dr Jaiswal's view, safe care and treatment was being provided at Meir Park by January 2021.

76. Dr Jaiswal explained that he had a lot going on by April 2021 so he just left communication with the CQC to Mr Sarin. Dr Jaiswal only responded directly when the emails concerned the grievance raised against Dr Jaiswal. Dr Jaiswal explained that he did not visit Meir Park once due to the grievance and thought it was best to stay away. He left it to Mrs Kirk and she would feed back to Dr Jaiswal about the plans.

77. Dr Jaiswal was taken aback by the request to record the meeting of 21 July 2021. He did not take any notes during the meeting and saw the meeting as an opportunity to demonstrate compliance. He left the responses to Mr Sarin as the manager and felt it was his role to respond when the questions were clinical. Dr Jaiswal had left the updating of the plans to Mr Sarin but the plans were not being updated as he had thought. Dr Jaiswal accepted that he had significant concerns about Mr Sarin and he had no second line oversight of the documents. Dr Jaiswal had not completed his audit by July 2021 as there had

been a huge amount of meetings. He was doing case reviews and recoding issues he was identifying and kept on finding a pattern, but there was no provision in place for trend analysis. He accepted that the approach to significant event reviews was not recorded anywhere.

78. Dr Jaiswal explained that Mr Sarin had not added all of the actions to the risk register and that he had discussed this with Mr Sarin, but did not check it with him. He explained that practice meetings were taking place with Ms Shaw and Mr Sarin and then the risk register was updated. The risks were discussed at the meetings. Dr Jaiswal accepted that he was not happy with the risk register – it was missing the incident with the infant – that should have been recorded.

79. He explained that he did not check any of the documents before Mr Sarin sent them to the CQC. He was not sure if a governance strategy had ever been completed. He couldn't say if he had looked at the CQC document 'guidance for providers on meeting the regulations'. He accepted that documents were incomplete and accepted that he did not visit Meir Park between 10 March and 26 July 2021 as he felt it would have been awkward to go there due to the grievance.

80. Dr Jaiswal explained that if his appeal was successful, he would plan to keep Mr Sarin in place until he had managed a handover with a new business manager brought into post. He accepted that he could have worked on documentation, including, updating the risk register.

The Tribunal's conclusions with reasons

81. For the reasons set out below, the Tribunal has concluded that the appeal shall be dismissed because the Appellant has failed to prove, on the balance of probabilities, that he was complying with and would continue to comply with Regulations 12 and 17 of the Regulations. In turn, we have found that the decision to refuse his application to register as a sole registered provider for Broadway Medical Practice is a proportionate one.

82. In considering the proportionality of the decision, we considered that the fresh determination we are required to undertake, as at today's date, allowed us to carefully consider a number of points made by Dr Jaiswal in his concerns about the CQC's decision making. These concerns included: the amount of time it took the CQC to reach its decision on his registration application, the factors it took into account, the fact that Dr Jaiswal did not send written representations after he received the notice of proposal and the level of seriousness it attached to the regulatory history of Meir Park, in particular.

83. We found all of the witnesses called by the Respondent to be credible and consistent with the evidence in their witness statements. The witnesses were realistic in their evidence, making it clear that up until the point when the Tesco Pharmacy incidents came to light, there had been a general view that Dr Jaiswal's application could be approved. The position changed as a result of the focused assessment interview on 21 July 2021 and the Tribunal accepted the evidence as to why the position changed.

84. We understand that this decision will be extremely disappointing to Dr Jaiswal. We make it clear that we heard and read relevant evidence which demonstrates

that there are no concerns whatsoever with Dr Jaiswal's ability to practise as an effective and competent GP. He is not subject to any fitness to practise findings. No element of the grievance raised against him in the early part of 2021 was upheld. This decision carries no reflection on his clinical abilities or his integrity as a practising GP. The decision is made in the context of Dr Jaiswal being able to demonstrate that it is more likely than not that he did and will continue to comply the regulatory requirements which are placed on a registered provider. We were not able to conclude that Dr Jaiswal had discharged the evidential burden he carried in this appeal as we were not persuaded that he would be able to demonstrate compliance with Regulations 12 and 17.

Dr Jaiswal's leadership and accountability

85. The Tribunal found Dr Jaiswal's approach to leadership and decision making was of concern. Dr Jaiswal accepted that he had not carried out adequate due diligence before making the decision to merge with Dr Sarin's practice to become Meir Park and Weston Coyney Medical Practice. He read the overviews of the CQC inspection reports into Meir Park Surgery and decided to put his trust in the people and based on his father's relationship with Dr Sarin. In the Tribunals' view, this was the beginning of a pattern of insufficient curiosity and reassurance about a service for which he carried regulatory responsibility in his role as a jointly registered provider.

86. The Tribunal found it surprising that at the points when Meir Park Surgery was being inspected by the CQC during a period of 18 months, starting in March 2019 with a rating of inadequate, Dr Jaiswal had left the process to Dr Sarin and Mr Sarin. He attended one CQC inspection at the beginning and then left. He did not engage with the other CQC inspections. This did not give the Tribunal confidence in his ability to demonstrate good governance when even at the point at which Meir Park Surgery was subject to a number of regulatory interventions due to breaches of Regulations 12 and 17, Dr Jaiswal did not consider it appropriate that he take an active role in the inspection process, to reassure himself of how Meir Park Surgery was being run. At all times, Dr Jaiswal demonstrated an acceptance of his regulatory and leadership responsibilities in relation to the Meir Park site. As a matter of effective leadership and to demonstrate good governance, the Tribunal would have expected Dr Jaiswal to have taken an active role in providing oversight to Meir Park and ensuring compliance with the Regulations. It was clear to the Tribunal that the two sites were run as separate practices with different governance and procedures.

87. The Tribunal found it significant to note that Dr Jaiswal was not sure if he had ever read the CQC's 'guidance for providers on meeting the regulations', a copy of which was in the hearing bundle. This did not give the Tribunal confidence that Dr Jaiswal would be able to comply with the Regulations if his registration was approved.

88. At various points in the hearing, Dr Jaiswal sought to lay blame with Mr Sarin. The Tribunal found this concerning. By the point of early 2021, on his own account, Dr Jaiswal did not consider that Mr Sarin was competent in his role, to such an extent that Dr Jaiswal would not agree to Mr Sarin's offer to become a non-clinical registered provider. In spite of this, Dr Jaiswal allowed Mr Sarin to

take the lead on communicating with the CQC in relation to Dr Jaiswal's application to become a sole registered provider. The Tribunal did not hear an adequate explanation as to why Dr Jaiswal thought it was an acceptable approach to have Mr Sarin submit documents which the CQC wished to review in order to reassure itself as to Dr Jaiswal's suitability to be registered as a sole provider. Even more surprising was that Dr Jaiswal did not review any of the documents before they were submitted. Dr Jaiswal was able to accept, in oral evidence, that the documents were inadequate. He appreciated that the risk register was not updated and not accurate, even at the date of the hearing. Even at the date of the hearing, the risk register still did not contain, as a risk which needed to be addressed, the significant event of an infant being prescribed 50 times the recommended dose of a medication and the significance of that typographical error being left to the dispensing pharmacy to pick up. The Tribunal noted that the risk register attributed nearly every risk, as an owner, to Mr Sarin, an individual who, by the time of meeting with the CQC in July 2021, Dr Jaiswal did not consider to be a competent and effective business manager. At that point, Dr Jaiswal had also come to the conclusion that Mr Sarin had provided misleading information as part of the earlier grievance investigation. Furthermore, Mrs Kirk had identified Mr Sarin's lack of competence in his post within a short space of time of working at MPWC – from 16 May to 26 July 2021. In spite of all of these known issues with Mr Sarin, Dr Jaiswal left the updating of the risk register and the management of the risks (and mitigation of them) to Mr Sarin. This was a role which Dr Jaiswal should have taken on actively in order to reassure himself, as the registered provider, that there was proper recording of all issues, a timeline for actions and that the actions were being completed. Dr Jaiswal's lack of involvement in the process contributed to the Tribunal's conclusion that he could not demonstrate compliance with Regulations 12 and 17 as at the date of the hearing.

89. Furthermore, the Tribunal found it deeply concerning to hear from Dr Jaiswal, in his oral evidence, that if his registration as a sole provider was approved, he would place Mr Sarin back in post as the business manager in order to provide a handover at the point when a new business manager was recruited. This did not give the Tribunal any reassurance that Dr Jaiswal would be able to lead the service effectively and in keeping with the requirements of Regulation 17.

90. The Tribunal accepts that Dr Jaiswal notified the CCG of concerns he had with Dr Sarin's prescribing practices in May 2020. However, the Tribunal was not persuaded that Dr Jaiswal was able to demonstrate sufficient evidence to support a conclusion that he understood the breaches of the Regulations apparent from the CQC inspections of Meir Park Surgery and had formulated a plan for how he was going to improve the service to bring it into compliance. This conclusion is supported by the fact that Dr Jaiswal continued to take responsibility for Weston Coyney Surgery as clinical lead and the two sites were effectively operated independently of one another until such a time as Dr Sarin agreed to retire. The decision to effectively work separately even whilst Dr Jaiswal continued to carry regulatory responsibility for Meir Park Surgery did not reassure the Tribunal that Dr Jaiswal would be able to demonstrate compliance with the Regulations if operating as a sole provider for both sites.

91. The Tribunal found it concerning that Dr Jaiswal did not take any of his own notes during the meeting with Mr Shin and Mr Singh on 21 July 2021. By that point, he was aware that the CQC had received an incident report from Tesco

Pharmacy which set out a number of prescribing concerns about MPWC. It would have been reasonable to take notes, particular given that Dr Jaiswal did not wish to have the interview recorded. Furthermore, the Tribunal found if of concern that even in that interview, which was to consider his application for registration, Dr Jaiswal allowed Mr Sarin to take the lead in answering most of the questions. This combined with Dr Jaiswal's own account that he allowed Mr Sarin to send documents to the CQC on his behalf without checking them first led the Tribunal to conclude that Dr Jaiswal was not demonstrating an ability to comply with the requirements of good governance as he did not appear to have effective oversight of the service.

92. The Tribunal noted the evidence from Dr Jaiswal that by the point when Dr Sarin retired, he considered that Meir Park was being run 'pretty well'. The Tribunal was not able to find that it was and finds Dr Jaiswal's perception of how the service was being run to be unpersuasive. Mrs Kirk, who was called as a witness in support of Dr Jaiswal's appeal, provided evidence about the unsafe practices which were in place at Meir Park Surgery when she started in post on 16 May 2021, approximately two months prior to Dr Jaiswal's interview meeting with Mr Singh and Mr Shin and some five months after Dr Sarin had retired. At that point, she was unable to gain access to the controlled drugs cupboard for a period of time and when she did, she found expired drugs. Furthermore, she found that a health care assistant had been working outside her area of competence. It was significant to note that these issues were discovered some five months and more after Dr Sarin had retired and at a time when Dr Jaiswal thought the service was operating pretty well. Mrs Kirk's evidence did not, in the Tribunals' view, support the perception Dr Jaiswal had of the service. She had a better understanding of it, as after all, she was attending the service directly and on Dr Jaiswal's evidence, he had not been attending the service at all due to his concerns about the grievance. The Tribunal did not find the reasoning on this convincing. Dr Jaiswal could have attended the service outside of core working hours, if he had concerns about meeting the member of staff who had raised a grievance against him. Instead, he relied upon Mrs Kirk's attendance at the service, which, given his role in across MPWC, was not a sustainable approach to take. By that point in the application process, Dr Jaiswal should have been engaging in proactive and direct oversight of the improvements that he required. The Tribunal did not consider he was and the evidence points towards Dr Jaiswal's not understanding the direct line of accountability he had for ensuring the implementation of improvements and assuring himself that the improvements were embedding.

Compliance with Regulations 12 and 17

93. It was the evidence of all CC witnesses involved in the decision-making process relating to Dr Jaiswal's registration application that the evidence from Tesco Pharmacy was highly significant. Prior to that, the Respondent had been inclined to grant Dr Jaiswal's application.

94. At a number of points in his evidence, Dr Jaiswal did not appear to take issue with the issues raised by Tesco Pharmacy. The Tribunal accepts that he did not agree with the issues that were being identified by Ms Cartilage. However, Dr Jaiswal appeared to accept that Tesco Pharmacy had raised a number of concerns about medicines management and prescribing processes at MPWC. Some steps were taken by Dr Jaiswal in response to the concerns, in the form

of a 'practice learning events' log. However, the Tribunal found that the document was an inadequate response to the issues raised, which were issues previously raised as part of the CQC inspections of Meir Park Surgery. Dr Jaiswal accepted that he had not completed any root cause analyses to identify learning points – something Mr Singh would have expected to see. There were no policies in place for the updating of the risk register or the 'practice learning events' log. There were no records to demonstrate that staff knew about the documents and knew how to update them. The Tribunal was not provided with any evidence of audits undertaken to demonstrate quality assurance and to show how improvements were identified and implemented across the practice. This did not reassure the Tribunal that Dr Jaiswal would be able to comply with the requirements of Regulation 12, against a regulatory backdrop of service which has been unable to demonstrate sustained compliance with Regulation 12 since 2019.

95. The management of the significant event involving the overdose in the prescription for the infant demonstrated a lack of proper oversight and assurance as to future risk to safe treatment and care of patients. Dr Jaiswal accepted that the incident was not recorded on any versions of the risk register which were before the Tribunal. Not only that, but the significant incident report for the event recorded only one action, which was a hospital letter review for all patients under the age of five. There was no evidence that such a review took place. Furthermore, other actions were undertaken which were then not recorded in any of the records generated in response to the significant event – such as the telephone conversation with the infant's mother. This did not provide sufficient assurance to the Tribunal that Dr Jaiswal would be able to comply with the requirements of Regulation 12.

96. The documentation presented by Dr Jaiswal as part of the appeal hearing was still not up to date and accurate. This was the position with the risk register and the medicines management improvement plan, which had last been updated in April 2021 and which was deemed inadequate by Mr Singh during the assessment interview meeting in July 2021.

97. The documentation provided by Dr Jaiswal to demonstrate that he would comply with Regulations 12 and 17 was not sufficient, even at the point of the appeal hearing. The risk register remained out of date and Dr Jaiswal accepted in evidence that there was nothing to stop him from updating the risk register for the hearing or at any point during the appeal process. The same can be said for the governance strategy, which was not in place by the point of the hearing and which Dr Jaiswal accepted had not been completed by its target date. He accepted that the updates to the documents would have assisted the Tribunal in making its decision. This was a significant omission on the part of Dr Jaiswal as it would have gone some way to demonstrating a commitment to complying with the requirements of the Regulations and an intention to comply as a registered provider of a service with an inconsistent regulatory history.

98. Furthermore, it was apparent that at no point during the application or appeal process had Dr Jaiswal taken the time to draft a strategy to show how he was going to reach compliance and sustain compliance at the service. A document such as this would have been a significant, positive step to provide the Tribunal with reassurance about his ability to comply with the Regulations. The lack of such a document, compounded by the reliance on Mr Sarin at various points,

including at points when Dr Jaiswal did not consider him competent in his role and Dr Jaiswal's lack of understanding about the regulatory requirements led the Tribunal to conclude that it was more likely than not that Dr Jaiswal would not be able to comply with Regulations 12 and 17 of the 2014 Regulations.

99. In terms of proportionality, we considered if there were any conditions which could be formulated to enable Dr Jaiswal's registration, whilst also taking into account the public interest in the promotion of the health, safety and welfare of the people who use health and social care services and the Respondent's ability to fulfil its registration functions. Given the wide-ranging nature of the Tribunal's concerns with Dr Jaiswal's ability to comply with the regulations and his understanding of his accountability, we do not consider that we could formulate appropriate conditions to provide the required level of assurance as to risk.

Decision

The appeal is dismissed.

Judge S Brownlee

First-tier Tribunal (Health, Education and Social Care)

Date issued: 19 December 2022