Care Standards

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

Heard on the papers on 26 October 2018

[2018] 3490.EA-MoU

Before

Hugh Brayne (Judge)

Denise Rabbetts (Tribunal Member)

Pat McLoughlin (Tribunal Member)

Dr Silvasailam Submarony

Appellant

V

Care Quality Commission

Respondent

The appeal

1. Dr Subramony is referred to in this decision as "the appellant" and the Care Quality Commission as "the respondent". References section numbers are to sections within the 2008 Health and Social Care Act. References to regulations are to regulations within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
2. The appellant was registered with the respondent on 1 April 2013 under section 31 as a provider of the following regulated activities at Medina Medical Centre, 3 Medina Road, Luton, Bedfordshire LU4 8BD: diagnostic and screening procedures; maternity and midwifery services, surgical procedures, and treatment of disease, disorder or injury. We refer to Medina Medical Centre as "the Centre".

3. The respondent suspended the appellant's registration on 27 September 2018 under the powers (see below) set out in section 31. The suspension runs until 27 January 2019.
4. The Appellant appealed to the Tribunal under section 32 on 14 October 2018.
5. The appellant requested in his appeal application a hearing without oral evidence (Rule 23 The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008. Judge Khan ordered a hearing on the papers in directions issued 16 October 2018. The present panel considers it appropriate, and in accordance with the overriding objective of fairness and justice, to consider this appeal on the papers.

The legal framework for suspension

6. Section 31 Health and Social Care Act 2008 provides as follows:

Urgent procedure for suspension, variation etc.

(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.

7. The Regulations set out a number of important requirements with which a registered provider must comply. They identify fundamental standards which must be met. The most relevant regulations to this case are Regulation 12, Safe care and treatment, and Regulation 17, Good governance.
8. Under section 32(5) the Tribunal may either uphold the suspension decision or direct that it shall cease to have effect.

The respondent's case for suspension

9. Most elements of the respondent's case have not been disputed by the appellant, so we do not set out the evidential basis for those factual elements. Where a matter is factually disputed, this is shown in our summary of the appellant's case.
10. The respondent carried out an unannounced inspection on 24 August 2018, following which it decided to carry out a further inspection, which took place on 4 September 2018.
11. The respondent's inspectors inspected the Centre a third time on 20 September 2018. Michele Golden, the respondent's Head of Inspection, wrote to the appellant the following day setting out eight areas of serious concern. These, summarised, were the following:
    1. Failing to carry out appropriate investigation of a patient on treatment for prostate cancer, the patient later being admitted with metastatic prostate cancer.
    2. Failing to take action where a patient's blood pressure was high and, where the patient was claimed by the appellant to have refused prescribed medication, failing to take steps to record blood pressure and keep it under control.
    3. Unnecessary delays in getting an urgently-needed referral to a renal specialist where a significantly abnormal renal blood test result had been obtained.
    4. Failing to provide clinical oversight, evidenced by the failure by a responsible clinician to review in a timely manner abnormal monitoring results obtained during an asthma review.
    5. Failing to do proper checks before engaging staff who acted as chaperones.
    6. Failing to provide adequate equipment and training for staff, and to show ability to deal with medical emergencies, evidenced by staff not feeling confident to identify a sick patient in the waiting area and not having a paediatric oximeter.
    7. Failing to ensure safety of people on the premises, evidenced by absence of risk assessments for fire safety and related issues.
    8. Failing to provide co-ordinated practice management, evidenced by the absence of a practice manager and steps to ensure the practice was appropriately managed.
12. The appellant was required to provide documentary evidence, by 3 pm 24 September 2018, to demonstrate that the risks had been, or would imminently be, removed.
13. The appellant's written response is dated 23 September 2018. In relation to the eight concerns in the respondent's letter of 21 September he said (we summarise) the following:
    1. The doctor who had started this patient's [prostate cancer] treatment had left the practice and the appellant could not discuss with her why she had not followed best practice guidelines. The appellant had been on sick leave for three months during this period. The appellant assumed

from patient notes that this was a new patient already prescribed the treatment from his former GP. The notes showed that the patient thought he was receiving medication for urinary problems. The appellant did see this patient himself later, the patient complaining of various pains; the appellant had suspected a hip fracture, and referred him to A & E for an urgent X ray. The appellant had learned from this incident and circulated an updated protocol to staff.

2. This patient was on medication for blood pressure and the patient's daughter-in-law had been advised to ensure the patient took her medication. Two review appointments had been set up and not attended. The nurse [in the practice] had felt the family was supporting the patient's needs. The practice had now updated its policy for DNAs (did not attend).
3. The patient was in hospital at the relevant time, and the blood test had been requested by the hospital, so the Centre had not received the result. The hospital would have been expected to organise the necessary follow-up after discharge. The practice had now reviewed its system for reviewing blood test results.
4. This patient (the asthma patient) could not be found from the reference provided by the respondent.
5. These documents had been stolen. The new practice manager had been instructed to do DBS checks for all staff. Staff had undertaken chaperone training, but until reception staff had been trained the practice nurse would do all chaperoning. The Centre's recruitment procedures covered interview notes etc.
6. The outgoing practice manager had failed to follow up the CCG's provision of paediatric pulse oximiters, but two had been ordered and were to be delivered the next day. Staff training certificates had been stolen but were being replaced. The appellant referred to recent or forthcoming training provision including training on CPR, asthma and diabetes.
7. Risk assessments had been taken by the previous practice manager. Fire Safety Services had been contacted and a date for them to attend to carry out a risk assessment was awaited. A company had been instructed to help with health and safety and HR. They would attend on 25 September to carry out a risk assessment on the building.
8. The appellant had liaised closely with the Clinical Commissioning Group (CCG) on identifying management support from an experienced practice manager. The interim practice manager had worked for 16 years at the surgery and knew admin and reception procedures and all of the duties. She had gaps in relation to practice finance and claims, and EMIS [patient records] training. Other practices were known to promote internal staff to management responsibilities.

14. The appellant's response was not felt by the respondent to provide evidence that sufficient action had been taken to provide the required assurances. Following meetings with key stakeholders (see paragraph 14 of witness statement of Vicki Wells, Head of Inspection for General Practice for the respondent) the respondent concluded that the breach of condition 12 remained

"high" and the breach of condition 17 "extreme". A decision was taken to suspend the appellant under section 31. According to paragraph 16 of Ms Wells' statement, the option of imposing conditions was not thought appropriate because the appellant had shown a lack of insight and a lack of appropriate leadership, resulting in patients being at risk of harm.

15. The respondent's notice of decision, dated 27 September 2018, set out 12 grounds, which we summarise as follows:

    1. In relation to starting the patient referred to above on prostate cancer treatment without taking appropriate steps to clarify the diagnosis, the appellant's response had not set out how he had changed or would change the clinical practices to ensure necessary checks and examinations would be carried out. Until that was done the respondent had reasonable grounds for believing patients were being exposed to risk of harm.
    2. In relation to the patient with the high recorded blood pressure referred to above, the appellant had explained what had happened in that specific case but not provided details of changes to policy or system that had been made. Until such changes were made there were reasonable grounds for believing patients were exposed to risk of harm.
    3. [In the decision letter this paragraph relates to point 2 above, and we mention this only to retain the original numbering.]
    4. In relation to the incident where an abnormal monitoring reading had been taken during an asthma review, the appellant had explained what had happened in that instance but had not shown why a timely review was not scheduled routinely with the responsible clinician in such situations. The absence of such policy and system changes provided reasonable grounds for believing patients were put at risk.
    5. In relation to failures to carry out checks on staff acting as chaperones, the appellant had initiated steps but until these were complete for all staff there were reasonable grounds for believing patients were being put at risk of harm.
    6. (A matter not raised in the letter of 21 September 2018) during the inspections of 24 August and 4 September 2018 the appellant had failed to provide up-to-date records of skills, qualification and training of staff, or evidence of arrangements for appraisal and career development. Particular areas of concern were the absence of records of role-specific safeguarding training and Mental Capacity Act training for relevant staff, including the appellant himself. There was no evidence of the experience or competency of the interim practice manager. Until adequate systems and processes were in place there were reasonable grounds to believe patients were exposed to risk of harm.
    7. A number of failures to assess risk in relation to fire and other safety issues had been identified. The appellant had said he had arranged fire safety risk assessments but not provided a date for this. He had planned a comprehensive health and safety assessment for 25 September. Inspections had not found risk assessments for cleaning and other hazardous products; a legionella assessment had been carried out by a person not shown to be suitably competent, was not dated, and did not

specify any actions to mitigate risk; the business continuity plan of 20 September was incomplete (no alternative premises identified for use in an emergency, and no emergency or other relevant phone numbers); there had been no evaluation of services against the requirements under the Equality Act 2010 in relation to disability, and problems were identified in relation to on-site parking, absence of communication aids, and access to upstairs consulting rooms. Until systems and processes were in place to ensure the premises were fit for purpose and safe, there were reasonable grounds for believing patients were exposed to risk of harm.

8. The appellant had not implemented a systematic approach to infection prevention and control. Problems identified in inspections were carpeting throughout (other than in the nurse's room); floor tiles in the corridor which were cracked and could harbour infectious organisms; chairs which were of a fabric type, except first floor waiting room chairs which could be wiped clean; cleaning schedules which did not provide for deep cleaning of fabric chairs and carpets; no wall-mounted soap dispensers and towel dispensers in consultation and treatment rooms; the lack of confirmation of the immunisation status of applicable clinical and non-clinical staff; and no available records relating to staff training on infection prevention and control. The respondent noted that the appellant had been invoiced for a replacement of all flooring, but the absence of a systematic approach provided reasonable grounds to believe patients were being exposed to risk of harm.
9. The appellant kept no records of, and had no documented processes or staff guidance for, managing or learning from significant events such as safety alerts and other related incidents such as complaints. Until the appellant had safety monitoring systems there were reasonable grounds to believe patients were exposed to risk of harm.
10. The appellant had not taken steps to ensure the practice was managed by a competent and qualified practice manager. The appellant had responded to the letter of 21 September to say he was liaising with the CCG to obtain practice management expertise, and had appointed a member of the administrative team as interim practice manager, but there was no evidence or assurance that the person was suitably qualified or experienced, and no relevant documentation or review of her performance. Until the appellant had implemented co-ordinated practice management there were reasonable grounds to believe patients were exposed to risk.
11. Inspections of 24 August and 4 September had noted blank prescription forms in an unlocked room accessible to members of the public. Records showed that during a four week period in July and August the fridge temperature was not being monitored each day the practice was open. At the inspection on 20 September the respondent was informed that an electronic data logger had been purchased but not yet installed. Until the appellant had proper and safe management of medicines the respondent had reasonable grounds to believe patients were exposed to risk of harm.

12. Inspections on 24 August and 4 September had revealed major flaws in leadership and governance. The respondent repeated the concerns over the absence of a practice manager and the competence of the medical secretary who was carrying out that role on an interim basis. The respondent said there was a lack of practice-specific policies setting out staff roles. There was no information for patients as to how to make a complaint or reference to the Parliamentary and Health Ombudsman. There was no evidence of pre-employment checks; for example a receptionist had been appointed on 17 September but there were no interview notes, references or risk assessments to determine the need for a disclosure and barring check on her personnel file. There was no evidence of clinical and practice meetings in relation to significant events and complaints. The practice had undertaken only one quality improvement activity in the past 12 months. There was no patient engagement, no patient participation group, no surveys and no action in relation to the national GP patient survey. Until appropriate governance arrangements were in place there were reasonable grounds to believe patients were exposed to risk of harm.
13. All staff bar one when interviewed had declined to discuss issues concerning the provider or the previous practice management, for fear of implications for their own employment. There were no appropriate channels to enable staff to speak up confidentially, and the appellant had not established a safe and no-blame culture where potential patient safety issues could be raised. Until adequate systems and processes were implemented to create a safe and no-blame culture there were reasonable grounds to believe patients were exposed to risk.

16. The purpose of the suspension was, the respondent stated, to give the appellant the chance to work towards meeting the requirements of the regulations so as to resume the regulated activities.

The appellant's case for lifting the suspension

17. In his appeal application the appellant relied on a number of grounds, which we summarise as follows:
    1. The previous practice manager had been suspended, had made a complaint to the CQC, and had stolen all contracts and documents and deleted policies from the computer.
    2. The CQC had reassured the appellant during the first inspection that there were no concerns as to the appellant's care as a clinician.
    3. The Clinical Commissioning Group had recommended an experienced and qualified practice manager to provide training to his acting practice manager.
    4. The doctor involved with the patient with the prostate treatment had now left the practice.
    5. The patient with the blood pressure and renal issues was the same patient, and because of dementia she refused to attend appointments or take medication.

6. The appellant had himself reviewed the case of the asthmatic patient. The appellant had determined an appropriate course of action to advise the patient, but the patient had not attended the appointment.
7. Safety of the premises had been the responsibility of the sacked practice manager. Because she had stolen relevant documents the appellant needed time to collate documents and information from scratch.
8. The time allowed to deal with all the issues had been too short.
9. A caretaker practice had taken over the management of the practice. This caretaker practice was running it with only one doctor (the appellant ran it with two), and was doing so on premises the respondent said were unsafe.
10. The appellant had now arranged for work to take place to deal with the issues such as flooring and chairs, paid for out of his own savings, as he could not earn as a practitioner.
11. The appellant had not had sufficient notice to make the required changes. The practice had been rated "good" by the respondent in 2015. It was difficult to make the necessary improvements without access to the premises. He had provided a number of testimonials. It was the patients who were not getting the care they deserved from a regular GP.

18. We also note the following additional information from other documents provided by the appellant (we do not repeat matters already covered in the above or the additional submissions below):
    1. Letter to the respondent of 24 September 2018. The appellant says there was a paediatric pulse oximeter on the premises and he had been unsure and, therefore, wrong to tell the respondent that the Centre did not have one.
    2. Undated statement and other documentation dealing with conduct of the sacked practice manager.
    3. Statement dated 26 September 2018 addressing allegations made against the Centre by the sacked practice manager, from interim practice manager, identifying the practice nurse and eight administrative staff as co-authors.
19. The appellant provided further submissions, dated 20 October 2018, addressing the respondent's response to the appeal. We mention only matters not already identified above.
20. The appellant did not feel it was right to have to prove beyond reasonable doubt that documents had been stolen. The former practice manager and her daughter had spoken of ensuring that the appellant lost his licence. She and her daughters had made physical threats against the appellant. It had not been possible to talk to the respondent during the short time allowed to address the concerns in the letter of 21 September. The appellant's access to the Centre was very restricted which made it difficult to address the respondent's concerns, and it would be difficult to deal with these by the end of the period of suspension. "The appellant invites the panel to lift the suspension with immediate effect due to the extreme unfairness, impractical and punitive measures relating to access to the appellant's surgery made by CCG and the caretaker practice". In relation

to the numbered concerns identified in the decision letter the appellant raised the following additional matters:

1. It was the responsibility of the clinician who saw the patient to make the appropriate decision, and policies were not required. Nevertheless the appellant would now have a policy on having a prostate examination and blood test in relation to male patients with urinary symptoms.
2. and 3. This patient had repeatedly been admitted to hospital for heart problems due to non-compliance with medication, despite good family support. When this patient had been discharged from hospital the appellant had checked the patient's notes and transferred the blood test results to the Centre's computer system. The appellant had himelf referred her to the nephrologist.
4. Already addressed above.
5. The appellant submitted that matters 5-11 were all responsibilities of a practice manager, not matters with which the appellant was expected to be familiar. In this case he could not ascertain if the dismissed manager had taken these steps. The appellant would attempt to employ an experienced practice manager as soon as the suspension was lifted. Character references had been carried out for new staff, and DBS checks for all staff. Appraisals could not take place until the suspension was lifted.
6. Safeguarding certificates for all staff and the appellant were now provided. The healthcare assistant was not seeing patients with diabetes and asthma, though it was incorrect to say she did not review the asthma patient correctly.
7. Fire safety training and drill was now completed. Cleaning and hazardous product risk assessments, and legionella risk assessment, had been completed and were attached. It had not yet been possible to identify alternative premises in an emergency. Disabled patients had always parked in the staff car park. There was a ramp for wheelchair access. A hearing loop had been installed. Patients were always asked if they could climb stairs and appointments not booked upstairs if they could not do so. A poster in the waiting room now explained this.
8. Tiles and carpet had been replaced with vinyl throughout. Plastic chairs were on order and would arrive shortly to replace all fabric-covered chairs. Wall-mounted soap and towel dispensers had been installed. Immunization certificates for the appellant and the second doctor were now completed and the appellant's hepatitis C certificate was provided. Staff training records for infection prevention and control were provided. Systems for safety and significant event monitoring were in place, but in the absence of co-operation from the caretaker surgery no guidance was yet completed.
11. Blank prescription forms were now locked securely and a system was in place to monitor them.
12. The appellant accepted that a new practice manager would need to provide proper leadership and governance. Until the manager was in place the appellant and non-clinical partner would lead the team. While

meetings had not been regularly held by the dismissed manager, they would be held regularly by the appellant and the non-clinical partner, and patient surveys would be dealt with in the same way. A practice patient group had taken place on 10 October, and minutes were attached.

13. The appellant was very approachable and staff always encouraged to speak up. Their reluctance to speak to the inspectors was probably from fear that the surgery would close. A reluctance to speak up could also be a cultural issue, as staff were all south Asian.

Tribunal's findings and reasons

21. We have read and considered all of the evidence provided, even if no specific mention has been made above, or is included below, of any particular item.

22. We reminded ourselves of the test to be applied in cases of suspension and the test to be met in deciding whether the Respondent's decision should be upheld. Section 31 states that if the Respondent, and the Tribunal on appeal "has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm," that enforcement action is justified. The burden of proof is on the Respondent. The standard of proof 'reasonable cause to believe' falls somewhere between the balance of probability test and 'reasonable cause to suspect'. The belief is to be judged by whether a reasonable person, assumed to know the law and possessed of the information, would believe that any person may be exposed to risk.

23. We note that, on the evidence before us, the appellant claims to have made or nearly completed important changes to the premises – flooring, dispensers, chairs in particular – and that he has done so in circumstances where the Centre is not always accessible to him. In the time available the respondent has not yet re-inspected to verify these improvements.

24. Similarly the evidence also indicates that much documentation, in particular evidence relating to training and checks recently completed, has been made available. This documentation does not address previous gaps in, for example, training or recruitment.

25. We note the appellant's stated commitment to actively seek to recruit a qualified practice manager if the suspension is lifted.

26. The respondent has not commented on the credibility of the appellant's evidence that many of the problems relating to missing documents was caused by the acrimonious dismissal of the appellant's practice manager. Although we understand from the appellant that he reported this theft to the police, he has supplied no crime number or detail of any police or other investigation into what is a very serious crime and data breach. If accepted at face value, the theft explains why these documents were not available for the respondent to inspect, but does not explain the absence of any back up, at least of the electronic material deleted by the manager.

27. There is little evidence that the appellant knew how that practice manager was operating, and no evidence at all relating to the extent to which the appellant appreciated a need to supervise her. It is somewhat surprising that in the documents relating to her dismissal it emerges that she had been claiming for more hours than she was contracted to work, but the appellant had no systems in place to prevent such alleged fraud.

28. Of particular concern to the panel is the fact that other matters of importance were, as the appellant himself accepts in his submissions of 20 October, left largely to the practice manager, which is why, in her absence, he appears to have been unable to answer or provide information to inspectors as to important aspects of the practice's policies, documents or procedures. We are concerned that in this respect, and in other submissions to the respondent and to this Tribunal, he seeks to distance himself from shortcomings on the basis that they were not his responsibility: failures relating to the clinical decisions of a colleague provide an example, as does his submission to the Tribunal of 20 October 2018 that he should not be expected to be familiar with matters which were the responsibility of the practice manager. That the appellant was unaware of important issues, and the reactive rather than reflective way he has dealt with concerns, is reflected in what he says about the oximeter. He told inspectors that the Centre did not have one, and then ordered two, only to find out later that the Centre did have one after all.
29. The reasons behind the reason for the reluctance of practice staff to speak freely with CQC inspectors remains unclear and may require further investigation. The appellant's own explanations for this reluctance do not suggest that he understands that the inability of staff to speak openly is a concern.
30. The way the appellant has responded to the inspections and the suspension decision appears to demonstrate a reactive rather than self-critical approach. Where criticised in relation to systems that allowed treatment of a patient with prostate cancer without proper investigation, he has limited his response to a new protocol relating to male patients with urinary complaints, rather than looking at the systemic problem which may or may not have lead to the initial clinical failure, but probably did impact on the subsequent failure of monitoring.
31. We are puzzled that the appellant both sought to explain the Centre's management of the patient with the asthmatic reading, but also submitted that this patient could not be identified from the EMIS number provided.
32. The panel has some concerns about the appellant's insight into his role in the management and leadership of the practice. For example, his acceptance of his own overall responsibility for failures of oversight, for the absence of a self-critical culture and for specific instances of risks to patients. Questions remain such that it is difficult to be confident of the appellant's ability to manage the changes in systems and culture that are required at this stage without further enquiry.
33. We note, but cannot attach weight to, matters which have caused difficulty for the appellant in responding to the respondent's concerns and producing evidence relating to risk of harm. He refers to the short time available to the appellant to address the deficiencies identified in the letter of 21 September. This was not a particularly short time to produce existing evidence relating to current concerns. A longer time is now available, during the suspension, to make changes to address those concerns. Nor can we attach weight to difficulties associated with addressing concerns while the Centre is being run by a caretaker medical practice, with whom, it appears, there is evidence of some bad feeling on the part of the appellant. Those difficulties do not affect our assessment of whether there is cause to believe patients may be at risk of harm.

34. In conclusion, we note that the appellant is willing to address point by point specific criticisms. Some of these, though, have been promised, but have not yet happened, such as the appointment of a sufficiently qualified and experienced practice manager. But, without evidence that the appellant, as yet, understands and accepts that it is his overarching responsibility to ensure that the practice is well managed, safe and compliant with best practice, there remains reasonable cause to believe patients may be at risk of harm.

Order

1. The appeal is dismissed.
2. The suspension decision is confirmed.

Hugh Brayne, First-tier Tribunal Judge

Denise Rabbetts, Tribunal Member

Pat McLoughlin, Tribunal Member

30 October 2018