Care Standards

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

[2020] 3980.EA-MOU

Heard on
13 February 2020 at Manchester Tribunal Hearing Centre &
5 & 6 March 2020 at Manchester Crown Court
Panel deliberation on 18 March 2020

BEFORE
Mr H Khan (Tribunal Judge)
Dr D Cochran (Specialist Member)
Mr J Churchill (Specialist Member)

BETWEEN:

A & E Life Support Ltd

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. A & E Life Support Ltd ("the Appellant") appeals pursuant to section 32 of the Health and Social Care Act 2008 ("the Act"), to the Tribunal. The appeal is against the decision of the Care Quality Commission ("the Respondent") dated 23 January 2020 ("the Decision") to suspend the registration of the Appellant as a service provider at 15 Forythia Drive, Clayton-Le-Woods, Chorley, Lancashire, PR6 7DF from 24 January 2020 until 24 April 2020

The Hearing

2. The hearing took place on 13 February & 5 & 6 March 2020. Following the hearing, we concluded that we would direct written submissions as Mr Hewitt had spent considerable amount of time giving oral evidence

and we considered it appropriate to give him the opportunity to consider what submissions he wished to make. Following the hearing, written submissions were provided by both parties.

Attendance

3. The Appellant was represented by Mr Les Hewitt (Nominated Individual and Operations Director). There were no witnesses other than Mr Hewitt.

4. Ms Rebecca Hirst (Counsel) represented the Respondent. The Respondent's witnesses who attended the hearing and gave oral evidence were Ms Judith Conner (Head of Hospital Inspections), Mr David Roberts (Inspector) and Ms Jacqueline Hornby (Inspection Manager).

Restricted reporting order

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

6. We should add that both the Appellant and the Respondent made it clear at the hearing that they did not object to the making of such order.

Preliminary Matters

7. The Appellant had notified the Respondent that they intended to call Mr Gulfraz Ahmed and Mr Ross Ciralolo. Following the hearing on 13 February 2020, we made directions allowing the Appellant to serve any additional evidence including any statements from these two witnesses. No statements were served from these witnesses. At the hearing on 5 March 2020, Mr Hewitt indicated that the Appellant was not intending to call either of those witnesses and wished to proceed with the hearing.

Background

The Appellant

8. The Appellant was registered on 28 June 2016 to carry on the regulated activities of 'Transport Services, Triage and Medical advice provided remotely' from the location known as Event City, Barton Dock Road, Urmston, Manchester, M41 7TB'.

9. The Appellant primarily provides patient transport services for vulnerable adults and children who suffer from mental health problems. Such activity has been previously undertaken for patients who have agreed to be transported voluntarily as well as those who have been Sectioned under the Mental Health Act.

10. The conditions of registration applicable to the Appellant for the provision of the regulated activity as stated in the Certificate of Registration are as follows:

    The Registered Provider must ensure that the regulated activity Transport services, triage and medical advice provided remotely is managed by an individual who is registered as a manager in respect of that activity at or from all locations.

    This Regulated Activity may only be carried on at or from the following locations: Event City, Barton Dock Road, Urmston, Manchester, Lancashire M41 7TB

11. Mr Les Hewitt is the Nominated Individual for the regulated activity. There has been no Registered Manager in place since 16 February 2018.

The Respondent

12. The background of the Respondent was set out in the witness statement of Mr David Roberts.

13. The Respondent was established on 1 April 2009 by the Health and Social Care Act 2008 ('the Act'). The Respondent is the independent regulator of healthcare, adult social care and primary care services in England. The Respondent protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

14. Under Section 3 of the Health and Social Care Act 2008 ('HSCA 2008') the Respondent's objectives are to protect and promote the health, safety and welfare of people who use health and social care services.

15. In exercising its statutory functions, the Respondent's role is to encourage the improvement of health and social care services, the provision of health and social care services in a way that focusses on the needs and experiences of people who use services, and the efficient and effective use of resources in the provision of health and social care service.

16. Under Regulation 8 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014 ('the 2014 Regulations') the Respondent is under a statutory duty to ensure that providers comply with Fundamental Standards of care. These are standards below which standards of care must never fall, and the Respondent's role is to ensure that all care provided by the Appellant not only meets the fundamental standards but is consistently and continuously maintained

Events leading up to the issue of the Notice

Inspection History

17. The Appellant has been inspected on three occasions since the beginning of November 2019.

18. A focussed inspection was undertaken on 5 and 6 November 2019 following concerns that the Respondent had identified during routine monitoring of the service. On 8 November 2019 an urgent Notice of Decision to suspend registration as a Registered Service Provider in respect of a regulated activity was served under Section 31 of the Health and Social Care Act 2008. This notice provided that the regulated activity was suspended from 8 November 2019 until 24 January 2020.

19. A focussed inspection was then undertaken on 25 November 2019. During this inspection, the Respondent identified that the Appellant had not made sufficient improvements for the original urgent decision to be removed.

20. The inspection that led to the current decision to extend the suspension of the Appellant's registration was undertaken on 17 January 2020. This inspection was undertaken using a focussed methodology, looking specifically at parts of the safe, effective and well-led key questions. The Respondent found that the Appellant was in breach of a number of regulations.

21. Following this inspection, the Respondent issued a Notice of Decision to extend the suspension of the Appellants registration. The Notice of Decision to suspend the Appellant was made on the basis that the Respondent believed that a person will or may be exposed to the risk of harm unless it takes such action. In particular, the Respondent relied upon breaches of the 2014 Regulations that were rated as a 'high' risk (Regulations 12, 13,17 and 19).

The Legal Framework

22. The statutory framework for the registration of providers of regulated services is set out in the Health and Social Care Act 2008. There was no dispute about the legal framework and the Respondent helpfully set out the legal framework in its skeleton argument.

23. The Respondent may suspend the registration of a service provider on the ground that the regulated activity is being, or has been, carried out other than in accordance with the relevant requirements (s.18 Health and Social Care Act 2008 (the Act)).

24. The relevant requirements for the purposes of these proceedings are to be found in the Health and Social Care Act (Regulated Activities) Regulations 2014 (the 2014 Regulations). Regulation 8 provides that a regulated person (which the Appellant is) must comply with regulations 9 to 20A.

25. If the Respondent has reasonable cause to believe that unless it acts any person will or may be exposed to the risk of harm, it may, by giving notice in writing under this section to the person registered as a service provider take various steps as set out in S.31(2) of the Act. The steps referred to include an urgent suspension.

26. An appeal against the decision is permitted by s.32 of the Act which provides that the Tribunal may confirm a decision of the Respondent or direct that it shall cease to have effect (s.31(5) of the Act).

27. The Tribunal also has the power to impose discretionary conditions and vary the period of suspension. (s.32 (6) of the Act). The burden of proof is on the Respondent. The findings of fact are on the basis of whether the Tribunal is or is not satisfied as to those facts on the balance of probabilities. The Tribunal considers the position as at the date of the its decision.

Evidence

28. We took into account all the evidence that was presented in the bundle and at the hearing. We have summarised the evidence insofar as it relates to the relevant issues before the Tribunal. We wish to make it clear that what is set out below is not a reflection of everything that was said or presented at the hearing/hearing bundle.

29. Ms Hornby explained that at the inspection on 4 and 5 November 2019, the Respondent identified the following breaches of the following Regulations;

a. Regulation 12: Safe care and treatment;
b. Regulation 13 Safeguarding from abuse and improper treatment.
c. Regulation 15: Premises and equipment;
d. Regulation 17: Good governance
e. Regulation 18: Staffing
f. Regulation 19: Fit and Proper Persons.

30. Following this inspection, the Appellant was required to provide a report detailing actions that would be taken to address the breach of Regulations.

31. On 8 November 2019 the Respondent served an urgent notice of decision pursuant to s.31 Health and Social Care Act 2008 to suspend the registration as the registered service provider in respect of a regulated activity. This was considered as necessary as it was determined that a person will or may be exposed to the risk of harm if action was not taken. She summarised the reasons for the decision were as follows;

a The Respondent was not assured that staff were suitable or had the qualifications, competence, skills and experience to care for patients safely. These concerns exposed service users to risk of harm
b The Respondent had found that patients were being transported

without proper records to ensure staff had access to required information about their care and treatment needs. This placed patients at risk of receiving unsafe or inappropriate care and treatment.

c Assurance was not provided that there were effective systems of governance, risk management and quality monitoring to ensure patients received safe care and treatment.

d Assurance was not provided that equipment used by the service provider for providing care or treatment to a service user was safe for such use.

32. Mr Roberts explained that on 17 January 2020, the Respondent undertook a further inspection of the Appellant company's service provision. The inspection identified the following areas of serious concern presenting serious risk of harm to service users. The inspection identified continued breaches in respect of Regulation 12, 13, 15, 17, 18 and 19. The specific concerns around the "high risk" breaches (Regulation 12, 13,17 and 19) are set out below.

Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment)

33. During the inspection on 17 January 2020, the Respondent identified that the service had implemented a patient risk assessment form for staff to complete. This covered important topics such as if the patient's risk assessment had required amendment since the original risk assessment had been undertaken. However, the service did not have a policy or a process outlining how this should be completed. In addition, there was no guidance or process to support staff when deciding what actions to take if a patient had been identified as a medium or a high risk.

34. The service had introduced a ligature risk assessment policy. However, there was no evidence of a completed ligature risk assessment for any vehicle other than the vehicle that was used for secure patient transfers. Mr Roberts set out that the ligature risk assessment completed had an action identified but this had not been completed at the time of this inspection. The risk assessment was not comprehensive and did not identify all ligature risks. The risk assessment had not been updated since the last inspection. There was no evidence of a completed ligature risk assessment for patient transport service vehicles that had been recently purchased which were intended for use of transport of mental health patients not under a section of the Mental Health Act 1983.

35. Furthermore, the Appellant did not have a clear process for managing the deteriorating patient. The Respondent was informed by the Appellant that if a patient deteriorated, they would be transported to hospital for treatment. It was unclear how the service would manage a mental health patient whose behaviour had escalated. Although the Respondent was informed that the police would be called, there was no policy or process outlining the requirement for this.

36. There was no information or policies available to support staff in recognising what restraint equipment was available (3x different handcuffs, leg restraints and a spit hood) and how these should be used safely. The Respondent was informed that this was covered in the mental health training that had been delivered, no evidence was provided of this.

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding from Abuse and Improper Treatment).

37. A staff member who had been identified in November 2019 as not previously having undertaken safeguarding training had now completed safeguarding adults level 2 via e-learning. However, there was no evidence that they had completed safeguarding level 2 or 3 for children.

38. It was identified that there was a safeguarding policy in place which outlined that the training would be in accordance with the safeguarding strategy and training needs analysis. The Nominated Individual and Director did not know of a safeguarding strategy or training needs analysis but outlined that everyone needed safeguarding children and adults level 2 and as the safeguarding lead they would need level 3 training. The policy was updated with the training requirements during the inspection.

39. On reviewing the safeguarding policy, Mr Roberts noted that there was reference to staff working in another organisation as part of the procedures which appeared to be an error in the policy. The policy did not contain key contact details for staff. This was the same finding as had been identified in previous inspection in November 2019 and the policy had not been updated to support staff in making timely referrals at all times.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance)

40. Mr Roberts set out that the service had completed three health and safety risk assessments; storage and use of medical gasses, general work within the public domain and administering first aid in both primary and secondary care. Although these had all been risk scored and controls to minimise risks had been implemented, it was unclear how often these should be reviewed. In addition, other important risk assessments such as COSHH had not yet been completed.

41. There were no risks identified for the organisation, for example, staffing, incidents, finance and any equipment failures or shortages to ensure safe patient transport. The risk management policy and procedure outlined what should be included. It stated that the identification, assessment and management of risk is linked to the achievement of the company's objectives; all areas of risk are covered for example, financial, governance, operational and reputational. It also stated that as part of its business planning process, a risk register will be developed. This register is a 'living

document' and forms the baseline for further risk identification. However, during the inspection in January 2020 the inspectors were not provided with evidence of this.

42. Since the November 2019 inspection, meetings were now been recorded following a standard template which included topics such as complaints, safeguarding, service delivery and financial performance. Although actions to take forward had been identified it was not always clear who was responsible for the action and timeframes for completing the action. This meant there was a risk that actions would not be implemented in a timely way.

43. The inspectors identified that not all policies being used within the Service had a review date. Out of nine paper copies of policies reviewed during the inspection in January 2020 only five had a review date. This meant there was a risk that policies would not be in line with updated risk assessments and the provider could not evidence a system for ensuring these were updated regularly and staff aware of any updates.

44. Mr Roberts noted that not all policies were reflective of the service. For example, the recruitment and selection policy made reference to a human resources manager, human resources staff and a human resources directorate and these were not part of the structure of the Appellant's organisation. The training policy also made reference to the word 'Trust' when this service was an independent private provider and it made reference to the staff training and development committee which again was not part of the meeting structure. There was an infection, prevention and control policy in place but throughout the policy there was reference to another NHS ambulance organisation (WYMAS) which would be confusing for staff employed by AELS and was not relevant to the organisation. There was also advice on aircraft cleaning which again referenced another NHS organisation and was not relevant to this organisation.

45. The inspectors were informed by the provider that the only meetings taking place were monthly management meetings and board meetings.

46. Mr Roberts recognised that the Service had made some improvements regarding patient records since the inspection in November 2019. A journey log, individualised care plan and a risk assessment record had all been implemented. However, the service had not implemented any policies or processes to support the implementation or monitoring of these policies.

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and Proper Persons)

47. During the inspection of 17 January 2020, the inspectors reviewed the DBS certificate for six members of staff. Of these, one had completed a standard DBS despite having previously provided care and treatment to vulnerable patients. Two had completed enhanced DBS. One had an enhanced DBS completed but transferred from a different provider in April

2019. In respect of staff members there was no evidence of an enhanced DBS. However, for one of these staff, there was evidence of a letter from an NHS Trust stating that an enhanced check had been completed as part of their substantive employment.

48. Mr Roberts set out that the concerns from the inspection undertaken in November 2019 continued to present. The January 2020 Inspection revealed a continued lack of remedial action by the Appellant, with the concerns of the previous inspection in November 2019 remaining

49. Ms Connor explained that she first became involved with the Appellant in September 2019 following concerns being raised by an enquirer regarding the regulated activity being undertaken by them

50. Ms Connor explained that in relation to the current decision, a management review meeting took place on 22 January 2020. This was attended by a number of individuals. There was a discussion as to whether or not the Appellant had sufficiently addressed the breaches of regulations that had led to the suspension. As a consequence of the seriousness of the ongoing breaches and the lack of improvement in the areas the Respondent identified on its inspection on the 6th November 2019, Ms Connor made the decision to impose a further period of suspension for a time limited period. This would continue to immediately protect patients from the risk of harm and would enable the Appellant to look at the Respondent's concerns, reflect upon them and put actions, systems and processes in place to mitigate the risks to patients. Ms Connor was satisfied that the suspension was for a long enough period to enable the Appellant to address the issues.

The Appellant's position

51. Mr Hewitt give evidence on behalf of the Appellant. Mr Hewitt's statement set out that he had received information from a reliable source informing them of a link between one of the inspection managers and the malicious complaint to the Respondent about the Appellant.

52. Mr Hewitt set out that the ligature risk assessment had been undertaken in relation to the one mental health vehicle owned by the Appellant. This was the only vehicle that would be used for transport within the company. He referred to the process for managing any deteriorating patient been clearly identified within the company's "duty of care policy".

53. Mr Hewitt referred to the various policies including the Training and Development Policy and the company's Mental Health Policy as sources where information relating to equipment could be found.

54. Mr Hewitt believed that it was always the intention of the Respondent to suspend the registration of the Appellant. He believed that major changes such as a change in "relationship owner" should have been communicated personally.

55. Mr Hewitt set out that there was no legal requirement to carry out DBS checks on staff working with events as opposed to undertaking regulated activity. This was down to each individual company and its policy. Event staff were sourced a number of ways, often on a last-minute temporary or one-off basis. Appropriate checks were being carried out.

56. The Risk Register of the business was being updated at the time of the January 2020 inspection and its current status was shown to inspectors. The Appellant explained to the Tribunal that he had already created an alternative company (A & E Support (AES)) to take over from AELS should the suspension remain.

The Tribunals conclusion with reasons

57. We took into account all the evidence that was included in the hearing bundle and presented at the hearing. We have summarised the evidence insofar as it relates to the issues we determined.

58. We wish to place on record our thanks to Mr Hewitt, Ms Hirst and the witnesses for their assistance at the hearing.

59. We found the evidence of Ms Connor, Ms Hornby and Mr Roberts to be credible. Their oral evidence was well supported by evidence in the bundle and we concluded that, based on what we read and heard, that they had carefully considered this matter and taken a measured approach to addressing the issues raised. We were not presented with any persuasive evidence at the hearing of any link between any of the inspection managers and a “malicious complainant”.

60. We acknowledge that the Appellant was represented by Mr Hewitt at the hearing. Mr Hewitt explained that he did not have a legal background but he conducted the case with diligence and asked pertinent questions when cross-examining the Respondent’s witnesses

61. We concluded that we would confirm the Respondent’s decision dated 23 January 2020. We took into account all the circumstances as at the date of our decision. We concluded that we had reasonable cause to believe that unless a suspension order is made any person will or may be exposed to the risk of harm. Our reasons for doing so are set out below

62. We acknowledged, as did the Respondent, that the Appellant had undertaken steps to meet the 2014 Regulations (such as implementing a patient risk assessment and introducing a patient ligature assessment), however, in our view, although this was a step in the right direction, it was not sufficient to persuade us that we should direct that the decision to extend the suspension should cease to have effect.

63. We reminded ourselves that the Appellant undertakes transfer of patients. As the report of the Respondent from the November 2019

inspection found, the main activity carried out by the service was the non-emergency transport of patients with mental health conditions. The Appellant did not seek to challenge the summary of activities as set out in the report. Whilst this is a non-emergency situation, this included patients detained under the Mental Health Act. There had been at least 60 such transfers and the patients were often noted as having high risk behaviours such as the risk of absconding, self-harm, violence, aggression infection risks and suicide risks.

64. We considered all the breaches of the regulations which taken overall led us to conclude we had reasonable cause to believe that unless a suspension order is made any person will or may be exposed to the risk of harm. This included the main breaches of the regulations which led to the notice of decision to suspend the Appellant. These were regulation 12 (Safe Care and Treatment), regulation 13 (Safeguarding) regulation 17 (Good Governance) and regulation 19 (Fit and Proper Persons).

65. We concluded that the Appellant was in breach of Regulation 12 (safe care and treatment). We found that the policies/processes provided were insufficient for setting out how the risk assessment was to be completed or used by the staff. Furthermore, there was a failure to guide support staff as to how to complete the risk assessment which meant that it may not be done adequately and, if done, may not be implemented appropriately if a medium or high risk was found. There were no clear processes for the management of a deteriorating patient nor was there any clear information procedures to how to manage a mental health patient whose behaviour was escalating. Furthermore, the evidence of Mr Ashmore does not suggest that there was any training provided as to how to implement any risk assessment or to conduct any risk assessment.

66. We acknowledge that the Appellant had made some progress as he had obtained documents from other sources. However, in our view, it was important for the Appellant to consider how each policy addressed the risks, operations and process that the Appellant would be exposed to while undertaking its work. For example, there was some substantial force in the Respondent's submission that the policies may have been "cut and pasted". For example, the documents we were referred to made reference to other unrelated organisations, departments and services. There was a reference to unrelated third parties such as WYMAS documentation, risk assessments referring to the construction industry and not adequately addressing the step the Appellant needs to take. We noted that the witness statement of Mr Hewitt denied that there had been any reference to any other organisations but in fairness to Mr Hewitt, in his evidence, he accepted that there was such reference. We concluded that the policies were not adequately drawn up. It was also clear to us from the evidence of the Appellant, that although he was well-intentioned in trying to address this deficiency, there was a lack of knowledge and training on his part to be able to do so properly. In our view, the reference to having a policy is not simply to tick the box to say that one is available, it is to establish what is required to undertake the tasks properly and to manage the risks.

67. We also concluded that the Appellant was in breach of regulation 17. There was a lack of information available in relation to supporting staff in recognising what restraint equipment was available and how these should be used safely. There was no evidence that this had been covered in training including in the mental health training to staff. Furthermore, whilst the Appellant's policy outlined areas of risk that should be covered, there was no evidence that it was being covered. We had no reason to doubt the Respondents evidence that out of 9 policies reviewed on inspection, only 5 had a review date.

68. We also found that the service had not maintained oversight of the maintenance of important equipment such as stretchers and wheelchairs which were used by the service when regulated activity had previously been undertaken. We found that the recruitment and selection policy did not reflect the Appellant's service. For example, the recruitment and selection policy referred to a Human Resources Manager, Human Resources Staff and a Human Resources Directorate and these were not part of the structure of the Appellant's organisation.

69. We found these failings to be so significant so as give us reasonable cause to believe that unless a suspension order is made any person will or may be exposed to the risk of harm. For example, the safe care and treatment of patients is central to the purpose of the Act and regulations. Managing risk is also about keeping patients and staff from the risk of harm. There is a risk of harm to both patients and the staff. The evidence that the Appellant put forward does not provide us with reassurance that the breaches outlined have been or are being fully addressed.

70. Furthermore, we observed that the breaches were widespread and the Appellant had been given sufficient notice of them given that this was the second period of suspension. In our view, we agreed with the assessment of the Respondent that each breach was important in its own right but taken together it demonstrated significant shortcomings across a widespread area of the Appellant's functions.

71. We also considered the position that the Appellant does not have a Registered Manager and is not operating from a registered address (the address which had been registered he said he had been locked out from). We reminded ourselves that the Appellant cannot carry out registered activities without a Registered Manager. To do so would be an offence.

72. The Appellant accepted that there is no Registered Manager and there has not been one since the previous one was de-registered (which, according to the Respondent, was February 2018). However, despite that situation Mr Hewitt (in his witness statement) accepted that that the Appellant had been carrying out regulated activities without a Registered Manager although unsuccessful applications had been made. We therefore considered that it was both necessary and proportionate for the

suspension to remain in place in order to provide a suspension of regulated activity.

73. We reminded ourselves that the suspension is time limited. It permits the Appellant to remedy the breaches. Whilst some steps have been taken, in our view, they are not sufficient for us to direct that the suspension should cease to have effect. We considered the imposition of conditions as well as varying the period of suspension. We declined to do so on the basis that, in our view, the decision to impose a suspension was both necessary and proportionate having considered the circumstances of the case.

74. We remind ourselves that the Respondent will be conducting an inspection shortly before the end of the suspension period in order to assess any further improvements.

75. Accordingly, for the reasons set out above and taking the circumstances of this case into account, we concluded that we had reasonable cause to believe that unless a suspension order is made any person will or may be exposed to the risk of harm.

76. We direct that the appeal is dismissed and that the Respondent's decision dated 23 January 2020 to extend the suspension of the Appellant's registration from the 24 January until 24 April 2020 as a service provider in respect of regulated activity is confirmed.

Judge H Khan
Lead Judge Primary Health Lists/Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued:07 April 2020