First-tier Tribunal Care Standards

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

[2022] 4544.EA-MoU VKinly

Hearing held by video link
on 9, 10 and 11 May 2022 (and reconvened on 17 June 2022)
Deliberations on 16 May 2022 and 17 June 2022

BEFORE
Ms S Brownlee (Tribunal Judge)
Dr David Cochran (Specialist Member)
Mrs Denise Rabbetts (Specialist Member)

BETWEEN:

Charlton House Medical Centre
(Dr Hafizur Rahman)

Appellant

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. Dr Hafizur Rahman ('the Appellant'), the registered service provider at Charlton House Medical Centre ('CHMC'), 581 High Road, London N17 6SB appeals pursuant to section 32 of the Health and Social Care Act 2008 ('the Act'), to the First-tier Tribunal. The appeal relates to a decision of the Care Quality Commission ('the Respondent') dated 29 March 2022 to suspend his registration on an urgent basis respect of the regulated activities of 'diagnostic and screening procedures', 'treatment of disease, disorder or injury' and 'maternity and midwifery services'.

The Hearing

2. The hearing took place on 9, 10 and 11 May 2022. This was a remote hearing which was not objected to by the parties in advance. The form of remote

hearing was by the Kinly CVP video platform. A face-to-face hearing was not held because it was not practicable, and no-one requested one. We considered that the issues in this appeal could be determined in a remote video hearing. The documents that we were referred to are in the electronic combined hearing bundle provided in advance of the hearing (5260 digital pages). Some participants were working from hard copy bundles and some from digital bundles. We also worked from one supplementary hearing bundle consisting of an updated index and some additional documents in part A of the combined hearing bundle. Finally, we had a Scott schedule and the parties' skeleton arguments.

3. During the hearing, we received additional documentary evidence from the Respondent. A point arose in relation to any records retained by the Respondent regarding a management review meeting ('MRM') which took place in March 2022. The record of the meeting was provided by the Respondent and duly admitted as it was clearly relevant to issues in the appeal.

4. All participants were able to connect their video and audio for all of the hearing. Overall, no participants experienced significant connectivity issues – to such an extent that their engagement with the hearing was impacted. At the conclusion of the hearing, both legal representatives confirmed that they considered they had been able to engage with the appeal hearing effectively. Dr Rahman confirmed the same.

Attendance

5. Dr Rahman was represented by Mr Simon Butler of counsel, instructed on a direct access basis. Dr Rahman gave oral evidence and called no witnesses. Mr Simon Connolly of counsel, instructed by Ms Julie Ford, solicitor at Hill Dickinson LLP, represented the Respondent. The Respondent called five witnesses: Mr Sampana Banga, head of inspection at the CQC, Mr Andrew Norfolk, inspection manager at the CQC, Mr Jonathan Wall, inspector at the CQC, Mrs Sian Jopling, inspector at the CQC and Ms Catherine (Cassie) Williams, chief executive officer at Federated4Health. The Tribunal also considered witness statements from Dr Zoe Spyvee, GP specialist advisor at the CQC and Ms Vanessa Piper, assistant director of Primary Care Contract and Commissioning for NHS North Central London Clinical Commissioning Group. During the course of the hearing, the parties agreed that Ms Piper was no longer required to attend the hearing to provide oral evidence.

6. At various points over the course of the public hearing, there were attendees from the internal and external legal teams of the Respondent, taking notes of the proceedings.

Preliminary issues

7. On 6 May 2022, the Respondent had submitted an urgent application to adjourn the appeal hearing, which was opposed by the Appellant. The Appellant had submitted his evidence in compliance with the Tribunal's case management directions – on 29 April 2022. However, due to the period of time between 29

April and 6 May (which included a bank holiday), the Respondent had not had the opportunity to fully consider the evidence from the Appellant. By the beginning of the appeal hearing, the position had changed. The Respondent wished to withdraw its application to adjourn on the condition that the late evidence, in the form of a supplementary witness statement and exhibits from Mrs Jopling, would be admitted. The Appellant took no issue with the late evidence, and it was duly admitted by the Tribunal as it was of relevance to the issues in the appeal and Mrs Jopling was attending, so her evidence could be tested in cross examination. Mrs Jopling's supplementary witness statement concerned a review of the Appellant's 'remediation' evidence dated 29 April 2022.

8. Next, we dealt with an issue raised in the Respondent's response to the grounds of appeal and its skeleton argument, namely that the Tribunal ought not to consider issues such as reasonableness, legitimate expectation and 'pure public law points' advanced on behalf of the Appellant on the basis that it lacks jurisdiction. We considered this issue carefully and concluded that we would not limit the arguments being advanced by the Appellant. It is clearly of relevance to the section 31 test, as the Tribunal applies it afresh at the date of the appeal hearing, considerations such as fairness, reasonableness and the Appellant's understanding of what was required of him after the Tribunal appeal hearing of 8 February 2022 and to the present day. The Tribunal did not consider it just, fair or proportionate, in accordance with the overriding objective, to limit the arguments being advanced by the Appellant on the basis that they concern public law principles. It is quite clear that the Tribunal must apply the 'test' at section 31 of the 2008 Act and in doing so, it will be relevant to the Tribunal to consider the reasonableness of the decision, as well as the approach of the decision maker (which may call into question issues of partiality) and legitimate expectations, particularly concerning the extent to which it was reasonable for an Appellant to rely upon representations from a Respondent.

Background

9. Dr Rahman has been registered as a service provider with the CQC since 13 May 2021. He also holds a General Medical Services ('GMS') contract for Charlton Medical Health Centre, in Tottenham, North London, with a registered patient list of approximately 7,500. He is registered to provide the three regulated activities set out at paragraph 1 above. As a result of an anonymous complaint, the Respondent conducted an announced, on-site inspection on 8 June 2021. The day after the inspection, Dr Rahman was made the subject of an interim suspension order by the General Medical Council (for 18 months). On 16 July 2021, the Respondent issued two warning notices pursuant to section 29 of the Act. The warning notices concerned failures to comply with Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulations'). They are the two Regulations which are consistently relevant throughout this appeal. Regulation 12 concerns safe care and treatment and Regulation 17 concerns good governance. By the time of 19 August 2021, the Respondent accepted that the Appellant had remedied four out of 29 Regulation 12 breaches and none of the Regulation 17

breaches. As a result, the Respondent published its inspection of 8 June 2021 with an overall rating of 'inadequate'. On 22 September 2021, the Respondent conducted a follow up inspection, focusing on Regulations 12 and 17. As a result, on 27 September 2021, the Respondent issued a decision suspending the registration of CHMC in respect of the three regulated activities referred to above. On the same date, the Respondent received an email from the clinical lead at CHMC (who had been in post since approximately 7 July 2021), notifying it of his immediate resignation. The suspension commenced on 28 September 2021 and Federated4Health commenced its caretaker role of CHMC from 29 September 2021. Dr Rahman filed an appeal to the First-tier Tribunal against that decision on 5 October 2021. On 8 February 2022, the parties agreed terms of settlement of the appeal, which led to the appeal being withdrawn, on the agreement that the Respondent would reinspect CHMC by 4 pm on 28 March 2022 to determine if the CHMC had remedied the concerns set out in the decision of 27 September 2021. The consent order was issued by Judge Trueman on 9 February 2022.

10. On 23 March 2022, the reinspection took place. Dr Rahman attended, along with three prospective partners (two GPs and a practice manager). The Respondent decided that CHMC remained in breach of Regulations 12 and 17. On 29 March 2022, the Respondent served a notice of urgent suspension, making CHMC the subject of an urgent suspension of its registration, which will expire on 29 June 2022. On 13 April 2022, Dr Rahman filed his appeal against the decision to the First-tier Tribunal.

Legal Framework

11. Section 3 of the Act invests in the Respondent registration functions under Chapter 2. By virtue of section 3(1) of the 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.

12. 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.

13. 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.

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

15. Section 31 of the 2008 Act gives the CQC the power to urgently suspend the

registration of a service provider of a regulated activity on the grounds that the CQC has reasonable cause to believe that unless it acts, any person will or may be exposed to the risk of harm.

16. Section 32 of the Act provides for a right of appeal to this Tribunal against a decision to cancel 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, or it can vary, cancel or impose any conditions on the registration that it sees fit.

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

18. The Respondent bears the burden of persuading the Tribunal that urgent suspension of the provider's registration is a proportionate decision as at the time of the appeal hearing. The Respondent must establish there is reasonable cause to believe that without an urgent suspension in place, any person will or may be exposed to risk of harm. 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.

19. 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 and should take into account evidence which post-dates the notice of decision (subject to fair notice). Reasonable cause requires the Tribunal to consider whether a reasonable person, with knowledge of the law and the relevant evidence in the specific case, would believe that any person will or may be exposed to risk of harm. If the Tribunal concludes that there will or may be exposure to risk of harm, the Tribunal must also consider whether urgent suspension is necessary and proportionate.

Issues

20. The key question for the Tribunal is whether the Respondent is able to demonstrate, on the balance of probabilities, that the decision to urgently suspend the registration of the Appellant remains a proportionate and reasonable one (as at the date of the haring), when considered alongside the requirements in sections 3, 4 and 31 of the Act.

21. 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 oral closing submissions.

The Appellant's position

22. The Appellant contends that the Respondent was only entitled to reinspect on 23 March 2022 to determine whether the concerns raised in the notice of suspension dated 27 September 2021 had been remedied. As a result, the

Appellant was not prepared for the other issues raised by the Respondent at the reinspection.

23. As a result of the order made by Judge Trueman on 8 February 2022, the Respondent should have paid regard to the policies and procedures adopted by the caretaker practice at the time of the reinspection.

24. The Respondent raised 'new issues' for the first time at the reinspection, but in any event, the Appellant has produced policies and procedures which demonstrate that he has remedied the issues to such an extent that he does not present a risk of harm to any persons.

25. The Appellant contends that the Respondent had predetermined the outcome of the reinspection.

26. The Appellant requests that the Tribunal allows the appeal and directs that the urgent suspension order cease to have effect.

The Respondent's position

27. The Respondent submits that the decision to urgently suspend the Appellant's registration should be confirmed, as a decision that remains justified, reasonable and proportionate given the Appellant's poor history of compliance with the requirements of the Act and the Regulations, particularly since the time of the first inspection in June 2021. The Respondent further submits that the evidence presented of the improvements made since the reinspection is not sufficient to engender confidence in the Appellant to be able to provide safe and effective care in a well-led and well-governed practice in the future.

Evidence

28. 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 hearing bundles.

29. Mr Banga explained that the CQC's primary relationship is with the provider on the register, understanding that there are times when the provider is unable to deliver services and it is then the responsibility of the CCG to ensure care continuity as it has the primary responsibility to meet the health needs of its population. He indicated that it's fair to say that the policies and ways of working from the caretaker practice are adopted to provide care and from his understanding, there is no relationship between the caretaker practice and the registered provider. The relationship with the registered provider is suspended and so the CQC does not have a relationship with the suspended registered provider as they are not delivering care. However, the CQC will find out the extent to which the suspended registered provider has remedied the issues in the suspension. When any notice is issued by the CQC, it provides a very detailed summary of the issues identified and it provides a check list guide that the registered provider may wish to use to remedy the areas of deficit. The

adoption of policies or protocols from a caretaker practice is not an issue for the CQC.

30. Mr Banga chaired the MRM after the reinspection on 23 March 2022. There is a standardised format for such meetings and legal colleagues are included. The CQC's decision tree is used to help structure the meeting, decide on where the evidence sits and help the participants to agree on the proportionality and impact in coming to a decision. In Dr Rahman's case, the MRM looked at the extent to which Dr Rahman would be able to sufficiently understand what needed to be done to remedy the issues. Mr Banga explained that the MRM considered Dr Rahman's understanding of particular risks. He accepted that at the time of the issuing of the suspension notice in September 2021, the issues identified had been with specific patients, but by the time of the MRM in March 2022, there had been a prolonged period of regulatory engagement during which Dr Rahman did not seem to be motivated to bring his practice into compliance with the Regulations. He had to give the CQC assurance that he had reflected and established his practice to make sure he could deliver care safely. He explained that the CQC has no interest in 'catching people out', wishing to support providers to ensure safe and competent care is being delivered. Further, he explained that the CQC had given Dr Rahman a detailed breakdown of what steps he could undertake to ensure compliance with Regulations 12 and 17. From his understanding of the new material provided by Dr Rahman on 29 April 2022, it gave him concerns about effective dissemination and implementation and he would have concerns about the potential for further breaches of the Regulations. He accepted that the caretaker practice steps into the shoes of the registered provider to the extent that the current caretaker has to be registered with the CQC to provide regulated activities at the location and the CQC has to be satisfied that the caretaker practice is putting measures in place to ensure compliance. It was put to Mr Banga that the caretaker practice has remedied the concerns with the 11 patients' records (from a sample of 15) by the time of the reinspection on 23 March 2022. Mr Banga explained that the CQC viewed the concerns with patients' records as indicative of a generalised concern around how care was being delivered. At the time of the reinspection, the CQC was looking for some form of appraisal, setting out that Dr Rahman had reflected on the way in which the service had failed patients.

31. Mr Banga explained that as the prospective partners (who have been added to a contract variation with the CCG) were not registered with the CQC at the time of the reinspection on 23 March 2022 and they were not introduced as formal members of the practice, it was a reasonable decision not to interview them. Mr Banga explained that the CQC has a methodology of interviewing people who work at practices. Mr Banga confirmed that the notes of the MRM he chaired were an accurate summary of what was discussed. He indicated that the reinspection found three things: (1) Dr Rahman had some understanding of clinical issues and action that should be taken; (2) he had not reviewed and implemented appropriate policies and procedures to ensure patients were not exposed to a risk of harm; and (3) the partners had not prepared and so were unable to submit any control mechanism (policies and procedures to prevent patients becoming at risk of harm). The MRM attendees considered

cancellation but ruled it out as the CQC decided to extend the suspension to address the ongoing issues and think about what should happen when the suspension period came to an end. Mr Banga explained that in September 2021, the CQC considered that Dr Rahman was capable of remediation but by March 2022, he demonstrated that this may not be the case. Mr Banga was clear that the reasons for deciding to extend the period of suspension included that it would be confusing to patients if the CQC did not and that it would be harmful to the caretaker practice not to extend, on a continuity of care basis. Mr Banga clarified that the MRM notes were not a complete and entire note of what was discussed.

32. Mr Norfolk explained that he was on leave on 23 and 24 March 2022, so he dialled into the MRM on 24 March 2022 to provide support to the team. The focus of the meeting was on the action taken by Dr Rahman and what Mrs Jopling had found during the reinspection, as well as Dr Rahman's answers to questions from Mrs Jopling and Dr Spyvee. Mr Norfolk indicated that he has been to a number of MRMs and the notes provided to the Tribunal represented quite a high-level document, outlining some of the discussion which took place. He explained that the meeting was at least one hour long. He considered that there was very limited assurance or confidence that the CQC could 'hand the keys back to Dr Rahman and patients would receive safe and competent care. There was no dissent over the course of action which was chosen and the decision was to extend the suspension as it would be harmful to the practice to do anything else. He considered there was a clear risk to patients if there was no continuity of care and because of the difficulties with the caretaker practice and Dr Rahman's GMC registration. Further, he expected to see safe care and was surprised at how little action had been taken. He explained that he had had limited sight of the policies and procedures sent in by Dr Rahman on 29 April 2022, but what he did not see was a credible plan. By that, he meant a plan around who would take the lead on specific areas and how governance would work, different roles and meeting structures. A credible plan around the practice and how it would be managed if the keys were to be handed back. He observed that there was no clinical lead in the absence of Dr Rahman so he needed to see a plan to understand that things would be safe for patients.

33. Mr Wall was involved in all three inspections for CHMC, but was not able to be on site during the reinspection on 23 March 2022. After negotiations, before the beginning of the appeal hearing listed for five days on 8 February 2022, the previous appeal of the suspension (which expired on 29 March 2022) was withdrawn on an agreed basis. He explained that the presiding judge (Judge Trueman) asked the CQC to provide the Appellant with notes and guidance about what the CQC would be looking for at its reinspection. Mr Wall prepared the guidance note dated 9 February 2022. From his perspective, by the time of the reinspection, there were no suitable control mechanisms to ensure that patients were not exposed to harm or risk of harm. He explained that there had been discussions about whether CHMC could benefit from the policies and procedures of the caretaker practice. Mr Wall's view was that it was for the registered provider to liaise with the caretaker practice about the adoption of policies in seeking to satisfy regulatory responsibilities. As Mr Wall explained, the CQC does not mandate how the registered provider decides on

documentation.

34. Mrs Jopling explained that she had dealt with the issuing of urgent notices of suspension multiple times as it is part of her role to write the notices, given that she works as an enforcement inspector supporting other inspectors with serious whistleblowing allegations and practices that are rated as inadequate or with warning notices in place. She explained that in her eight years with the CQC, until this case, she had not dealt with a situation where the CQC has had to extend the period of suspension as the majority of times, when a practice is reinspected, it has managed to reassure the CQC and the suspension has been lifted. At the time of the reinspection of CHMC, Mrs Jopling was on site with Colin Babb and Mr Wall was available remotely. Dr Spyvee was also with Mrs Jopling as the GP specialist advisor to focus on the clinical issues. Dr Rahman showed the CQC inspectors some documents on a screen, during his interview with them. He also shared some policies and an Excel spreadsheet, which he had previously shared. After the interview, he provided papers copies and followed that up with an email of electronic versions of the paper copies.

35. Mrs Jopling explained that at the June and September 2021 inspections, 11 patients were identified as a sample. They were treated as a sample and the CQC has been concerned with what steps Dr Rahman had taken to address record keeping as a whole. Dr Rahman acknowledged that record keeping needed to improve and the record keeping failures were covered in his presentation at the reinspection. Poor record keeping fell into Regulations 12 and 17, with Dr Rahman providing a policy on record keeping that dated back to 2016. Mrs Jopling did not have confidence, based on the 11 patient records, that Dr Rahman had ensure the 2016 policy was implemented at CHMC. Dr Rahman provided a number of policies which were deemed inadequate due to their age or the lack of evidence to demonstrate they had been implemented and followed at CHMC. From Mrs Jopling's perspective, nothing at the practice had changed since the inspection of June 2021. She explained that she held a very through discussion with Dr Rahman and he did not raise any concerns about the areas which were the subject of the reinspection. Her overall conclusion was that nothing had changed with the practice to make patient safe at all and she had never come across a thought process of the six months being seen as a holiday period.

36. As to the large volume of policies and procedures produced by Dr Rahman on 29 April 2022, she began her review of them after the bank holiday. Mrs Jopling observed that the policies were not ‘bespoke’ to CHMC and referred to other practices. She viewed a number of them as ‘screen dumps’, by which she meant the copying and pasting of information from internet resources into a document. She did not consider the quality of the policies and procedures provided on 29 April 2022 could lead her to conclude that Dr Rahman would be able to effectively lead the practice. She did not consider them to be valid policies as they were not bespoke to CHMC and appeared to have been copied and pasted from other practices. she concluded that these actions represented an inability to lead and implement and take responsibility and demonstrated a complete lack of insight into good governance. She concluded that as of March 2022, even with a limited amount of time on site, she found serious issues.

Further, Mrs Jopling explained that systems and processes affect staff and patients and she observed that Dr Rahman did not care enough for patients, was still in breach of Regulations 12 and 17 and she found that to be 'an absolute disgrace'.

37. In cross examination, she indicated that Mr Wall had drafted the March 2022 notice of urgent suspension. She did not consider that the case reached the threshold for cancellation. Mrs Jopling did not accept that the CQC did not notify Dr Rahman, in the 27 September 2021, that record keeping was a generic concern. She indicated that was why the inspectors did not ask him about the specific patients when they returned on 23 March 2022 – the questions in interview related to how Dr Rahman planned to address the issues for all patients. She accepted that the original 'sample' of patients' records (15, of which concerns were noted with 11) was not a representative sample due to limited time. Mrs Jopling disagreed with the assertion that she did not ask for specific policies in the interview on 23 March 2022.

38. Mrs Jopling explained that if a practice wishes to use policies from NHS England, which it is entitled to do, she would consider it screen dumping if the practice had simply copied and pasted the policies without making them bespoke. She explained that even if Dr Rahman had policies and procedures in place and they are appropriate, the CQC would still maintain that the suspension should remain on the grounds that he is not going to implement them. Mrs Jopling stated that she had had little time to review the policies so her details in her supplementary witness statement and reviews notes were based on her preliminary review and without clinical input. She accepted that Dr Spyvee did not raise any specific clinical concerns with Dr Rahman's knowledge.

39. Mrs Jopling explained that the practice's records are computerised and so the sample of 15 patients' records was based on specific searches in relation to high-risk medicines. She explained that the inspections took place during Covid-19 restrictions, which meant that a shortened period of time was spent on site in September and the inspection in June was conducted remotely. She was not sure how the sample size reflected or represented the whole population of the practice's patient demographic. she explained that if the initial inspection had taken place on site, she would have done a full, longer inspection and gone for bigger sample sizes. She did not consider the sample was random as it involved searches against high-risk conditions. She thought the sample was fair as what was discovered was really serious, however, it would have been nicer to have a larger sample size. She explained that a document constitutes an effective policy if it is bespoke and that you cannot test it until it is put into practice.

40. Ms Williams explained that the caretaker contract is where her federation goes into a practice, at short notice, to manage the practice. She referred to the issues which her federation had to deal with when it went into CHMP, which included issues with accumulated debt and a lack of a valid lease. She made it clear that the caretaker practice is not there to remediate regulatory concerns. The caretaker practice enters into its own contract with the CCG and it is there

to look at the totality of the practice and work on turning it around and putting safe systems in place. If the caretaker practice was to hand back the practice to the registered provider, policies and systems put in place would be available to consider and potentially adopt – it would depend on the team going in with the registered provider and it would be for the registered provider to review them and decide if they wished to adopt them. She acknowledged that she had never been in a position where the previously suspended partnership has come back in. She confirmed that Dr Rahman had not spoken to her about taking on Federated4Health's policies and processes. Dr Rahman attended the practice on two occasions. He came in on 21 February 2022 to meet with Ms Williams and agree on access and times. He returned to the practice on 25 February 2022 but didn't need to come in as he was able to access the records remotely on a read only basis. He returned to the practice on the day of the reinspection.

41. Dr Rahman explained that the suspension in September 2021 happened quickly. On 27 September 2021, he received a call from Mr Wall at 9 am and then held an urgent meeting with Ms Piper about one hour later during which he learnt that CHMC had been suspended with immediate effect. He did not know that he could appoint people to carry on the contract and felt that the caretaker practice was imposed on him. He did not have access to CHMC and had to request access to documents during his first appeal. Dr Ahmed resigned on 27 September 2021 as he had not been added to the variation contract and he felt that Dr Ahmed was 'rattled'. Dr Ahmed's resignation left Dr Rahman in a difficult position. Prior to the notice of suspension of 27 September 2021, CHMC employed approximately 15 to 20 staff, from full time GPs, locum GPs, part-time nurses and health care assistants, as well as pharmacists, a physiotherapist, a manager and deputy manager and administrative staff.

42. He stated that he wasn't surprised when he read through the notice as he felt that each case raised had issues, but he considered that of a practice with about 8,000 patients, to have 11 identified with issues from a sample of 15 would not be any different from another similarly sized practice. He knew there were issues with patients going abroad and lots of problems with getting patients to engage with the practice during the pandemic due to extended periods of lockdown and many people who had issues and used the practice frequently would be shielding. He also observed that the practice demographic is about 98% individuals from ethnic minority backgrounds and individuals from those backgrounds typically tended to be more vulnerable and it was difficult to get them to engage. He gave the example of trying to call a patient in for a blood pressure check-up and the patient saying, 'are you serious, coming in for a blood pressure check during a pandemic?'.

43. After the outcome of the appeal in February 2022, he contacted the caretaker practice to gain access and he faced quite a lot of resistance, but access was eventually given so he could use the clinical system on a read only basis. He was not allowed to have any input with staff and eventually had access to a laptop which meant he could work remotely towards remedying the issues. By that point, he had recruited his proposed team of partners. Once he had been able to run searches on the system, he did what he could to prepare for the next inspection planned for March 2022.

44. On 23 March 2022, he met with Mrs Jopling and Dr Spyvee. He was not introduced to Mr Wall (working remotely). The proposed partners were asked to leave, and the majority of questions put to Dr Rahman were from Dr Spyvee and concerned general clinical knowledge and drugs. They discussed various conditions and long and short-term indications. He felt that when he tried to address the issues in hand, he was steered away. He also felt that he didn't interact much with Mrs Jopling, who was taking notes. The process took about 2.5 hours. He was asked how he would implement actions and explained that he would have a protocol, policy or system. He was not able to access his own servers and shared network drive to present copies of the policies, but he did have a USB stick with the master policies, which he had made initially. He had to go by what he had and after the reinspection, he provided the policies to Mrs Jopling on email. The managing partner (part of the proposed partners team), Ms Mukherjee, was working on updating the policies and Dr Rahman provided her presentation as part of the reinspection process. He accepted that he had used policies and procedures from other sources and other practices as his view was that if someone else had developed a good document, which followed current guidelines, he would use it.

45. Dr Rahman did not accept that the concerns raised in June, September 2021 and March 2022 were serious enough to warrant a suspension order. He accepted that he has regulatory responsibilities to patients and to the CQC and is aware of his duties in this respect. He did not accept that the issues with record keeping, identified in June and September 2021 were references to the general record keeping of CHMC. He explained that the inspections did not access shared care notes and clinical letters, which show that when medication were issued, the practice checked when the last blood test had been taken, as an example. He did not accept that the suspension was put in place because of record keeping, but due to patient safety. He understood that issues of record keeping contributed to the suspension but were not the reasons for the suspension. He saw the individual record keeping issues with the 11 patients as learning points, to be improved.

46. Dr Rahman explained that he has selected his new partners to ensure future regulatory compliance as they have lots of experience and one is a chair of East London CCG. His plan is that until he is able to return to clinical work, we will need with ensure regulatory compliance with his team of partners. Dr Rahman explained that he was guided by legal advice and had made a decision not to call his partners to provide evidence, but he could arrange for them to give evidence. He considered that they are not part of this appeal and were not recognised by the CQC at the time of the reinspection. He had no issue with the competency of his three prospective partners and he believed they would be effective in their roles, as assigned to them in the proposed structure. He explained that it takes months or even years to go through the process for registration ensuring they get clearance, and their applications can be approved. In any event, he did not consider that issues with his partners' registrations should impede on his registration as a registered provider.

47. Dr Rahman explained that the policies requested by the CQC during the

reinspection were emailed to them later that same day. He was under the impression that the caretaker practice would have policies in place, and he was unaware that the CQC would want to see policies from him. Dr Rahman was taken to the guidance note prepared by Mr Wall on 9 February 2022 and explained that he had not seen the document before it was put into the hearing bundle for this appeal. He had not seen the email to which the document was attached. It was an email sent directly to Mr Butler. Dr Rahman accepted that the guidance note would certainly have been of help to him if he had been aware of it in preparing for the reinspection on 23 March 2022. He accepted that he had produced a lot of remediation evidence late in the day, but it was in response to the issues identified in the notice of urgent suspension, issues which he had not prepared for fully in advance of the reinspection as he was unaware of the guidance note from Mr Wall. He explained that his three partners should be given an opportunity to implement their new roles.

48. Dr Rahman took over from the senior retiring partner in 2013 and in 2018, his partner retired, leaving him on his own. He explained that he received his first remedial notice from the CCG due to the need to become registered with the CQC as the process was taking too long. His second remedial notice concerned the first CQC inspection and the third remedial notice was sent in February 2022 once he had been suspended from the practice. He saw his role as the registered provider to ensure that things are working effectively at the CHMC, ensuring that the clinicians are working effectively and being audited. He would plan to engage with patients as they enter the practice and his week would be broken down into clinical work oversight, quality assurance and QOF work. He explained that Ms Mukterjee had just received her DRB check and Dr Mohi has indicated the same. The other partner has his in place, so he expects them to make their applications to the CQC within the next few weeks. He understood that the current caretaking practice has a notice period of 30 days and he saw his first priority as securing appropriate staff. He explained that Ms Mukterjee was well placed to have staff in place within one month. He saw the top three priorities as being staff, handover time to work with the caretaker practice and once he had taken over, to immediately start to remedy the concerns with the QOF work, as well as any other prescribing and monitoring issues.

49. As to the issue regarding the guidance note dated 9 February 2022, prepared by Mr Wall. That guidance note was never received by Dr Rahman, on his evidence. That was corroborated by the correspondence emails, which demonstrated that Mr Butler objected to the note and did not agree it, in emailed correspondence with Hill Dickinson LLP. Hill Dickinson LLP then flagged that issue with the CQC, on the basis that Mr Butler had indicated he would apply to the Tribunal for further directions on the issue. No further steps were undertaken and it is accepted that the guidance note was not reviewed by Dr Rahman until he reviewed the hearing bundle. Mr Wall had assumed that the guidance note was passed to Dr Rahman and the first time Dr Rahman raised the fact that he had not reviewed any guidance note (directed by Judge Trueman on 8 February 2022) was during his oral evidence on the third day of the appeal hearing.

The Tribunal's conclusions with reasons

50. Dealing with the factual matters which remained in dispute, as set in the Scott schedule. The Tribunal reminded itself that the evidential burden rests with the Respondent. We are grateful to all of the witnesses who attended to give oral evidence at the appeal hearing, which assisted us significantly in reaching our decision.

51. As a starting point, we accept that we must apply the test at section 31 of the 2008 Act to the reinspection which took place on 23 March 2022. By that point, Dr Rahman had been on reasonable notice, since at least 27 September 2021, that the Respondent considered CHMC to be in breach of two Regulations. We heard at length from the witnesses and reviewed the documentation to establish if the Appellant should have been reasonably aware, by the time of the reinspection, as to the issues which the Respondent would focus on. The reinspection process was clearly going to focus on the Appellant assuring the Respondent that CHMC would be able to provide safe care and treatment and good governance. The decision of 27 September 2021 made it clear that the reason why the Respondent believed that a person will or may be exposed to risk of harm was due to the failure to appropriately review the care and treatment for 11 out of 15 patients, clinical care of long-term conditions, coronary heart disease and hypertension diabetes and mental health. Furthermore, failures in Dr Rahman's leadership were found to represent a breach of Regulation 17, as there was a lack of systematic oversight of the or review of locum clinicians' work by a lead GP, there was no evidence of discussions taking place with the clinical team, no programme of clinical audit to improve patient care and no system to discuss the care of patients who may require a multi-disciplinary approach.

52. What is clear to the Tribunal is that the decision to urgently suspend Dr Rahman's registration (on 27 September 2021) was based on the failures to address the concerns raised relating to 11 patients in the warning notices, a lack of systems to manage patients with certain conditions, the fact that clinical data indicated that the practice was performing significantly below other practices in the area and due to the failure to address the issues, the Respondent could not be assured that the practice had demonstrated adequate governance or leadership.

53. On the basis of those reasons, the Tribunal found that by the time of the reinspection in March 2022, it was reasonable for the Appellant to expect that the Respondent would focus on demonstration of remediation of the issues from the inspection in September 2021 and assurance that there were plans and systems in place to ensure that risk of repetition and therefore risk of harm were minimised. We have found that the Appellant did not have sight of the guidance note, prepared on 9 February 2022, as a result of the settlement of the appeal relating to the decision of 27 September 2021. We had not evidence before us to counter Dr Rahman's assertion that he had not seen the guidance note and the documentation from the CQC supported the clear conclusion that the guidance note had not been shared with Dr Rahman, for whatever reason.

54. Looking at the detail of that guidance note, it is helpful in two respects. Firstly, it makes clear the focus of the Respondent in its reinspection, which is about the Appellant demonstrating remediation of the issues identified in the decision of 27 September 2021 and assuring on future risk. The guidance note also makes it clear that the Respondent intended to review the issues from the 27 September 2021 decision and part of that review would concern Dr Rahman's demonstration of learning to lower future risk, policies and procedures and the staff structure to ensure appropriate management of clinical and non-clinical processes. The Tribunal considered these three elements of the reinspection on 23 March 2022 to be highly significant to its assessment of risk. It seems to the Tribunal that it should take the three elements into account, in assessing risk, at the point of the appeal hearing, as they were clearly decision-making factors for the Respondent in reaching its decision of 29 March 2022.

55. The Tribunal does not accept the argument advanced by Dr Rahman, that there was a legitimate expectation that the CQC would reinspect only in relation to the issues raised in the notice of decision of 27 September 2021. The power to issue or extend an urgent suspension only requires the notice of urgent suspension to set out the reasons why it has reached a decision that it has reasonable cause to believe that unless it acts, any person will be or may be exposed to the risk of harm. The statutory test does not limit what can be taken into account. Equally, it is clearly of significance if by the point of the reinspection or the point of the appeal hearing, the Appellant is able to demonstrate that he has remedied the concerns and that there are no longer breaches of Regulations 12 and 17.

56. We also took into account the fact that Dr Rahman had not has sight of the guidance note of 9 February 2022. This clearly would have assisted his preparation for the reinspection and he accepted as much in cross examination on this point. We consider it significant that he did not have sight of this guidance note. It is significant to this extent – it provides an explanation as to why Dr Rahman provided so much documentation during the appeal. He is entitled to do so – this is his appeal and the Tribunal makes the decision afresh, as of today. We do not say that to absolve Dr Rahman of all responsibility for preparing properly for the reinspection on 23 March 2022, but we take it into account in explaining why Dr Rahman has produced a number of policies and procedures after the reinspection had taken place. He had mistakenly and wrongly assumed that the reinspection would be concerned only with the concerns raised in September 2021.

57. As to the issue of the caretaker practice and its role. We have accepted the evidence from Ms Williams, that the caretaker practice is subject to its own regulatory relationship with the CQC and its role, in taking over CHMC, as with any other practice, is to ensure continuity of care for the CCG and to take a holistic approach to ensuring the practice is run approximately, in accordance with its own regulatory requirements and the contractual requirements with the CCG. It was correct that Dr Rahman, if returned to registration, would be entitled to request the policies and procedures implemented by Federated4Health, and adopt them for his practice, CHMC. However, we do not accept that this arrangement somehow 'absolved' Dr Rahman of his

regulatory responsibilities with the CQC and the requirement to demonstrate remediation of the issues which lead to his suspension in September 2021 and its continuation in March 2022. He was aware, at the time of the suspension in September 2021, that a key reason was the issue of governance, in that he did not have sufficient systems and policies in place to reassure the CQC that he had sufficient oversight of the work of his team. The fact that another practice was caretaking CHMC did not mean that Dr Rahman was no longer required to complete remediation work on good governance, including the content of his policies and procedures, the structure of his senior team and the responsibility for clinical and non-clinical oversight.

58. Dr Rahman's position, that the concerns with the records for the 11 patients identified in June and September 2021 had been remedied by the caretaker practice by the time of March 2022 was not challenged by the Respondent. In addition, the evidence from Mrs Jopling and Dr Spyvee, as to the concerns identified in March 2022, no longer concerned the quality of the records relating to the 11 patients. That was a reasonable conclusion, given that Dr Rahman's registration had been suspended since 29 September 2021 and his involvement in record keeping for patients was not in existence from then until the present day. He had read only access to the records. In any event, we accept the position from the Respondent, that the focus of the reinspection was to look at three elements - Dr Rahman's demonstration of learning to lower future risk, policies and procedures and the staff structure to ensure appropriate management of clinical and non-clinical processes.

Concern 1: record keeping

59. We have carefully considered the record keeping policy which Dr Rahman has submitted (dated March 2022). We have found that it is a sufficient policy for staff to understand the requirements of good record keeping.

Concern 2: clinical oversight

60. We have carefully considered the clinical supervision policy (dated April 2022). We have found that it is a sufficient policy for staff to understand how they will be supervised.

Concern 3: asthma management

61. We have carefully considered the protocol to prevent Salbutamol inhaler overprescribing and asthma management (dated April 2022). We have found that it is a sufficient policy for staff and in describing the responsibilities for reviews.

Concerns 4, 5 and 11: Methotrexate monitoring, Bumetanide management and Lithium monitoring

62. We have carefully considered the high-risk drug monitoring policy (dated April 2022), the audit calendar from 2021, the high-risk drug monitoring data log, reduced quantity template and refusal of blood test monitoring. We have found that these are sufficient policies for staff and the registered provider.

Concern 6: monitoring of patients diagnosed with heart failure

63. We carefully considered the chronic disease management guidance (dated April 2022) and the heart failure guidance note dated 2021. We have found that these are sufficient policies for staff and the registered provider.

Concern 7: monitoring of prescribing for patients who travel abroad

64. We carefully considered the repeat medication policy for patients and for prescribers (dated April 2022) and concluded that they were sufficient policies for staff and the registered provider.

Concern 8: monitoring of patients with a high protein level

65. We carefully considered the blood test policy (dated April 2022) and the dealing with path lab results policy (dated April 2022) and concluded that they were sufficient policies for staff and the registered provider.

Concern 9: monitoring of patients with diabetes

66. We carefully considered the chronic disease management policy (dated April 2022), chronic disease management: diabetes (2021) guidance note and guidance note for diabetes screening tests and gestational diabetes (undated) and concluded they were sufficient policies for staff and the registered provider.

Concern 10: monitoring of patients prescribed controlled drugs (Tramadol and Co-codamol)

67. We carefully considered the controlled drugs prescribing policy (dated April 2022) and the standard operating procedure for prescribing a controlled drug and the collection of the prescription (dated April 2022) and concluded that they were sufficient policies for staff and the registered provider.

Concern 12: monitoring of patients with anaemia

68. We carefully considered the anaemia management protocol (dated April 2022) and concluded that it was a sufficient policy for staff and the registered provider.

Concern 13: monitoring of patients being prescribed Levothyroxine

69. We carefully considered the Levothyroxine prescribing/monitoring guidance (dated April 2022) and concluded that it was a sufficient policy for staff and the registered provider.

Concern 14: management of patients with long-term conditions

70. We carefully considered the chronic disease management policy (dated April 2022) and concluded that it was a sufficient policy for staff and the registered provider.

71. We carefully considered Mrs Jopling's evidence. She assisted the Tribunal to the best of her ability, particularly in relation to the review work which she

conducted in the days leading up to the appeal hearing. She noted a number of concerns which she held with Dr Rahman's documentation, submitted in support of his contention that he has remedied the remaining concerns relating to Regulations 12 and 17. In the Tribunal's view, Mrs Jopling's evidence was, at times, influenced by personal factors. The Tribunal noted her closing oral evidence in which she described Dr Rahman's practice as 'an absolute disgrace'. She also used her experience of a family member's asthma diagnosis to inform her view of Dr Rahman's asthma management with patients. We were not persuaded as to the relevance of this personal experience. We found that Mrs Jopling's oral evidence was, overall, credible, but it was impacted by subjective views she held of Dr Rahman. We noted her role as an enforcement inspector and understood that a large part of her role involved dealing with registered providers who were not in regulatory compliance. We considered that this is more likely than not to have led to Mrs Jopling having a subjective view of the documentation submitted by Dr Rahman on 29 April 2022. Further, we took into account the fair point that Mrs Jopling made, she acknowledged that with certain documents, she could not comment on them as she was not a clinician.

72. We carefully considered the witness statement Dr Rahman prepared for the appeal hearing, as well as his oral evidence. We accepted his explanation as to the creation and review of policies and procedures – he had taken into account good examples of policies from colleagues and other practices. We accepted that there is nothing to prohibit this approach, as long as he ensures he adapts them for the needs of CHMC. Mrs Jopling was critical of the policies, considering them to be 'screen dumps', historical policies and some are not policies at all, but notes and guidance. Mrs Jopling also accepted in evidence that the most effective way to 'test' policies is to implement them. We agree with that position and must consider whether there remains reasonable cause, as of today, to believe that any persons will or may be exposed to risk of harm.

73. Further, we reviewed Dr Rahman's plans for the practice, including the leads for each area of work at the practice. We were reassured by this planning work which he has now put together to ensure appropriate levels of oversight from his team.

74. We took into account the concerns which had been raised in September 2022, the concerns raised in March 2022 and Dr Rahman's evidence by the time of the appeal hearing. We were struck by the notes from the MRM, noting that the reasons considered for arriving at the decision to continue with the suspension, which appeared to involve confusion to patients and harm to the caretaker practice. Further, we accept that the key concern, after the reinspection was the failure on the part of the provider to take sufficient action to prevent patients being at risk of harm. By the time of the appeal hearing, we were satisfied that Dr Rahman has taken appropriate steps to remedy the concerns, to such an extent that we could not be satisfied that there remained reasonable cause to believe that any person will or may be exposed to the risk of harm.

Post hearing issues

75. The appeal hearing concluded on 11 May 2022 and the Tribunal panel deliberated on 16 May 2022. On 20 May 2022, Mr Butler made an application to the Tribunal panel to admit late evidence – a second witness statement from Dr Rahman, which appeared to have been prepared after the hearing had concluded. The witness statement submitted in the application was in fact Dr Rahman's first witness statement, dated 28 April 2022. On 20 May 2022, the CQC responded to object to the admission of a second witness statement and to query the statement, given that appeared to be the first witness statement of 28 April 2022. On 20 May 2022, the Tribunal panel indicated to the parties that it would not admit the second witness statement from Dr Rahman, given that the hearing had concluded and the deliberation had taken place. This decision was communicated to the parties on 23 May 2022.

76. On 25 May 2022, the Respondent contacted the Tribunal to request additional time, until 26 May, to make representations to the Tribunal panel as to the current position. On 26 May 2022, the Respondent submitted an application, inviting the Tribunal panel to reconvene to allow the parties to make representations in light of the Respondent's concern that the Tribunal had been misled by Dr Rahman's oral evidence in cross examination.

77. The Tribunal panel considered the application from the Respondent and issued an order on 1 June 2022, directing the parties to submit a list of issues for the Tribunal panel to consider at the reconvened hearing and listing the reconvened hearing on 16 June 2022. After some communication between the parties and the Tribunal, the date for the reconvened hearing was moved to 17 June 2022. We are grateful to the parties for their flexibility in reconvening the hearing.

78. On 13 June 2022, the Respondent submitted a list of unagreed issues and an application to admit the following documents:

- A witness statement from Ms Julie Ford, previously a solicitor at Hill Dickinson LLP, dated 20 May 2022. In the statement, Ms Ford recounted an alleged telephone conversation with Mr Butler, which was said to have taken place on 19 May 2022; and
- An email file note prepared by Ms Ford at 8.21 am on 20 May 2022, detailing the same alleged conversation with Mr Butler on 19 May 2022.

79. On 14 June 2022, the Appellant submitted a skeleton argument for consideration in advance of the reconvened hearing. On the morning of 17 June 2022, Mr Butler, Mr Connolly, Miss Kiran Bhogal (solicitor at Hill Dickinson LLP) and Dr Rahman attended the reconvened hearing. The Appellant resubmitted a copy of his second witness statement dated 20 May 2022. The Respondent submitted a position statement.

80. We carefully considered all documents detailed above and the oral submissions from the parties on 17 June 2022. Mr Connolly confirmed that Ms Ford was

available to provide oral evidence under oath or affirmation. Dr Rahman confirmed that he would be prepared to answer further questions under oath or affirmation. Mr Butler, on behalf of Dr Rahman, objected to the admission of Ms Ford's witness statement and email file note.

81. Dealing firstly with the application to admit the second witness statement from Dr Rahman. We considered fairness and relevance, having particular regard to the materiality of the evidence to the issues in this appeal and proportionality. In considering fairness, we understood that if Dr Rahman's evidence was to be admitted, it would necessarily open up the question of discussions with his counsel, Mr Butler, and would be highly likely to lead to Mr Butler becoming a witness in the appeal. Mr Connolly helpfully indicated that he would wish to ask Dr Rahman about the contents of Ms Ford's alleged discussion with Mr Butler. This would necessarily lead to the Tribunal panel hearing from Ms Ford in oral evidence and, as a result, Mr Butler, given the indication that the account of the telephone discussion was contested.

82. We next considered proportionality. This is an appeal against a decision to impose an urgent suspension, which is due to expire on 29 June 2022. We did not consider it proportionate to admit the witness statement with the accompanying risks as to the issues it placed before us. The further issues it would open were not, in our view, material to the decision we have reached in this appeal, namely that the Respondent has not provided sufficient evidence of ongoing risk to support the conclusion that an urgent suspension remains necessary and proportionate. The evidence from Dr Rahman was that the February guidance note was rejected by Mr Butler, on his behalf, and he did not consider it in preparing for the reinspection in March 2022. The Tribunal panel concluded that the steps undertaken by Dr Rahman since the reinspection on 23 March 2022, in response to the issues identified, were highly relevant to the assessment of ongoing risk.

83. As to the witness statement from Ms Ford, detailing an alleged conversation she had with Mr Butler on 19 May 2022 about his apparent discussion with Dr Rahman after Dr Rahman had given oral evidence, we concluded that Ms Ford's witness statement as to a lawyer-to-lawyer discussion after the appeal hearing had concluded, was not relevant or material to the decision we had reached in this appeal. Accordingly, we did not consider it relevant or fair to admit her evidence.

Decision

The appeal is allowed.

The Respondent's decision of 29 March 2022 to urgently suspend the registration of Dr Rahman shall cease to have effect.

Judge S Brownlee

Care Standards & Primary Health Lists Tribunal

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

Date issued: 24 June 2022