First-tier Tribunal Care Standards

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

[2023] 4852.EA-MoU
Neutral Citation number: [2023] UKFTT 433 (HESC)

Hearing by video-link
on 21, 22, 23, 27 and 28 March 2023
Panel deliberations on 29 March 2023

BEFORE:
Tribunal Judge Siobhan Goodrich
Specialist Member Dr David Cochran
Specialist Member Pat McLoughlin

BETWEEN:

SPECIALIST MEDICAL TRANSPORT LTD

Appellant

- v -

CARE QUALITY COMMISSION

Respondent

DECISION AND REASONS

The Appeal

1. This is an appeal against the decision made by the Respondent on 12 January 2023 using the urgent procedures power provided under s. 31 (1) of the Health and Social Care Act 2008 ("the Act"). The decision was to impose a condition on the Appellant's registration the effect of which was to prevent the Appellant from providing any regulated services at SMT North with immediate effect until 3 April 2023 at 23.59 hours.

2. The evidence concluded on 28 March 2023. Having received written submissions pursuant to directions made on 28 March 2023, and having deliberated, the Tribunal issued a short form decision on 30 March 2023 allowing the appeal. We have amended the short form decision pursuant to rule 44 of the Tribunal Rules. We now provide our full reasoning.

3. When we refer to “the Appellant” we refer to the company as an entity. Mr Bryne is the sole owner/provider.

Restricted Reporting Order

4. 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 in this case, so as to protect confidentiality and privacy.

The Background

5. This includes the following:
    a. The Appellant provides patient transport services including the secure transport of patients detained under the Mental Health Act (MHA). Its services are commissioned by NHS Trusts and Integrated Care Boards (ICBs).

    b. The Appellant provides these services, which are regulated activities, at two registered locations: Basildon, at which the company head office is also situated, and SMT North in North Shields.

    c. Two other sites are managed remotely under the Basildon registration: in Hampshire and Devon.

    d. The Basildon location was first registered on 24 April 2019. When inspected in January 2022 it was rated as “good” overall for patient transport services and emergency and urgent care.

    e. SMT North was registered as an additional location on 12 May 2021.

    f. The decision under appeal only concerns SMT North where Mr Cooper was appointed as the Registered Manager (RM) for SMT North. Ms Cooper (his daughter) is the Operations manager.

    g. The Registration certificate granted describes the regulated activities which are relevant to this appeal as “Transport services, triage and medical advice provided remotely”.

    h. On 5 December 2021 the Respondent received allegations from a whistle blower (WBA). The allegations included: staff on the road without prior training BLS (blue lights) oxygen; staff acting as Emergency Care Assistants without qualifications; no training in manual handling so patients are being put at risk; staff driving on blue lights without qualifications; IPC (infection prevention control) not being followed; staff members under investigation for assault to patients (mental health) stealing patient money and still on road; staff working shift without 11 hours in between; patient confidentiality at risk, staff talking openly about patient situations including names, addresses, diagnoses etc.

i. Mrs Wood, an inspector for the CQC, was the relationship owner for SMT North from November 2022. She had briefly been the Relationship manager earlier that year. In light of the WBA she wrote to Mr Cooper by email requesting a number of documents on 5 December 2022, 7 December 2022 and 12 December 2022. Mr Cooper responded on 6 December, 9 December and 12 December 2022. There were also telephone calls in that period. As summarised in Mrs Dronsfield's witness statement on 14 February 2023 at [21], there were still concerns about the use of physical and mechanical constraint, and training and audit data had limited details.

j. Following a Management Review Meeting (MRM) on 19 December 2023 with Mr Storton, the Inspection Manager, it was decided that review of the initial and additional information provided had highlighted concerns about the management of service and governance processes in place to ensure that the service was being run safely. The CQC was not assured that that best practice was being followed. It was therefore decided to bring forward the scheduled inspection from later in the first quarter of 2023 to January 2023. This was to be the first inspection of SMT North following registration in May 2021.

k. On 10 January 2023 the Respondent carried out an inspection with two CQC inspectors, Mrs Wood and Mrs Preston, and with a specialist advisor Mr Rob Cole, a consultant paramedic with 28 years' experience in the NHS Ambulance Service.

l. Notice had been given by Ms Wood at 1pm on 9 January 2023 because it was recognised that Mr Cooper might otherwise be working as crew. The inspection began at 9am and concluded at 16.45 hours.

m. In her witness statement dated 15 February 2023 at [62] Mrs Wood said that when asked by Mr Cooper if it was possible that there would be urgent actions taken she said yes. At [65]) Mrs Wood described that, at the end of the inspection, she had advised Mr Cooper and Ms Cooper that she and the inspectors held significant concerns about the quality of personnel files, governance, training and DBS checks and that they would be attempting to contact mental health patients for feedback. Mr Cooper became visibly upset. Mrs Woods advised Mr and Ms Cooper to approach the outcome of the inspection with a positive attitude, to use the concerns raised as a learning opportunity, and to get their governance in order. This would prepare them well for the future and their transition to emergency care services.

n. On 11 January 2023 Mrs Wood and Mrs Preston presented their inspection findings to Mr Storton, Inspection Manager, and Mrs Dronsfield, the Deputy Regional Director and the decision maker, at an MRM. Following the presentation of the evidence, advice was sought from the CQC legal team. Following immediate re-presentation to the

legal team the decision was made on 12 January 2023 to impose a condition to prevent all regulated activity at SMT North for three months.

o. On 12 January 2023 the Respondent sent the decision under appeal by email to Mr Cooper and also to Mr Bowyer, the CEO of the Appellant company.

p. On the same day Mr Storton and Mrs Wood held a Teams call with Mr Cooper to inform him of the "decision to suspend regulated activity" for three months (Mrs Wood's statement at [20]). At the request of Mr Cooper the same information was repeated to Mr Bowyer, the Appellant's Chief Executive Officer (CEO).

q. SMT North therefore ceased all regulated activity on 12 January 2023. Some 14 of its bank staff, engaged as independent contractors, were laid off. Some 5 employees were kept on salary - including Mr and Ms Cooper.

r. On 7 February 2023 the Appellant lodged its appeal.

s. On14 February 2023 the Respondent sent the draft Inspection Report to the Appellant.

t. On 28 February 2023 the Appellant submitted some 169 points under section B of the Factual Accuracy (FA) process. Section B involves the accuracy of the evidence in the draft inspection report. Section C of the FA process concerns additional or omitted information. The Appellant also submitted 7 points which largely concerned a new form it had devised to record "Dynamic Risk Assessment".

u. As at the date of the hearing, the outcome of the FA process had not been communicated to the Appellant because the response was still subject to the final checking process. The inspection report had, therefore, not been published by the date of the hearing - although the draft was before us.

v. In summary the Inspectors identified 6 breaches of regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 14: Meeting nutritional and hydration needs
- Regulation 17: Good governance; and
- Regulation 19: Fit and proper persons employed.

x. Across these breaches the Inspectors identified that there were some 17 areas where the Appellant must improve, and 2 areas where the Appellant should improve.

y. The overall rating for the location was:
- inadequate in the inspection domains of safe, effective, and well led, and
- requires improvement in the domains of caring and responsive to people's needs.

6. We consider that, unless the various challenges to factual accuracy were to be substantially accepted by the Respondent, the formal and published outcome of the inspection undertaken on 10 January 2023 would ordinarily result in the imposition of Special Measures.

The Decision under Appeal

7. In the NoD the Respondent stated that it made the decision under s. 31 (1) of the HSCA 2008 to take immediate effect because it reasonably believed that *"unless this urgent action was taken a person will or may be exposed to the risk of harm if we do not do so."*

8. In summary paragraphs [2] – [7] set out in the NoD provide the "stem" of the allegations with details of the matters of concern held provided thereafter. We have taken account of all the detail provided. For present purposes we refer to the stem only.

"2. You do not have systems and processes to ensure staff assess, and make plans to respond to, the risks presented to service users in carrying on the regulated activities. You have not maintained appropriate records to evidence service users' risks and needs were assessed and met prior to and during transports. This puts service users at the risk of harm.

a) The service did not have clear criteria or service specification to ensure staff assess whether they are able to meet the needs to service users prior to accepting bookings.

b) Staff did not undertake risk assessments prior to accepting a booking to ensure service users would receive safe care. Staff did not undertake an assessment of, or make plans to manage, service users' presenting risks or needs prior to commencing the journey. Staff did not maintain records of journeys to evidence service users' risks were managed and needs were met. We reviewed and took copies of the records of journeys for 19 service users…..

3) You have not implemented effective processes to safeguard service users from the risk of improper treatment and/or abuse. You do not have systems or processes to ensure the control or physical or mechanical restraint of a service user is the least restrictive option, is necessary and is proportionate to the risk

in order to prevent a risk of harm to service users or others. This puts service users at the risk of harm….

4) You have not ensured all staff have the training, competencies, supervision and appraisal required to provide safe care. This puts service users at the risk of harm….

5) You have not ensured care and treatment is provided with the consent of service users, or ensured staff have the training and experience required to consider and assess capacity for service users who may lack the mental capacity to consent to their treatment. This puts service users at the risk of harm…

6) You do not have effective governance and systems and processes to identify, assess, record, manage and mitigate risks in the delivery of the service. This puts service users at the risk of harm…

7) You have not ensured all staff recruited by the service are fit and proper persons for their roles. This puts service users at risk of harm…"

The Appeal

9. The Reasons for the appeal included that: the safety of users has not been compromised and service users will not be exposed to the risk of harm if the condition were not to apply; the findings in the decision are for the most part not based on full and correct information and many subjective conclusions based on incomplete facts had been reached; the Respondent's methodology and rationale for issuing the decision is inherently flawed; the decision was made in haste; the areas for improvement were not, in and of themselves, sufficient to justify the decision; sufficient steps have been taken and continue to be taken in relation to areas for improvement; the decision was disproportionate; the Respondent had other options available which it could have considered; the Respondent has not properly set out its reasons in the decision by failing to reference regulatory breaches throughout the decision; the Respondent is elevating regulatory requirements into a criminal breach through the imposition of conditions.

10. The Appellant submitted with the appeal (Appendix B) a 34 page "Detailed Response to the issues set out in the Notice of Decision" along some 60 or more appendices. Amongst other matters, the Appellant's case is that it had systems and processes in place to ensure that the risks presented to service users are considered and mitigated against. In relation to MHA patients in particular, it contends that the Respondent had failed to understand the nature of the service provided, the features of which include that the request for the booking is made by an Approved Mental Health Practitioner (AMHP). The process essentially involved: a Secure Transport Booking Form; that the AMHP communicates and discusses risks with the Appellant when booking is requested; a Conveyance Plan (provided by the AMHP); that the journey was authorised, and the needs of the patient and issues regarding consent, capacity and restraint, had been risk assessed by the AMHP who, if not accompanying the patient, or travelling in a following car, is available to be contacted.

The Respondent's Reply

11. The formal Response (settled by different counsel) to the appeal on 14 February 2023 was relatively short. It relied on the NoD and contended that the decision was proportionate. The overarching points made were that:

    - the Respondent was mindful that the cohort that the service catered for is amongst the most vulnerable in society.
    - Given the identified safeguarding concerns and its statutory duties it is incumbent on the Respondent to take appropriate action when safeguarding concerns such as those identified in the inspection are raised.
    - The condition itself is proportionate – it is in place until 3 April 2023. This enables the CQC to protect patients whilst giving the Appellant the opportunity to improve and embed any improvements.

Attendance

12. The Appellant was represented by Mr Mark Ruffell and the Respondent by Ms Rebecca Griffiths. Others in attendance included the following witnesses from whom we heard evidence.

    For the Respondent

    Mrs Kim Wood: Lead Inspector

    Mrs Toni Preston: Inspector

    Mr Storton: Inspection Manager

    Mrs Dronsfield: Deputy Director of Operations, and the decision maker.

    For the Appellant:

    Mr Byrne: the owner of the Appellant company.

The Bundles and Late Evidence Applications

13. We received before the hearing a very large e-bundle (and in hard copy) which comprised some 3260 pages which included the parties' skeleton arguments. We also received, along with T109 applications, the Appellant's further witness statement dated 17 March 2023 and exhibits, together with the Respondent's Review of some of the documents submitted by the Appellant. Yet further evidence was produced during the hearing with the agreement of the parties. The parties agreed that the late evidence was relevant and that it was fair that we should receive it. We therefore agreed to the reception of the late evidence.

The Hearing

14. At the start of the hearing the judge, on behalf of the panel, sought to identify the core issues in the exercise of case management. The panel was aware that the

order was due to expire on 3 April, leaving some 6 or so working days after the hearing was scheduled to conclude. Ms Griffiths informed us that the Respondent's intention was to perform a further inspection before the condition expired on 3 April 2023.

15. Matters canvassed included (not necessarily in this precise order):

a) The parties agreed that the core issue was the assessment of risk, and proportionality, in the context of urgent procedures under s. 31.

b) The judge referred the parties to **GM and WM v Ofsted** (see below) which, albeit in the context of an interim suspension pending investigation and under different legislation - could be taken to support that the assessed risk, when considering the imposition of an urgent measure under s. 31, should be one of "significant" harm in order to meet the requirement of proportionality.

c) Ms Griffiths did not agree. She explained the Respondent's position:

- this was not a suspension decision but was a proportionate decision to impose a condition.
- The proportionality of the decision made is shown by the fact that the condition was only imposed on SMT North and not at Basildon.
- the word "harm" should not be qualified in any way because the word "significant" does not appear in s. 31 (1) of the Act.

d) When asked further about this, Ms Griffiths submitted that the Respondent's position was that "harm" for the purposes of s. 31 (1) would only need to be "more than trivial".

e) The judge asked the parties to consider the Court of Appeal decision in **Jain v Trent SHA** (see below) which, although involving an appeal against urgent *cancellation*, and thus involving the *likelihood* of *serious* harm, might provide some guidance regarding the general principles to be considered when considering the discretionary use of urgent procedures under the Act.

f) The panel noted that the Respondent had provided extensive background reference/guidance documents from various sources, but without identifying which particular parts of the same it relied on.

g) The panel also noted that an important aspect in this appeal was that there appeared to be a large gap between the parties regarding the approach in the context that an Approved Mental Health Practitioner (AMHP) is inevitably involved in risk assessment regarding the patient's transfer/conveyance and assessment of issues of consent and mental capacity. A great deal of guidance had been produced by the Respondent but without any specific analysis of how it assisted the panel

in relation to the issues. The panel asked the parties to consider Chapter 17 of the Mental Health Code of Practice (MHCoP). It seemed to us that Chapter 17 might be relevant to the apparent gap between the parties and consideration of this by the parties might possibly save time.

h) The panel noted that no Scott Schedule (SS) had been provided. We understood both parties to say that there had been no direction for a SS. As the panel pointed out soon after, this was incorrect: direction had been made on 9 February 2023 and repeated on 15 February 2023. In our view the fact that the Respondent did not prepare a SS, to which the Appellant would have had to respond, did not further the overriding objective. Apart from anything else the discipline of a SS means that the parties have to focus their attention to the facts and matters relevant to the assessment of risk, and to specify which particular parts/pages of the 3000 plus pages it relies on.

i) The judge referred to the very large amount of material submitted by the Appellant when the Notice of Appeal was lodged and since. She asked the parties to liaise to see if there were any possible areas where the matters relevant to its consideration of risk might be further narrowed.

j) Ms Griffith offered that Mr Storton should go through the decision letter to identify the matters that were still "live" as per the decision letter. The effect of Mr Storton's analysis was that everything was live, save that he stated that the issues raised regarding para 3 b) to d) (training) would need to be considered in the context of the further inspection which was imminent.

16. By the late afternoon on 21 March 2023/early on 22 March 2023:

- the Respondent provided a schedule of the guidance that it considered relevant. However, this did not refer to page or paragraph numbers relied on.
- The panel were provided with a document that reflected the parties' collated positions regarding Ground 2 and 3 of the NoD.
- Following cross examination of Mrs Wood the judge requested that a joint document be prepared recording the evidence she had given regarding risk assessment.

The General Legislative Framework

17. Amongst other matters s. 2 of the Health and Social Care Act 2008 (the Act) invests in the CQC *"review and investigation functions…."* – see s. 2 (b).

17. Section 3 provides that:

"(1) The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services.

(2) The Commission is to perform its functions for the general purpose of encouraging–

(a) the improvement of health and social care services,

(b) the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and

(c) the efficient and effective use of resources in the provision of health and social care services…"

18. Section 4 provides:

Matters to which the Commission must have regard

"(1) In performing its functions the Commission must have regard to—

(a) views expressed by or on behalf of members of the public about health and social care services,

(b) experiences of people who use health and social care services and their families and friends,

(c) views expressed by Local Healthwatch organisations or Local Healthwatch contractors about the provision of health and social care services,

(d) the need to protect and promote the rights of people who use health and social care services (including, in particular, the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005 (c. 9), and of other vulnerable adults),

*(e**) the need to ensure that action by the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed**.*

(f) any developments in approaches to regulatory action, and

(g) best practice among persons performing functions comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable and consistent)."

(**our **bold italics)

19. Section 31 provides:

"31 Urgent procedure for suspension, variation etc.

*(1) If the Commission has **reasonable cause to believe** that **unless it acts under this section** any person **will or may be exposed to the risk of***

***harm**, the Commission **may**, by giving notice in writing under this section to a person registered as a service provider or manager in respect of a regulated activity, provide for any decision of the Commission that is mentioned in subs. (2) to take effect from the time when the notice is given.*

(2) Those decisions are—

*(a) a decision under s. 12(5) or 15(5) to vary or remove a condition for the time being in force in relation to the registration **or to impose an additional condition;***

(b) a decision under s. 18 to suspend the registration or extend a period of suspension.

(3) The notice must—

(a) state that it is given under this s.,

(b) state the Commission's reasons for believing that the circumstances fall within subs. (1)

(c) specify the condition as varied, removed or imposed or the period (or extended period) of suspension, and

(d) explain the right of appeal conferred by s. 32…"

*(our **bold italics)***

The Regulated Activity Regulations

20. Under section 20 of the Act the Secretary of State is empowered to make regulations in relation to the regulated activities. The regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 (the Regulations). Part 3 contains various provisions under the heading "Fundamental Standards".

21. In this appeal Ms Dronsfield explained that she focused on four of the fundamental standards when undertaking the risk assessment.

Regulation 12: "Safe care and treatment",
Regulation 13: "Safeguarding service users from abuse and improper treatment"
Regulation 17: "Good governance"
Regulation 19: "Fit and proper persons employed."

The Parties' Closing Submissions

22. There are some aspects of the law made in the parties' closing submissions (ACS/RCS) that we are unable to accept at all - and others which we cannot accept without appropriate qualification. For example:

    i. The Appellant submitted in the ACS at [5] that the burden of proof lay on the Respondent to satisfy the Tribunal of facts which supported the Respondent's reasons, and proportionality, on the balance of probabilities. In our view this is incorrect in law and, if adopted, would amount to a material misdirection/ error of law.

    ii. We are unable also to agree with the Appellant's submissions regarding the decision in **Jain and another v Trent Strategic Health Authority** [2007] EWCA Civ 1186. In our view the distinction the Appellant seeks to make i.e. that the effect of the condition imposed amounted to a suspension, has no real bearing on the correct threshold test when the exercise of powers under s 31 (1) are being considered.

    iii. We noted that the Appellant's submission regarding "no course other" as per Lord Carswell in **Trent Strategic Health Authority v Jain** [2009] UKHL 4 at [51], However this was said in the particular context that the impugned decision was made *ex parte* before the Magistrate i.e. that no opportunity had been provided <u>at all</u> to enable the appellant in **Jain** to address concerns.

    iv. We consider the Respondent's submissions are more closely aligned with the law. However, there one aspect of the Respondent's legal submissions with which we do not entirely agree. Ms Griffiths submits that we are not in a position to find any facts because our function is that of risk assessment. Whilst we entirely agree that our ultimate function is that of risk assessment in the light of all circumstances, the circumstances can include any findings of *past fact* that we consider can be fairly be made on the evidence before us.

Self-Direction

23. In so far as any past facts may need to be decided which are relevant to our essential task of risk assessment, the Respondent bears the burden of proof. The standard of proof is the balance of probabilities.

24. The burden of satisfying us that the threshold test under s. 31 (1) is met and that the decision is necessary and proportionate lies on the Respondent. The standard of proof 'reasonable cause to believe' falls somewhere between the balance of probability test and 'reasonable cause to suspect'. The belief is to be judged by whether a reasonable person, assumed to know the law and possessed of the information, would believe that a person may be exposed to a risk of harm. It is a low threshold test.

25. **GM and WM v Ofsted** [2009] UKUT 89 (AAC) concerned the exercise of the power to suspend under the Childcare Act 2006 in relation to a similarly low "threshold" test. At [20] Lord Justice Carnwath said that:

"….Although the word "significant" does not appear in regulation 9, both the general legislative context and the principle of proportionality suggest that the contemplated risk must be one of significant harm…."

26. There is no definition of "harm" in the Act. It is an ordinary word and needs no gloss. In the overall legislative context of the Act we take "harm" to embrace harm to the health, safety and welfare of service users. We also consider that "harm" includes physical or psychological harm.

27. The appeal against the urgent decision made by the Respondent lies under s. 32(1)(a) of the Act. On consideration of the appeal the Tribunal may confirm the decision or direct that it is to cease to have effect – see s. 32(5).

28. Under s. 32 (6) of the Act the Tribunal also has power to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates. "A "discretionary condition" means any condition other than a registered manager condition required by s. 13 (.

29. We have considered the parties submissions regarding the decision of the Court of Appeal in **Jain and another v Trent Strategic Health Authority** [2008] QB 246 which involved an urgent cancellation decision under s 30 (1) (b) of the Registered Homes Act (repealed but substantially re-enacted in the Care Standards Acts). The threshold test for cancellation under s. 30 the RHA was the same as that now found in s.30 (1) of the Act i.e. "it **appears** to the justice that, unless the order is made, there **will** be a **serious** risk to a person's life, health or well-being." (our **bold**). This is a higher threshold test than applies in this appeal and it involves a higher standard of proof.

30. In terms of matters which we consider are of general application, we noted that Lady Justice Arden said this at [79]:

> *"I have not found in any of the authorities to which we have been referred any explicit discussion of what is meant by the requirement [referring to s. 30(1)(b)) that there should appear to the magistrate to be a serious risk to the life, health or well-being of residents unless the order is made. However, in my judgment, it is implicit in that requirement that there should be a significant risk that the residents will suffer harm within the timescale that would otherwise be required under the ordinary procedure provided for by ss 28 and 31 to 33. That question involves making a judgment on a number of matters, including the vulnerability of the residents, the seriousness of the shortcomings…. and how long it would take for the proprietors to put them right…".*
>
> *(our underlining)*

Our Consideration and Reasoning

31. We have considered all the witness statements, documentary and oral evidence before us as well as the skeleton arguments and closing written submissions. If we do not refer to any particular part of the evidence or submissions, it should not be assumed that we have not taken them into account.

32. The Appellant's essential case is that even if everything was not documented as well as it might/should have been, dynamic risk assessments were being made by staff and proper care was being provided. It relies, amongst other matters, on the positive evidence provided. That said, Mr Byrne acknowledged in the appeal documents that various aspects of process and documentation needed improvement and were being addressed. In particular, the Appellant's case is that it has recognised the need to positively record and demonstrate how it meets the fundamental standards and assesses care needs and risk. The Appellant's case is that a great deal of work has been undertaken to address the many concerns raised by the Inspectors. In cross examination Mr Byrne agreed that some of the revised documentation could be the subject of further refinement. However, the Appellant's core case is that the urgent order made on 12 January was unnecessary and wholly disproportionate.

33. In summary the Respondent's case in closing is that:
    a. There has been poor organisation in SMT in responding to the issues raised;

    b. Whilst SMT has put some additional measures in place, considering the history, these should have been put in place some time ago, and they remain incomplete;

    c. The provider has not shown it has sufficient understanding of the robust procedures required for ensuring safe systems within the regulatory regime, having had 3 months to reflect and make changes, or 1 year, if considering the inspection at Basildon;

    d. There is not cogent evidence of sufficient change, and of all the necessary changes having been embedded, such as would be necessary for the condition to be removed; and

    e. The nature and extent of the ongoing concerns are such that there is a significant risk that, unless the condition remains, any person will or may be exposed to the risk of harm.

Overview

34. The fact that we make a *de novo* decision provides the opportunity for any Appellant, subject to fairness, to provide/call evidence that addresses the relevant issues as at today's date. It also allows the Respondent, also subject

to fairness, the opportunity to rely upon matters which did not feature in its original reasoning and/or further evidence. The fact that we can take into account evidence as at the date of hearing does not alter the fact that we are deciding an appeal against the decision made on 12 January 2023.

35. The 64 appendices that the Appellant provided with the appeal included a Detailed Response and also included statements from Mr and Ms Cooper as well as the other personnel to whom the Inspectors and Specialist Adviser spoke on 11 January 2023. None of these statements from staff/personnel contained a statement of truth and none of these witnesses were called as witnesses. In these circumstances we attach no weight to their contents.

36. By way of general background/context there are some matters regarding the inspection on 10 January 2023 about which there is, however, no dispute. Mr Cooper became tearful during the interview and, according to Mrs Wood, broke down on some four occasions. However, he declined the offers made by the Inspectors to take a break. On any basis, it appears that he found the process difficult and challenging. This is a neutral fact. Immediately after the decision Mr Cooper offered his resignation to his employer. He and Ms Cooper were signed off from duties on grounds of ill health. They are still employed by the Appellant.

37. In his evidence Mr Byrne told us that he has recently started the process of seeking to secure the ending of the current employment relationship with Mr Cooper. He wants to employ Mr Lee Palfrey as the RM. Mr Palfrey had been RM until he resigned due to health reasons. Mr Palfrey has recently made an application to the CQC for appointment as RM. That application awaits consideration by the Respondent's registration department.

38. Mr Byrne said in evidence that he felt let down by Mr Cooper. The broad impact of his evidence is that he had been mistaken in his assessment of Mr Cooper's management abilities. We agree with the Respondent that this appears to suggest a lack of insight and/or governance oversight into the quality of Mr Cooper's management as RM at SMT North.

39. We find that the basic chronology is as set out at [4] above.

40. The opinions of Inspectors, when reached in a manner that addresses the issues in a balanced and objective manner, ordinarily command respect. The right of appeal is, however, meaningless unless the panel performs its duty to carefully consider the issues in the context of the general legislative context and carefully examines the opinions expressed regarding the issue of risk. Importantly, the panel must form its own view regarding the level of risk, necessity and the exercise of proportionality in the light of all the evidence, and in so doing, must take account of the guidance contained in the Respondent's Enforcement Policy and Decision Tree, amongst other guidance documents.

41. In the interests of transparency the judge explained to the parties that, based on our collective experience over many years, the use of the *urgent* procedures under s. 31 (1) to impose a condition that has the effect of preventing the continuation of regulated activity for any period of time is rare. The parties did not disagree.

42. Under the *non-urgent* procedures, which can include - and in our experience, often does include a decision to impose condition(s) on a substantive basis, the statutory process requires the Respondent to set out the reasons for the enforcement action it is contemplating in a Notice of Proposal (NoP) - see s. 26 - to which the Registered entity or individual, as the case may be, has the right to respond within 28 days - see s. 27. A decision to adopt the NoP cannot be made until the time permitted for response to the Notice of Proposal has expired. There is a right of appeal against the decision made. If exercised, the decision cannot take effect until the determination or abandonment of the appeal – see s. 28 (6).

43. If an appeal against a *non-urgent* decision is made the appeal process is likely to take between about 6 and 12 months before it comes to a hearing. By this time any forensic issues regarding the finalisation of an Inspection Report in the context of the Factual Accuracy process will have been long since completed. It is within the experience of this Tribunal that appeals in non-urgent procedure cases may often be resolved because, for example, necessary improvements have been made and, if so, there has been the opportunity to see if and to what extent any improvements have been embedded. It sometimes occurs that proceedings are stayed or the time-table for hearing is extended, or even that hearing dates are postponed, often at the request of both parties, to enable further inspection and the extent of any progress to be fully assessed. The overall point is that the use of the non-urgent procedure involves a statutory process whereby the Respondent has to explain its concerns, give notice of its proposal, and consider any response. The practical effect is that this enables any Appellant a very substantial period of time to seek address the issues and to show improvement.

The Assessment of Risk

44. The NoD stated that the matters it relied at paras 2) to 7) on “puts service users at risk of harm.” There was no reference in the NoD to the degree/extent/nature of risk relative to the breaches raised. The assessment of risk at the MRM was reached via the application of the Enforcement Policy and the Decision Tree. The ultimate decision was made by Mrs Dronsfield.

45. In his oral evidence Mr Storton referred to the need for the delivery of care to be “safer” and the need to “mitigate risk to the minimum”. Of course, we agree that improvement of services is of very high importance to the fulfilment of the statutory duties imposed on the CQC. However, we are here concerned with the imposition of a condition using the *urgent* procedures, and one which required the cessation of all regulated activity for a period of 3 months. We consider that this involves consideration of justification, necessity and proportionality in the context of all relevant circumstances.

46. Justification in this context refers to procedural justification i.e. whether the decision was in accordance with law/regulations/guidance that is published, known and/or accessible. We consider that there can be no doubt that some form of enforcement action was justified on 12 January 2023.

47. In our view, a decision as to whether to use the urgent procedure, as opposed to non-urgent procedures, requires that a considered view is reached about the degree/nature of risk in the context of all relevant circumstances, and that the decision reached is necessary and proportionate.

48. Since our function is to determine the appeal de novo any deficiencies in reasoning in the NoD are unimportant and/or can easily be cured by further evidence. For example, the Respondent did not specify which breaches of the Regulations it has identified but it has now done so. There was little in the NoD that indicated how the Respondent had assessed the level or significance of the risk of harm or why the decision made was proportionate in all the circumstances.

49. The written and oral evidence from Mrs Dronsfield addressed how she reached her decision. In her statement dated 14 February 2023 she said that:
    a. The seriousness of the breach, following discussion with the inspection team and legal advice, was identified as “extreme ” - see [25]. This is a term drawn from the Decision Tree.

    b. A discussion therefore took place about urgent cancellation or urgent suspension. This was discounted as the inspection team had identified risk at only one of the Appellant’s locations and Basildon was currently rated as good – see [27]. She explained that she considered it proportionate to impose an urgent condition (rather than suspension) - because otherwise the Basildon registration would also have to be suspended.

    c. Urgent removal of location was considered but this would be one of the most serious actions and would not offer the provider the opportunity to improve – see [28].

    d. The short-term impact of suspending regulated activities at this location would have on service users and other providers was considered. It was considered that the need to protect patients outweighed the impact that

this would have which could be overcome by alternative provision - see [29].

e. She went on to refer at [30] to the decision she made as "the urgent imposition of conditions under s. 31 to suspend regulated activity" at SMT North. She made the decision to:

"impose the condition to suspend the regulated activity for a time limited period as this immediately protected patients from the risk of harm, it enabled the provider to look at our concerns, reflect upon them and put action, systems and processes in place to mitigate the risks to patients and it was a long enough period for the provider to address the issues identified."

50. Distinctions have been drawn in this appeal regarding whether this was or was not a decision "to suspend" and/or to impose a condition". In our view it is obvious that Mrs Dronsfield, and Mrs Wood on 12 January 2023, had referred to suspension precisely because they recognised that the effect of the condition imposed amounted to an immediate suspension of all regulated activity for a period, in all but name. In our view the fact that the condition imposed had the effect of an urgent suspension is not important in itself. The key point is that Mrs Dronsfield's witness statement shows that her initial decision making started at the very top of the Decision tree.

The Respondent's Policy/Guidance

51. It is not for us to conduct an overall critique of the Respondent's Enforcement Policy or the Decision Tree. Experience informs us that both these documents have been the product of consideration and review and have been in place for very many years. We only seek to summarise the main elements of the guidance so as to consider its application in this case. We recognise that the Decision Tree must be read in the context of the Enforcement Policy (EP).

The Enforcement Policy

52. The Introduction to the EP recognises that:

"there will be occasions, when, depending on the facts of an individual case it will not be appropriate to follow the precise steps described in this policy. It should be read as a general guide to good practice when carrying out or considering enforcement action. It cannot substitute for judgement in individual cases."

53. The purpose and principles of enforcement are described at pages 7 and 8 of the policy. The main features of the EP are that:
    a) The two primary purposes of the CQC are:

1. To protect people who use regulated service from harm and the risk of harm to ensure they receive health and social care services of an appropriate standard.

2. To hold providers to account for failures in how the service is provided.

b) The principles that guide the use of enforcement powers make clear that the starting point for considering the use of all enforcement powers is to assess the harm or risk of harm to people using the service.

c) As to Proportionality section 3 (at page 9) of the EP states:
"We will only take action that we judge to be proportionate. This means that our response, including the use of enforcement powers must be assessed by us to be proportionate to the circumstances of an individual case. Where appropriate, if the provider is able to improve the service on their own and the risks to people who use the service are not immediate we will generally work with them to improve standards rather than taking enforcement action. We will generally intervene if people are at an unacceptable risk of harm or providers are repeatedly or seriously failing to comply with their legal obligations."

The Decision Tree

54. We focus on Stage 3 of the Decision Tree (DT) which concerns the selection of appropriate enforcement action. Amongst other matters this states:

"…the decision-making process seeks to ensure that we take consistent and proportionate actions without being too prescriptive. It should not result in mechanistic recommendations but should guide decision makers to reach appropriate decisions."

This stage uses two criteria which are:

- "Seriousness of the breach
- Evidence of multiple and/or persistent breaches".

55. The DT then addresses Stage 3A (1) "Potential impact of the breach" which concerns the assessment of the level of the potential impact that would result if the breach of the legal requirements was repeated. "The focus is on reoccurrence to assess if we should act to protect people using regulated services from harm in the future." It provides three categories: Major, Moderate and Minor

56. "Major" is defined as:

"The breach, if repeated, would result in a serious risk to any person's life, health or wellbeing including:

- permanent disability
- irreversible adverse condition

- significant infringement of any person's rights or welfare (of more than one month's duration) and/or
- major reduction in quality of life"

57. "Moderate" is defined as

"The breach, if repeated, would result in a risk of harm including:

- temporary disability (of more than one week's but less that one month's duration
- reversible adverse health condition
- significant infringement of any person's rights or welfare (of more than one weeks but less than one month's duration); and/or
- moderate reduction in quality of life."

58. "Minor" is defined as:

"The breach, if repeated, would result in a risk of:

- Significant infringement of any person's rights or welfare (of less than one week's duration; and/or
- minor reduction in quality of life
- minor reversible health condition."

59. The next stage 3A (2) refers to the assessment of "Likelihood that the facts that led to the breach will happen again". The likelihood should be based on the control measures and processes in place to manage the risks identified, including changes in practice.

60. Stage 3A (3) deals with the "Seriousness of the breach". It provides a chart which, by reference to the assessment of the potential impact of the breach (3A (1) above), and the likelihood that the fact giving rise to the breach will happen again (3A (2)) above, produces a description of the potential impact in grid form ranging from low, medium, high and through to "extreme".

61. Stage 3A (4) is then used to reach an initial recommendation about which enforcement powers should be used to protect people using the service from harm or the risk of harm. The initial recommendation where the seriousness of the breach has been identified as "Extreme" is:

"Urgent cancellation

Urgent suspension

Urgent imposition… of conditions."

62. Where the risk is judged to be "high" the initial recommendation is for the same actions as above but on a non-urgent basis.

63. Stage 3B involves “Identifying multiple and/or persistent breaches.” This can result in a change to the initial recommendation for enforcement action by increasing or decreasing the severity. This stage involves consideration of the 3B factors:

- 3B (1) Has there been a failure to assess or act on past risks?
- 3B (2) Is there evidence of multiple breaches?
- 3B (3) Does the provider’s track record show repeated breaches?
- 3B (4) Is there adequate leadership and governance?

64. The DT guidance is that, depending on the answers to each of the above, inspectors should make an overall assessment about the most appropriate action to take. The answers to the 3(B) questions above may increase or decrease the severity of any recommended enforcement action.

65. We focus on the evidence given as to how the DT guidance was applied when the discretionary decision to use the urgent procedure was reached in the context of this particular case.

66. We have already set out Mrs Dronsfield’s approach as set out in her witness statement: see [49] above.

67. In his oral evidence Mr Storton explained that the outcome of the chart at 3A (3) was “High” which was based on the potential impact being viewed as “moderate” and the likelihood that the facts giving rise to the breach will happen again as “probable”. He explained that the outcome of consideration of the Stage 3 B factors identifying multiple and persistent breaches was to increase the severity of enforcement action to a position where it was considered that the criteria for the imposition of Urgent conditions was met (i.e. the seriousness of the risk as “Extreme”.) We will return to the DT in due course.

68. In many cases the fact of multiple breaches of the fundamental standards can readily be seen to support that there is or may be a risk of harm such as to render the decision necessary and proportionate. However, each case turns on the context in which the regulated services are provided.

69. In our view the core of the Respondent’s concerns relates to the adequacy of the records, systems and processes to demonstrate the quality of the care provided and the assessment of risk to patients - see the NoD at 2) and 3) in particular and the facts and matters relied on. For example, reliance is placed on the absence of any records recording why the cell and/or other restraint had been used. A repeated theme in the evidence of Ms Dronsfield was that the absence of evidence was “evidence in itself”. Her oral evidence, which was in line with that of Mr Storton, was that the provider “could not demonstrate mitigation of risk to the lowest point.” In our view the quest for “mitigation to the

lowest point" (whilst an obviously desirable goal) is not the core issue when considering the imposition of urgent measures.

70. Of course, we accept that the fundamental standards spell out the need to demonstrate in the records the consideration has been given to all aspects of care needs and that patient risk assessments are undertaken and recorded.

71. The discretionary use of urgent enforcement procedures has to be proportionate to the risk of harm engaged in all the circumstances and the nature and seriousness of the breaches alleged/concerns, in the overall context of the service,

72. Nobody disagrees that there was a need for the Appellant to improve the systems and process regarding the essentials of risk assessment and decision making, and to include explicit records regarding the core aspects of the care provided to a service user or MHA patients, including clear reference to any de-escalation techniques used, related issues of consent and capacity, and the rationale for the use of any form of restraint.

73. However, it appears to us that the Respondent when making its decision did not take into account the particular context on which the Appellant's services are provided and, in particular, the role and involvement of the AMHP in requesting secure patient transfer of patients under the MHA.

74. During the cross-examination of Mrs Wood the gap between the Respondent and the Appellant regarding the context of risk assessment was narrowed. We refer to the document setting out the agreed position regarding risk assessments. Mrs Wood understood that the Appellant would receive a risk assessment from the Approved Mental Health Professional (AMHP) or other appropriately qualified professional at the point of booking and that the Appellant would rely on that risk assessment to inform the Appellant's own risk assessment. She also understood that once the service user was collected by the Appellant, the service user was under the dual care of both the commissioning body (normally represented by the AMHP) and the Appellant, with each required to comply with their duties under the Mental Health Act 1983 and other relevant regulations. The risk assessment carried out by the Appellant at the point of booking would include the level of risk posed by the prospective service user to harm themselves or others, and/or abscond, and the appropriateness of whether restraint should be used, including the necessity for the use of a cell and/or handcuffs. It would also cover an assessment of whether the Appellant was able to accept the risk by providing a sufficient number of appropriately qualified staff and an appropriate vehicle.

Assessment of Risk of Harm

75. We agree that it is not necessary for the Respondent to show that actual harm has occurred. However, in our view, the absence of any demonstrable past

harm is a matter that can be taken into account when weighing and assessing the issue of risk and the proportionality of the urgent measure imposed.

76. In our view there is a paucity of evidence to show that the overall care provided by the Appellant's employees had resulted in any, or any significant harm, to any of the 1664 patients it transported between January 2022 and December 2022, some 440 of which had involved the patient being placed in a cell.

77. There appears to be an unspoken/implicit assumption on the part of the Respondent that the extent of the use of transportation in a cell was more than it should have been. We consider that any view about that would require some form of comparator evidence. This has not been adduced.

78. We agree that the use of any restraint has to be the minimum necessary in the circumstances. We noted that mechanical restraint (handcuffs) had been recorded 21 times during the same period and that, on at least three occasions, this involved a child/young person. Of course, we accept, as does the Appellant, that the rationale of staff for the use of restraint, any attempts at de-escalation and the reasons why restraint was required should be explicitly recorded. Full records are needed, amongst other matters, to demonstrate consent, the capacity to consent, and to show that before any restraint or restriction is applied the need for the same has been assessed to be the minimum necessary in all the circumstances.

79. There has been no relevant complaint adduced before us from any patient or relative, or an AMHP, regarding restraint or any other matter.

80. There is evidence that suggests that de-escalation techniques were employed. We found Mr Byrne's evidence that he views the need to communicate and to use de-escalation techniques to lie at the very heart of the service was credible but we looked for other evidence. It appears to us that the letters of thanks /testimonials support that communication and de-escalation was part and parcel of how the service was generally delivered at SMT North.

81. The comments from those involved with the Appellant's service consists of about 20 documents. We refer to some examples. These included one letter commenting on the service provided to a violent 68 year old man. This referred to the "high degree of care and compassion" shown and said that the staff were focused and professional. The feedback from a ward manager in December 2022 was that the staff were "worth their weight in gold". In October 2022 it was said that the crew were "absolutely marvellous" and went out of their way to treat the patient with respect. The author (the AMHP) noted that the staff had considered all options to transfer in the least restrictive way and that care was patient and person-centred. Another letter in August 2022 refers to the professional caring attitude with patient and family, and also an "excellent understanding with mental health patients in relapse". The author said that the staff were the most caring efficient team ever worked with. In April 2021 an

AMPH praised the team for handling all types of patients and commented that crews have good working knowledge of mental health and risks and said that they always discuss conveyance together and reach a mutual plan. It was also said that it was good that crew are trained in control and restraint and using cuffs for when the need arises.

82. In our view the "high water mark" regarding the potential significance of harm was the three "Ligature incidents" which occurred on 27 November 2020, 6 October 2021 and 12 April 2022.

83. We noted that in the NoD this was said at para 3 e):

> *"Incident data showed three incidents had occurred where a service user had attempted to harm themselves using a ligature. There was **no evidence** staff had investigated and learned lessons from these incidents or recognised potential safeguarding factors in these incidents." (our **bold**)*

84. Pausing there, the reason given relates to the process of post incident investigation. We noted that no specific criticism was made in the NoD as to how the actual incidents had been handled by the staff involved in terms of the care provided.

85. We consider that the NoD was inaccurate in the assertion that there was "no evidence" of the investigation of incidents. Mrs Preston accepted in cross examination that on 10 January 2023, she had, in fact, been shown the Incident Review document. This showed, at the very least, a recognition of the need to review each of the incidents. We consider that some form of review had taken place. Her opinion was that the reviews were inadequate: effectively because she considered that the record did not show the extent of any investigation with a view to finding out what, if any, lessons were to be learned. Her overall criticism was that the Reviewer (Mr Cooper) had not identified any learning.

86. We noted that in her witness statement Mrs Preston had not referred to the ligature incidents at all. When referred to how the matter was put in the NoD, (see above), she seemed to criticize the care provided. She appeared to us to be reluctant to acknowledge that there were any strengths at all in how any of the ligature incidents were managed by the Appellant's staff at ground level. Amongst other matters she said that one patient on 27 November 2020 had been unconscious. When asked about this she said it had been recorded as a "near miss".

87. In our view the actual records of care re the incident on 27 November 2011 are reasonably full. Members of staff described what happened in some detail. The record shows that the staff made checks on breathing, pulse etc. which tends to suggest that they responded appropriately and provided the care needed. We recognise that the phrase "near miss" was recorded. There is no actual evidence that resuscitation was required or that the patient was unconscious. The nearest evidence suggesting this was that in the FA process, reference

was made to the Incident Review and referred to the patient being “brought round”. This does not, however, appear in the actual records of care that day or in the Incident Review.

88. Ms Preston expressed the very firm opinion in her oral evidence that had the first ligature incident (which involved two attempts at self-harm by ligature in one journey) been properly reviewed, the next incident could have been avoided. She agreed that the evidence regarding the first incident where the AMPH had advised that there was no risk of self-harm suggested that the members of staff were being observant but then said that “the other two were known self-harmers who were able to get a ligature around their necks.” The overall effect of her evidence was that any ligature incident is always avoidable and, therefore, the provider had placed service users at avoidable risk of significant harm. In our view if this had been part of the consideration of the Respondent’s risk assessment we would have expected it to have featured in the NoD and/or in Mrs Preston’s written statement and/or in her evidence in chief, or in the evidence of others.

89. Our joint experience, including the experience of specialist panel members over many years, informs us that the complexities of service users with mental health issues are such that ligature incidents can and do occur despite risk assessment, and despite the provision of appropriate care. In the first incident recorded, the AMHP had expressly said there was no risk of self-harm. In our view the response to this incident at ground level showed that the staff reacted appropriately, and commendably, to an unexpected risk. We recognise that this patient then attempted to self-ligature by another means. However, this was acted on promptly by staff. The important point is that the care provided meant that this patient was, in fact, protected from the potential consequences of both of his/her acts of self-harm, as were the other two patients.

90. We were unimpressed by Mrs Preston’s oral evidence. Overall, she did not demonstrate the measured, balance and objective approach which, in our experience, is usually displayed by CQC Inspectors. She came across as dogmatic, and as a witness who lacked a balanced perspective.

91. We do, however, agree with the overarching point made in the NoD and by Mrs Preston that learning from these incidents should have been drawn and should have been disseminated. We agree that this is a valid point regarding improvement. In our view, however, it is a very large leap to say that the weaknesses in the Incident Review process for any of these incidents translated to a risk of significant harm to patients which, of itself, was sufficient to necessitate the urgent action taken to require the cessation of all regulated activity at SMT North.

92. Further, in our view there was also little, if any, recognition by any of the CQC witnesses that these three ligature incidents were a very small proportion of the 440 journeys which concerned patents detained under the MHA in the period

January 2021 to December 2022, and were also an even smaller proportion of the 1660 secure patient transfers undertaken in the longer period of January 2020 to December 2020 (see the IR at C291). In so far as there appeared to be a veiled suggestion that these three incidents may not be an accurate reflection of all incidents, this has not been substantiated.

93. We recognise, of course, that the ligature incidents were not the only matters of concern. We have had regard to the totality of the evidence regarding the concerns multiple breaches of fundamental standards.

94. We also recognise that harm can be caused in ways that can be difficult to quantify or assess. We recognise, for example, that any infringement on liberty can cause distress and psychological harm to mental health patients who are already detained pursuant to powers under the MHA. However, such harm can also arise even when the circumstances of restraint are objectively justified, and even when fully documented and recorded.

95. S. 4 (b) of the Act requires the Respondent (and so the panel) to have regard to the views of service users. We agree that it is important for the service to devise methods to seek feedback as this can inform the provider about the experience of service users and so feed into further patient-centred improvement.

96. Mrs Wood told us that the Inspectors did not accompany any patients on any journey ("ride out") in order to see how the service performed in terms of care. In effect she said ride outs were not part of inspection because it was not realistic and would not add any benefit over and above talking to staff. She referred also to patient confidentiality. It seems to us that in situations where written feedback can be difficult to obtain from a particular group of patients (such as MHA patients or, for example, those with learning disability) observation of the delivery of care may well be informative and can reasonably be achieved without undue intrusion regarding patient confidentiality. Of course, it would require planning in that more inspectors/specialist advisers might well be required or a longer inspection would need to be planned.

97. Mr Byrne told us that, in the Inspection at Basildon in January 2022 where the service was rated as Good overall, the need for direct MHA patient feedback was something that has been the focus of suggested improvement. These had not been a requirement but a suggestion for improvement. He told us that he has considered whether forms for patients be made available in the van in a perspex container attached to the walls. The Appellant has not yet implemented this. Mr Byrne said that he had concerns about the possible risk of the perspex container being used to cause injury.

98. When considering the discharge of our functions, standing in the shoes of the Commission, we are also required to have regard to the views of contractors - see s. 4 (c). The evidence that is before us in the form of the views of Trust staff

is that they value the service provided. There is positive evidence from the AMHPs who are the effective legal guardians regarding the best interests and needs of MHA patients and issues such as consent and capacity.

99. We consider that the fact that an AMPH, with full access to the patient's history and needs, has been involved in planning, requesting and assessing the risks of transfer as well as advising on the need for the use of a cell and/or mechanical restraint is a highly relevant matter to the context of the services provided by the Appellant.

100. In our view the Respondent's assessment of the risk of harm did not adequately take into account the following matters:

a) The needs of the users of the medical transport service provided by the Appellant fell into two different main categories: secure patient transfers and hospital discharge transfers.

b) A very large majority of transport journeys undertaken by the Appellant related to short journeys from point A to point B and usually under 2 hours in total.

c) During the journey, of whatever duration, the Appellant is responsible for the care, health and well-being of the service user but, in relation to MHA secure transfers in particular, there is a duality of care.

The overall context regarding the assessment of risk

101. We consider that the assessment of risk in a private transport ambulance type service has to be seen in the context that:

i. the dependence of service users on the Appellant's service is generally of relatively short duration – see above.

ii. In cases involving patients subject to the provisions of the MHA the Code of Practice describes the standards for the professionals involved: the AMHPs, who are usually either medical practitioners or social workers with accredited experience in the MHA. Amongst other matters, the AMHP is under a duty to consider the mode of transfer and issues such any risk of self-harm, the need for use of a cell and/or other restraint such as handcuffs, as well as consent and capacity issues.

iii. In our view there is also a built-in check and balance where a service user (whether an MHA patient or otherwise) has been placed into the care of the Appellant by professional carers, and when the service user is frequently also received by professional carers.

iv. Of course, there may be situations where a service user is discharged/transported back home. On the evidence before us this appears to be less common.

v. None of the above should be taken to say that the provider of a pre-booked transportation service does not have to carry out its own risk assessment before, during and at the end of the transfer. Far from it. In our view, however, the Respondent did not give any weight to the fact that more than one service provider is usually involved.

vi. This is particularly the case regarding when those being transported/conveyed are detained under the MHA where there is an ongoing responsibility retained by the AMHP.

vii. In our view a pre-booked ambulance transport service is very different to, for example, an emergency NHS ambulance which may be called to attend to the needs of a person "at scene" about whom little or nothing may be known other than the recorded reasons for the call and basic details.

102. We recognise that patients/users of the Appellant's service are likely to be vulnerable for many and different reasons. This is particularly so with MHA patients. All service users/patients are dependent because they rely upon those requesting, and those who are actually providing the required transportation service, to assess and meet their needs and to treat them with care, respect and dignity: when the trip is planned; when collected; during the conveyance; and on arrival/handover.

103. An important feature in assessing risk is the degree/extent of dependence of the service users upon the main provider of care. In our view the duration and intensity of the service provided by the Appellant is very different indeed to that which applies when dependence on a care giver can be near enough total i.e. residents in a home whose 24/7 needs are solely met by one service provider, or those whose daily care needs at different points across the day are provided by (often) different domiciliary carers supplied by a provider - and often in the context of little, if any, interaction with any other care provider or others i.e. such as the GP and/or tertiary services and/or little interaction with family or others.

104. In these situations of high and continuing dependence it is not, in our experience, hard to recognise when a person will, or may be, exposed to the risk of harm because of a pattern of breaches of the fundamental standards of care regarding the assessment and recording of care needs. By way of contrast the Appellant is the provider of episodic, rather than longitudinal, care.

105. In our view the start of the process of applying the DT guidance at 3A (3) led to the adoption of "moderate" potential impact which then contributed to the

initial assessment being viewed as at the "top of the tree". We consider that the distinction between the definitions of Minor and Moderate impact as per the DT are difficult to apply in all the circumstances of this service and yet the decision regarding potential impact was a significant part of the calculation at the beginning of the exercise. In our view the potential impact could have been reasonably viewed as "Minor", in which case the eventual outcome would have been very different.

106. It is notable in Mr Storton's evidence that he considered that the 3A (3) initial analysis led to a "high" likelihood that breach would happen again. If this was so the initial recommendation under the DT, applying 3A (4) would have initially pointed to non-urgent enforcement action. Of course, we recognise that this is not the end of the process under the DT. In our view, even when the multiple and persistent criteria are applied, the fact that there was no prior history or "track record" of non-compliance does not appear to have been given any or any significant weight. It is important to note that this was a first inspection at SMT North.

107. We return to the essential point made in the EP. The Respondent's policies provide guidance but recognise the need for judgement in the individual circumstances of each case.

108. Overall, the Respondent has not satisfied us that its consideration took into account all the circumstances relevant to a balanced assessment of the issue of risk, even in the context the risk of recurrence and the multiple breaches of fundamental standards.

109. We have considered the overall context of the service provided and have considered the EP and Decision Tree. It appears to us on the basis of all of the material before us that the risk of harm to service users/patients to which any service users might be exposed if urgent measures were not imposed by the Appellant's services was low.

Proportionality

110. In our view the concept of proportionality requires consideration is given to the least restrictive measure necessary to adequately address the risk of harm. In order to strike the proportionality balance the impact of the decision on the service and the livelihoods of those providing services should be considered and weighed in the balance against the risk of harm to patients/service users.

111. We noted also that in the NoD and in the evidence before us there was no reference to, or consideration of, the potential impact of the decision upon the Appellant and its employees. It is a stark fact that the condition imposed led to the immediate loss of work for 14 people and to a very significant loss of income for the Appellant company. It also led to the immediate disruption of a service

that had seemingly been valued by the NHS Trusts and the ICBs, and for which, we consider it reasonable to infer, bookings had been planned.

112. The Respondent has not persuaded us that its decision was necessary and proportionate. *A*mongst other matters:

a. At the time the decision was made there was no real analysis or consideration which discriminated between the two distinct groups of service users; MHA transfers and other patients/service users. The information before us in the draft inspection report is that of the 6716 total number of journeys from January 2020 to December 2022 some 5052 were patient hospital discharge transfers. The vast bulk of the Respondent's concerns related to MHA secure transfers. In our view the Respondent's decision was not "targeted where it was needed" - see s. 4 (e) - and was disproportionate.

b. Because of the risk assessment reached, no consideration was given to the use of any lesser measures such as Requirement Notices and/or far less restrictive condition(s) that would have enabled all aspects of regulated service to continue whilst addressing the safeguarding concerns in priority. For example, Requirement Notices could (and should) have been issued directed to specific matters. In our view a condition could (and should) have been considered requiring the Appellant to provide a detailed Action Plan to address the need for improvement in any of 17 specific areas which were of concern, in priority, and by given dates.

113. It is argued that the decision was proportionate because the Respondent had offered to re-inspect at any time of the Appellant's choosing. This invitation was not contained in the NoD or any subsequent correspondence that we have been shown. Evidence that this offer was made orally was not set out in any of the written statements of the Respondent's witnesses. These were to the effect that Mrs Wood and Mr Storton had explained that the Respondent would inspect before 3 April 2023. That is different to an offer that the Appellant could itself *invite* re-inspection at any time. The offer of inspection at a time of the Appellant's choosing was not adduced as new/additional evidence in the oral evidence of Mrs Woods or Mr Storton – who, on the evidence before us, were the only witnesses who had any contact with SMT North after the decision was made. Mr Storton told us that he had not expected "radio silence". In our view, the Respondent's assertion that it had effectively informed the Appellant that it could invite inspection at any time has not been substantiated. This is, however, a very minor point in context. In our view, the Respondent's decision to use the urgent procedure under section 31 (1) was unnecessary and disproportionate when it was reached. It could not, in reality, be saved/mitigated by an offer to re-inspect even if we were to assume in the Respondent's favour that this offer has been made or clearly communicated.

114. We make our decision as at “today” - in this case the date we made our short form decision - and taking into account all of the evidence available at the date of hearing. The Respondent’s case is that the Appellant is not ready to re-open.

115. In our view, much of the cross examination of Mr Byrne, which took place over some five or so hours, focussed on very detailed and critical examination of how the revised forms and new processes presented might be further improved. We consider that there was very little acknowledgement of the positive efforts that have been made by the Appellant to address the concerns raised. The Respondent’s approach was somewhat rigorous in a case that essentially involves the assessment of risk in the context of an *urgent* procedure case. Of course, we take fully into account that some of the Appellant’s evidence was provided very late. However, based on our collective experience over many years, our view is that the tenacious challenge to the Appellant’s case was much more akin to that which may be undertaken in an appeal against a substantive non urgent decision after the s 26 -28 process had been followed.

116. In our view the Appellant has made significant efforts to improve systems and processes, even if Mr Byrne was not able to address all the issues raised with the forensic precision that the Respondent required in cross examination. We acknowledge that the Appellant at the time of the decision viewed matters from a limited perspective that did not take comprehensive account of the full importance of each and every aspect of the fundamental standards. The Respondent contends that the Appellant’s response is “all too little and too late”. We disagree. The Respondent also contends that the Appellant has been disorganised. This may be so but this has to be viewed in proper and fair context. Our impression was that Mr Byrne (who has dyslexia) is not a “word smith”. In our view he is someone who is very comfortable in describing his philosophy of care but who struggled with detail regarding process. However, he came across as someone who is truly committed to providing a service that meets proper standards.

117. We remind ourselves that had non-urgent enforcement action been taken the Appellant would have had a period considerably in excess of 3 months to address the issues of concern. Further, whatever criticisms can be made of Mr Byrne’s evidence, we consider that he is a provider who does know “what good looks like”. The CQC recognised this in January 2022 when it rated the service at Basildon as good overall. We acknowledge that the fact that one provider location is good does not mean that another provider location is good. We take on board that ratings for one location can also change, and even over a short period of time. It nonetheless appears to us that, in essence, the same systems and processes that underpinned the delivery of the service at Basildon, and were considered good in January 2022, underpinned the service at SMT North although it is clear that Mr Cooper did not, on the day, demonstrate or articulate this to the satisfaction of the inspectors.

118. We also consider that overall Mr Byrne now has a fuller understanding of the need to demonstrate compliance with the fundamental standards that regulate activity. Overall, we formed a favourable impression of his insight and his willingness to effect improvement. In our experience it can occur that the impact of an adverse regulatory judgement, may push people into defensive or polarised mode, and not least where, whether rightly or wrongly, there is a sense of injustice. Moreover, Mr Byrne is not a "one-man band": he has a senior leadership team which, judging by the overall quality of the new processes now being implemented, appears to us to be responsive to the issues raised and to be broadly competent. In our view the Appellant has demonstrated development and improvement in many of the new processes which have been developed.

119. There are, we acknowledge, still issues regarding recruitment, training, safeguarding training at suitable levels, securing DBS certificates, appraisal/supervision, blue light accreditation, and all necessary audits including IPC, amongst other matters. Some of these matters obviously require urgent attention in relation to any staff who might now be engaged to work at SMT North. In our view all of these could have been the subject of Notice Requirements and/or an action plan.

120. The use of "blue lights" merits brief consideration. It appears to us that this issue had taken on a significance it did not deserve. On the evidence the use of "blue lights" was a rare occurrence and, when it occurred, was usually associated with instruction by the police and/or the delivery of transplant organs (which is not a regulated activity in any event). Of course, we accept that the provider must have in place a proper audit system so that it knows, and the regulator can be assured, that the use of blue lights is only ever undertaken by duly accredited drivers. In our view, in proper context, this was not a matter that added materially to the risk of any or any significant harm when viewed at 12 January 2023, or now.

121. Even if we are wrong in our view that the risk of harm was low and that the decision was disproportionate as at 12 January 2023, we consider that the risk of harm today is clearly less "today" i.e. as at the date of the hearing. We consider that the core issues regarding systems and process have been actively addressed. The Appellant has devised new forms that, in our view, substantially address the concerns raised by the Respondent. These may not be perfect but they are very substantially improved. These are not yet embedded but this is understandable in proper context.

122. Much reliance is placed on the fact that improvements are not complete, or yet embedded, even at Basildon where the new forms are being trialled. The Respondent submits that it would be "irresponsible" that SMT North be allowed to re-open before the Respondent has performed a further inspection. We disagree because the Respondent has not satisfied us to the lower standard

that the threshold test for urgent action under section 31 of the Health and Social Care Act 2008 ("the Act") was met at the date of the decision on 12 January 2023, or that it is met today. We consider that the decision to impose the condition on an urgent basis, and which had the effect of suspending all regulated activity at SMT Ltd North, was not necessary, reasonable or proportionate then or now.

123. It ordinarily follows applying s 32 (5) that it is appropriate to direct that the decision of 12 January 2023 "is to cease to have effect." We have considered s32 (6) which also gives us wider powers. This includes the variation of an existing condition or the imposition of a new condition.

124. It appears that the outcome of the draft Inspection when published is likely to result in the service being placed in Special Measures. This allows up to six months to show improvement to at least Requires Improvement in all domains, and if not demonstrated at that point, up to six months for the Respondent to take (substantive) regulatory action. The point is that the Respondent will not lack the opportunity to monitor progress and/or to inspect in furtherance of its statutory duties, and in the public interest, simply because the outcome in this appeal results in a direction that the decision is to cease to have effect. In all the circumstances, we do not consider it is appropriate to vary or to impose different conditions using any discretionary powers available under s. 32 (6) (a), (c) or (d).

125. This is not to say that there are no matters which still require attention by the Appellant regarding the services it provides on an ongoing bass. There are, but we have found that in all the circumstances the decision on 12 January 2023 to impose a condition that prevented the provision by the service of regulated facilities was unnecessary and was disproportionate. The appropriate outcome is that the decision on 12 January 2023 is to cease to have effect.

126. Ms Griffiths suggested that the fact that Mr Byrne wants Mr Palfrey to be appointed as the RM at SMT North when his application has not yet succeeded means that SMT North cannot now operate. We deal with this for the sake of completeness.

127. So far as we are aware the Respondent had not, by the date of hearing, issued a Notice of Proposal to Mr Cooper on the grounds that he is unsuitable to be an RM. If this had occurred we would expect to have been informed. If the Respondent were to seek to take action regarding Mr Cooper's suitability as RM, there is a clear and defined statutory process to be followed under s 26 to 28 of the Act. In the meantime, it does not appear that there is anything to prevent Mr Cooper carrying on the RM role whilst Mr Palfrey's application is pending. Of course, SMT North requires an RM to lawfully operate but experience tells us that the Respondent usually recognises that, for any number

of reasons including, for example, illness, there may be an overlap where an outgoing RM and a new manager/prospective RM work together whilst a registration application for a new/prospective manager is being considered by the Registrations department at the CQC. We have experience also of situations where an RM has voluntarily left employment in the RM role and suitable interim arrangements pending consideration of the application of a new manager have been risk assessed and considered satisfactory pending consideration of the new RM application.

Summary

128. The Respondent had not satisfied us to the lower standard that:

- the low threshold test for urgent action under section 31 (1) of the Act was met at the date of the decision on 12 January 2023, or that it is met today.
- in all the circumstances, the discretionary decision to impose the condition on an urgent basis, and which had the effect of suspending all regulated activity at SMT Ltd North, was necessary, reasonable or proportionate, then or now.

Decision

The appeal is allowed. Pursuant to s 32 (5) we direct that the decision dated 12 January 2023 is to cease to have effect.

Judge Siobhan Goodrich

First-tier Tribunal (Health Education and Social Care)

Date Issued: 17 May 2023