Care Standards

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

IN THE MATTER OF AN APPEAL
BETWEEN:

St Mary's Medical Centre

Appellant

-v-

Care Quality Commission

Respondent

[2016] 2632.EA-MoU

Heard on the 30 March 2016 on the papers before:

Judge Meleri Tudur, Deputy Chamber President
Specialist Member Patricia McLoughlin
Specialist Member Denise Rabbetts

DECISION

1. The Appellant is a partnership known as St Marys Medical Centre and provides GP services from its main location in Nottingham.

2. On the 10 February 2016, the Respondent carried out a comprehensive inspection of the services at St Mary's Medical Centre and identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations").

3. On the 15 February 2016, the Respondent issued a notice to urgently suspend the registration of the Appellant as a service provider in respect of regulated activities of family planning services, treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures for a period of three months until the 15 May 2016.

4. The Appellant appealed to the Tribunal on the 14 March 2016 against the Respondent's decision.

Legal framework

5. The appeal is brought under section 31 of the Health and Social Care

Act 2008 ('the 2008 Act') against the Respondent's suspension decision.

6. Section 31 provides:

> *"**Urgent procedure for suspension, variation etc.***
>
> *(1) If the Commission has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm, the Commission may, by giving notice in writing under this section to a person registered as a service provider or manager in respect of a regulated activity, provide for any decision of the Commission that is mentioned in subsection (2) to take effect from the time when the notice is given.*
>
> *(2)Those decisions are—*
>
> *(a) a decision under section 12(5) or 15(5) to vary or remove a condition for the time being in force in relation to the registration or to impose an additional condition;*
>
> *(b) a decision under section 18 to suspend the registration or extend a period of suspension.*
>
> *(3)The notice must—*
>
> *(a) state that it is given under this section,*
>
> *(b) state the Commission's reasons for believing that the circumstances fall within subsection (1),*
>
> *(c) specify the condition as varied, removed or imposed or the period (or extended period) of suspension, and*
>
> *(d) explain the right of appeal conferred by section 32."*

7. The 2014 Regulations set out a number of important requirements with which a registered provider must comply. They identify fundamental standards which must be met. The most relevant regulations to this case are set out below:

(a) Regulation 12 Safe care and treatment:

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

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

(a) assessing the risks to the health and safety of service users of receiving the care or treatment;

(b) doing all that is reasonably practicable to mitigate any such risks;

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g) the proper and safe management of medicines;

(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

(i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

(b) Regulation 13 Safeguarding service users from abuse and improper treatment:

13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

(4) Care or treatment for service users must not be provided in a way that—

(a) includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,

(b) includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,

(c) is degrading for the service user, or

(d) significantly disregards the needs of the service user for care or treatment.

(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

(6) For the purposes of this regulation—

“abuse” means—

any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(1),
ill-treatment (whether of a physical or psychological nature) of a service user,
theft, misuse or misappropriation of money or property belonging to a service user, or
(d)

neglect of a service user.

(c) Regulation 17 good governance:

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

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to—

(i)persons employed in the carrying on of the regulated activity, and

(ii)the management of the regulated activity;

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e)

Evidence

8. In the course of the current suspension, a comprehensive witness statement was prepared by Peter Bluff, Primary Care Inspector and lead inspector in the inspection, Dr V R Doel, GP specialist adviser inspector, C A Bake, specialist nurse adviser, three members of the Health Visitors Team locally and J Clarke, Community Nursery Nurse.

9. The statement of Peter Bluff set out the findings of the inspection which supported the conclusion that there were inadequate systems and processes in place to protect patients from harm. He identified five areas of particular concern, by way of examples of the inadequacies found: lack of recording of patient consultations and inconsistencies in patient records; absence of formal meetings to discuss safeguarding concerns with other health and care professionals; lack of awareness and associated documentation in relating to the status of safeguarding cases for those children registered at the practice which generated an increased risk to children at risk of harm; no vulnerable adults having been identified by the practice and read codes not being used correctly for patients to indicate patients at risk.

10. Mr Bluff described the evidence of inadequate assessment of risks or mitigation of risks such as individual care plans not in place and particular concerns about the practice's approach to end of life care, with such care and DNACPR not discussed with patients and a consultation with a patient who had a diagnosis of cancer not being recorded.

11. The statement reported findings of evidence that systems and processes were not in place such as no actions evidenced following an external infection control audit in March 2015, and no record maintained of prescription numbers to ensure that prescriptions could not be misappropriated and misused as well as significant events not adequately managed.

12. The inspector had requested an Action Plan from the Appellant to address the inadequate findings, and although an Action Plan was produced as requested by the 15 February 2016 that acknowledged that improvements were required in a significant number of areas, the vast majority of actions to be completed were not time-limited and whilst Dr Tarun Arya accepted the need to improve practices, there was little reference to such an acceptance or actions to be taken by Dr Saroj Arya who had, during the verbal feedback session following the inspection, been unwilling to accept the majority of the concerns raised. Consequently, the inspectors concluded that they could not be satisfied that sufficient improvements would be made quickly enough to protect patients from the risk of harm.

13. Mr Bluff reported in his statement that he had received a telephone call from Dr T Arya on the 2 March 2016 informing him that he had completed some audits and was now ready to reopen the practice. At that point he had not received the draft report from the inspection and Mr Bluff formed the view that the response of Dr Arya demonstrated a lack of awareness of the severity and gravity of the findings from the inspection.

14. The draft inspection report was disclosed to the Appellant on the 8 March 2016. The inspection findings were set out in the written Inspection Report, signed by the Chief Inspector of General Practice Professor Steve Field CBE FRCP FFPH FRCGP, the outcome of which was to take urgent suspension enforcement action for a period of three months. The report set out the findings from both the inspection itself and the pre-inspection information provided by the Appellant in advance. It set out the detail of the breaches found and rated the practice as inadequate in four of the five key areas inspected, with the fifth rating "Requires improvement".

15. The Appellant disagreed with the Respondent's decision to suspend their registration on the basis that it was not a good decision for patients. The findings of the inspection about child protection was disputed on the basis that the practice had arranged a meeting with the health visitor the week following the inspection and that Dr S Arya had discussed the two vulnerable children on the child protection register in July 2015. It was asserted that there had been a review prior to the suspension and the practice was looking to improve

further and that there had been no issues with any harm coming to children at the practice. Similarly, the notice of appeal stated that vulnerable adults who were housebound were identified by the practice and steps taken with a City Central Cluster Housebound Initiative to take measures to try to improve their healthcare. Two patients had been recently identified as being possibly vulnerable and referred to the care co-ordinator. It was acknowledged that the failure to code vulnerable adults on the computer system was the practice's mistake and that it had been agreed to rectify the error.

16. The grounds of appeal responded to the description of a Prostatic Specific Antigen (PSA) test being ordered without discussion with the patient and it was alleged that the patient's verbal consent had been obtained although not documented. In response to the findings regarding palliative care and the absence of a list of palliative patients, it was stated that because the practice was small, the list could vary and at the time only two palliative care patients were on the list, one who had recently died and one recently identified.

17. The Appellants reported physical changes undertaken to remedy some of the issues raised in the inspection such as putting a code lock on the reception door and implementing a recording system for prescription numbers and improvements to the read coding of letters and patient care.

18. The Appellants provided a copy of an undated letter from the Care Co-ordinator of City Care Partnership confirming that St Mary's Medical Centre have frequently held meetings at their practice "..to discuss patients that are either at risk of admission to hospital, vulnerable, palliative, been diagnosed with multiple long-term conditions or requiring social care interventions." The letter stated meetings had been held on a monthly basis since she started in post in July 2014.

Tribunal's conclusions with reasons

19. The Tribunal has considered the evidence presented and the documents provided by the Appellants which identified the areas of dispute between the parties in the evidence. From reading the grounds of appeal and the supporting documentation, it appears that there is an acknowledgement that there are a number of areas where improvements are required, with the submission that suspension is not justified by those areas of weakness.

20. We reminded ourselves of the test to be applied in cases of suspension and the test to be met in deciding whether the Respondent's decision should be upheld. Section 31 states that if the Respondent and the Tribunal on appeal:

"*has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm,"*

that enforcement action is justified. The burden of proof is on the Respondent. The standard of proof '*reasonable cause to believe'* falls somewhere between the balance of probability test and '*reasonable cause to suspect'*. The belief is to be judged by whether a reasonable person, assumed to know the law and possessed of the information, would believe that any

person might be at risk.

21. We read the evidence very carefully and noted that there was a spread of concerns raised during the inspection. We noted the following particular areas where the concerns were at their greatest.

22. Firstly, we noted that there was a lack of recording of consultations and lack of accurate record keeping across the practice. Regulation 17 of the 2014 Regulation requires among other things that the service provider:

"maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;"

Failing to maintain such records is a fundamental failure which has potentially far reaching consequences, especially where a sole practitioner is managing the care. If the practitioner became incapacitated then there would be no means by which to identify the ongoing medical treatment of patients and the potential risk of harm in the event that incomplete records were used would be significant. Dr S Arya indicated that her memory was also not always reliable.

23. Secondly, the practice lacked effective means of identifying vulnerable children and adults under their care, contrary to Regulation 13. Whilst it is stated by the Appellant that no harm has befallen any of the patients in the practice so far, such a statement cannot be substantiated. Effective identification and information sharing with other professionals cannot be underestimated as an effective means of ensuring the welfare of vulnerable individuals. The confirmation letter from the Care Co-ordinator, stating that multi disciplinary meetings took place monthly may evidence that those meetings took place, but the absence of any record of the meetings within the practice or record of actions to be taken following the meetings means that no effective mechanism was in place to ensure that agreed outcomes and actions were fulfilled and that there was a risk that the welfare of patients would be compromised. It also begged the question of which patients were discussed, since it was alleged in the grounds of appeal that the practice had only two vulnerable adult patients at the time of the inspection.

24. Thirdly, we noted that the end of life care and discussion of resuscitation and palliative medications were absent from the records and this was justified on the basis that the doctor practitioner, Dr S Arya, did not wish to upset the patients. Such a patriarchal approach to patient care has not been regarded as good practice for many years, and it is now the obligation of the doctor to discuss the outcomes and the approaches with their patients. A particularly stark example was that of the patient with the raised PSA scores who was referred both for the test and potentially to the hospital on the shortened timetable, without any record of discussion with him either of the implications or the impact of the test scores. The absence of recorded information about the need for a test and the discussion and consent for it to be carried out we conclude to be a serious failure and breach of the regulations.

25. We were persuaded by the evidence of Mr Bluff and Dr Doel that there were sufficient examples of bad practice demonstrated within the inspection

as to lead to the reasonable belief that persons may be placed at risk of harm unless action is taken. There were assertions made by the Appellants about the changes put in place after the inspection, but we considered that the action plan lacked sufficient substance and did not identify a timescale within which the improvements were to be achieved. We concluded that the evidence presented by the Respondent supported the conclusion that there remains a lack of insight into the seriousness of the situation and the need to comply with the fundamental standards set by the 2014 Regulations. In our conclusion, the identification of the issues above are sufficiently serious and significant to provide reasonable cause to believe that patients may be placed at risk of harm unless a suspension is in place.

26. We are satisfied on the evidence presented that unless the suspension continues, there may be a risk of harm to the patients within the practice in this case and the appeal against the suspension fails.

Decision

Appeal dismissed.

The notice of suspension is confirmed.

Judge Meleri Tudur
Deputy Chamber President
Care Standards & Primary Health Lists
First-tier Tribunal (Health Education, Social Care)

Date Issued: 5 April 2016