Care Standards

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

[2019] 3850.EA-MoU

Heard on the papers on 17 October 2019

BEFORE
Ms. M Daley (Tribunal Judge)
Ms. Rabbetts (Specialist Member)
Ms. P Mcloughlin (Specialist Member)

BETWEEN:

Robert James Wallace
Salop Medical Services (UK) Limited

Appellants

-v-

Care Quality Commission

Respondent

DECISION

The Appeal

1. On 4 October 2019, Mr. Robert James registered manager of Salop Medical Care (UK) Ltd made, an Application, on behalf of himself and in his capacity as Director of Salop Medical Services (UK).("The Service Provider)" to The Tribunal. The Appeal was against the Order of 6 September 2019, of the District Judge at the Newcastle under Lyme Magistrates Court. The order was made under Section 30 of the Health and Social Care Act 2008.

2. The order made by the District Judge was that the registration of Salop Medical Services (UK) Limited as registered provider and Mr. Robert Wallace as a manager in respect of the regulated activities be cancelled forthwith. As Mr. Wallace is director for Salop Medical Services Limited, and is also the manager, the Appellants are referred to as the Service Provider in this decision. The Respondent in this matter is the Care Quality Commission (CQC).

3. The Application was listed for a paper hearing, pursuant to Rule 23 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 (‘2008 Rules’). For the matter to be listed for a hearing on the papers, both parties must consent, which they have in this case, however, The Tribunal must also consider that it is able to decide the matter without a hearing. The Tribunal was satisfied that we had sufficient information, and that it was appropriate and proportionate to deal with this matter on the papers. We considered the Appeal on the papers on 17 October 2019.

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 so as to protect their private lives.

Late Evidence

5. The CQC by an application dated 15 October 2019, applied for the witness statements and bundle of evidence to be admitted as late evidence. Judge Khan by an order dated 7 October 2019, required the evidence to be filed by 12 noon on 11 October 2019. The CQC in their application apologised for the late filing of the evidence which were due to problems with IT. The Tribunal agreed to admit the evidence. The Tribunal bore in mind the reason for, and the relatively short period of the delay. Further the Tribunal considered that it would be unable to deal with this matter fairly without this evidence. The Tribunal noted that the Service Provider has not provided any evidence of prejudice caused by the delay neither had a request been made by the Service Provider for an extension of time to file evidence in reply.

6. The Tribunal decided to admit the evidence in accordance with in considering the late evidence, the Tribunal applied rule 15 and took into account Rule 2 of the overriding objective of The Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008.

Background

7. On 27 April 2018 Salop Medical Services (UK) Ltd (“SMS”) the Service Provider registered with the Care Quality Commission under the provisions of the Health and Social Care Act 2008 (the 2008 Act) to provide the regulated activity of transport services, triage and medical advice which was to be provided remotely.

8. The service was registered to provide patient transport services, supported by staff during transportation between care homes, service users’ own homes and hospitals. The service primarily serves the community of Shropshire. The Service Provider had two ambulances which were used for

this purpose. The provider had at times up to seven staff/contractors who were engaged to carry out the services.

9. On 11 January 2019 a Focused Inspection took place, in response to concerns raised by a whistle-blower. This inspection was around the safety and suitability of the ambulances and their equipment and medicines management. The CQC stated that verbal feedback was provided to the registered manager immediately after the inspection. A copy of the Focused Inspection Report was sent to the Service Provider on 26 July 2019.

10. On 9 July 2019 SMS Base was inspected by the CQC who carried out a scheduled comprehensive inspection. The service was rated 'Inadequate', full details of the findings of the inspectors were set out in the inspection report. The CQC found that the Service Provider was in breach of regulations set out in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulations 12, (Care and treatment are provided in a safe way to service users) 13, (Safeguarding service users from abuse and improper treatment) 17, (Managing the service in line with regulations) 18, (Having suitably qualified trained, skilled and competent staff) and 19 (Persons employed in the service to undertake regulated activities are fit and proper persons.

11. On 12 July 2019 following the full inspection, the CQC inspectors served the service provider with an urgent Notice of Decision, notifying of their intention to suspend the registration to carry out the regulated activity of transport services, triage and remote medical advice.

12. The CQC had made findings that people would or may be exposed to the risk of harm if the provision of the regulated activity continued. The suspension was for an eight week period which was designed to give the service provider the opportunity to address the concerns set out in the report. A Notice of Decision to suspend the service for 8 weeks was given to the Service Provider on 12 July 2019.

13. The CQC carried out an Announced Inspection on 4 September 2019 by Helen Nicholls and Mary Gaskin (CQC inspectors). During this inspection it was found that improvements had not been made. In her witness statement Ms. Nicholls noted that she found "…on-going and new concerns relating to patient transportation services that they stated would place people at serious risk to their life, health or well-being"

14. The CQC stated that they had applied their decision making matrix when coming to this decision. They stated that the major concern was that the conditions demonstrated that the Service Provider had not made any of the necessary improvements to the service.

15. An order was applied for on 6 September 2019 and granted in the Newcastle under Lyme Magistrates Court canceling the registration of the registered manager Mr Robert Wallace and the service provider Salop Medical Services (UK) Limited forthwith.

Legal Framework

16. The Tribunal applied the following legislation in reaching its decision. Section 30 of the Health and Social Care Act 2008 states:-

Urgent procedure for cancellation

(1) If—

(a) The Commission applies to a justice of the peace for an order cancelling the registration of a person as a service provider or manager in respect of a regulated activity, and

(b) 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,

the justice may make the order, and the cancellation has effect from the time when the order is made.

(2) An application under subsection (1) may, if the justice thinks fit, be made without notice having been given to the registered person.

(3) As soon as practicable after the making of an application under this section, the Commission must give notice of the application……….

(4) An order under subsection (1) must be in writing.

(5) Where such an order is made, the Commission must, as soon as practicable after the making of the order, serve on the person registered as a service provider or manager in respect of the regulated activity—

(a) a copy of the order, and

(b) notice of the right of appeal conferred by section 32.

32. Appeals to the Tribunal

(1) An appeal against—

(a) any decision of the Commission under this Chapter, other than a decision to give a warning notice under section 29, or

(b) an order made by a justice of the peace under section 30,

lies to the First-tier Tribunal.

(2) No appeal against a decision or order may be brought by a person more than 28 days after service on the person of notice of the decision or order.

(3) On an appeal against a decision of the Commission, other than a decision to which a notice under section 31 relates, the First-tier Tribunal may confirm the decision or direct that it is not to have effect.

(4) On an appeal against an order made by a justice of the peace the First-tier Tribunal may confirm the order or direct that it is to cease to have effect.

(5) On an appeal against a decision to which a notice under section 31 relates, the First-tier Tribunal may confirm the decision or direct that it is to cease to have effect.

(6) On an appeal against a decision or order, the First-tier Tribunal also has power—

(a) to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates,

(b) to direct that any such discretionary condition is to cease to have effect,

(c)to direct that any such discretionary condition as the First-tier Tribunal thinks fit shall have effect in respect of the regulated activity, or

(d) to vary the period of any suspension.

(7) In this section—

- “discretionary condition”, in relation to registration under this Chapter, means any condition other than a registered manager condition required by section 13(1);

The burden of proof is on the CQC. 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 the matters alleged.

The Evidence

17. The Tribunal was provided with a hearing bundle which included the following documents which we took into account when reaching its decision
    a. The Applicant’s application and the grounds of appeal
    b. The CQC’s response to the Appeal
    c. The reasons for opposing the Appeal
    d. The statement of reasons dated 6 September 2019
    e. The witness statement of Ms. Helen Nicholls Inspectorate with the CQC dated 6 September 2019
    f. The Certificate of Registration
    g. The Notice of Decision dated 12 July 2019
    h. An email dated 5 September 2019 from Robert Wallace sent to the CQC
    i. Photographs taken of the interior and exterior of the ambulances registration No ‘AE04UWL’ and NW58 HWA
    j. The post Inspection Feedback Report dated 15 July 2019
    k. A copy of the staff list for the Section 30 Application
    l. The CQC draft Inspection Report of the inspection of 6 July 2019
    m. The factual accuracy check form for the first draft Inspection Report

n. The CQC Inspection Report of the inspection of 11 January 2019
o. A letter dated 25 July 2019 from CQC inviting feedback on the base report dated 11 January 2019
p. The witness statement of Bernadette Hanney Head of Hospital Inspection CQC dated 11 October 2019

The Tribunal's conclusions with reasons

18. We concluded that there was a serious risk to a person's life, health or well-being if the cancellation order ceases to have effect. Our reasons for doing so are set out below.
19. The Tribunal referred to the CQC Inspection Report, which provided details of the inspection carried out on the 9 July 2019 and the witness statement of Ms. Helen Nicholls which provided details of the CQC inspector's findings at the Announce inspection on 4 September 2019.

20. We accepted this evidence. The July report details a number of breaches of the standards. Including that defects were noted to both ambulances. The ambulances contained stretchers which were only fitted with horizontal straps which meant that nothing was provided to prevent patients moving up and down.

21. We found that there was no new evidence before us that undermined the findings made by the CQC at the date of this Appeal; there was no information to suggest that additional strapping had been put in place. We considered that the lack of suitable strapping on the stretchers put service users at risk of harm in the event of an emergency stop or an accident.

22. We noted that the report stated that there were no Pediatric straps: we considered this to be of particular importance because one of the service users was a child aged 9. We noted that the strapping used to protect an adult would be insufficient to protect a child. We concluded that this would lead to a genuine risk to life, in the event of an emergency stop or an accident.

23. We were concerned that the CQC report stated that ambulance registration AE04 UWL contained equipment which was not secured which would, in the event of an emergency stop or accident, become a potential projectile. We had no information that steps had been taken to remedy this potential dangerous situation. We found that in the event that the ambulance needed to break suddenly, this would put service users at severe risk of harm. We noted in Helen Nicolls evidence that oxygen cylinders were not secured and continued to be a potential projectile. New potential projectiles were identified in ambulance NK58 HWA in the September inspection. We were concerned that this suggested that rather than being remedied, the situation had in fact deteriorated. We consider that this would present a risk to life in the event of sudden breaking of the ambulance.

24. Ambulance NK58 HWA was described as having loose and exposed electrical wiring in the front and back. The hazard light on ambulance AE04 UWL was broken. We consider that the defects to this ambulance meant that it was unsuitable for transportation of service users; we noted that although some remedial steps had been taken to address this, at the time of the inspection in September, hazards still existed within both ambulances, we accepted on the evidence that those hazards existed, and that at the very least an ambulance should as a mode of transport be free from hazards. In the absence of evidence to the contrary that this had been effectively remedied, we found that this would put service users at risk of harm.

25. In respect of Regulation 13(Safeguarding) and Regulation 18 (having suitably qualified trained, skilled and competent staff) the CQC Inspector noted that only 5 staff files were available at the base for inspection. No staff files were available for paramedics E, F and G. There was no evidence to show that these paramedics had been assessed as suitable to work for the service. And there was no evidence of DBS or to confirm that they were suitably qualified and trained.

26. We had no information at the date of hearing that assessments had been made, concerning the suitability of the staff or that DBS checks had been completed. We found that this breached a fundamental requirement for this service.

27. Records for a staff member, referred to as staff member C showed that he had a positive DBS check with a "significant criminal concern" going back to 2013. There was no evidence to suggest that a risk assessment had been carried out in respect of staff member C. We could not be confident, without a risk assessment that staff member C was an appropriate person to carry out this role or that his employment would not put service users at risk of harm. We had no information to suggest that in the absence of risk assessments, that staff member C was no longer in this role therefore we found that his continuing employment, without the appropriate safeguards that a risk assessment would provide put patients at risk of harm.

28. We found that at the date of hearing there was no information concerning completed staff training or plans put in place to ensure that a training matrix had been prepared for the service which would provide the staff with Level 3 safeguarding training. We found that knowledge of the requirements of safeguarding was fundamental to this service in that it provided staff which the necessary skills to promote the health and well-being and rights of individuals to live free from abuse, harm and neglect.

29. We were of the view that without this knowledge staff would be unaware of the requirements in their role or be able to appropriately raise concerns.

This placed service users at risk of harm.

30. We found that at both inspections there was evidence that staff lacked training and equipment to effectively manage infection control. There were no records that up to date infection control training had been undertaken and where such training had been undertaken it was reported as being out of date. Further the service had, following the July inspection, agreed that hand audits would be carried out. There is no evidence that these audits occurred. Given the breaches in relation to infection control, we could not be confident that the issues concerning safe and effective hygiene had been dealt with. We found that this meant that there was a serious and on-going risk of cross infection.

31. There was no evidence of risk assessments or any details of any incident policy that had been put in place. It had been noted that one service user had required oxygen on the way to her place of residence. No information was recorded about the administration of oxygen, or concerning the decision to return the service user to her home. We could not be confident that this incident had been dealt with appropriately or that the service provider had put in place measures to deal with risks, such as ensuring that trained staff using the right equipment were available to support this service user. We accepted that without appropriate record keeping there was a danger that such incident would place service users at a serious risk to life, health or well-being,

32. The Service Provider did not provide a witness statement or any further evidence in compliance with the directions neither did he substantially challenge the evidence in the application.

33. The Tribunal accordingly considered the reasons for the Appeal set out in the application as the Service Provider's submissions and evidence. The Tribunal noted that his appeal centered on the process that had been followed by the CQC, in particular the delay in providing the service with the written report following the inspection which took place in January 2019. The Service Provider noted that the service had been given 8 weeks to improve. However, it was stated that much of this period was in the summer holidays. The Service Provider considered this to be unfair in that he cited that the service was unable to complete improvements as contractors were on holiday and training courses were not available.

34. Although the Service Provider submitted that "there were multiple inaccuracies in the full report, due to the nature of the work and the status of the staff which would ultimately change the nature of the report". The Service Provider provided no details of this or how in his view it would change the nature of the report.

35. The Service Provider stated:-"… I am led to believe, from the CQC website

that the normal procedure for a company that is rated as inadequate is for a further inspection to be carried out after 6 months and then if the company remains inadequate for further measures to be taken…"

36. The Tribunal noted that nothing set out by the Service Provider in the Appeal undermined the seriousness of the breaches that had been reported by the CQC or which the Tribunal had subsequently found proved on the evidence before it

37. The CQC's inspectors on 4 September 2019 noted that there were further and continuing breaches. Although this was not acknowledged by the Service Provider in the application, there was no dispute concerning the overall condition of ambulance registration Nos AE04 UWL and NW58 HWA or the findings of the CQC in respect of safeguarding and staff training. The Service Provider appeared to accept that if the appeal was allowed the rating of "Inadequate" should remain in force.

38. In reaching its decision The Tribunal has noted that although the Service Provider referred to a new management team and external governance that had been put in place since July 2019, no additional information or evidence had been provided to enable us to be satisfied that as at the date of the hearing, the breaches which we considered to be a serious risk to a person's life, health or well-being, had been remedied.

39. Having considered all of the evidence including the Service Provider's Application. We consider that the CQC has discharged the evidential burden.

40. The Tribunal finds that the breaches are serious and that unless the order is made, there will be a serious risk to a person's life, health or well-being serious as to expose any person to risk of harm.

Decision

i. The Tribunal therefore confirms the Order made under Section 30 of the Health and Social Care Act 2008.

ii. The Appeal is therefore dismissed.

iii. The Order made on 6 September 2019 is confirmed and registration of the Service Provider, Salop Medical Service (UK) Limited and Mr Robert Wallace as Registered Manager is cancelled.

Tribunal Judge M Daley

[2019] UKFTT 0645 (HESC)

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

Date Issued: 28 October 2019