Care Standards

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

Heard on 24, 25, 26 & 27 September 2019 at the Leeds Magistrates Court

[2018] 3573.EA

BEFORE
Timothy Thorne (Tribunal Judge)
Wendy Stafford (Specialist Member)
Lorna Jacobs (Specialist Member)

BETWEEN

GREASBROUGH RESIDENTIAL AND NURSING HOME (A)

Appellant

-v-

CARE QUALITY COMMISSION (R)

Respondent

DECISION

The Appeal

1. This is an appeal by A pursuant to section 32 of the Health and Social Care Act against the decision made by R on 03/12/18, to make an order under Section 17 of the Health and Social Care Act 2008 cancelling A's registration

Background

2. A was registered to provide the following regulated activities at the location of Greasbrough Residential and Nursing Home, Potter Hill, Greasbrough, Rotherham, South Yorkshire, S61 4NU ("the Home"):

    a. Accommodation for Persons who Require Nursing or Personal Care;
    b. Diagnostic and Screening Procedures; and
    c. Treatment of Disease, Disorder or Injury.

3. A was originally registered with R as a service provider as a partnership between Dr M H Hussain and Mrs J M Hussain. R inspected A on 5 occasions between March 2015 and August 2018. The results of those inspections are as follows:

    a. In March 2015 A was rated as 'Requires Improvement' overall and 'Inadequate' in the domain of 'safe'.

b. In May 2016 improvements were found and it was rated overall as 'Good' in all domains.
c. In March 2017 A was rated as 'Requires Improvement' overall and 'Good' only in the domain of 'caring'.
d. In May and June 2018 several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. The home was rated as 'Inadequate' overall and as a result was placed into Special Measures. The Local Authority, Rotherham Metropolitan Borough Council (RMBC) provided the home with support.
e. On 6th August 2018, R carried out a further focussed inspection and found breaches still occurring, in addition to further, new breaches.

4. A Notice of Proposal ('NOP') had been issued by R on 11/07/18 which proposed to cancel A's registration. In response, A submitted written representations against that NOP on 10/08/18.

5. After considering the relevant evidence (including inspection reports, factual accuracy summaries in response to the reports and written representations from A) on 23/09/18, R issued a Notice of Decision ('NOD') to adopt the proposal in the NOP and cancel A's registration. The NOD was originally sent to the wrong address, therefore R re-submitted the NOD to A on 3/12/18. A the submitted an appeal on 21/12/18 and R submitted its response on 26/01/19.

Further Background

6. A was also registered with Rotherham Metropolitan Borough Council (RMBC) from around 1999 and had a contract with them to provide personal and residential care to older people. RMBC was alerted to several safeguarding and contractual concerns and as a result it also inspected A and found several breaches of contractual standards. As a result, A was placed into the aforementioned 6-week Special Measures Improvement Plan and monitored by the RMBC Compliance Team. The necessary improvements were not achieved and RMBC issued a Notice of Termination on 10/08/18 and the RMBC residents were removed from the home over time.

7. The last resident moved out on 28/09/18 and A went into administration on 16/10/18. The home was sold in April 2019 and is no longer owned by A.

8. In summary R contends that the decision to cancel A's registration was made in accordance with the provisions of section 17 HSCA and pursuant to the CQC Enforcement Policy Decision Tree and was reasonable, appropriate and proportionate.

The Appellant's Case

9. This was set out in a skeleton argument served on behalf of A which was undated and submitted at the beginning of the hearing. The panel rejected an application made by R to exclude this document as it was served late. The panel took the view that as it was helpful to the Tribunal it should be admitted. The document can be summarised as follows:

a. A is willing to concede that in light of the low threshold required to issue a Notice of Proposal there was a basis on which R could properly have done so.
b. A's case is that it was determined to improve highlighted areas of concern and it was working through its action plan and had engaged care consultants.
c. Had A been given time to action and "in bed change", R would have been satisfied and not proceeded to issue a Notice of Decision or not opposed the subsequent appeal.
d. It was not until it received R's inspection report on 25/06/08 that A was aware of the extent of the concern.
e. R rushed to judgement with no proper weight being given to what was being proposed by A to put matters right.
f. A accepts that RMBC placed a suspension on admissions to the home on 23/05/18, however its compliance officer had visited the service on only 2 occasions in the preceding 15 months.
g. It was accepted that the home had now been closed down and placed into administration and sold. However, A believes that had R provided A with an opportunity to continue to effect and embed change then it would have been successful in doing so and would have been in a position to persuade its regulator that the home had turned a corner.
h. In summary A submits that it would have been fair and proportionate to stay further enforcement action and at the end of the stay, review the position. If a stay had been granted and insufficient steps taken in the intervening period and R then proceeded to issue its NOD then A could have no complaint.

Representation

10. Before the Tribunal, A was represented by Paul Spencer of Counsel and R by Danielle Gilmour of Counsel.

Restricted Reporting Order

11. 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 users of the service in this case so as to protect their private lives.

Late Evidence

12. There were no further applications to admit late evidence.

The Hearing

13. The Tribunal took into account all the documentary and oral evidence that was presented. The documentary evidence comprised of over 5000 pages. The following is a precis only of that evidence.

14. The Tribunal first heard oral evidence from **Ms. Sarah Powell, (SP)** the CQC Inspector. She adopted her 2 witness statements which indicated that she was a qualified nurse and had worked in a hospital from 1987 until 2002. She had been a CQC inspector since 2012. She said that she had either taken part in or had personal knowledge of the various inspections of the home between 2015

and 2018. She exhibited the relevant CQC Inspection reports. Her statement recorded the following overall concerns and history which she and her colleagues identified:

SP's Evidence about Overall Concerns and History of Inspections

15. Inspection on **10/03/15** & **11/03/15** – breaches were found in relation to Regulations 9 – Person centred care, 10 – Dignity & respect, 12 – Safe care and treatment, 17 – Good governance. & 18 – Staffing.

16. Inspection on **12/05/16** – improvements had been made and the service was rated as good overall.

17. Inspection on **09/03/17** - This was carried out in response to concerns raised by RMBC in January 2017. Breaches of the following regulations were identified: Reg 11 – Need for consent & Reg 17 – Good governance. The overall rating was – requires improvement.

18. Inspections on **15-17/05/18 and 06/06/18** - At these inspections serious concerns with regard to the safety of service users, lack of governance and oversight, and staffing were identified. The Home was rated as Inadequate overall and placed into Special Measures because of breaches of the following regulations: Reg 9 – Person centred care, Reg 11 – Need for consent, Reg 12 – Safe care and treatment, Reg 14 – Meeting nutritional and hydration needs, Reg 17 – Good Governance & Reg 18 – Staffing. The overall rating was inadequate.

19. After the **15-17/05/18** inspection, R wrote to A about these serious concerns and provided an action plan template to assist A in taking urgent remedial action.

20. After the **06/06/18** inspection R sent an urgent letter to A warning of possible enforcement action. The letter also advised that A should consider obtaining legal advice and set out action that they should take. A responded and this was considered but R remained concerned and therefore issued the Notice of Proposal (NOP) to cancel A's registration. The Home was placed in special measures.

21. Inspection on **06/08/18** - R carried out this further focussed inspection following further concerns raised by the Local Authority. R found that the service remained inadequate in the domains of safe and well-led, and there were still concerns for the safety of service users. Breaches were found of the following: Regulations 12 – safe care & treatment, 17 – Good governance, 18-Staffing and 19 – Fit and proper persons. The overall rating was inadequate. As a result, R decided to proceed with issuing the NOP.

SP's Evidence about Particular Service Users

22. SP gave a number of examples of alleged breaches of the Regulations that she observed or were recorded by colleagues during the various inspections. The following is a precis of that evidence as it related to particular service users.

Service User I (SUI)

23. During inspections in May and June 2018 it was discovered that SUI had 5 falls between March and April 2018. SP said that a referral was made to the care home team on 26/03/18 but there was no record of anyone at the home following up on this. The last "falls risk assessment" dated back to January 2018 and merely recorded the heightened risk but failed to identify how that risk could be managed or reduced. In addition, it had not been updated to record more recent falls.

24. The mobility care plan dated 23/03/18 gave no guidance to staff as to how they could support SUI. The accident analysis did not identify falling as a concern.

25. In the witness's view the documents which were shown to her in cross examination were not really risk assessments. She agreed the home reacted to the UTI by referring the service user to hospital but they did not link it to the falls. She agreed that external health professionals had been brought in but these visits were not added to the information on the relevant risk assessments and care plans. The GP came in routinely to review residents. She was shown an accident form that was filled in but she was concerned that the staff were not following up on the accident and the information was not added to on the relevant risk assessments and care plans. She said that staff had told her that they were not provided with adequate information.

26. She was also shown SUI's risk assessment dated 27/03/18. The copy she had been given (at C241) was not the same as the copy now exhibited by A in their bundle of documents at D1782. She noted that the copy now produced by A had been altered by the addition of numbers representing risks identified and also a box had been circled that had not been in the copy given to her. There was no explanation for this.

27. In addition, on 15/05/18, inspectors observed SUI (who could not eat unaided) being left alone during meal-times and not being assisted despite calls for help.

Service User C

28. During inspections in May and June 2018 it was discovered that the falls risk assessment for C dated March 2018 identified an extremely high risk of falling. The care records and accident forms recorded that C was falling very often. A health care professional saw C in December 2017 but there was no records of other intervention from health care professionals or referrals. The inspectors were told that no-one had referred C to the falls team for support. C had 4 falls in March 2018 and 5 falls in April 2018. This was not identified in the accident analysis as being of concern.

29. A health care professional visited C on 23/05/18 and advised that the home should provide C with a sensor mat for his mattress so as to alert staff if he got up and therefore reduce the risk of falling. However, at the inspection on 06/06/18 it was discovered that no mat had been obtained. C had suffered a further fall on 04/06/18 which could have been averted if the mat had been in place. According to SP in oral evidence she was told by the Registered Manager that he had tried to buy one but had been stopped by the registered provider, Dr. Hussain who said he didn't have the money.

30. In cross examination she was shown a number of care plans and risk assessments. She said that all care plans were locked in the medicine room on the ground floor which meant that they were not readily available to staff working upstairs. She was shown C's mobility care plan but did not agree that it was an appropriate document. It was only compiled after R's inspection had alerted staff to its absence. Moreover, it had not worked to protect C from his risks. There was a lack of coordination between the formal risk assessment and the associated care plan.

31. She agreed that the staff had behaved appropriately by referring C to the external falls team but again this was only done after the inspectors alerted them to the problem. She was shown C's risk assessment dated "May 2018" and commented that although the risk was identified there was nothing about how that risk could be reduced and managed such as adequate monitoring or provision of a frame. In relation to C's Urinary Tract Infection (UTI) she would have expected the risk assessment to recommend monitoring on a fluid chart and provision for extra liquid if necessary. This was absent from the document. Moreover, the risk assessments had not cross referenced his falls with his UTI, despite the obvious correlation. Therefore, staff were not in possession of all relevant information to effectively care for C.

32. She was shown C's moving and handling risk assessment and again made the point that that although the risk was identified there was nothing about how that risk could be reduced and managed. She also noticed that the recorded information was wrong as C had in fact fallen 7 times in 2 months but the document recorded in April, May and June that he only had 3 falls in the last year. Moreover, the document added up his risk scores wrongly and did not recommend any actions to reduce or manage his increased risk.

33. She was shown C's Cognition Care plan and commented that although it existed it was incomplete as it made no reference to his falls and in any event it was not followed. She was also shown C's Memory Care plan and commented that although it existed it was incomplete as she would have expected more information to assist staff meet his needs when he became agitated as he had dementia. She was also shown C's Behaviour Care plan and commented that it was also incomplete as there was a need for more information such as topics of conversation to help staff know what to say to calm him down.

34. She was also shown C's Evaluation Sheet but said that although it was recorded that he was "lashing out" on occasions there was no information as to what might have triggered such behaviours so as to help staff manage him. She was also shown C's Care plan which was dated simply April 2018 and commented that it was also incomplete as there was a need for more information about his life and history. Moreover, there was information in that document which contradicted information in C's care plan dated 15/04/18 as to where he liked to spend most of his time.

35. She was shown a referral plan dated 31/07/18 but she was unable to comment about whether the referral was timely or not. She also noted that the falls

assessment box was not ticked which it should have been. She accepted that staff reacted appropriately to a letter received from the falls team. She was showed another transfer form dated 01/04/18 made by the home to the hospital but she commented that this referral was not reflected in the care plan and risk assessment. She went on to say that these and other referral documents indicated that the home was responding to incidents but they were not asking why the falls were happening and how the risk could be managed and reduced. She said that inspectors visited the home on 15 May and the home had still done nothing about the fall which occurred on 09/05/18.

36. She was referred to a number of documents which recorded staff making referrals to various external health professionals and their visits to the home. She acknowledged that these referrals had been made but was concerned that this information had not been fed through to the relevant risk assessments and or care plans. She was shown C's Behaviour Chart and commented that some of the actions of the staff in response to C's behaviour was not appropriate, such as sitting him down alone in the corridor until he had calmed down.

Service User E

37. During inspections in May and June 2018 it was discovered that a report dated 05/04/18 from a speech and language therapist recommended specific dietary advice for E. However, this was not followed. E was observed to be being fed sitting upright and sweets positioned by his bed created a risk of choking. Moreover, E had suffered from serious weight loss. The nutritional risk assessment recorded significant weight loss but did not identify it as a concern. The care plan stated that E should be referred to a dietician but there was no record that this had been done.

38. In cross examination SP was shown E's Daily Mood Charts. She said that they had not been provided when she asked for them during the inspections. She was told by the Registered Manager that they had not been keeping them for E. Also, she noted that information which was on the Mood Charts now produced (such as episodes of agitation) were not recorded on E's Behaviour Charts as it should have been.

Service User H

39. During inspections in May and June 2018 it was discovered that staff were not following H's care plan by monitoring his behaviour and recording the results on a behaviour chart. This had been requested by a Community Psychiatric Nurse. The daily records showed behavioural difficulties but this was not recorded on the behaviour chart. Staff told SP that they did not know they had to record this. This put H at risk as he was not being monitored properly and health care professionals could not assess him properly.

Service User JB

40. During inspections in May and June 2018 it was discovered that JB was subject to Deprivation of Liberty Safeguards (DOLS) with conditions which required staff to monitor his mood and visits. There was no record that this was being done.

Service User L

41. During inspections in May and June 2018 it was discovered that L had been admitted for respite care but no care plans existed. L was nursed in bed but there were no moving or handling assessments. L was isolated in his room and told SP that he wanted to get up out of bed. No referral had been made to an Occupational Therapist. There were no plans to manage his risk and is wishes were not considered.

42. In cross examination she was shown documentation concerning L's time in hospital before coming to the home and also a risk assessment chart body map, skin care plan and a care plan dated 11/07/18. She accepted that in the past L had been treated in hospital in bed but a care home was a different setting and he should have been allowed out of bed if he wished.

43. The witness broke down crying when she recounted how she had seen L isolated in his room and how he told her that he wanted to get up out of bed. She was shown no care plans for him during the inspection and those produced now all post-dated her inspection. Even though he was coming to the end of his life the home should have assessed his suitability to be allowed out of bed (perhaps in a chair) so that he could have some interaction with people and so that his wishes could be taken into account. His best interests were not assessed.

44. She accepted that the records indicated that the tissue viability nurse had no concerns. It was put to her that as the Occupational Therapist had recorded, L could not get out of bed but SP replied that the care plan said that he could get out of bed for 2 hours at a time but there was no record that this was ever implemented. Moreover, it may be that he could not get out of bed unaided but nevertheless he should have been helped to get out and change his environment and end his isolation if he wished.

Service User D

45. During the inspection on 06/08/18 it was discovered that staff were not keeping a record of how they were applying cream prescribed for D which had to be used in a particular directed way. There was no adequate record of skin deterioration over time and staff did not react in a timely manner to serious deterioration in D's skin condition.

Service User F

46. During the inspection on 06/08/18 it was discovered that F was not being adequately protected from the risk of pressure ulcers or problems with their eyes being sticky. There was no eye care plan in place and staff did not attend to or clean the eyes during the inspection.

47. In addition, an inspector found that even though F had been prescribed a fluid thickener that should be added to their drink this was not done and un-thickened fluid was left by the side of the bed.

Service User B

48. During the inspection on 06/08/18 it was discovered that staff knew that B had been in pain and that paracetamol had been prescribed. However, there were

no records that staff were monitoring the effectiveness of this medication. SP found B to be in pain.

49. In oral evidence she was shown B's Mood Chart exhibited in A's bundle but none were shown to her during the inspections and she said that the Registered Manager had told her that none were being kept.

SP's Evidence about Additional Specific Regulatory Breaches

50. SP gave a number of further examples of alleged breaches of the Regulations that she observed or were recorded by colleagues on the various inspections. The following is a precis of that evidence.

Regulation 9 – Person Centred Care

51. During inspections in May and June 2018 care staff were observed engaged in personal conversations with each other and not attempting to engage with service users. Staff were task oriented and failed to engage in social interaction and stimulation with service users, including those with dementia, often leaving them isolated and under-stimulated.

52. During inspections in May 2018 it was apparent that service users had limited access to fresh air and exercise in the garden which made them more likely to become agitated and distressed. Doors to the garden were locked and one was incapable of being opened. A care worker told inspectors that service users were generally bored and had no stimulation.

Regulation 11 – Need for Consent

53. Inspectors discovered that mental capacity was not always clearly recorded in the care records. It was not recorded why so many service users were kept in their beds. H had bed rails on his bed despite having no capacity to consent to such restraints. The Registered Manager told inspectors that there was no best interest decision in place for H. Moreover, there was no monitoring of service user B's mood as required by his DOLS conditions.

Regulation 12 – Safe Care & Treatment

54. In addition to the matters outlined above, inspectors discovered that staff had not been properly monitoring the status of service user G's pads and cushions so as to manage his pressure sores.

55. On 15/05/18, inspectors also found that medication policy and procedures were not always followed by staff. There were no carried forward amounts recorded on the medication administration record. There were no records to confirm the application of service user M's prescribed medication and no records to show care staff how, where or when it should be applied. This made it impossible to confirm whether the medication had been given as prescribed or at all. It was not clear from the records if service users in general were receiving their medication appropriately.

56. In addition, it was noted that medicines were not stored appropriately. The medication storage rooms and fridges lacked monitoring and had broken locks. The medication fridge was 7 degrees warmer than the maximum recommended

storage temperature. A promised to improve procedures but a report from the clinical quality advisor dated 13/06/18 showed no improvement. The report also identified additional problems and 3 service users were referred to the local safeguarding authority because they had not received their medication as prescribed.

Regulation 14 – Meeting Nutritional & Hydration Needs

57. During the May 2018 inspection, it was observed that staff at meal times were task oriented and did not respond to the individual needs of service users. Service users were not supported with their nutritional needs. Those who needed it were not sat up properly. In particular SUI was not given assistance while eating despite repeated requests. Choice was not facilitated by the use of picture menus

Regulation 17 – Good Governance

58. During the May 2018 inspections it was noted that there were systems in place to monitor quality but they were ineffective. The audit system did not cover this aspect of the provision of care. For example, there was no robust system in relation to the monitoring of prescription medicine.

59. Moreover, staffing levels were not calculated using a dependency tool. However, after the inspection one was introduced. The Registered Manager did not work any management hours. Staff rotas indicated that he and staff were always on shift. This meant the service was not effectively managed.

Regulation 18 – Staffing

60. During the May 2018 inspections it was noted that there were inadequate staff on duty to provide basic care and stimulation, especially for service users upstairs in bed. For example, an inspector found service user E alone in her room unable to use the call bell to get help. The inspector had to go and get a member of staff to assist.

61. In addition, staff had not received training in person centred care and managing challenging behaviours. A staff member confirmed this. Moreover, although staff had received some dementia training there were no systems in place to ensure that it was effectively put into action. A staff member complained that the training was inadequate. They were told by management that “You’re in the wrong job if you can’t handle it.”. Some staff received injuries from service users exhibiting challenging behaviours. Staff had not received a medication supervision or competency assessment which might have ameliorated the problems observed about the medication administration and storage.

The Decision to Cancel Registration

62. SP also explained the mechanics of the decision making process. Management Review Meetings (MRMs) was held on 18/05/18, 13/06/18 and 14/06/18. She was of the opinion that R’s actions were necessary and proportionate. She said that A had failed to demonstrate an ability to address risk and sustain improvements over time. A had failed to reassure R that they had the ability to ensure the quality and safety of the service was maintained and improvement sustained. A had failed to demonstrate they could comply with fundamental

standards and maintain such compliance over time. In addition, the local authority also had serious concerns about the service and that is why they removed all service users.

63. In cross examination SP opined that if A had brought in the consultants earlier then there might have been a chance to turn around the home but as it was, the ongoing risks to service users meant that R had no option other than to act. She said in her supplementary witness statement that Cornerstones were only approached by A in August 2018 whereas R had identified serious concerns in May in June 2018. Moreover, the consultants only attended the home for a few days from 14/08/18 to 22/08/18. She also said that she had had a lengthy conversation with Pamela Clarke from Cornerstones about the home.

64. She also said in oral evidence that she had given copies of detailed feedback to the Registered Manager and Registered Person at the time of the inspection on 15/05/18 in order to inform them of the defects in the service and what remedial action was necessary. R also sent them a letter outlining the concerns again. The affected service users were not identified by name but she was confident that in light of the detailed feedback already provided, A could readily identify them. In any event they should have reviewed their processes in relation to all service users generally.

65. The panel then heard from **Sarah Leyfield (SL)** who adopted her 2 witness statements which indicated that she had been a CQC Inspector since 2012, She had either attended all the inspections of the home or had information about them. She corroborated what was said by SP.

66. In relation to service user D she agreed that the records showed that he arrived at the home on 27/03/18 and had sustained a fracture before arrival. She agreed that the care home filled in a transfer form on 01/04/18. She was also shown various other documents about him. She had never seen some of the documents before. She said that D's care plan had not been updated to reflect his changing needs. Staff told her that they did not have access to the care plan as they wished because they were stored in a different unit to which they did not have access. A care worked told her that they had no idea when D last got out of bed. SL said that D's wishes were not being taken into account and there was no best interest assessment undertaken. She accepted that the Occupational Therapists might have given contradictory advice

67. SL was also shown documents in relation to service user E and his nutritional needs and in particular his desire to eat sweets. But she maintained that he was left at risk because sweets were left next to his bed when it was dangerous for him to eat otherwise than sitting upright and staff were not monitoring him to see he was safe. She said that during her inspection she observed that E was left on his own for about 2 hours.

68. She was also shown weight monitoring forms which recorded the weight change of many but not all of the service users. She pointed out that this was inadequate as the form did not contain an assessment of what needed to be done about any weight changes. The form was updated to include this

information but only after the CQC inspectors advised them that this was necessary and was what most homes did. Moreover, such information was not included in service users' risk assessments or care plans as it should have been.

69. In addition, an analysis of these forms showed that much of the data was inaccurate and had not been added correctly. Moreover, there were examples of service users who had extremely high and rapid weight gains and this information was not entered in the care plans and no action was taken. She also added that care plans should be updated whenever new information came to light so that staff knew how to cater for service users safely.

70. She also said that during the inspection on 06/08/18 she had been told by a member of staff that that there were not enough staff and they were often working alone in the lounge area and service users' needs were not always met. At the end of the inspection on 06/08/18 the inspectors gave detailed feedback to the 2 directors; Dr. Hussain and his daughter. CQC were not assured from what they said that the provider could remedy the concerns. She said that "the service had been deteriorating for a while and had not always acted in a way to mitigate risks to people who used the service." She attended a meeting with RMBC on 17/05/18 where information about A was exchanged.

71. The witness concluded that the Registered Manager was not always supported appropriately by the Provider and the Manager told her that he did not have the experience to drive the Home forward. Also, the care staff lacked appropriate leadership and management from the Provider. She further concluded that R "was not assured that the provider could make and sustain the necessary improvements so that people who used the service could receive good quality, safe care which maintained their safety."

72. The Tribunal then heard evidence from **Gordon Waigand** who adopted his witness statement and explained that he was Head of Service for independent living and support for RMBC. In his witness statement he had collated information provided to him on the RMBC "Safeguarding duty spreadsheet" and from other records within the local authority. He said that there had been a contract between RMBC and A since 1999 to provide residential and nursing care. The contract was amended in 2016. In October 2016 an extensive action plan was implemented by the Contract Compliance Officer due to concerns with the service,

73. Following CQC inspections in May and June 2018 RMBC was informed of the outcome. Subsequently RMBC found A to be in breach of the contractual standards and served a contract default notice on A dated 23/05/18. Dr. Hussain was told that he had 6 weeks to satisfy the council that improvements to the care home had been made. This was followed up by a meeting between RMBC and A's registered manager Tim Hopkins and Dr. Hussain the registered person. RMBC told A that they had 6 weeks to meet the objectives of the "Special Measures Improvement Plan". RMBC and allied health professionals implemented a programme of support for A and progress was monitored by a multi-disciplinary team.

74. On 11/07/18 a further meeting between RMBC and Dr. Hussain was held and RMBC came to the view the required improvements had not been made. On 02/08/18 a further meeting between RMBC and Dr. Hussain and his daughter Robina Hussain-Naviatti was held to discuss the possible termination of the contract because of a lack of progress.

75. On 06/08/18 the CQC carried out its focussed inspection and on 08/08/18 a MDT was held between RMBC and CQC. It was concluded by RMBC that despite the help given to A, there continued to be serious concern about the wellbeing of residents and the consensus at the meeting was that there was no confidence in the staff at the home who had not engaged sufficiently with the support provided. RMBC took the view that A continued to be in breach of the contract and the service was not safe. Therefore, RMBC met with Dr. Hussain on 09/08/18 and informed him of the decision to terminate the contract. On 10/08/18 a Notice of Termination was hand delivered to A. RMBC then worked with the home, residents, relatives and advocates to find residents alternative accommodation.

76. The witness statement contained information about the safeguarding and contractual concerns between 2016 and 2018. During that period there were recorded 15 contracting concerns of which 4 were substantiated. Of those 15, 10 were recorded as “Quality of Care”. During the same period there were also 34 safeguarding concerns which came from a number of sources including the CQC, relatives of residents and health professionals. The number of incidents in 2018 were much higher than in preceding periods. They appeared to be increasing in volume. RMBC therefore found it necessary to undertake an organisational abuse enquiry.

77. The witness statement made it clear that most if not all of the 34 safeguarding concerns were resolved in one way or another. However, RMBC took the view that “the concerns leading to the initial referral were still relevant to be considered as part of the organisational abuse enquiry as they may have contributed to a conclusion that residents could be at risk of neglect”. On 25/01/19 there was a further meeting between RMBC and Dr. Hussain and Robina Hussain-Naviatti at which they were informed that the local authority had concluded on the balance of probabilities that organisational abuse had occurred in relation to documentation, care provision, equipment and management and staffing levels.

78. The witness statement also made it clear that it was normal practice for RMBC and the CQC to work closely together in such cases and to share information. It was also stated that the CQC did not place any pressure on RMBC at any time during the process. In oral evidence he said that it was very unusual for RMBC to take such action and remove residents from a care home in this way.

79. Exhibits produced by Robina Hussain-Naviatti indicated that during the time the Home was in special measures staff from RMBC including Lisa Sykes came to the home on a regular basis to try and support change.

80. The Panel also heard evidence from **Sheila Grant** (CQC Head of Inspections for Adult Social Care in the North Central Region) who adopted her witness statement which sets out the procedure that was followed by R in deciding to issue the NOP and the NOD. In oral evidence she said that she had been in post for 5 years and managed 80 staff. Her first direct involvement with the Home had been in May 2018 but she had been aware of it before.

81. She stated that the NOP was signed by her and the NOD by Claire Robbie, Head of Representations. She stated that R applied the CQC Enforcement Policy and followed the Decision Tree. In her opinion A had failed to assess or act on past risks, there were multiple breaches of regulations, there was a previous history of breaches and there was a lack of adequate leadership and governance. Although the breaches were serious she did not think it necessary to take urgent action to cancel registration because RMBC were offering support to the home.

82. She explained how the Enforcement Decision Tree sets out the various stages of the decision making process and provides guidance on the selection of appropriate enforcement action. She explained her reasons for deciding to cancel A's registration as opposed to the other options, i.e. suspension or the imposition of conditions. Having reviewed the evidence including the previous inspection findings, she concluded that suspension was not appropriate because she did not believe that this would result in the service improving as A had not been able to sustain improvements over a 3 year period. The imposition of conditions was also not appropriate as the service was already in special measures and A had failed to assess or act on past risk, there was evidence of multiple breaches and inadequate leadership and governance.

83. She stated "…I was particularly concerned that Regulations 12 and 18 had been breached at a previous inspection in March 2017 while Regulation 17 had been in breach at previous inspections in March 2015 and March 2017 and continued to be in breach. In addition, Regulation 19 was a new breach. I was particularly concerned that the Appellant had been unable to sustain improvements needed at previous inspections and had not been able to rectify the breach of regulation 17." She also noted that the focussed inspection on 6 August continued to reveal failings, breaches of Regulations and inadequate service provision.

84. She stated that before the Notice of Decision was made, the representation period was extended and further representations were submitted by A. She explained that R had employed an independent decision maker Claire Robbie who had had no previous involvement with the service to consider A's representations and evidence before issuing the NOD.

85. In cross examination she confirmed that she had not sought to influence Claire Robbie. The NOD was first issued on 23/09/18 but sent to the wrong address. It was then re-sent to the correct address on 03/12/18. She decided to re-issue the NOD and explained, "I re-read the NOD and considered whether it was proportionate to do so."

86. She stated that in her opinion R's decision was made in line with CQC policy and methodology and was necessary, appropriate and proportionate in order to protect service users.

87. She also stated that A only has one location registered with the CQC, i.e. the Home, which has now been sold. Therefore, because A "no longer owns the location, it is not possible for the CQC to complete a comprehensive inspection to determine if the Appellant has made improvements." In cross examination she said that she was aware that someone from Cornerstones had contacted the CQC and that normally there should be engagement with such an external consultant. However, she did not know the details of those contacts with Cornerstones.

88. Next the panel heard from **Ms. Robina Hussain-Naviatti** who adopted her 2 witness statements in the bundle. She had made a previous one which was not now being relied upon and had not been submitted. She said that along with her mother and father she was a director of A and had been so since 2014. She said that she was also a psychotherapist and non-practising barrister. In the past she had been the director of a charity and worked for an ombudsman.

89. She later said that she able to spend about a quarter of her time on the home and the rest of her time pursuing her other professional and business interests. In oral evidence she was asked what qualifications she had in relation to the management of care homes and she replied that she used to work in a prison. She had no prior experience of working in the care home sector.

90. She explained that the home opened in July 1997 and it normally had 60 residents and 60 staff. In oral evidence she said she did not know exactly what the proportion of private to local authority funded service users was.

91. In her 2 witness statements (which ran to a total of 58 pages) she outlined at great length why she did not agree with many of the details of what the CQC inspectors had found. She also explained what the home proposed to do in relation to those concerns. She said how disappointed she had been to learn of the outcome of the May and June 2018 inspections and she responded with an urgent action plan and referred the service users identified at risk to health professionals. She was surprised to receive the CQC letter on 18/05/18 threatening enforcement action and demanding another action plan. She said that she did not understand the nature of the concerns and felt CQC should have told her exactly what they needed. She felt that CQC had not discussed them with the home. In cross examination it was pointed out that the inspectors had left detailed feedback forms and had had detailed discussions with the Registered Manager (RM). In addition, it was pointed out to her that the letter from CQC had full details of the regulatory breaches.

92. She explained all the new audit tools that the Home had instituted and how new care plans were drawn up. She did not understand why CQC did not find them adequate. She also blamed CQC for influencing RMBC in making their decision to issue a default notice and suspend placements of service users. She

commented that RMBC Compliance Officers Lisa Sykes and Lynn Flynn visited the home regularly.

93. In her witness statements she maintained that staff did have access to all records at all times and could not understand why the inspectors had come to a different conclusion and had said that staff had told them that they did not have access. She considered that all service users were properly cared for. However, her evidence was contradictory because she also accepted that there were regulatory breaches and CQC were entitled to issue the NOP because of them. She said that "there was some basis and some regulations have been breached, some I'm not sure about. I'm not trained to translate [sic] of how a service is provided and how it breaches regulations." She later said, "Many aspects needed to be improved. Whether they are breaches is a difficult question. I'm open to the possibility. I don't understand if Regulations were breached." She added, that they were working with Cornerstones to try and take remedial action. She also said that Cornerstones were the best judges of whether there had been breaches or not. She added, "If they told us it was a breach we would have taken action. Also we would take advice from the CQC. They are always right and we have tried to implement what they say. Their opinion is equally reliable. The CQC is the expert in this field."

94. She later added, "I accept that at certain moments in time probably all of those regulations have been breached. Its fluid and when we are told we react and do something. We have tried to respond to everything raised and tried to react to problems as a when raised." She also said that they were pro-active and "I thought we had taken appropriate action. Maybe there were further things we needed to do." She added, "There are different reasons why we breached the same regulations. We didn't remain static."

95. She accepted that breaching the regulations created serious risks for service users and it was "fair" for the CQC to serve the NOP but that they "rushed" to the NOD. She was sure that with help of Cornerstones everything would be put right. She also complained that the CQC had not given her sufficient details of what was wrong. She later explained that "we were aware of the seriousness [of the breaches] but we weren't aware of why it was happening. So we needed to undertake further investigations." She also said that it was only when she received the NOP that "I realised there was a problem with the management structure".

96. She also blamed the Registered Manager Tim Hopkinson for not producing the necessary documents to the CQC Inspectors. She found it "incomprehensible" as to why he had not produced them at the time. She also thought he might be responsible for the alterations to various documents. It was pointed out that it was bad practice to alter retrospectively documents which are supposed to be contemporaneous records. She said, "We could improve our way of doing this probably." She also accepted that some of the care plans were not updated quickly enough. She said "It was a weakness that we did not update more regularly than monthly. We wanted Cornerstones to help us do this."

97. She was asked about the new Cornerstones action plans and whether she thought that the time scales for achieving compliance were appropriate. She said that she did not know and just trusted Cornerstones as "they had brought many care homes around." She hoped that after they left "we could maintain the standards." She said that they had always tried their best to respond to the deficiencies identified by the CQC in the past. She gave a full explanation of some of the medical difficulties experienced by some service users and how she responded. She also explained the attempts made to change the management structure and update paperwork in the past.

98. She was asked whether anyone in the Home had specific qualifications to work in a care home and she said that she was not sure. She said, "I would have to look at the CVs of the staff." She again reiterated that she was not happy with the way the local authority terminated their contract with the Home.

99. She was asked why she had not brought in Cornerstones earlier. She replied, "We received the CQC inspection report on 25th June and we were bemused. Then people took holidays."

100. She also explained that Tim the Registered Manager worked 9am to 5pm Monday to Fridays and was not on the care rota. Later however she said that he was on the care rota in May and June 2018. Nonetheless she believed that he had enough time to do his job. However, she also said that he complained that he did not have enough time to do his job and that was why "we gave him an administrative assistant."

101. Next the panel heard from **Ms. Lucy Corner** who adopted her witness statement which indicated that she was the managing director of Cornerstones a company specialising in working with care providers. Her experience included working as an NHS nurse and as the Registered Manager of a large care home. In addition, she said that she was a part time CQC inspector but had not undertaken any such inspectors for the last 3 years.

102. She said that she was first approached by the Home in August 2018 "to assist with the home's turnaround following a negative CQC assessment." She arranged for her colleagues Tim Linford and Pamela Clark to work with the Home. They began work on 14/08/18 and reported back to her. They prepared an action plan for the Home which was produced for the panel to inspect. She said that although "Tim and Pamela ultimately spent less than 2 weeks at [the Home] (due to the CQC and local authority action to remove all residents) the home made significant progress and was well on route to achieving full compliance." In her witness statement (para.9) she explained that the action plan was last updated on 22/08/18 when Tim and Pamela stopped their work at the Home. They left after working at the Home for 8 days. Her view was that the problems at the home could be "remedied in a relatively brief period of time." In oral evidence she said that the action plan was actually updated in September 2018. She did not know why this was not mentioned in her witness statement dated 31/05/19.

103. She thought that the owners of the Home were very motivated and did everything that was recommended. The directors and staff were all very kind. In oral evidence later, she said that she got the impression that the directors of the Home "had only just realised the seriousness" of their position when the contacted Cornerstones.

104. She said that "our assessment was that, as is not uncommon, the primary failure was documentation related, i.e. not documenting everything that was done in a way which was easily accessible to CQC inspectors." She said that Cornerstones had a 100% success rate in turning around failing care homes, most of which were in a far more serious position that the Home. In her witness statement she said that the Home would have reached full compliance and a "good" CQC rating within 3 months with Cornerstone's support (para. 12). In oral evidence, however, she said that the Home would be "safe" for residents in 6 months with their help and it would take 2 years for the Home to achieve a "good" CQC rating. She later said that it would take "2 years to get the Home back up to 60 residents in a safe manner."

105. She criticised the CQC for the way "they" closed down the Home and refused to engage with Cornerstones. She even described "hostility" from the CQC towards them. She said that the CQC sent her "aggressive emails." She also thought that the way that the CQC's behaviour in removing residents from the home was "much worse than anything cited in the CQC reports regarding Greasbrough." In her opinion the CQC should have given the Home "more time" to turn things around. In oral evidence she later stated that she only assumed that the CQC were involved in the decision to remove residents and had no information to support her belief.

106. In oral evidence she said that she had never actually inspected the Home herself but relied on the reports provided to her by Tim and Pamela who had no background as CQC inspectors as she did. She also accepted that the CQC had spoken to consultants at Cornerstones. She said that the job of the CQC inspectors was to identify failings and breaches of the Regulations. They "are not trained to identify solutions. It's not their job. They are not supposed to give advice." She also accepted that when the action plan was drawn up and assessments were made about time scales for improvement there were only about 14 service users left in the Home (and at the end only 8) whereas previously there had been 60 and that was the normal number of residents. The action plan produced to the Tribunal was only an initial version as it was "designed to be updated."

107. Next the panel heard from **Dr. Mohamed Hussain OBE** who adopted his witness statement which recorded that he used to be the director of the Home and recorded his many professional and civic achievements. He spoke with great pride and affection about the Home and what he believed he had achieved over its 21 years of operation. In more recent years he had handed over day to day running of the Home to his daughter. However, he would still visit the Home every day, if only for 5 minutes. He thought that everyone (staff and service users) were happy there. He produced numerous photos of the Home and commented how nice it looked and how his wife had played a big part in its interior design.

108. He explained the history of the Home and its previous managers including Michael and Rebecca Smith who left in August 2016. John Hirst then became the "Home Supervisor" for a period and that Tim Hopkinson took over as Manager in November 2017. He was not sure when he stopped being the Manager. He never formally resigned. He also gave details about the staff in general and how the Home was managed. When necessary agency staff was employed. He denied Tim Hopkinson ever told him about the need to buy a sensory mat and said he was not telling the truth about him refusing to spend money on it. He later blamed Tim Hopkinson and said that "when things go wrong he seeks to put it on someone else."

109. In addition, he explained how he had tried to react to the deficiencies identified by the CQC in their inspections. He said in oral evidence that "We desperately wanted to get things right. We needed to improve." He also added that he and his staff were "flabbergasted" at being told that the CQC had found deficiencies in how they delivered care. He said, "Yes there were risks just like any home." He added that staff asked him why does the CQC want us to make these changes and he told them "Never mind just do it." He went onto explain that "We couldn't understand. We knew they were unhappy but couldn't understand why. We would have done anything if we were told." He later said, "We were not perfect and we wanted to do whatever we were told. We were trying to comply. That was the great distress for me. Please tell us what to do. I'm not criticising the CQC. It was a nice home which had underlying problems."

110. He was highly critical of the way RMBC had behaved in cancelling their contract with the Home. He thought that they had tricked him in some way. He also explained how he had employed Cornerstones on 14/08/18 to try and turn the Home around and deal with the deficiencies identified by the CQC. He believed that if he had been given more time and had not had to close the Home down everything would have been put right. He said that he had a great respect for the CQC and believed that he had had a good relationship with them.

111. He further explained that the loss of the Home had been a traumatic experience for him and his family. After RMBC cancelled the contract they simply could not afford to continue operating and therefore the Home went into administration and was sold. He had no plans to go back into business but wanted to pursue the appeal because he felt that his good name had been besmirched and his reputation tarnished. He wanted to clear his name. He said that he had been subject to negative comments in the media, he had been subjected to racist abuse and someone had even tried to murder him, although this last event apparently had no connection with his difficulties with the CQC. At times during his oral evidence he became very emotional and said that "I want my name cleared."

112. The panel read a witness statement from **Ms. Judith Hussain** in which she supported what had been said by her husband Dr. Hussain. In addition, the panel read a witness statement from **John Hirst** in which he said that he initially worked at the Home as a maintenance engineer and then in 2015 he became the Home Supervisor. He was also the nominated Health and Safety Officer. He explained

in detail (inter alia) how maintenance, infection control and fire safety were undertaken at the Home.

113. In addition, the panel read a number of letters and cards from previous service users and family who all spoke very highly about the Home. In addition, we read letters from a doctor and fire safety consultant who also said very positive things about the Home

114. The panel also read written **closing submissions** which were received by the Tribunal on 10/10/19 in accordance with directions.

Regulations & Guidance

115. Section 20 Health and Social Care Act 2008 (HCSA) provides for the Secretary of State to make regulations in relation to regulated activities. The Health and Social Care Act (Regulated Activities) Regulations 2014 ('the 2014 Regulations') set out the Fundamental Standards which providers must comply with when carrying on a regulated activity.

116. The relevant regulations for the purposes of this appeal include:
(a) Regulation 9 – Person-centred care
(b) Regulation 11 – Need for consent
(c) Regulation 12 – Safe care and treatment
(d) Regulation 13 – Safeguarding from Abuse
(e) Regulation 14 – Meeting nutritional and hydration needs
(f) Regulation 17 – Good governance
(g) Regulation 18 – Staffing
(h) Regulation 19 – Fit and proper persons employed

117. Regulation 21 of the 2014 Regulations provides that the registered person must have regard to the guidance issued under section 23. This reads as follows

Section 23 HSCA 2008 provides:
(1) The Commission must issue guidance about compliance with the requirements of regulations under section 20, other than requirements which relate to the prevention or control of health care associated infections
(2) The guidance may, if the Commission thinks fit, also relate to compliance for the purposes of this Chapter with the requirements of any other enactments.
(3) The guidance may—
(a) operate by reference to provisions of other documents specified in it (whether published by the Commission or otherwise);
(b) provide for any reference in it to such a document to take effect as a reference to that document as revised from time to time;
(c) make different provision for different cases or circumstances.
(4) The Commission may from time to time revise guidance issued by it under this section and issue the revised guidance.

In relation to Adult Social Care, the CQC guidance issued pursuant to section 23 includes:

(a) Key Lines of Enquiry (KLOE): What we look at when we inspect and monitor
(b) Government Regulations (including fundamental standards)
(c) Activities we regulate

Legal Framework

118. The power to cancel a provider's registration is governed by the section 17 of the HSCA 2008:

"17 Cancellation of registration
(1) The Commission may at any time cancel the registration of a person ("R") under this Chapter as a service provider or manager in respect of a regulated activity—
(a) on the ground that R has been convicted of, or admitted, a relevant offence;
(b) on the ground that any other person has been convicted of any relevant offence in relation to the regulated activity;
(c) on the ground that the regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements;
(d) on the ground that R has failed to comply with a requirement imposed by or under Chapter 6;
(e) on any ground specified by regulations."

119. Section 4 of the HSCA 2008 provides that the CQC must have regard to various matters when exercising any of its functions:

HSCA 2008 section 4:
(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) Experience 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 people detained under the Mental Health Act 1983, of persons 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 taken 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 approach to regulatory action, and
(g) Best practice among persons performing functions comparable to those of the Commission (including principles under which regulatory action should be transparent, accountable and consistent).

(2) In performing its functions the Commission must also have regard to such aspects of government policy as the Secretary of State may direct.

The Burden and Standard of Proof & the Role of the Tribunal

120. Applying the rationale identified in **Care Management Group Ltd v CQC [2017] 316.EA**, para 34 (an appeal also pursuant to section 32 of the Health and

Social Care Act) the panel is required to determine the matter de novo and make its own decision on the merits. Both counsel agreed that the test to be adopted is whether as at the date of the hearing the decision to cancel the registration should be confirmed or directed to be of no effect. The panel can take into account all the evidence submitted including new information or material that was not available (or presented) when the CQC made its original decision.

121. The panel "stands in the shoes of the CQC" in carrying out this function and must therefore apply the same statutory framework, policy and guidance as the CQC as set out above. The Tribunal must be satisfied on the balance of probabilities, that cancellation of the registration is necessary and proportionate.

Conclusions & Reasons

122. For reasons given below the panel concludes that the Respondent has proved to the requisite standard that cancellation of the registration was and remains necessary and proportionate. This is because the Tribunal is satisfied on the balance of probabilities that the Home was carrying out regulated activities otherwise than in accordance with the relevant Regulations and that it was necessary and proportionate to cancel the registration in order to protect service users.

123. The panel was impressed by the credibility and reliability of the CQC's witnesses and is satisfied that the inspections of the Home as evidenced above were undertaken fairly, professionally and proportionately. We accept that the findings as recorded in the CQC reports (and as explained to us under oath and supported by documentary evidence) were accurate, fair and reliable.

124. In particular the panel accepts that the CQC inspectors correctly identified multiple breaches of the Regulations at the inspection on 15 and 17 May and 6 June 2018, including repeated breaches of Regulations 11 and 17. These are set out in detail in the evidence set out above. In addition, the panel accepts that in relation to the Home, all domains were rated as Inadequate and the service was rated as Inadequate overall.

125. Moreover, the panel accepts that A promised to carry out a number of remedial actions (as outlined in their Representations) but that when R carried out the focused inspection on 6 August 2018, it was discovered that they had not done so. In addition, the CQC inspectors discovered further, continued breaches of Regulations 12 and 17 and an additional breach of Regulation 19. These are set out in detail in the evidence set out above.

126. The panel agrees with the analysis provided by Sheila Grant (CQC Head of Inspections for Adult Social Care in the North Central Region) in her evidence that "I was particularly concerned that Regulations 12 and 18 had been breached at a previous inspection in March 2017 while Regulation 17 had been in breach at previous inspections in March 2015 and March 2017 and continued to be in breach. In addition, Regulation 19 was a new breach. I was particularly concerned that the Appellant had been unable to sustain improvements needed at previous inspections and had not been able to rectify the breach of regulation 17." The panel notes that the focussed inspection on 6 August 2018 continued

to reveal failings, breaches of Regulations and inadequate service provision.

127. The panel also notes that, A accepts that the test for the enforcement action was met and that the Notice of Proposal was justified. Indeed the 2 directors of the Home who gave oral evidence agreed that the CQC were justified in issuing the NOP because of the multiple and persistent breaches of Regulations that were found. The panel notes that Ms. Robina Hussain-Naviatti accepted that there had been clear breaches of Regulation 12, and that there were many aspects of the service that needed to be improved. She said, "I accept that at certain moments in time probably all of those Regulations have been breached…..". She also said, "There are different reasons why we breached the same regulations. We didn't remain static." She accepted that breaching the regulations created serious risks for service users and it was "fair" for the CQC to serve the NOP but that they "rushed" to the NOD.

128. The panel does not accept the claim made by A (in counsel's final written submissions) that the CQC "abandoned objectivity and fairness and acted contrary to good regulatory practice." The panel accepts that the CQC inspectors acted in good faith and the CQC acted proportionately and fairly in issuing the NOD. The panel accepts the evidence of Sheila Grant that the CQC followed the Enforcement Decision Tree which sets out the various stages of the decision making process and provides guidance on the selection of appropriate enforcement action.

129. The panel accepts that the CQC acted appropriately (in accordance with its published policy) in deciding to cancel A's registration as opposed to the other options, i.e. suspension or the imposition of conditions. The panel accepts that the CQC were justified in concluding that suspension was not appropriate because (even with the help of Cornerstones) it was not likely that the service would improve because A had not been able to sustain improvements over a 3 year period.

130. The panel also accepts that the CQC were justified in concluding that the imposition of conditions was not appropriate as the Home was already in special measures and A had failed to assess or act on past risk and there was evidence of multiple breaches and inadequate leadership and governance. In light of all the evidence that panel accepts that R's decision was made in line with CQC policy and methodology and was necessary, appropriate and proportionate in order to protect service users. Moreover, the panel takes into account that as a matter of fact the last resident moved out of the Home on 28/09/18, A went into administration on 16/10/18 and the home was sold in April 2019. Therefore, it is not possible for the CQC to have completed a comprehensive inspection to determine if A has made improvements.

131. The evidence establishes in the judgement of the panel that R acted fairly and proportionately in that it did not issue the NOD until after the further focussed inspection on 6 August 2018, which found insufficient improvement and further breaches of fundamental standards. Moreover, R did not issue the NOD without first considering A's section 27 representations on 10th August 2018 and its

further representations on 3rd September 2018, which included a factual accuracy response to the draft report and an action plan.

132. The panel accepts that the CQC fully considered the action plan and templates for auditing care plans, medical administration and pain assessment monitoring. However, the evidence establishes that none were completed and no working examples were provided to evidence future compliance with the Regulations. In addition, the panel accepts that the timescales in the action plan (ranging as they did from one to six months) were inappropriately long because service users were at risk.

133. The panel does not accept that the CQC acted in bad faith or in some way conspired with RMBC to close down the Home in some spiteful manner. There is no adequate reliable evidence of any undue influence or conspiracy to close down the Home between the CQC and the Local Authority. The evidence of Gordon Waigand of RMBC was clear that the CQC did not place any pressure on the RMBC to close down the Home. The 2 directors of the Home who gave evidence could only refer to a suspicion of foul play and Ms. Lucy Corner said in oral evidence that she only assumed that the CQC were involved in the decision to remove residents and had no information to support her belief. The good faith of the CQC was in fact noted by Dr. Mohamed Hussain OBE who said that he had a great respect for the CQC and believed that he had had a good relationship with them.

134. The panel also does not accept that the CQC acted in an aggressive or unfair manner towards Cornerstones. The panel notes that Ms. Lucy Corner said that the CQC sent her “aggressive emails” but none were produced in evidence. It was alleged that the CQC refused to communicate with Cornerstones but in her oral evidence Ms. Corner accepted that the CQC had spoken to consultants at Cornerstones.

135. The panel notes that a serious allegation is made in A’s written closing submissions that after the hearing, the CQC told Ms. Corner that they would no longer instruct her because of the testimony she gave. There is however no actual evidence submitted (as opposed to uncorroborated submissions) about this and the panel gives the allegations little weight.

136. In coming to its conclusions, the panel takes into account the glowing testimony of the service users and their families and the doctor and fire safety consultant. This is positive evidence but of limited value in appraising the proportionality of the CQC’s decision to issue the NOD and resist the appeal. This is because there is inadequate evidence that these individuals have a working knowledge of the Regulations we are considering or had access to the evidence that we have read and heard.

137. In coming to its conclusions, the panel also takes into account the good character of all the directors of the Home and the fact that for most of its history the Home functioned well. The panel accepts that in particular Ms. Robina Hussain-Naviatti and Dr. Mohamed Hussain OBE acted in good faith and tried their best to respond to the many serious and persistent breaches of Regulations

highlighted by the CQC. Unfortunately, their best was not good enough. Again and again the evidence established that although they tried their best to react to problems as they were identified, Ms. Robina Hussain-Naviatti and Dr. Mohamed Hussain were (and remain) simply incapable of understanding the problems even after they were identified.

138. Despite clear evidence that the CQC explained the problems on multiple occasions, the 2 directors were unable to identify what was wrong or understand what needed to be done. The panel accepts the evidence of Sarah Powell that she had given copies of detailed feedback to the Registered Manager and Registered Person at the time of the inspection on 15/05/18 in order to inform them of the defects in the service and what remedial action was necessary. Moreover, the evidence establishes that after the 15-17/05/18 inspection, R wrote to A about the serious concerns identified and provided an action plan template to assist A in taking urgent remedial action. The evidence also establishes that after the 06/06/18 inspection R sent an urgent letter to A warning of possible enforcement action. The letter also advised that A should consider obtaining legal advice and set out action that they should take.

139. Despite this information the 2 directors were (and continue to be) unable to identify what was wrong or understand what needed to be done. In her oral evidence Ms. Robina Hussain-Naviatti said that “there was some basis and some regulations have been breached, some I’m not sure about. I’m not trained to translate [sic] of how a service is provided and how it breaches regulations.” She later said, “Many aspects needed to be improved. Whether they are breaches is a difficult question. I’m open to the possibility. I don’t understand if Regulations were breached.” She later explained that “we were aware of the seriousness [of the breaches] but we weren’t aware of why it was happening.” She also said that it was only when she received the NOP that “I realised there was a problem with the management structure”. Moreover, she still did not understand why the CQC did not find the new audit tools and care plans adequate.

140. Dr. Mohamed Hussain said that he was “flabbergasted” at being told that the CQC had found deficiencies in how the Home delivered care. The staff asked him why does the CQC want us to make these changes and he told them “Never mind just do it.” He went onto explain that “We couldn’t understand. We knew they were unhappy but couldn’t understand why. We would have done anything if we were told.”

141. In addition, the evidence showed (and continues to show) a lack of ability to act pro-actively and identify risks before they escalated into problems. Ms. Robina Hussain-Naviatti said that in her view Cornerstones were the best judges of whether there had been breaches or not. She added, “If they told us it was a breach we would have taken action. Also we would take advice from the CQC. They are always right and we have tried to implement what they say.” Her re-active approach and inability to identify the requirements of the Regulations herself is further evidenced when she said that “when we are told we react and do something. We have tried to respond to everything raised and tried to react to problems as and when raised.”

142. Dr Husain in his oral evidence stated that that the Home had had problems with staff since the 2017 inspection and that they were aware that Tim Hopkinson was struggling to perform his duties. But, the evidence establishes that no action was taken then or now to remedy this problem.

143. Moreover, there was (and remains) a worrying lack of understanding about the need for risk assessments and care plans and what was required to produce them. The evidence from the inspections was that care plans had not been updated to reflect the changing needs of service users. Staff told an inspector that they did not have access to the care plans as they wished because they were stored in a different unit to which they did not have access. Moreover, the evidence established that an analysis of these forms showed that much of the data was inaccurate and had not been added correctly. In oral evidence Ms. Robina Hussain-Naviatti accepted that care plans were not updated quickly enough. She said "It was a weakness that we did not update more regularly than monthly. We wanted Cornerstones to help us do this." It is concerning to the panel that she needed Cornerstones to educate her as to how important it was to keep care plans up to date.

144. There was also a worrying lack of trust and communication between the RM, provider and staff. The CQC inspector concluded that the Registered Manager was not always supported appropriately by the Provider and the Manager told her that he did not have the experience to drive the Home forward. Also the care staff lacked appropriate leadership and management from the Provider. In her witness statements Ms. Robina Hussain-Naviatti maintained that staff did have access to all records at all times and could not understand why the inspectors had come to a different conclusion and had said that staff had told them that they did not have access. She also blamed the Registered Manager Tim Hopkinson for not producing the necessary documents to the CQC Inspectors. She found it "incomprehensible" as to why he had not produced them at the time. In addition, Dr. Mohamed Hussain denied Tim Hopkinson ever told him about the need to buy a sensory mat and said he was not telling the truth about him refusing to spend money on it. He blamed Tim Hopkinson and said that "when things go wrong he seeks to put it on someone else."

145. In coming to its conclusions the panel has also taken into account the fact that A employed Cornerstones. However, the panel concludes that this was "too little, too late". Ms. Robina Hussain-Naviatti was asked why she had not brought in Cornerstones earlier. She replied, "We received the CQC inspection report on 25th June and we were bemused. Then people took holidays." This shows a lack of understanding of the seriousness of the breaches. Moreover, the panel notes that Ms. Corner said that she got the impression that the directors of the Home "had only just realised the seriousness" of their position when the contacted Cornerstones in August 2018.

146. In the judgement of the panel the decision to employ Cornerstones does not provide adequate evidence that the CQC's decision to issue the NOD and resist the appeal was unfair or disproportionate. The panel gave only limited weight to the evidence of Ms. Lucy Corner for the following reasons. Although she had experience working as the Registered Manager of a large care home and was a

part time CQC inspector, nonetheless she had not undertaken any inspections for the last 3 years. Moreover, in oral evidence she said that she had never actually inspected the Home herself but relied on the reports provided to her by Tim and Pamela who had no background as CQC inspectors and did not make witness statements or give evidence before the Tribunal. In addition, Tim and Pamela were only at the Home for only 8 days.

147. Moreover, there were a number of inconsistencies in Ms. Corner's evidence which undermined her credibility. In her witness statement she said that her view was that the problems at the home could be "remedied in a relatively brief period of time." She opined that the Home would have reached full compliance and a "good" CQC rating within 3 months with Cornerstone's support (para. 12). In oral evidence, however, she said that the Home would be only "safe" for residents in 6 months with their help and it would take 2 years for the Home to achieve a "good" CQC rating. She later said that it would take "2 years to get the Home back up to 60 residents in a safe manner."

148. In addition, in her witness statement (para.9) she explained that the Home's action plan was last updated on 22/08/18, but in oral evidence she said that the action plan was actually updated in September 2018. She was unable to explain why this was not mentioned in her witness statement dated 31/05/19.

149. The panel therefore concludes that there was inadequate evidence that even if given further time the Home could be "turned around". Moreover, the evidence of the 2 directors of the Home indicated an overreliance on Cornerstone and a lack of appreciation of their own responsibilities. Ms. Robina Hussain-Naviatti was asked about the new Cornerstones action plans and whether she thought that the time scales for achieving compliance were appropriate. She said that she did not know and just trusted Cornerstones. Moreover, she hoped that after they left "we could maintain the standards." Even after the intervention of Cornerstones and as at the date when they gave oral evidence (as outlined above) the 2 directors exhibited a worrying lack of understanding of what the nature of the problems were at the Home. This indicates a continuing lack of understanding and a wholly re-active approach to risk management.

150. The panel would like to reiterate that we are satisfied that Ms. Robina Hussain-Naviatti and Dr. Mohamed Hussain OBE acted in good faith and tried their best to respond to the many serious and persistent breaches of Regulations highlighted by the CQC. However, in light of all the evidence the panel is driven to conclude that A and these 2 directors were (and remain) unable to identify, understand or take action to comply with basic, fundamental standards, as set out in the Regulations.

151. The panel is also satisfied that A and its directors do not have adequate understanding of their responsibilities and obligations as Registered Providers and that (in light of their inability to do so under the supervision of the Local Authority compliance team) they are unable to improve their performance even with the assistance of Cornerstones.

152. The panel has every sympathy with Dr. Hussain and his family and

understands that they feel very strongly about this matter as they have run the Home as a family business for many years and genuinely believed they were doing the right thing. The panel abhors any unfair critical media comment about them. It also goes without saying that the panel condemns in the strongest terms any racially charged criticism of their actions.

153. However, in light of all the evidence (and for reasons set out above) the panel is satisfied on the balance of probabilities that the Home was carrying out regulated activities otherwise than in accordance with the relevant Regulations and that it was (and remains) necessary and proportionate to cancel the registration in order to protect service users.

Decision
The appeal is dismissed.

The order made by the CQC against the Appellant within the Notice of Decision (NOD) dated 3 December 2018 is confirmed.

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

Date Issued: 08 November 2019