First-tier Tribunal Care Standards

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

[2023] 4911.EA
NCN: [2024] UKFTT 00263 (HESC)

Heard on 1, 2, 8 & 9 February 2024 by Videolink
Panel Deliberation: 27 February 2024

Before
Mr H Khan (Judge)
Ms J Heggie (Specialist Member)
Ms R Smith (Specialist Member)

Between:

Divinus Support Limited (1)
Angela Burke (2)

Appellants

-v-

Care Quality Commission

Respondent

DECISION

The Appeals

1. Divinus Support Limited ("the First Appellant") appeals the Care Quality Commission's ("The Respondent") Notice of Decision ("NOD") dated 24th January 2023 to cancel its registration as a Registered Service Provider in respect of the regulated activity of Personal Care, pursuant to section 17(1)(c) of the HSCA 2008.

2. Ms Angela Burke ("the Second Appellant") appeals the Care Quality Commission's ("The Respondent's") Notice of Decision dated 2nd February 2023 to cancel her registration as Registered Manager in respect of the regulated activity of Personal Care, pursuant to section 17(1)(c) of the HSCA 2008.

3. The two appeals were commenced independently of each other but were consolidated and heard together.

Video Hearing

4. This was a remote hearing. The form of remote hearing was by video. The documents that we were referred to are in the main electronic hearing bundle (1347 pages), first supplementary bundle and a second supplementary bundle.

Attendance

5. The Appellants were represented by Ms Angela Burke (Managing Director). Its witnesses were Mr Cameron Burke (Financial Director), Ms Charmaine Constable (Associate Director), Mr Matt Constable (Associate Director) and Ms Lorraine Furness (PA to the Managing Director).

6. The Respondent was represented by Ms R Griffiths (Counsel). Its witnesses were Ms Deborah Willcox (Inspector), Ms Naomi Lucas-Adams (Lead Inspector) and Ms Sharon Moran (Operations Manager).

7. The Tribunal took account of the Appellant being unrepresented and made adjustments to enable the Appellant to fully participate in the proceedings.

Restricted reporting order

8. 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 any service users so as to protect their private lives.

Preliminary Issue

9. The Respondent applied to admit late evidence in the form of an email from Claire Fisk from Suffolk County Council dated 10 November 2023. The application was not opposed. We agreed that the evidence would be admitted as it was relevant to the issues that the Tribunal has to determine.

10. We also permitted further evidence (contained in the supplementary bundles) including evidence from Ms Burke in between the hearings. In considering any late evidence, the Tribunal applied rule 15 and took into account the overriding objective as set out in rule 2 of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008.

11. We concluded that it was appropriate to admit the late evidence as its admission was mainly agreed between the parties and it was relevant to the issues in dispute. In order to ensure fairness, we did allow the Respondent's witness (Ms Willcox) to re-enter the witness box (which

was not opposed) after having given evidence and in order to respond to the late evidence provided in between the hearings.

The First Appellant

12. On 1st October 2010, the First Appellant registered with the Respondent as a Registered Service Provider for the regulated activity of Personal Care from the location at Divinus Support Ltd, Unit 1, Highbury Road, Brandon IP27 0ND.

13. Divinus Support Limited is a domiciliary care service providing personal care to people in their own homes.

14. In or around 10 June 2021, Divinus Support Ltd changed its name to Divinus Support Limited and a new certificate was issued to reflect the change in name on 10th June 2021.

The Second Appellant

15. On 1st October 2010, the Second Appellant Ms Burke was registered as Registered Manager of the Provider in respect of the regulated activity of Personal Care. In or around June 2021, Ms Burke was issued with a new certificate of registration when the provider's name was changed. Ms Burke's registration in relation to the regulated activity of Personal Care is subject to the following condition:

"*The regulated activity may only be carried on at or from the following locations: Divinus Support Limited, Unit 1 Highbury Road, Brandon, IP27 0ND*".

The Respondent

16. The Respondent is a statutory body established by the HSCA 2008 to independently regulate the provision of healthcare, adult social care and primary care services in England. The Respondent also protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act 1983 (as amended). Pursuant to section 3 of that Act, the Respondent's primary objective is '*to protect and promote the health, safety and welfare of people who use health and social care services*.'

17. The Respondent's enforces the fundamental standards contained in the HSCA 2008 (Regulated Activities) Regulations 2014 ("the Regulations"), which are a baseline below which no service provider's care should fall. It is for the service provider to demonstrate not only that the fundamental standards are being met, but also that they are

being consistently and continuously maintained, and the Respondent inspects service providers to ensure that they are.

Events leading up to the decision.

18. The chronology of key events is set out below. The dates were taken from the agreed chronology provided in the hearing bundle.

19. The Appellant was inspected on 12 February 2019 when it was rated as "Requires Improvement".

20. It was further inspected on 21 January 2021 when it was not rated.

21. A Warning Notice was issued on 25 February 2021 for breach of Regulation 19. A follow-up inspection in September 2021 found compliance with that notice.

22. There was an inspection in April 2021, published on 24th June 2021, The first Appellant was rated as *'Requires Improvement'*.

23. The Respondent carried out a further planned follow-up inspection, with an announced office visit on 2nd November 2022, and then until 7th November 2022 gathering evidence by telephoning staff and service users and their relatives to get direct feedback. This was a focussed inspection of the Provider in respect of the regulated activity of Personal Care. At that time, there were 29 service users, 18 of whom were in receipt of personal care.

24. At that inspection, the Respondent alleges that it found the service to be in breach of five of the requirements under the Regulations, namely:

    a. Regulation 12: safe care and treatment.
    b. Regulation 13: safeguarding service users from abuse and improper treatment.
    c. Regulation 17: good governance.
    d. Regulation 18: staffing.
    e. Regulation 19: fit and proper persons employed.

25. Since the end of the inspection on 7th November 2022, the Appellants have been receiving enhanced support and guidance from the local authority.

26. On 5 December 2022, the Respondent issued Notices of Proposal ("NOP") to the First Appellant to cancel its registration in respect of Personal Care and to the Second Appellant to cancel her registration as Registered Manager.

27. The Appellants were both given the opportunity to make written representations against the NOPs within 28 days. The Respondent was

granted extensions for those representations when informed that Ms Burke was away from work with ill health. In due course, Divinus sent representations, but Ms Burke did not.

28. On 24 January 2023, a Notice of Decision was served on the First Appellant to cancel its registration as a Service Provider.

29. On 2 February 2023, the Respondent served a Notice of Decision to cancel the Second Appellant's registration as a Registered Manager.

30. A further inspection was carried out from 5th to 10th October 2023. At that inspection, it was found that there were breaches of the five regulations identified previously as well as a breach of a further regulation, Regulation 20 (duty of candour).

Legal Framework

31. There was no dispute as to the applicable law as set out in the written submissions prepared by Respondent's legal representatives. We have adopted the legal framework as set out in the Respondent's skeleton argument.

32. Section 3 of the HSCA 2008 sets out the Respondent's main purpose and objectives as follows:

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

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

(a) The improvement of health and social care services;

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

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

33. One of the Respondent's functions as the independent regulator of healthcare, adult social care and primary care services is the review and assessment of the carrying on of regulated activities as set out in Chapter 3 of the HSCA 2008.

Section 46(1): *"The Commission must, in respect of such regulated activities and such registered service providers as may be prescribed:*

(a) conduct reviews of the carrying on of the regulated activities by the service providers,

(b) assess the performance of the service providers following each such review, and

(c) publish a report of its assessment."

Section 46(3): *"The assessment of the performance of a registered service provider is to be by reference to whatever indicators of quality the Commission devises."*

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

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

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

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

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

(d) the need to protect and promote the rights of people who use health and social care services (including, in particular, the rights of 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 the 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."

35. The Regulations came into force on 1st April 2015 and Part 3 of those regulations set out the Fundamental Standards with which providers, including the Appellants, must comply when carrying on a regulated activity.

36. Regulation 21 of the 2014 Regulations provides that the registered person must have regard to the guidance issued under section 23, which 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.

37. The Respondent's power to cancel the registration of a person as a service provider or manager in respect of a regulated activity is governed by section 17 of the HSCA 2008:

"(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.

(4) In this section "relevant requirements" means—

(a) any requirements or conditions imposed by or under this Chapter, and

(b) the requirements of any other enactment which appears to the Commission to be relevant.

38. The procedure for such cancellation is set out in section 26(4) and (6) of the HSCA 2008:

26 Notice of proposals

(4) Except where it makes an application under section 30 or gives notice under section 31, the Commission must give any person registered as a service provider or manager in respect of a regulated activity notice in writing of a proposal:

(a) to cancel the registration (otherwise than by virtue of section 17(2) or in accordance with an application under section 19(1)(b)),

(b) to suspend the registration or extend a period of suspension,

(c) to vary or remove (otherwise than in accordance with an application under section 19(1)(a)) any condition for the time being in force in relation to the registration, or

(d) to impose in relation to the registration any additional condition.

(6) A notice under this section must give the Commission's reasons for its proposal.

39. The procedure for appealing a section 17 decision is governed by section 32 of the HSCA 2008:

(a) Section 32(1)(a): An appeal against a decision pursuant to section 17 HSCA 2008 is made pursuant to section 32(1)(a) HSCA 2008 to the First Tier Tribunal.

(b) Section 32(3): the First-tier Tribunal may confirm the decision or direct that it is not to have effect.

(c) Section 32(6) and (7) state:

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

i. to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates,

ii. to direct that any such discretionary condition is to cease to have effect,

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

iv. 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);

40. The rules applying are the Tribunal Procedure (First-Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (as amended).

41. The Tribunal makes its decision on the basis of all the evidence available to it at the date of the hearing and is not restricted to matters available to the Respondent when the decision was taken.

42. The onus of satisfying the Tribunal that the criteria was met falls on the Respondent and that the relevant standard is the civil standard, namely on a balance of probabilities.

Evidence

43. We took into account all the evidence that was presented in the bundle and at the hearing. We heard evidence from a number of witnesses at the hearing. The following is a summary of the evidence that was

presented at the hearing and in no way is it meant to reflect everything that was said at the hearing by the witnesses.

44. Ms Willcox set out the history to the matter including the inspection history. Ms Willcox denied that her approach was anything other than appropriate. She was the relationship owner for Divinus Support Limited as this service was currently on her portfolio of services. She undertook the inspection that was carried out on the 2 to 7 November 2022. The previous two inspection were carried out by another Inspector.

45. Ms Willcox explained that during the inspection on 7 November 2022, the Respondent identified breaches of the HSCA 2008. These were

- breach of Regulation 12 – safe care and treatment;
- breach of Regulation 13; Safeguarding service users from the risk of abuse and improper treatment;
- breach of Regulation 17- Good governance;
- breach of Regulation 18 – Staffing;
- breach of Regulation 19 – Fit and proper persons employed;

46. Ms Willcox was also involved in the inspection carried out between 5 to 10 October 2023, and in collaboration with the lead inspector Naomi Lucas-Adams. Ms Lucas'-Adams explained that during the inspection they identified continued breach of the following

- Continued breach of Regulation 12 – safe care and treatment;
- Continued breach of Regulation 13; Safeguarding service users from the risk of abuse and improper treatment;
- Continued breach of Regulation 17- Good governance;
- Continued breach of Regulation 18 – Staffing;
- Continued breach of Regulation 19 – Fit and proper persons employed;
- Breach of Regulation 20 – Duty of Candour (new breach);

47. Ms Willcox explained that the Appellant continued not to fully identify, assess, manage, and review the risks to the health and safety of service users and take action to do all that is reasonably practicable to mitigate those risks. In her judgement this placed people at risk of harm.

48. Ms Willcox set out her finding in relation to the breaches of the regulations. This included the lack of robust systems in place to protect

individuals from the risk of abuse. Her concerns included the failure to identify any risks associated with staff handling of service user's finances.

49. Ms Willcox acknowledged that whilst there had been some improvements made as a result of a significant support provided by the Local Authority following the October inspection, it was agreed that the service would remain in special measures and that there was insufficient evidence to remove the Notices of Decision.

50. Ms Lucas-Adams explained that she was asked by the Operations Manager to carry out a focused inspection of the First Appellant. She was accompanied by Ms Willcox. Ms Lucas-Adams set out that at that inspection they found the following breaches;

- Continued breach of Regulation 13; Safeguarding service users from the risk of abuse and improper treatment;
- Continued breach of Regulation 17- Good governance;
- Continued breach of Regulation 18 – Staffing;
- Continued breach of Regulation 19 – Fit and proper persons employed;
- Breach of Regulation 20 – Duty of Candour (new breach)

51. Ms Lucas-Adams explained the issues around the MAR charts which included the failure to identify, assess, manage and review the risks to the health and safety of service users and to take action to do all that is reasonably practical to mitigate those risks. In Ms Lucas-Adams judgement, that placed service users at risk.

52. Ms Moran set out the inspection history. Ms Moran made it clear that she had not had any involvement in the October 2020 inspection. This was because she had changed jobs. She denied that the aim was to close the provider. Each case was good on its facts. It was never a decision that was taken lightly. Ms Moran explained that there was no interest in taking a resource from a difficult market.

53. Ms Moran explained how the decision was taken by the Respondent. Ms Moran had looked at the options available which included cancellation, suspension and more significant conditions. However, it was felt that conditions were not appropriate. This was due to the history of the case. There had been multiple breaches. There had been inspections, warning notices and Ms Moran did not consider that the Appellants would be able to improve and maintain those improvements. She explained that the Provider had a history of breaches of regulations, these were multiple breaches and there was inadequate leadership and governance.

54. Ms Moran had worked with the LA. There were meetings with them. However, any decision of the Respondent was taken on the merits of

the case itself. Towards the end, the Appellants were on the agenda even though meetings with the LA were not called to discuss the Appellants specifically.

55. Ms Moran had considered conditions. Any conditions would be too far ranging. This is because there were different breaches. Warning notices had been given before. Although it was accepted that a warning notice had been given and complied with, Ms Moran was not satisfied that any improvement will be able to be sustained.

56. Ms Moran explained that there had been a lengthy period of decline. It was getting more serious. Nothing would give Ms Moran any confidence that the provider could turn this around.

57. Ms Constable explained that Ms Burke was a fantastic manager. She found a solution to any personal issues and was always willing to go the extra mile. Ms Constable explained that Ms Burke wanted to inspire people and that is what she did.

58. Mr Constable explained that Ms Burke was always working 24/7. He explained that Ms Burke would go out of her way to sort issues and things like equipment for people she supports, even though it was not always for her to do. She had been a good leader and had undertaken supervisions for everyone. He thought on this occasion, the Respondent had come across as wanting to close the company down.

59. Mr Burke explained that he had been married to Mrs Burke for 16 years. He explained that she was conscientious and if she ever missed a phone call, she would call them back. He explained that Ms Burke worked 24 hours a day.

60. Ms Furness set out her role as that of an administrative assistant to the Managing Director. She was not a support worker. She set out what happened on 2 November 2022. She set out some concerns regarding Ms Willcox's approach on that date.

61. Ms Furness accepted that she had not had any training in risk assessment. She acknowledged that for some medication there were side-effects but she typed up what she was told. Ms Furness acknowledged the importance of ensuring that any information (such as that relating to alendronic acid) was correct particularly when it came to medication and how it is to be administered.

62. Ms Burke explained that she had worked in care since 1994. She had also worked in the community, in a hospital care home and for a charity prior to working for herself.

63. Ms Burke described how she would do her utmost to help out staff. Ms Burke set out that she acknowledged that she could have provided more evidence. She explained that at the inspection November 2022,

she thought the inspector had displayed an attitude which to her suggested that the inspector wanted to close her company. In the past, she explained that she had some really good inspectors who have helped, supported, advised and understood how hard it was to keep everything up and running.

64. Ms Burke set out her concerns regarding inspection. The attitude of the inspector was inappropriate. Ms Burke explained that she had only been off on one occasion.

65. Ms Burke also accepted that she could have put more evidence before the Tribunal. She also thought that as "*long as you tick the boxes and you do not complain*" everything would be okay. Ms Burke accepted that in hindsight she should have written everything down but it was "*in her head*".

66. Ms Burke accepted that the office was cluttered but it was not cluttered for that long. They were dealing with deliveries. Ms Burke could not explain why there were so many different matrixes of the training form.

67. Ms Burke set out that it didn't matter what they did. The Respondent was never happy with it. Ms Burke set out the medical issues that she had experienced in the last few years.

The Tribunal's conclusion with reasons

68. We took into account all the evidence that was included in the hearing bundle and presented at the hearing. This includes the Appellants' and Respondent's evidence.

69. We wish to place on record our thanks to Ms Burke and Ms Griffiths and to all the witnesses for their assistance at the hearing.

70. We reminded ourselves that the Tribunal considers the circumstances as at the date of its decision and the onus is on the Respondent to satisfy the Tribunal that the relevant standard, namely the balance of probabilities was met.

71. We concluded, having considered the circumstances of the case, that we would confirm the decisions of the Respondent. Our reasons for doing so are set out below.

72. We acknowledge that the Appellants were represented by Ms Burke. Ms Burke raised issues regarding the conduct of the inspector but she did not focus as much on addressing the issues raised in the appeal itself. For example, much of the Respondent's <u>evidence</u> was not challenged but what was challenged was the <u>conduct</u> of Ms Willcox. Both Ms Burke and Ms Furness in their evidence referred to evidence which was not in the bundle. Ms Burke, in fairness acknowledged that she "*could have put evidence before the Tribunal*".

73. We also acknowledge Ms Burke's case that evidence did exist but that the inspectors did not look at it during the inspections. However, we would have expected to see such evidence put before the Tribunal by the Appellants. The Appellants had been given opportunities during the course of these proceedings to put forward its evidence but had failed to do so. We acknowledge that Ms Burke was acting as a litigant in person and the Tribunal made allowances for the Appellants by admitting evidence in between the hearings. On one occasion, we admitted evidence after the Respondent's witnesses had finished their evidence but allowed one of the Respondent's witnesses to return to comment on any late evidence.

74. We found the evidence of Ms Willcox and Ms Lucas- Adams to be clear, credible and supported by the evidence. We acknowledge that there have been concerns raised regarding the conduct of Ms Willcox by the Appellant. However, in our judgement, we found that the findings of Ms Willcox arose as a consequence of the inspection and was supported by the evidence before us. Furthermore, whilst Ms Willcox came across as a robust inspector, we noted that a large number of her findings were not challenged by the Appellants.

75. We were particularly persuaded by the evidence of Ms Moran. We found her evidence to be measured, well-reasoned and clear. Ms Moran very clearly explained the process in which the decision had been taken and why the decisions to cancel had been taken.

76. We also acknowledge that Ms Burke believed her evidence was honest. It was clear that Ms Burke was passionate and committed to her work. We acknowledge that she believed that she was doing her best.

77. We found that the evidence of the Appellant's witnesses which involved her children and her husband was largely limited to evidence around her commitment and did not address the substantive reasons as to why the Respondent had taken the decision it had.

78. We considered the position as at the date of the hearing. There had been a further inspection in October 2023. At that point, we reminded ourselves that the Appellants had been receiving enhanced support and guidance from the LA.

79. We considered all the circumstances of the case and all the evidence placed before us. We concluded that the Appellants were in breach of the regulations set out below.

Regulation 12

80. We found that the Appellants to be breach in Regulation 12. The evidence of the Respondent in relation to 9 service users at the October 2023 inspection was not disputed. We found that the

medicines were not consistently managed safely. For example, Service User A had a MAR chart in place but it did not contain any administration instructions to enable staff to be clear about the prescriber's instructions and to administer the medicine safely. Furthermore, in relation to Service User A there was a handwritten entry of "*alendronic acid*". The use of such medication required special administration instructions, for example not eating drinking or taking any other medications for at least 30 minutes and not lying down for at least 30 minutes. However, these important specific administration instructions were not included on the MAR chart for Service User A. Furthermore, there were also similar issues raised in relation to service users B, G and H.

81. In fairness, Ms Furness, accepted during her cross-examination the risks that this could cause. Whilst we acknowledge that Ms Furness wanted to assist and had begun to type up the MAR charts which would have avoided any handwriting issues, some of the most recent MAR charts were still inadequate. Ms Furness herself acknowledged that she would "*google it on the NHS website*" when asked where she would find specific instructions to put on an MAR chart, for example in relation to the alendronic acid. We agreed with the Respondent's submission that this highlighted the risks to service users of MAR charts being completed by someone who was unqualified and untrained.

82. We also noted that the Appellant had not put forward persuasive evidence to address the concerns around the MAR charts. The MAR charts submitted in the 2nd supplementary bundle, did not contain details as to what was contained in the "*dosette box*" and there was an absence of specific administration instructions for the medication. Furthermore, in the October charts audit, a problem was identified, namely, "*one medication error by family as one extra tablet was in dosette box*". The outcomes were recorded as "25/10/23 note left for family". The documents record that the daughter had replied that it was her error for putting in too many tablets in the box. However, even though it was identified that a service user had been given too much medication, nothing further was added. For example, there was no analysis of what action might be taken to prevent risk to service users from this happening again.

Regulation 13

83. We noted that Regulation 13 requires the Appellants to ensure systems and processes are established and operated effectively to prevent abuse of service users. This includes ensuring staff are trained to understand their roles and associated responsibilities in relation to any of the Appellants policies, procedures or guidance to prevent abuse.

84. We found that although there was a financial risk assessment, completed by the Registered Manager for some service users, the assessments failed to identify the risk of a member of staff using the service users cashcard to buy items. For example, the risk assessment

for “Peggy R” provided to the Tribunal dated 31 January 2023 made reference to staff members using her bank card but failed to identify any risk of staff abusing that trust. This carried some additional concern as it was recorded that this service user “*unfortunately doesn’t have regular family visitors*” and therefore any unexplained payments may have been missed. Furthermore, we noted that this service user was also known to have dementia and short-term memory problems to the extent that she cannot remember whether carers had been, yet none of these factors were identified in the risk assessment. Furthermore, although an undated financial risk assessment for service user “PR” dated 31 January 2023 was completed by Ms Burke, it also failed to identify the risk of a member of staff using the service user’s cashcard to buy items for themselves.

85. In addition, there was a common theme across some of the regulations as there was no cross-reference to the providers own “Service Users Finances Policy and Procedure” document. This policy had stated that where individuals who the provider supported lacked the mental capacity, the frequency of checks must be increased and determined by Ms Burke. We therefore concluded that although two financial risk assessments were completed, they were deficient in a number of ways putting the service user at risk of harm. The Appellant failed to present any evidence before the Tribunal by the time of the hearing that the Appellant was capable of doing any better despite the enhanced support they had been receiving.

86. Furthermore, we noted that the concerns in relation to Regulation 13 had increased by the time of the October 2023 inspection. For example, there remained a continued lack of evidence, such as shopping tasks being carried out without receipts being available for review and without care plans to provide guidance. Staff were still accessing service users’ bank cards and PINs. For example, in one risk assessment, for a service user, staff told the inspector Ms Willcox that they carried out shopping and paid bills yet the Registered Manager had ticked “no” to the question of whether there was any risk associated with staff handling that service user’s finances resulting in no corresponding care plan and thereby placing the service user at risk.

87. We found some force in the Respondent’s submission that it was remarkable that by the time of the final hearing, the Appellant had provided no records whatsoever whether in the initial bundle or in the supplementary evidence, to show that receipts were consistently being obtained and monitored. Nor was there evidence that there were systems in place to ensure that staff were not using their own personal store reward cards when purchasing goods, or even that any records of financial transactions had been completed. In our judgement, this put service users at risk of abuse, which management would have been unable to monitor in order to make any necessary improvements and protect them.

Regulation 17

88. We reminded ourselves that Regulation 17 requires registered persons to have effective overview and governance of the service.

89. We were persuaded by the evidence of Ms Moran who had assessed the seriousness of the breach of Regulation 17 as high. We also found that the Appellant had failed to adequately implement and sustain the governance systems to assess the quality of the service provided. The evidence from the inspection demonstrated poor oversight. Contemporaneous records were not complete. Staff were not given adequate support to understand their responsibilities and there was poor implementation of policies and procedures, or they were not present.

90. We found that the Appellants failed to fully understand the roles and responsibilities and failed to make the required improvements. One example of the failure to understand roles and responsibilities was the continued provision of blank documents. Examples in the main bundle are a blank Missed Calls Log, a blank MAR chart and a blank MAR audit.

91. Another example of the failure to understand roles and responsibilities was the lack of a sufficient contingency plan. We acknowledged Ms Burke's commitment and her evidence that she hardly ever took any time off. This was supported by the evidence of her family. However, much of the evidence demonstrated that in Ms Burke's absence, no-one else was fully capable of being able to fill in her various roles and responsibilities. For example, in Ms Furness' email dated 15 December 2022 she stated, *'I have spoken to Mrs Burke this morning and unfortunately there is not anybody to cover in her absence, due to the fact that there is not anybody who knows her job to the full extent that you require*.' When asked in evidence who had been covering for Ms Burke in her absence, up to 15 December 2022, Ms Furness replied, '*Possibly she was doing it from home which she shouldn't have been. Possibly Matt Constable was doing it and I only found out that day*.'

92. Ms Furness was also asked if there was a business continuity plan in place to ensure leadership and oversight in all circumstances; she replied, '*I don't know*.' We don't dispute that Ms Burke was committed and as she stated at the hearing, *"a lot of the information was in her head but should have been written".* However, the difficulty with not having a contingency plan was it was not clear as to what would happen in Ms Burke's absence. The evidence of Ms Furness who was a PA to Ms Burke demonstrated that even Ms Burke's PA did not know what the contingency plan was.

93. Furthermore, it was clear during the Respondent's inspection, that the office location where the staff worked, and where service users and relatives could visit, was cluttered and used to store and hold a large number of boxes. Whilst we acknowledged the explanation put forward

by Mr Constable, that he was tidying the office up, nevertheless, the office appeared to be in a similar state at the time of the video hearing.

94. We also found that the Registered Manager had not carried out competency checks on two of her own children employed as carers. We found that the Registered Manager, did not even consider the issues that this would create with regards to the lack of personal and professional boundaries.

95. Furthermore, we found that the Appellants' auditing systems were not completely effective and did not provide assurance that risk will be managed within the service and that the quality of service provided for users was robust. It was clear that although staff had some training, many had not received the training, support and supervision required to carry out the role safely. For example, there were various different versions of training records to the extent that it was not possible to identify definitively what training had been undertaken and by whom and by when.

96. Furthermore, whilst some medicine audits were completed, these audits were very basic and failed to pick up and independently identify any concerns. For example, the audits for June 2023 MAR which was completed on the 11 July 2023 did not contain any actions to be completed.

Regulation 18 & 19

97. We found that the Appellant failed to ensure safe recruitment procedures were followed and there were gaps in references, employment history and sparse application forms**.**

98. We found that staff had not received the training, support and supervision required to carry out their role safely. For example, half of the staff had not received training in safely moving people. The quality of the training and assessment for the rest was not sufficient; for example, online training in moving people with no practical assessment.

99. We considered the staff training records which showed multiple gaps where staff training had either not been refreshed or had not been undertaken. For example, the mandatory training matrix identified gaps in relation to the completion of training, and competency checks. For example, 3 staff had not undertaken moving and handling training and a further 3 staff had out of date training. 9 staff had not completed oral health training, 6 staff had not completed nutrition and hydration training and 7 staff had out of date safeguarding training. Practical and face to face training was not taking place. There were also multiple versions of the training record which meant that it was not clear what had been done.

100. The Inspection in October 2023 revealed that since the Respondent's last inspection only one new member of staff had been employed, staff

member D. We had no reason to doubt the Respondent's evidence that Staff member D's file contained a personal reference written by a friend 4 years *prior* to them starting work for Appellant. There was also a previous employer reference from 2018 but no reference had been obtained from the most recent employer or sufficient attempts to gain one. There was also no evidence of completion of the Care Certificate or any induction training, only blank forms were found on their recruitment file. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. There was one record of a shadowing opportunity provided during their induction and only one supervision provided.

101. Furthermore, Staff files for staff members E, F and G contained no evidence of an induction, limited supervisions and spot checks. The last medication competency for staff member E was 2010. Spot checks of performance were being completed by the Registered Manager who was related to three of the staff employed. Furthermore, two staff files reviewed showed staff had worked for the Appellant for over 13 years. During this time their Disclosure and Barring Service (DBS) check had not been renewed. Whilst there is no requirement to repeat a DBS check, Ms Willcox made it clear that services should undertake a risk assessment taking into the account the nature of the work staff undertake and the potential scope for abuse. No such risk assessment had been completed by the Appellant. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

102. We found that staff training continued not to be delivered in a safe and effective way to ensure staff had the necessary skills to keep themselves safe whilst delivering people's care. For example, despite using mobilising equipment to assist people to move safely, staff had still not received any practical 'hands on' moving and handling training to enable them to use equipment safely and their competency assessed to do so safely. The office administrator (Lorraine Furness) told Naomi Lucas-Adams that no staff training had been carried out since the last inspection in November 2022.

103. We had no reason to doubt Ms Willcox's evidence that staff she had spoken with during this inspection told her training was provided online only and staff were unable to confirm if any recent training had been provided. One member of staff said, "*We do all sorts of training but I can't remember exactly what. I know I am behind on a lot of the online training. I'm too busy*." All staff spoken with confirmed no practical moving and handling training had been provided. This meant staff had not been assessed as competent and safe to use equipment and ensure service users safety.

104. We found that by October 2023, the concerns of the Respondent had worsened. The breaches of regulations 12, 13,17, 18 and 19 were high. This was supported by the evidence of the Respondent as well as a striking lack of evidence from the Appellant. We found that there were ongoing and widespread concerns with regards to the quality of care provided to service users by the Appellant. The Appellants were not able to demonstrate sustained and embedded improvements.

105. We considered that the breaches of the above regulations were so serious in that they were sufficient to justify the cancellation decisions. Accordingly, we did not go on to consider Regulation 20 as this would not have made any difference to the outcome. Even if we had gone on to consider Regulation 20, our overall decision would have been the same and we would have confirmed the cancellation decisions.

106. We wish to place on record that we took into account the Appellant's personal circumstances including her passion and stated dedication to the care community. We listened carefully to her employment history. We had no reason to doubt her caring abilities. However, what the Regulations require is compliance and evidence of compliance. This is not a "tick box" as the Appellant submitted. The whole arrangement was based on the Appellant's personal knowledge and there was very little written documentation produced as to what had or needed to be done. It is evidence of compliance. That is what the Appellants are judged against. We acknowledge that the Appellant is now clear that she should have put in more evidence but we have to take account of the fact that both parties were given the opportunity to do so. We have based our decision on the evidence that was placed before us.

107. We consider it both necessary and proportionate for cancellation to take effect. We also considered whether or not it was appropriate to impose conditions. We concluded that it was not appropriate for conditions to be imposed. We were particularly persuaded by the evidence of Ms Moran and the inspectors that there was no longer any scope for this provider and registered manager to improve. We acknowledge that there had previously been a time when a good service had been provided.

108. However, the evidence demonstrated that in the more recent past, there has been a progressively more serious decline from "requires improvement", to a warning notice (which had been complied with), to additional breaches, to an "inadequate" rating and special measures, and then a repeated "inadequate" rating. We concluded that there were wide-ranging concerns covering a number of different breaches, and also different considerations within those breaches. The evidence demonstrated that despite the enhanced support from the Local Authority, the Appellants were unable to take the required steps and sustain the necessary improvements.

109. We concluded that, having considered all the circumstances of the case and the evidence before us, it was reasonable, necessary and proportionate for the Appellants registration to be cancelled.

110. We appreciate that this decision will come as a disappointment to the Appellants. We once again place on record our thanks to Ms Burke for her assistance at the hearing and we acknowledge her long-standing commitment and passion for her work in the care sector. We remind ourselves that the Appellants retain the option of applying to be registered again in the future. Any such application would be considered by the Respondent on its merits and any new registration application would carry with it a separate right of appeal to the first-tier Tribunal.

The Decision

1. The appeals are dismissed.

2. The decision of the Respondent in respect of Divinus Support Limited ("the First Appellant") dated 24th January 2023 to cancel its registration as a Registered Service Provider is confirmed.

3. The decision of the Respondent in respect of Ms Angela Burke ("the Second Appellant") dated 2nd February 2023 to cancel her registration as a Registered Manager is confirmed.

Judge H Khan
Lead Judge
First-tier Tribunal (Health Education and Social Care)

Date Issued: 28 March 2024