

**Care Standards**

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

[2019] 3676.EA

Hearing on 09-13 December 2019 at Cambridge Magistrates' Court  
Panel deliberation hearing on 03 January 2020

**BEFORE**

**Mr N. Sleight (Tribunal Judge)**  
**Ms C. Joffe (Specialist Member)**  
**Ms J. Everitt (Specialist Member)**

**BETWEEN:**

**ADR CARE HOMES (ST NICHOLAS CARE HOME)**

**Appellant**

**-v-**

**CARE QUALITY COMMISSION**

**Respondent**

**DECISION**

**The Appeal**

1. Mr and Mrs Rudd are the directors of ADR Care Homes [“the Appellants”]. Within this company Mr Rudd has been a registered provider with the Care Quality Commission [“the Respondents”] for 16 years. St Nicholas Care Home, Sheringham, is the registered home subject to this appeal [“the home”]. Mr Rudd became the registered provider for St Nicholas on the 25.10.10. He was also the nominated individual until 17.02.19.

2. On the 18.01.19 the Respondents wrote to the Appellant with a Notice of Proposal [“NOP”]. The registration in 2010 for this home was in respect of the regulated activity of accommodation for people requiring nursing or personal care. Pursuant to S12(5)(a) of the Health and Social Care Act 2008 [“HSCA 2008”] the NOP sought to vary condition two, namely that the Appellants be no longer authorised to carry on the regulated activity of providing accommodation for people requiring nursing or personal care from this home.

3. The Appellant supplied written representations on the 15.02.19. On the 26.03.19 the Respondents issues a Notice of Decision ["NOD"] pursuant to S28(3) of the 2008 Act. The Appellant lodged an appeal in respect of this NOD on the 23.04.19.

### **Representation**

4. The Appellants were represented by Mr David Hercock, Counsel. The Respondents were represented by Ms Laura Bayley, Counsel.

5. The Tribunal was provided with two full lever arch files prior to the hearing. By the end of the hearing, in light of further evidence admitted by agreement, we had the best part of a third lever arch file of material. The Tribunal had been provided with the relevant statutory and regulatory provisions/guidelines relating to this area of law.

6. At the close of business the week before the appeal began, a composite Scott Schedule had been provided. It contained a number of allegations by the Respondents, attempting to demonstrate either breaches of specified regulations (dating from Nov 18, May 19 to Nov 19) within the Health and Social Care Act (Regulated Activities) Regulation 2014 ["the regulations"] or evidence of a pattern of an ongoing failure within the home to comply with those regulations.

7. On the penultimate day of the appeal both Counsel were invited to prepare brief written submissions on the main issues. Both Counsel spoke to those submissions on the final day. The Tribunal found the combination of these submissions together with their skeleton arguments helpful. The issues in this appeal include consideration of the more detailed written evidence provided by both parties, as well as the oral evidence which had been subjected to cross examination, over the course of five days. We have considered all of the evidence and submissions before us. If we do not refer to any particular aspect of the evidence/submissions it should not be assumed that we have not taken this into account.

### **Restricted Reporting Order**

8. The Tribunal made a restricted reporting order under Rule14(1)(a) and (b) of the Tribunal Procedure (First Tier Tribunal) (Health Education and Social Care Chamber) Rules 2008 ["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**

9. In the weeks leading up to the appeal hearing, both the Appellant and Respondent made a number of written applications for the admission of late evidence. In respect of all matters, save for reference to paragraph 10 below, all additional evidence was admitted as it was agreed and dealt with at telephone case management hearings. On the morning

of the first day, a number of further documents were sought to be admitted. Once again the admission of these documents was agreed and the Tribunal, in considering late evidence, applied rule 15 and took into account the overriding objective as set out in rule 2 of the 2008 rules. We found the evidence was relevant to the issues. As there were a number of individual items we were asked to admit, we do not propose to particularise each and every item but we shall refer to them specifically where relevant.

10. On the 11.12.19, during cross examination of Mr Welham by Ms Bayley, she made reference to a PAMMS report and a PAMMS portal summary of the findings of that report. The portal summary was available on-line as from the 4.12.19. Mr Hercock objected to this line of questioning. This led to an application by Ms Bayley to put into evidence both the PAMMS portal summary and the full report. The Tribunal permitted the admission of the portal summary but not the full report. Mr Hercock then pursued an application to adjourn the appeal proceedings in light of our decision to admit the portal summary. We refused that application for a number of reasons expressed to the parties on the day, including but not limited to: the lengthy delay which would be caused on the matter which would inevitably go part-heard due to the evidence already heard by us, the fact that the Appellants had already been fully aware of the decision relating to the PAMMS assessment. We identified a number of safeguards already in place e.g. Mr Welham being well versed in the substantive material relating to the PAMMS assessment, Mr Hercock was afforded ample time to take instructions, Ms Bayley limited her cross examination to the domain results of the portal summary. In short, the Tribunal was alive to what both sides were suggesting about what weight we attach to the summary, it was not proportionate to adjourn for so long, both parties emphasized during the appeal that they felt everyone needed to know the outcome of this hearing. Thus our decision was:

We granted permission to the Respondent to admit the PAMMS portal summary.

We refused permission to admit the full PAMMS report.

We refused the application by the Appellant for an adjournment of these proceedings.

### **Background**

11. Within the bundle there was an agreed chronology from which a short history can be taken of the care home and its interaction/involvement with the CQC:

**2.05.12**                    Review of compliance inspection identified breaches of 4 regulations.

**17.08.12**                    A further inspection showed standards being met.

**18.03.13**                    3 Breaches of Regulations found on inspection.

- 9 & 12 July 13** 6 breaches of regulations found at further inspection, requiring improvement action
- 12 & 14 Nov 13** Improvements made and no breaches of regulations during compliance review.
- 14 & 18 Nov 14** 5 breaches found at a comprehensive inspection. A warning notice issued due for Breaches of Reg 9 and 18 (at that time it was Reg 22).
- 17,18, 20 Nov 14** Nine breaches of regulations found and the Service rated as inadequate overall.
- 3 Feb 15** 3 breaches of regulations service rate 'Requires Improvement' overall.
- 28 May 15** Improvements made and no breaches found. Service rated as 'good' overall.
- 30 Jan 17** Comprehensive inspection found breaches of 9 regulations and service rated 'inadequate' overall and placed in special measures.
- 19 June 17** Comprehensive Inspection. Service rated 'Requires Improvement' overall but 'Inadequate' for 'well-led'. The home remained in special measures.
- 5 & 6 Feb 18** Comprehensive Inspection. Service rated 'Requires improvement'. Remained in Special Measures.
- 20 Nov 18** Comprehensive Inspection found repeated breaches of 6 regulations. The home remained in special measures. (See details below concerning the Scott Schedule).
- 14 May 19** Comprehensive inspection found breaches of 7 regulations. Remained in special measures. (See details below concerning the Scott Schedule).

### **Legal Framework**

12. The Tribunal had regard to the following Acts, regulations and guidelines. The law was not in dispute between the parties, however each side naturally sought to emphasis particular aspects of the law, that best demonstrated how they argued we should consider the factual landscape.

13. The Respondent is a statutory creation arising from the Health and Social Care Act 2008 ["HSCA 2008"]. S2 of the 2008 Act provides the CQC with a number of functions, including at 2(a) the registration functions under Chapter 2.

14. It is important for the Tribunal to have regard to the overriding objectives set out for the Respondent to follow (S3):

**“3**

***The Commission's objectives***

(1)

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

(2)

*The Commission is to perform its functions for the general purpose of encouraging—*

(a)

*the improvement of health and social care services,*

(b)

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

(c)

*the efficient and effective use of resources in the provision of health and social care services.”*

15. The Respondent's objectives are guided by statutory matters to which they must have regard (S4):

**“4**

***Matters to which the Commission must have regard***

(1)

*In performing its functions the Commission must have regard to—*

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

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

(c) *views expressed by about the provision of health and social care services*

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

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

*(f) any developments in approaches to regulatory action, and  
(g) best practice among persons performing functions comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable and consistent).*  
*(2) In performing its functions the Commission must also have regard to such aspects of government policy as the Secretary of State may direct.”*

16. Mr Hercock reminded the Tribunal of the powers available to the Respondent pursuant to S30 ‘Urgent procedure for cancellation’ and S31 ‘Urgent Procedure for suspension, variation etc’. The criteria for either of these routes are well defined and known to the panel. In respect of cancellation:

*If there is a serious risk to a person’s life, health or well-being.*

For the variation or removal of a condition of a registration:

*If the Respondent has reasonable cause to believe that if it does not act under this section a person will or may be exposed to a risk of harm.*

17. The Respondent’s principal witness (Ms Wright) was asked about these urgent procedure powers in cross-examination, we deal that with below at paragraph 38. The point made by Mr Hercock was that, as neither of these powers open to the Respondent had been used historically, (e.g. in Nov 18) how could it therefore be argued that they would be satisfied now [para 4 of his written closing submissions]. Whilst the Tribunal addresses this below, as a matter of law, if in any given case the Respondent chooses not to exercise its powers pursuant to S30 or S31, as to the immediacy of the risk of harm (S31) or by way of their analysis of quantification of the ‘serious risk’, then why build into the statutory framework S12, namely the route the Respondent chose to take?

18. The Tribunal has to have regard to what weight it attaches to the purported breaches, both historically, but importantly, as at the time of the appeal hearing.

19. Pursuant to S12(5)(a) of the HSCA 2008 the Respondent has the right to seek to vary or remove any conditions of registration. A particular administrative/procedural route must be taken: pursuant to S26 they must give notice and written reasons to vary or remove a condition in relation to the registration. Pursuant to S27 the Appellant had the right to make representations to the Respondent within 28 days. Subject to the outcome of that the Respondent has the power (Pursuant to S28(3)) to adopt the proposals set out under S26 and must do so in writing.

20. S32 of the HSCA 2008 gives the Appellant the right to appeal the decision notice of the Respondent to the First-tier Tribunal. The Tribunal could therefore either approve/confirm the Respondent's decision as being correct or direct that the decision will no longer have effect.

21. It was not suggested by either party that there had been any failure to follow the correct procedure which gave rise to this appeal.

22. In so far as any past facts are relevant and/or in issue, the Respondent bears the burden of proof and the standard is the balance of probabilities.

23. The burden rests with the Respondent to show, on the balance of probabilities, that the variation to the condition proposed was necessary and proportionate. The ultimate issue involves a judgement as to the existence and significance of any risk, as viewed today, on the basis of all the material before us, including any findings we may make in relation to past facts.

24. It was common ground that we are required to determine the matter *de novo* and make our own decision on the evidence as at today's date. This can include new information or material that was not available when the decision under appeal was made. It is, for example, open to any Appellant in any given case to rely on evidence to show that the evidence underpinning the decision made was factually incorrect and/or that the opinions underpinning the reasons for the decision made were flawed or unjustified and/or that the issues have since been addressed. Mr Hercock argued that the focused inspection of Ms Wright (on 26.11.19) had led the Respondents to seek to introduce new matters by way of allegations of non-compliance with regulation 13 (safeguarding) and regulation 18 of the Care Quality Commission (Registration) Regulations 2009 ('notifiable incidents') ["the 2009 regulations"] and that these new matters were being used to justify the NOD made back in March 2019. These specific matters are addressed below, however it is axiomatic that, irrespective of these two specific matters raised, if an Appellant wishes to introduce new evidence or information (as the Appellants rightly did), then in reaching an evidenced based conclusion upon such, the Tribunal is still entitled to take account of all fresh information (attaching what weight it considers fit) including information provided by the Respondent.

25. The regulations made under section 20 of the 2008 Act include the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ["the 2008 regulations"]. Part 3 contains various provisions under the heading "Fundamental Standards" which include regulations regarding (listed are those contained within the NOD for this care home)

- 9 Person-centred care

- 10 Dignity and respect
- 11 Need for consent
- 12 Safe care and treatment
- 14 Meeting nutritional and hydration needs
- 17 Good governance.

26. The CQC has issued guidance in a document entitled “Enforcement Policy”, the latest version of which was published in February 2015. The CQC also issued “Guidance for providers on meeting the regulations” which was published in March 2015. The Tribunal had both documents within the trial bundle and had these in mind at all relevant times and are referred to as and when necessary below.

27. Mr Hercock helpfully reminded the Tribunal that, as the CQC is a specified regulator, it must meet the tests and obligations laid out within Part II of the Legislative and Regulatory Reform Act 2006.

“21

**Principles**

(1)

*Any person exercising a regulatory function to which this section applies must have regard to the principles in subsection (2) in the exercise of the function.*

(2)

*Those principles are that—*

(a)

***regulatory activities should be carried out in a way which is transparent, accountable, proportionate and consistent;***

(b)

***regulatory activities should be targeted only at cases in which action is needed.***

(3)

*The duty in subsection (1) is subject to any other requirement affecting the exercise of the regulatory function.”*

28. Mr Hercock also referred to the Regulator’s Code and with particular reference to paragraphs 2.2 and 5.1. The writer has taken the opportunity to re-read the full contents of this guidance, from para 1.1 to 6.5 [Regulators’ Code, Better Regulation Delivery Office, Published April 2014 by the then named Dept for Business, Innovation and Skills].

**Evidence**

29. The Tribunal heard oral evidence from the following witnesses (together with reading their identified witness statements):



For the CQC:

**Sarah Wright**, CQC Inspector - Witness statement (dated 26.06.19) and 60 exhibits, statement (dated 3.12.19) with a further 55 exhibits.

**Gemma Hayes**, CQC Inspector - Witness statement (dated 28.06.19).

**Jennifer Egmore**, CQC, Assistant Inspector - Witness statement (dated 9.07.19).

For the Care Home:

**Matthew Welham** - Witness statement (dated 5.7.19), updated statement (dated 18.11.19) together with 23 exhibits. Also appended to this admitted bundle [referred to in this Judgment as Supplemental Bundle No 1 ["SB1"]]. 3rd statement (dated 6.12.19) together with 4 exhibits.

**Rebecca Lincoln** - Witness statement (dated 5.7.19) and 9 exhibits. Updated witness statement (referred to below as "rebuttal statement") (dated 8.12.19) together with 4 exhibits.

**Phillippa Williamson**, Premier Care Solutions - Report on the care home (dated 10.10.19).

30. We also had regard to the witness statement of Anthony Rudd (dated 5.7.19). Unfortunately, Mr Hercock on the morning of the first day that Mr Rudd was unable to attend the appeal due to personal reasons. He did not attend to hear any of the evidence. The Appellants did not seek an adjournment or for any provision made for him to attend. The Respondents did not seek to call him as a witness to be cross examined upon the contents of his statement. In the circumstances of this appeal hearing, the Tribunal did not find it necessary to ensure his attendance, as the focus of the evidence for the Appellants was from Mr Welham and to a degree Ms Lincoln. We afforded what weight was necessary to Mr Rudd's written evidence and on occasions there were instances whereby Mr Welham gave a rather candid view of his employer, as set out below. For the purposes of this judgment Mr Rudd's evidence can best be summarised in that he set out and knew what his responsibilities were, including the following [D009-D010]:

- To provide direction and leadership to the care home
- to direct the development policy with regard to the services within the service, in accordance with legislative requirements recognise standards and best practices.
- to ensure that the defined management system is carried out
- to make an unannounced visit to the care home at least every month
- to ensure that regular reviews of all policies take place at the specified intervals
- recruitment of the registered manager
- lead, motivate and direct the registered manager
- he appoints the home managers at the care home and since 2003 stated he found it very difficult in recruiting a suitable home manager in January 2019, he engaged the

services of Premier care solutions and on their recommendations he appointed an Operations Director, Mr Welham, to assist with compliance and strategy duties within the care home.

The tribunal had identified at an early stage that one of the key issues in relation to this appeal was that of governance. It was clear that this was something identified by Mr Rudd himself at least as at the 5th of July 2019. Within his statement he said *“I take my role as the registered provider very seriously I work alongside my director, the manager and regional manager. I have stated in the representations that I’m very disappointed in the care quality commission inspection findings and subsequent actions and regret not making senior managerial changes earlier stop.”*

31. The panel viewed that last paragraph with some significance. Our conclusion, given the tone of that witness statement, was that it wasn’t Mr Rudd who was disappointed in the CQC by their actions, but that he was disappointed with the outcome for the home from the CQC findings. Thus as Director he was well aware of what needed to be improved.

### **Analysis and reasons**

32. A key starting point is to consider the ‘Scott Schedule’ and the issues surrounding that, as this incorporates both allegations of breaches of regulations (in both Nov 18 and May 19) but also sets out further examples of either alleged breaches or evidence of alleged non-compliance in Nov 19, arising from the focused inspection.

33. Ms Wright told the Tribunal that she had been at the CQC for 4 years and an inspector since December 2015. She said she was meant to do approximately 7 inspections per quarter, but did not have the finer detail to hand. She also said it depends on how much work each inspection generates. She had been the lead on the inspection of this care home when comprehensive inspections were carried out on 5/6 February 2018, 20 November 2018 and 14 May 2019. She was also the lead inspector on the focused inspection carried out on the 26 November 2019. She explained that the focused inspection was to look at compliance with the regulations i.e. with a focus on seeing if there was any evidence that improvements had been made since the comprehensive inspections in Nov 18 and May 19. The Nov 19 inspection was the focus of questions by Mr Hercock to Ms Wright in cross-examination, both about the quality of it, the ambit of it and the need for the CQC to provide advice and guidance in light of any findings. In terms of the fact a focused inspection was due to take place, this was firstly something that we found the Appellants were fully expecting. At a most basic level, and in particular, given the history of previously reported breaches of regulations and still being in special measures, it would be clear a further inspection was imminent. In her rebuttal statement dealing with the inspection in Nov 19, Ms Lincoln specifically references the fact she was

showing the two inspectors around the home, in which she (Ms Lincoln) was trying to point out all the improvements that had been made (para 4 of her rebuttal statement). Mr Welham accepted he knew there would be an inspection relating to this between the 25.11.19 and the 9.12.19. He went on to say that "...we were awaiting an inspection and knew the CQC would be doing an inspection prior to this appeal, we were not sure when."

34. A concern raised about the quality of the focused inspection was the fact it was essentially done by way of 'paper review', following a request for care plans and that the initial focused inspection report had not yet been written, thus not available to the Tribunal. The Tribunal was satisfied that the lengthy statement of Ms Wright (dated 3.12.19), irrespective of what we did or did not accept with in it, contained a detailed record of her observations and recordings of what she saw on the 26.11.19. Ms Wright we noted had been the lead inspector at the care home on at least 3 earlier inspections.

35. It is not always necessary to comment upon matters/issues on which the panel did not place any particular weight, however in this appeal we find it is important to address two matters at this stage, as they were dealt with by both Counsel in cross-examination:

A. Within her second statement, Ms Wright commented that upon arriving at the home (in Nov 19) she found Mr Welham to "...be hostile towards the inspection team." [para 13, p3 of 28]. She said Mr Welham asked why the CQC was only conducting a focused inspection, rather than looking at all improvements the home said it had made. Mr Welham confirmed he had indeed asked this question, the panel concluded the demeanour he was emanating at that time was probably more indicative of the pressure he felt under, given he said he "*..was nervous as I knew the significance of the inspection.*" [para 3 of Mr Welham's 3rd statement]. It was not a wilful or reckless attempt to put off or scare the CQC inspectors. Moreover, Gemma Hayes in her oral evidence indicated that upon arrival at the care home on the 26.11.19 she found Ms Lincoln to be positive and enthusiastic and keen to show them what had improved or changed. Ms Hayes said that Mr Welham, she imagined, was nervous as he came over as slightly less engaging and they had less contact from him. Thus the Tribunal did not draw any adverse inference against Mr Welham in this specific context. It is also right to say that the panel found the oral evidence of Ms Hayes powerful. She was an inspector who was present on the 26.11.19, she had not provided a written account/statement about her visit, but we noted she knew the home relatively well (having attended two earlier inspections) and she gave a clear account of her observations about the November focused inspection in her evidence in chief and during her cross examination. She was subject to detailed cross-examination, she conceded matters where it was right she did so, equally she remained firm on other matters (both of fact and opinion). Overall we found the nature and tenor of her evidence to be balanced, thoughtful and fair. She helped provide a clearer picture to the panel of the focused inspection in Nov 19.

B. As explained above, the Tribunal allowed cross examination of Mr Welham and Ms Lincoln in respect of a PAMMS portal summary which was admitted into evidence. As set out the Tribunal has not read the contents of that report and we only had regard to the portal summary which had been published online. The Domains and Standards vary and alternate between 'poor', 'requires improvement' to 'good'. The Overall Rating of the PAMMS summary we note was 'poor'.

36. The Nov 2018 inspection led to a number of alleged breaches of the regulations. These are detailed in the NOD. They are more fully set out within the Scott Schedule together with further alleged breaches in May 2019. The thrust of the Appellants case at this appeal was that, whilst not all historic matters alleged by the CQC had been accepted, many of them had, but it was never enough to justify the stopping of regulated activities, but the CQC have allowed the regulated activities to carry on, until the point of the appeal hearing i.e. some 13 months later. Secondly, and in addition to this, the general trajectory for the care home has been improved compliance since Mr Welham was employed, leading to the point now, that the effect of confirming the CQC decision would be disproportionate to service users, the care home and the Appellant.

37. Save for one specific preliminary point, it is instructive to deal with each alleged breach of the regulations from Nov 18 and May 19 (this being the approach favoured by Ms Bayley) to then look at, under each regulation, the more specific improvements that Mr Hercock urged had taken place within the home.

38. The preliminary point is that Ms Wright was asked in evidence by both Counsel about the decision making process which included the MRM (Management Review Meeting) after the November 18 inspection i.e why go down the route of an NOP in January 19 rather than the urgent notice route in December 18 [see SW/06 urgent notice of decisions to vary conditions and SW/07 NOP to vary conditions]. Ms Wright said that following the Nov 18 inspection, the findings did not meet the threshold to issue urgent actions, the concerns "need to be extreme". The final decision would have been made by the Head of Inspection and the Inspection Manager during the MRM. Ms Wright said she felt the NOP route was more proportionate. The Tribunal panel noted that the MRM did not recommend that the path to be followed was the urgent route. However, we noted that the subsequent NOP route still sets out a lengthy set of concerns which, were formed against a background, as set out in the chronology above.

*Regulation 9(1) Person-centred care & Regulation 10(1) Dignity and Respect*

39. The panel is satisfied that these two regulations can be dealt with together. On behalf of the Appellant it was accepted that in Nov 18 and May 19 these regulation had been breached in the following ways (taken from the Scott Schedule). In addition to those

admissions, we find as a fact that these allegations do amount to breaches of the regulations:

**Failed to ensure Service User A's care was appropriate for their most current needs**  
**SUA's care plan did not reflect the DOLs authorisation**  
**SUA's hospital passport did not detail up to date care needs**  
**SUA's pressure area risk assessment was not up to date**  
**Staff were not following SALT advice on eating and drinking**  
**SUA's preferences about their daily, routine, hobbies and interests and eating were not documented and/or followed**  
**Failed to ensure Service User B's care was appropriate for their most current needs.**  
**SUB's medicines risk assessment was not up to date.**

40. In respect of Service User C the following allegations were denied in the Appellants response to the Scott Schedule. These were allegations arising out of the May 19 inspection:

**Failed to adequately assess and meet Service User C's cultural, religious and spiritual needs:**  
**SUC's care plan did not address her cultural, religious and spiritual needs, as indicated in the Social Services review**  
**SUC's Emotional Support care plan did not address her difficulties with low mood and lack of inclusion.**

41. The panel raised on the first day of the hearing that the denial of allegations in the Scott Schedule appeared out of step when placed alongside the most recent statement from Mr Welham. He made more concessions than were set out in the response document to the Scott schedule. The Tribunal noted that within his statement of the 18.11.19, Mr Welham [para 9.1 to 9.9, Supp Bundle pages 010-012] was seeking to demonstrate where improvements had been made within the various care plans, but perhaps unwittingly to him, was also confirming that the problems remained as at May 19 when that inspection was carried out. He accepted this during cross-examination.

42. This response of Mr Welham was also repeated in regard the allegations of breaches of regulation 10 with regards the following matters relating to the Nov 18 and May 19 inspections, which had been denied, within the Scott Schedule:

**Failed to ensure Service Users received respectful care that upheld their dignity:**  
**SU toileting with door open to main corridor**

**Towels and bedlinen below acceptable quality**

**Cleanliness of environment not maintained**

**Service Users were provided with cracked, discoloured jugs**

**Service Users were not adequately supported with incontinence needs Records were not stored in a confidential manner**

**Where capacity assessments were recorded, they were not reflected in key decisions.**

**Failed to ensure Service User A received respectful care that upheld their dignity:**

**SUA was observed to have long, dirty fingernails**

**Failed to ensure SUA's autonomy and involvement in planning of care**

**Failed to ensure Service User C received respectful care that upheld their dignity:**

**A review of the daily records showed that SUC had not had continence care on 12 May 2019 between 09:48 and 22:53, contrary to their care plan**

**Failed to ensure Service User D received respectful care that upheld their dignity:**

**Failed to uphold SUD's privacy, dignity and respect regarding personal care requirements**

43. Within his statement Mr Welham inferred an acceptance of these allegations given his emphasis on stressing how matters had improved since those inspections. During his cross examination in evidence, he did when pushed, go so far as to concede that in respect of Service User C not having any records indicating any continence care on 12 May 19 that *"...if this was something observed by the inspector and brought to our attention I accept that."*

For clarity, with regards the concessions made by Mr Welham about alleged breaches (set out at paragraphs 40 and 42 above) we find as a fact that these allegations are proved and do amount to breaches of regulations 9 and 10.

*Regulation 11(1) need for consent*

44. The following matters were conceded in the Scott Schedule for the purposes of Nov 18 and May 19, again the Tribunal found as a fact those admissions were breaches of regulation 11:

**Failed to ensure that you worked within the principles of the MCA 2005, Service User A:**

**DOLs authorisation did not include personal care or call matt**

**Failed to involve Service User C in decision making about treatment and care:**

**No consideration given to involving SUC in decision making, care planning and delivery.**

45. The allegations below (arising from the Nov 18 and May 19 inspections) were not accepted on the Scott Schedule by the Appellant. We find as a fact that they were breaches by virtue of a. Mr Welham's response in his witness statement [para 11.1-11.5, page 016-017, SB1] and b. By his acceptance in cross examination that, as at May 19, the relevant documents still lacked detail. We noted that, despite by this time, a new computer system being in place, as recommended by Premier Care Solutions, the quality of the information inputted into that system and the monitoring of such, was still dependent upon the management structure in place at that time, which we concluded had been a big driver to the ongoing lack of sustained improvements across a number of the regulations.

**Failed to ensure that Service User L's mental capacity care plan was unambiguous, promoted their ability to make decisions and be involved in their care**

**Failed to ensure that Service User N's capacity assessments were adequately detailed, and supported giving best interests care.**

**Best interests care was not given to Service User N on 14 May 2019, following the discovery of an area of redness the previous day.**

**Failed to ensure that Service User O's mental capacity assessment was reflected in their care plan.**

46. Another aspect of an alleged breach of consent was that pertaining to a failure to ensure the Service Users' wishes and best interests were taken into account when using CCTV. A substantial, if not disproportionate amount of time was spent at the appeal focusing on this issue. It is clear that the NOD was concerned with other aspects of consent, not linked to CCTV. The initial statement of Ms Wright does not reference the issue of consent in respect of CCTV, she raised concerns about consent as dealt with above [C025-C026, para's 109-112]. When asked about this in her evidence in chief she said that the use of CCTV was questioned at the May 19 inspection. She said she was told it was only operational on the outside of the building. Her concern was due to some users not being able to give consent due to a lack of capacity. There was a degree of disparity between the observations of Ms Wright and Ms Hayes, when put to both of them about the sign on the door in cross examination, Ms Wright accepted she had not noticed it, Mr Hayes said she had. Mr Welham produced photographic evidence within his third statement [Exhibit MW/2 showing photographs of the sign about CCTV near the clock, at the door and a monitor screen which shows all CCTV covered areas within the home]. Mr Welham accepted in evidence that the CCTV was used within the inside of the care home, he did not know when this started (it was before he started working for the Appellants), the CCTV was not in use in the bedrooms. It did cover some communal areas whereby some personal care was being provided e.g. manual handling or feeding. Mr Hercocock made a number of submissions about whether or not CCTV fell within the ambit of Regulation 11. Put simply, the Tribunal does not find that the issue of consent or not with

service users and the care home in respect of CCTV, is determinative of this appeal and does not help us resolve the overall appeal. However, it is right to record that in answering questions to the panel Mr Welham accepted that:

- What he had heard described at the appeal was a possible invasion of service users' dignity.
- Following the appeal they would need to consult and review the consent for CCTV. He needed to get up to date with the guidance.

Ms Williamson said in her evidence that in respect of the CCTV there were some gaps in knowledge, homes often get conflicting advice from the CQC and a Local Authority at the same time, but generally most providers would be addressing the issue of consent in respect of CCTV.

*Regulation 12(1) Safe Care and Treatment, Regulation 13(1) Safeguarding Service user and Regulation 18(1) Notification of other incidents (the latter being part of the 2009 regulations)*

47. Whilst it is not ideal to converge 3 separate regulations together, it is pragmatic to do so, in the sense that the factual matters pleaded (in respect of regulations 12 and 13) and the analysis we have to carry out, are interwoven by the fact the same evidence is also relied upon by the Respondent as breaches of a notifiable event, pursuant to regulation 18.

48. The following allegations arising from Nov 18 and May 19 were accepted by the Appellants within the Scott Schedule (the list is not exhaustive but illustrative to demonstrate what was accepted as at those times) with regards regulation 12. Additionally, the Tribunal found as a fact the matters set out below were breaches of regulation 12.

**Failed to ensure SUA's moving and handling requirements were safely met**

**SUA's PEEP was inadequate**

**Gaps were found in SUA's TPAR Topical medicines were not securely stored in SUA's room**

**No way for SUA to summon assistance.**

**SUB's continence assessment and care plan were inadequate and did not deal with risk of urine infections, or how to treat them**

**Failed ensure that known risks relating to Service User C were assessed and managed:**

**SUC's moving and handling care plan was not up to date**

**Topical medicines were not securely stored in Service User D's room**



**There was no PRN protocol in place for Service User G's codeine phosphate medication**

**Gaps were found in Service User H's TPAR**

**Failed to ensure that accidents and incidents were reported appropriately in relation to SUH on 5 February 2019**

**Failed to ensure that accidents and incidents were reported appropriately in relation to Service User I on 5 and 7 November 2018**

**SUI had surplus medication, indicating a discrepancy between the stock levels and SUI's MAR**

**Failed to ensure that accidents and incidents were reported appropriately in relation to Service User J on 12 and 19 October 2018**

**Topical medicines were not securely stored in SUJ's room.**

49. The following matters (set out in bold below) were pleaded in the Scott Schedule as matters upon which it was said by the CQC, demonstrated either an ongoing breach of regulation 12 or 13, or, if not sufficient for a breach, then an ongoing inability of the Appellants to demonstrate an amelioration of concerns previously found from earlier inspections. Separately and distinctively it was also argued that they fell within a breach of Regulation 18 (notifiable events, 2009 regulations).

**A. Failed to investigate and report that a staff member was sleeping whilst on duty in October 2019 (Regulations 12 and 18)**

50. Ms Wright undertook a review of the weekly snapshot reports for Oct 19 and Nov 19. The report for the w/c 14.10.19 [SW/91] indicated that one member of staff had been dismissed after 3 shifts. Another member of staff was "*still sleeping on night duty, bad mouthing staff, refusing to work while on shift and still has a major personal hygiene problem.*" In her written evidence Ms Lincoln said that [para 34, her rebuttal statement] she believed the issue Ms Wright was referring to related to a young member of staff ("E") who was young and trying to do night work and go out during the day. Other staff members reported to Ms Lincoln that she was not staying awake. Ms Lincoln carried out her own investigation and found that E was not constantly sleeping as she did a two person turn of some service users and was logging onto the hand-held computer devices to confirm tasks were completed. Ms Lincoln spoke with her, off the record telling her not to fall asleep, E however continued to do and so was dismissed. Ms Lincoln also said historically there was another member of staff whom the home had a problem with sleeping, so that person resigned. Mr Welham's written statement on this matter also suggests an issue with two separate members of staff sleeping at the home. Mr Welham described the first occasion as being in August 2019, which concerned the Tribunal as this was not so long ago, compared to the obvious inference one could draw from Ms Lincoln's descriptions of it as being 'historic'. In respect of the August 19 occasion, Mr

Welham said that the member of staff was challenged and “...he said he only did it on his break and he woke up if there was an alarm call.” The Tribunal concluded that these two incidents demonstrated a number of matters of ongoing real concerns within the care home under regulation 12:

1. Despite the point being made, that by the summer of 2019, the staff had hand held devices to deal with patients, hence it being argued that if the tasks set on these devices were being completed, it demonstrated no service user was being harmed or being put at risk of harm and additionally it was said that the CCTV was there to help monitor the staff. What actually occurred, on the ground, was that the reason, at least one member of staff, became known to Ms Lincoln and Mr Welham as being asleep at night, was due to another members of staff telling them about this - else it may have continued to go unnoticed. The systems in place were not therefore adequate to identify this failing.
2. We had been told some service users were mobile and able to access commons parts of the care home. Whilst not all members of staff were asleep, it was inconceivable to the panel that there was not a potential risk to service users if a member of staff was asleep at times throughout the night. The Tribunal found that these issues around members of staff being asleep, had seemingly been trivialised by the Appellants, with regards the possible risk to service users.

**B. Failed to prioritise and maintain the safety and wellbeing of Service Users and staff by failing to adequately investigate and report allegations of sexual assault by a staff member in August/September 2019 (Regulations 13 and 18).**

51. This was an allegation involving a member of staff, known to both parties to this appeal [referred to as “X”]. The inclusion of this allegation within this appeal was disputed by Mr Hercock who made the point that for this to be considered by the Tribunal (whether as a breach of regulation 13 and/or 18) was wrong on the basis it was not part of the decision making process that led to this appeal back in April 2019. In his words it would allow the CQC to ‘enlarge’ their case in a way which separates out the appeal process from the actual decision.

52. Insofar as the Tribunal was concerned we were satisfied that:

- procedurally there had been no disadvantage or prejudice to the Appellants as they were fully aware of these factual matters at the time they occurred and they were aware from the Scott Schedule that the CQC sought to place reliance upon them. The Appellant did in fact deal with these issues via the statements of Mr Welham and Ms Lincoln. We were fully addressed on the law and regulations by Mr Hercock throughout the appeal process.

- as matters transpired it did not appear to the Tribunal that there was much factual dispute to what occurred at the home in respect of this employee (X), the issues related to how the matters were ultimately dealt with and the risk to staff and service users and the investigations of such.

What were the concerns?

53. In her rebuttal statement Ms Lincoln referred to the fact that a member of staff (X) told other staff that she was gay. X was close to other members of staff (not in a sexual way, but as colleagues and mates), this led to some fondling and banter in the office. Ms Lincoln said that it was reported to Mr Welham and he addressed it within supervision, then formal supervision. Mr Welham had a clarification meeting with X and, as it did not happen again and the staff did not feel uncomfortable, *'we were happy to deal with it in house.'* [Rebuttal statement of Ms Lincoln, para 36]. Within the paperwork before the Tribunal we had the minutes from a meeting with X on the 17.09.19. Mr Welham records in his 3rd statement that X had, in August 2019, touched one member of staff on the breast, one member of staff on her bottom and one member of staff on her arm. Mr Welham was clear that there has never been any issue of X's conduct with residents and no general repeat of this behaviour. By the time of the appeal, after having been advised to do so at the focused inspection, it (along with the sleeping issue of a staff member) had been raised as a safeguarding issue, with both Norfolk Local Authority and the CQC, they have both stated they are taking no further action.

54. It is instructive to bear in mind one of the passages from the supervision meeting with X on the 17.09.19, when discussing the sexualised incidents, part of the minutes have been redacted in the bundle for obvious reasons:

*"...then said about sexually touching the staff...and...said she hasn't done this in a. Few days....said that the next time this happens the police will be involved as this is sexual abuse and it will not be tolerated. No one else in the building sexually grabs or gropes people and ....is to stop.....said that this is a serious matter"* [see SW/115 second statement of Ms Wright].

55. The Tribunal found that this contemporaneous account demonstrated a more graphic account of what had occurred at the time in terms of sexualised behaviour by X. This, by itself, but also the fact the threat of contacting the police if it occurred again was mooted to X, demonstrated to us that as at the time of the appeal, there was a tangible attempt to downplay the significance of this incidence by the language and statements arising now, contrasted to at the time.

56. The Tribunal accepted the evidence of Ms Wright, that she was satisfied that no proper enquires or assessment had taken place to establish that there was no risk to any

service user, arising out of what happened with employee X and her sexual behaviour. The stock response in both written and oral evidence from the staff appeared to be that there simply was no risk to service users, as this was something the management did not contemplate. It was accepted that no residents had been spoken to about these issues. Whilst the Tribunal is fully aware that some residents lack capacity and therefore this investigation would not necessarily be straightforward, in our view this series of events, required a careful and thorough investigation to ensure no service user had been treated improperly or exposed to any risk of sexual harm or potentially psychological or emotional harm.

57. Should the issue of employee X and the issue of the one, possibly two employees falling asleep, have been notified to the CQC as incidents? The Tribunal were given the two referrals made by Mr Welham to the CQC, both notifications were made on the 27.11.19 [exhibit MW/6] after the focused inspection. It is correct that the CQC response stated that both matters fell outside their remit. Mr Hercock argued that neither of these matters were 'notifiable events' as they did not fall within the criteria for regulation 18, moreover by virtue of the fact the CQC said they did not fall within their remit then, with the benefit of hindsight, it confirmed the position Mr Hercock took. The Tribunal has to consider the point and purpose of Reg 18. The point of this regulation can be summarised by the section in the summary guidance [E644 bundle] namely "*Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services*". Mr Hercock sought to persuade us that this regulation is wholly specific and particularised, as a consequence the two matters, which were notified to the CQC, do not come within that definition. However, we found that the behaviour of employee X and the staff falling asleep would have been notifiable in the sense that it could have fallen within either of the two of the following categories set out under Reg18(e), namely 'any abuse or allegation of abuse in relation to a service user'. We noted that this includes '**allegation of abuse**'. 'Abuse' is defined and includes both of the following in relation to a service user (the definitions quoted are the pertinent ones): 'sexual abuse', 'neglect and acts of omission which cause harm or place at risk of harm' [reg 18(5)(b)(i) and (iv)].

58. In the Tribunal's view our conclusions were fortified by the fact that Mr Welham had felt it necessary at the time to speak to their HR insurance team given the magnitude of the matter.

59. In the view of the Tribunal, part of the rationale behind regulation 18 is to ensure that the CQC is aware of notifiable incidents to allow them to ultimately take any follow up action if required. If such an event is not deemed to require follow up action and/or is not in the view of the CQC a 'notifiable event' then so be it. However, the Tribunal view the conduct of the management at this care home in respect of the notifiable events as being illustrative of being a. Reactionary i.e. submitting a notification when requested to do so

following the focused inspection and b. A facet of the wider reaching issues of governance. The Tribunal found it telling that the evidence of Ms Williamson was clear, when she said she would've taken a 'belt and braces' approach and notified the CQC in respect of both employee X and the members of staff asleep. At a basic level of good practice, it was a worrying aspect for the Tribunal panel, that given the NOD and pending appeal, that the management did not proactively report either of these incidents to either the CQC or Local Authority at the time they occurred.

*Regulation 14(1) meeting nutritional and hydration needs*

60. A number of matters were accepted by the Appellants in relation to regulation 14 contained within the Scott Schedule. They do not need setting out here, save for clarity those matters accepted by the Appellants, the Tribunal finds as a fact that they amounted to breaches of regulation 14.

*Regulation 17(1) Good Governance*

61. As explained above the major concern for the Tribunal were those matters falling under Reg 17, namely governance. Various examples of this were pleaded within the Scott Schedule, notably none were accepted by the Appellants. The following examples are illustrative of our concerns which we find as facts, proved on a balance of probabilities:

A. The difficulty that Mr Rudd has had in recruiting a home manager since 2003 and the fact that there is no manager registered with the Respondent as required by the regulations.

B. Mr Welham was appointed the Operations Manager for ADR Care Homes Ltd in Feb 19. The Tribunal was provided with his detailed CV which demonstrates he has a number of years experience working in this sector. In addition to being the operations manager for all the care homes within the group, Mr Welham was also employed in a capacity to look at restructuring the finances of the ADR Group. No criticism is made of Mr Welham in this respect but simply an observation about the large portfolio of work he had undertaken. In his first statement he said he visited the care home once a week, by the time of his oral evidence this was up to twice per week. In terms of his input into the care home he travelled some 1 hr 45 minutes to get there on each occasion. He was in regular telephone contact with Ms Lincoln and could monitor compliance via the patient centred software remotely. As Miss Williamson indicated, this new software system, in terms of the substance of what it shows (whether in the quality of the service users care plan or otherwise) the quality is dependent upon the individual inputting the data.

C. Mr Welham was able to identify that when he joined ADR he was involved with the closure of Bethany Francis House (28.3.19) and St Catherines Care Home (10.7.19). Rebecca Lincoln gave evidence before us. We found her to be a hard worker, concerned about the situation at the care home and conscientious about the care of the residents and the future of the home. Ms Wright had found Ms Lincoln to

have a good understanding of person-centred care [C032] and was enthusiastic about improving matters. Ms Lincoln told us she had worked at the care home since May 17 as a senior carer on nights, she was then promoted to team leader and then transferred onto days, then to deputy and then home manager in Feb 19. We found that this task would be a huge one for any person, even an experienced manager. She said that when Sue Schofield had been the manager, Ms Lincoln had been given in-house training and e-learning. After Feb 19 Mary Rockcliffe was appointed the interim manager and the plan had been to train Ms Lincoln up as the manager. Mary Rockcliffe had to leave shortly thereafter Due to her health. Ms Lincoln said in her oral evidence, she viewed her role as an interim one, as she was aware that the company was planning to recruit. Much to her credit Ms Lincoln has now done NVQ level 3 and is set up to commence level 5 to assist herself in the future.

D. We found there was a lack of support to Ms Lincoln from Mr Welham. He makes reference to the CQC inspection which he could not attend due to being at an emergency meeting with Cambridgeshire CC about Keneydon House. He said with hindsight he wished he had asked for support for Ms Lincoln from Mary Rockcliffe, but he did not. He also conceded that he should have had another individual to go to the home to support Rebecca. It struck the Tribunal as obvious that as the Operations Manager, whilst engaged in a discussion about another home, having an inexperienced (in terms of management) member of staff having to deal with a CQC inspection, was a big task for Ms Lincoln. This may be simply one example, but in our view it typifies the general impression formed, having regard to all the evidence that Ms Lincoln, is not being supported in a way that she requires, having been thrust into that position. It still remains unclear to the Tribunal the efforts made by the Appellant to resolve the issue of a registered manager. One can fully understand why Ms Lincoln would be worried about this, yet Mr Welham continues to state that Ms Lincoln was offered support from Premier Care Solutions whilst she settled into her role. Some 10 months have now passed and the issue of a registered manager remains unresolved. As at the current time, the Tribunal remains worried about the fact that as the home has no registered manager, the onus remains on Mr Rudd, as the provider who retains overall responsibility.

E. At the focused inspection on the 26.11.19 Ms Wright was given the 'master action plan report' [Exhibit SW/105] dated the 23.04.19 and updated on the 24.04.19. It was clear however that this had been updated since that time as entries on it include 'action completed' on the 5.7.19 in respect of refresher MCA training to staff. Mr Welham said that there were in effect two parts to the plan: one for CQC and the second for PAMMS. Mr Welham also said that he completed monthly provider reports and Ms Lincoln did the monthly manager report called 'Make it Happen'. Mr Welham would review the 'make it happen' report as part of his monthly provider report. On his own evidence, Mr Welham accepted [para 43, page 10 of his 3rd statement] that he had not done a provider report for June 19, Oct 19 nor Nov 19 as it wasn't necessary

due to receiving either a PAMMS inspection, CQC inspection or the audit from Premier Care. The Tribunal concluded that this situation raised our worries further about governance. In the context that Mr Welham was a busy man, getting little support from the provider, trying to support an inexperienced Ms Lincoln (in terms of her management background) in terms of her having day to day support, feedback and guidance as to the information which she was the sole inputter into the software system, it was concerning that the processes they put in place to satisfy not just the CQC, but more importantly themselves that the regulations were being adhered to were not being completed. The idea that on 3 recent monthly occasions a provider report was not completed is troubling:

- i. Absent a monthly provider report how can both Mr Welham and Ms Lincoln be satisfied her monthly reports are being done properly and not raising any issues?
- ii. The rationale behind the two lots of monthly reports is to ensure the safety of users in accordance with CQC guidance. By not doing the reports in the very same months differing bodies (CQC, LA or Premier Care) are carrying out their own assessments is a fallacy i.e. if the internal processes are not done at the same time as inspections, how can staff/management identify or learn, if what the different body, finds is correct or not?
- iii. The impression we had formed was that Mr Welham, leaving the CQC or LA to conduct their own inspections, which then obviated the need for monthly provider reports was a fallacy, as neither Mr Welham and/or Ms Lincoln actually agreed with all the findings in the latest CQC focused inspection and/or PAMMS inspection, as they both stated.
- iv. Given an important aspect of the historical concerns at this home, as identified by the CQC, were in relation to poor paperwork and thus a lack of a proper analysis of the service users needs in light of such problems, it was perplexing to the panel why, at this critical time of an appeal pending, the identified remedies to the problems noted by the CQC (i.e. monthly reports and action plans) were not used all the time or kept up to date.
- v. We rejected the notion put forward by Mr Welham [para 43, page 10 of his 3rd statement] that "*Whenever we have a major inspection or audit there is no point in doing one (provider report) as we discussed actions points from the audit or report which is far more important.*" This carried little weight with us, as Mr Welham made it clear that the concerns were not accepted (Nov 19 inspection). Equally implausible is, if one takes the quote above from Mr Welham to its logical conclusion i.e. that if they did discuss and accept all the concerns found on the various PAMMS report/CQC focused inspections, then why dispute them at this appeal?

F. Miss Williamson gave evidence before us. She was first involved with the Appellants back in Feb 2019. She was brought in by Mr Rudd to assist with input into the care homes owned by the Appellant. There had been a previous working relationship between Ms Williamson and Mr Welham via Careport. We read her

Compliance Review of the care home (dated 10.11.19). She said that she had done the same process in Jan/Feb 19 in respect of the care home and agreed with the view of the CQC at that point. Her findings differed significantly in her Nov 19 report. She said that in Feb 19 the management from Ms Schofield was poor. She said that Mrs Rudd was doing the provider support. Ms Williamson was clear that at that time the environment was poor in the sense that the manager did not understand the safeguarding process and training was poor. Everything was poor in terms of policy or procedure. Ms Williamson said the following to which we attached significance:

- she recommended Mary Rockcliffe as a 'turnaround manager', she had worked for her at Careport.
- as at Feb 19 the team within the care home were not experienced.
- her general rule of thumb is that if there is a safeguarding concern it is best to ring someone about it.
- in terms of Ms Lincoln she said that she was in place by 'default'. She felt Ms Lincoln had the 'potential' but needed more support.  
During cross examination she accepted that:
- her report in Nov 19 did not uncover anything about the staff members sleeping nor employee X and her sexual behaviour (this is not a criticism of her report, merely a reflection that its purpose was not the same as the CQC focused inspection).
- she agreed Ms Lincoln was under-qualified and concurred that Mr Welham was pivotal to the success of this care home, if he left, the position would be unsustainable.
- she was surprised that the paperwork did not indicate any investigation or analysis of how the skin tear to service user M had occurred on the 15.8.19. She said that she would've expected a signing off by the home manager as to how it had occurred, was there a cause for it and she would want than doing the next day.

62. Overall, it was also clear to the Tribunal that it was not necessary to prefer the CQC focused inspection over the external report done by Ms Williamson or vice-versa. Both were done for different purposes. Ms Williamson recognised the wider governance concerns. Equally her day at the care home was known by the staff in advance and appeared to take place in very different circumstances: namely it was Armistice Sunday. She described the home as lively with the residents having several visits from family or friends.

### **Conclusions**

63. Drawing all matters together the Tribunal is wholly satisfied that the Notice of Decision to vary the condition of the care home was both necessary and proportionate. We do so being fully cognisant of the need to be no more intrusive than necessary and the impact



on the Appellant, employees and most importantly to service users. Having considered the matter carefully for 5 days, it is firstly clear that within the history of this care home a whole range of breaches of regulations were accepted as still occurring as at the inspection in May 19, some 7 years after the first alleged breaches were identified in May 12. The response of Mr Rudd and, to a degree Mr Welham, has been to seek to demonstrate an on-going trajectory towards improvement in compliance with regulations. However, despite the new management structure being put in place in Feb 19, a new person-centred computer system around the same time, no discernible improvements had been made by May 19 - some two months after the NOD. We acknowledge that there is a need for the CQC to follow its duties as a regulator to advise and assist the Appellant to get to a place whereby the CQC is of the view the care home is compliant with the regulations, as argued by Mr Hercock. Equally, it must be pointed out, that it remains incumbent upon this Appellant, as with all service providers, that their responsibility is to know the content of and apply the Regulations. The most recent focused inspection had identified, we were fully satisfied, ongoing real concerns about compliance with the previous breaches of the regulations. The panel have some sympathy for the position Ms Lincoln finds herself in, given the tasks she faced from February 2019. The Tribunal sadly does not have any confidence that due to the structural set up within the care home at this time that there is any prospect of change in terms of compliance in the short, medium or long term. This arises from the lack of support provided, the demands placed on the operational manager, the lack of effective support from the directors and the experience of staff within the home. The fact that the urgent procedure was not used in this care home has actually afforded the Appellants time to demonstrate improvements, which we conclude that they have not sufficiently demonstrated. This Tribunal is satisfied that the admitted breaches of the regulations in Nov 18, May 19 and as were found by us, coupled with the ongoing failures to demonstrate compliance, have proved a. A risk of harm to service users b. An ongoing risk of harm and c. The variation of the condition remains both necessary and proportionate.

### **Decision**

64. The decision by the Respondent to vary a condition on the Appellants such that they no longer be authorised to carry on the regulated activity of providing accommodation for people requiring nursing or personal care from St Nicholas Care Home, is confirmed. The appeal is dismissed.

**Tribunal Judge N. Sleight**  
**Care Standards**  
**First-tier Tribunal (Health Education and Social Care)**

**Date Issued: 22 January 2020**