Care Standards Tribunal

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

Heard on: 21, 22 and 23 March 2017
Heard at: Royal Courts of Justice, London

BEFORE
Tribunal Judge -Melanie Lewis
Ms Margaret Diamond–Specialist Member
Ms Caroline Joffe –Specialist Member

BETWEEN

Adastra Treatment Centre Ltd

Appellant

-v-

Care Quality Commission (CQC)

Respondent

[2016] 2796.EA

DECISION

Representation and Witnesses

1. Mr Adam Barrett Director and Registered Manager Adastra Treatment Centre Limited presented the case supported by Mr Gary Sutton and additionally Ms Merlin Glozier on Day One. He called Dr Iqbal Mohiuddin as a witness.

2. The Respondent was represented by Mr Cyril Adjei Counsel. By the Appellant's request only Ms Lea Alexander Inspector, Ms Zara Church Inspector, Mr Brian Brown National Medicines Manager and Ms Jane Ray Head of Hospital Inspection (Mental Health, Substance Misuse and Learning Disabilities) were called as witnesses.

Reporting Order

3. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the service users in this case so as to protect their private lives.

The Appeal

4. This is an appeal by Adastra Treatment Centre Limited ("Adastra") against the CQC's Notice of decision, dated 3 August 2016, to cancel its registration as a service provider in respect of the provision of regulated activities.

Background

5. Adastra has been registered with the Respondent since 8 December 2010 to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder and injury .Adastra is a private clinic which provides community based care and treatment for people with a drug addiction in a way that they see as being different from the commissioned services. It operates during the day and evening. It provides substitute medicines and counselling to patients. At the time of the last inspection (February 2017) Adastra was treating 148 clients.

6. At an inspection on 31 May 2011, CQC Inspectors found some clients who used the service did not have a record of their initial assessment for the service and others did not have regular reviews of their treatment or up-to-date risk assessments. Nine Compliance actions were issued. At an inspection on 25 October 2011, clients' individual care and treatment plans were not recorded and there was no record of the frequency of care and treatment reviews. Four Compliance actions were issued.

7. On 16 July 2012 and 14 August 2012 an inspection found the service to be compliant in all of the areas inspected.

8. Since April 2014, the Commission has implemented a new inspection methodology based on the assessment of services against five domains: safe, effective, caring, responsive and well led. Each domain is assessed using key lines of enquiry. Of note, the inspection process is more robust and typically is now carried out by a team of inspectors supported by experts by experience and specialist advisers. Focused inspections take place to check on areas of improvement in the service following enforcement action or where intelligence has been received, as happened in this case. .

9. Following a number of matters of concern brought to the attention of the CQC, they undertook an unannounced focused inspection of the service on 8, 11 and 22 March 2016.

10. On 7 April 2016 CQC sent a Notice of proposal to cancel registration.

11. Following this inspection the Appellant undertook not to admit any new clients to the service and submitted an Action Plan on 11 April 2016, which was updated on 11 May and 10 June 2016.

12. The decision to cancel Adastra's registration on 3 August 2016 followed serious concerns that were identified. These concerns constituted breaches of Regulations 12, 17 & 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations"). The reasons are

comprehensively set out in the CQC's inspection report dated 17 August 2016, including why the Action Plan was insufficient.

13. The Appellant appealed against the Respondent's decision in an appeal dated 26 August 2016. No further Action Plan was forthcoming.

14. A further unannounced inspection took place on 1, 2 & 3 February 2017 to check the progress that Adastra had made with regard to the breaches of regulations identified in the March 2016 inspection and to be able to provide the Tribunal with updated information in order to determine this appeal. While some improvements were identified at this further inspection, these were not significant. There were breaches of Regulations 12 & 17 and service users remained at risk or were receiving treatment that was not effective and did not meet their needs.

The Law

15. The main objectives of the CQC are set out in s.3 of the Health and Social Care Act 2008 ("HSCA"):

16. S.17(1)(c) of HSCA gives the CQC the power to cancel a provider's registration:

17. The relevant requirements for present purposes are to be found in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ("the 2010 Regs."). Regulation 8 makes it clear that a registered person must comply with the regulations in carrying out regulated activity.

18. The powers of the Tribunal are set out in section 32 of the Act. The Tribunal has the power to confirm the decision of the Respondent, direct the decision of the Respondent to have no effect and to direct the imposition of any such discretionary condition as it thinks fit. The Tribunal considers the appeal on the basis of the available evidence at the time of the hearing.

Notice of Decision to cancel registration

19. This broadly followed the headings of the earlier Notice of proposal to cancel registration. The list was extensive.

The headings covered some 145 points. To summarise the concerns it is more helpful to set out the conclusion which we quote below:

Following a thorough detailed consideration of the evidence contained in the Notice of Proposal, the representations and the actions proposed the remaining concerns were set out as follows:-

> *i. The service has not assessed the risks to the health and safety of your patients in receiving care and treatment. There is a lack of detail in the recording of assessments undertaken.*

ii. Prescribing of medication is not in line with either your policies or in line with national guidance. This does not protect patients from the risk of avoidable harm.

iii. you have not assessed and mitigated any risks from the environment. For example 3 clinic rooms are not fit for purpose, medical records not secured. Medications and equipment are not safely managed. Infection control practices are not robust.

iv. In terms of breaches in Regulations 17 good governance I find that you do not have policies which assist staff in providing a good service nor that protect patients from abuse or avoidable harm. Staff are not following policies that are in place and there does not seem to be a recognised process through which to address this. There is no robust system through which to monitor the service and take action to address deficits. Indeed the Notice of Proposal is clear that you have been failing to meet regulations for a significant period of time. The registered manager has been failing in their legal duty to manage and carry on the regulated activities. You have offered little in respect of addressing these issues.

v. In terms of employment and ensuring staff are appropriately employed and are competent to undertake their roles, employment of staff is undertaken in an ad hoc manner and does not comply with the requirements of the 2014 Regulations. Indeed, you are using the skills of an unregistered medical practitioner to assess and prescribe medication. There is ambiguity on the job roles of some of your staff and you have not provided adequate training or supervision to ensure that they can undertake their roles effectively.

The Scott Schedule Issues:

20. The major concerns were:-

20.1 March 2016 inspection: Breaches of Regulation 12 to provide safe care and treatment and Regulation 17 to provide good governance and regulation 19 to ensure that fit and proper persons were employed by the service.

20.2 February 2017 inspection: Improvements have been made but were not significant. The appellant remained in breach of the fundamental standards set down in Regulation 12 and Regulation 17. Service users remained at risk or were receiving treatment that was not effective and did not meet their needs. The response was reactive not proactive.

20.3 The Appellant responded to the Schedule and in their more detailed submissions maintained that they had worked hard on their governance, updated and revised policies and were writing new ones to address changes in service protocol. The difficulties in ensuring GP liaison were stressed. The 2017 inspection was perceived as pejorative rather than supportive and was

not seen as "working together as a partnership for the benefit and well-being of our users".

Late Evidence

21. Further to the order of Judge Brayne dated 14 March 2017, the Tribunal allowed Mr Barrett to submit an updating Witness Statement from Dr Mohiuddin. This was prepared overnight after the first day and having had an opportunity to consider in advance what he would say, Mr Adjei raised no objection to Dr Mohiddun being interposed as a witness. We additionally accepted testimonials from 10 service users, which Mr Barrett had submitted but had been returned by CQC as they were not in the correct witness format, together with a document entitled Adastra Going Forward March 2017. Mr Adjei raised no objection and given that the Appellant was presenting his own case, we thought it appropriate to exercise some flexibility to receive evidence that was relevant to his case and the issues overall.

The evidence

22. In advance of the hearing the Tribunal read Tabs A to F: totalling 730 pages and all the witness statements of those not called to be cross examined. We additionally considered the Grounds of Appeal, Response, Case Summary and the Skeleton Arguments prepared by both parties.

23. We read the detailed statement of Mr Stephen George Inspector dated 14 December 2016, which we clarified was sent to the Appellant shortly thereafter, together with all the other papers. It runs to some 109 pages.

24. At the time of the March 2016 inspection Mr Barrett was the registered manager and his wife Sandra Barrett the general manager. The current position is that they are separated and she has no involvement in the clinic.

25. Following the March 2016 inspection Mr Barrett submitted a recovery action plan. The heading states that the clinic had been trialling new database software for 18 months as they knew that their existing system was inadequate. They also stated that they were approaching Consultants in the Substance Misuse Field to undertake a comprehensive service review. They were confident that many of the findings could be remedied within 2 to 3 months. We clarified that the clinic had not had the resources to appoint such a Consultant. It was accepted that the timescale had not been complied with.

26. The points in the Action Plan go to each point of CQC's findings. We noted 131 action points across 19 areas.

27. Dr Grewal Consultant Psychiatrist accompanied Mr George on 22 March 2016. This included a 30 minute telephone interview with the then Medical Director Dr Alan Mititelu. The Appellant's case accepts that Dr Mititelu was not satisfactory but he is no longer in post.

28. Dr Grewal's review evidenced a number of concerns. Neither medical nor nursing staff completed a medical assessment. 'Opiate Substitution Therapy' was only occasionally based on medical assessments and was not compliant with the current Orange Guidelines: the 2007 edition of Drug Misuse and

Dependence: UK Guidelines on Clinical Management. There was inadequate frequency of urine or other drug testing. Correspondence to GPs was generally not completed, so there was a risk of 'double scripting'. The DVLA were not notified even when patients were known to drive while suffering from a dependence syndrome: contrary to 2015 Guidance. Whilst Dr Mititelu visited the clinic 2 to 3 times per week, prescriptions were occasionally sent or taken to him at his home rather than him attending. The doctor was practising beyond his competencies and the accepted guidelines. In particular he had no specific qualifications in addiction medicine or addiction psychiatry.

Oral Evidence

29. The only witnesses required for cross examination were those who covered the February 2017 inspection. We summarise only such evidence as is relevant to our decision.

30. We read the Statement of Ms Lea Alexander Inspection Manager dated 20 February 2017. A part of the Appellant's case was that there were inaccuracies in the conclusions drawn following the review of certain service users' files. That challenge fell away when Ms Alexander corrected her statement to read 5 (not) 7 of the 16 client files they looked at in their entirety did not include any risk assessment or management plan. A further 7 (not 5) had partially completed risk assessments. We queried how this error had occurred. Due to the timescales the inspectors were not able to do the usual 'Factual Accuracy' feedback but had amended the statement in the light of Mr Barrett's statement. The Statement pulled together a number of strands of information, since more than one person was involved in the file review. Ms Church gave the same explanation.

31. There is no issue that improvements were made. By the time of the 2017 inspection, 80% of clients' GPs had received a letter, although it was emphasised by Mr Barrett that some clients were resistant to this happening. The 'GP waiver' has been stopped. The current concern was that there was no policy or procedure stating the frequency with which GPs should be contacted. There was no written policy stating what they would do if they met with resistance from service users.

32. Mr Barrett put a number of questions around 'GP waiver'. At all points he stressed the need to work with the clients. The CQC's current concern was that if there were reasons not to notify the clients' GP the notes didn't reflect that.

33. There was the same concern around risk assessments; and there was no record of how identified risks would be managed and reduced. Time was spent looking at the case of Service User 13 who had diverted drugs to his wife. Mr Barrett conceded that the risk analysis should have been clearer. Another case discussed was Service User 39 who drank six units of alcohol a day. Mr Barrett stated that he accepted that the record-keeping was poor but he didn't accept that this put clients at high risk.

34. CQC acknowledged that Dr Mititileu had left the clinic and been replaced by a locum consultant psychiatrist Dr. Mohiuddin. Adastra had taken on a

number of clients from another private clinic 'Mindset' which led to the employment of Ms Samantha Banbury from that service, an experienced drug worker with a psychology background whose Statement we read.

35. Ms Ray is the Head of Hospital inspection who chaired the management review meeting on 6.2.17. The conclusion of this meeting was that whilst some improvements had taken place since the previous inspection, there were still significant concerns about the safety of the treatment being provided for the clients. The conclusion was that the provider did not have the knowledge and skills to recognise for themselves the improvements that needed to take place, such that they could not be assured that these were being addressed.

36. Ultimately Ms Ray's concern was that the leadership lacked insight into what 'good looked like'. Any changes were made on the back of CQC involvement. The CQC could not be satisfied that any improvement could be sustained because there was a lack of strong internal governance whereby the clinic could see for itself how to make improvement. Ms Ray accepted that the new doctor was appropriately skilled but he was only there for so many hours a week. One year on from the first inspection there were still fundamental questions around the clients' physical health assessments, issues around communication and a lack of robust risk assessments.

37. Mr Brown is employed as a National Medicines manager. He highlighted that there wasn't a safe and effective system for checking prescriptions. He personally observed Paul Beard the receptionist generating a batch of prescriptions which were then handed to Dr Mohiuddin for signature. Mr Beard told him he adjusted the doses and quantities based on the information given to him either verbally by the prescribing doctor or by notes left in the desk diary. Mr Brown noted that a client record in reception did not reflect the reduction in dose recorded on the doctor's record. We looked at whether there was now an effective system. Dr Mohiuddin now comes out to the Receptionist. He said he checked the prescription against the Blue Cards but there was a divergence of view as Mr Barrett said it was against the computer records. There is no written policy.

38. A further concern was that on the return of ampoules by clients, Mr Beard appropriately counted them, but the gloves he used were not disposable therefore a possible infection hazard. The use of the clinical waste bag did not accord with Guidelines for the safe use and disposal of sharps, which we clarified, was because they could cut the hands of the waste disposal team. Ampoules should have been disposed of in a 'sharps bin', which Mr Barrett told us was now used.

39. Mr Barrett accepted that the digital code on the door reception had not been changed for two years but denied there was any risk.

40. Mr Brown was concerned that 51/148 clients were prescribed injectable Methadone in excess of 120 mg a day. The Best Practice Guidance stated this would be exceptional. Similarly 37 out of 148 clients were prescribed Dexamphetamine Tablets, also not licensed for use in this way in the UK. Where prescribed medicines are not licensed for the treatment of substance

misuse, best practice guidelines indicate that systems and governance processes should be in place to ensure that treatment is effective and safe. He saw no evidence in the records of the current doctor of reasons for the exceptional prescriptions. Mr Barrett explained that they had taken on a number of clients from Mindset in July 2015 who had historically high prescriptions. He again accepted that the patient records were not robust enough and didn't explain why certain prescriptions were being given except in two cases. He said these issues had now been addressed

41. Dr Mohiuddin has been a Consultant Psychiatrist in the NHS and private sector since 2008. He has had a special interest in Addictions Psychiatry and Psychotherapy since 2007. He plans to complete Part two of the RCGP Certificate in Substance misuse this year. In his first statement dated 20 January 2017 he stated that he had worked with the Appellant since July 2016 as a locum. The clinic had taken on this large cohort of patients from another private clinic. Many of these were chronic and complex patients who were already on high maintenance medication, including intra-muscular medication. He acknowledged the problems with his predecessor, which had made his role more challenging.

42. We highlighted that we wanted to know more about the future role of Dr Mohiuddin in the clinic which led to the preparation of an overnight statement dated 21 March 2017. This was more detailed and set out how he had now reviewed 139 of the 142 patients within his limited part-time hours. He is working to reduce high-dose patients. He has written to GPs informing them of current diagnosis, prescribed medication, current physical and mental state, psychosocial issues, risk assessment and progress in treatment plans. We saw some examples.

43. There has been an issue that some GPs will not carry out blood tests and ECG monitoring of these private patients, stating that it is the clinic's responsibility. All patients would be reviewed on a three-monthly basis. Processes and policies have been updated. Financial challenges have meant that Dr Mohiuddin's working hours had to be limited. In his first statement he said the challenges were such that his locum role seemed quite impossible. He referred to discussions with Mr Barrett including being a joint responsible manager. In oral evidence he referred to employing a General Manager but we clarified this was not a firm plan.

44. Dr Mohiuddin acknowledged that it was an error to allow the 'GP waiver' to stand. He agreed that his note should make clear why a prescription was being issued and his assessment of the risks. He agreed that the generating of prescriptions, as described by Mr Brown was unsafe. He stated that they had a lot of ideas for the future. He acknowledged slippage in the original time scales for achieving compliance. He said that he had known about CQC's involvement when he started to work at the clinic in July 2016. Mr Barrett had been very frank about his health and issues in his personal and professional life in both his written and oral evidence. Dr Mohiuddin said he was aware of these issues at the time they happened and that Mr Barrett had been very open with him.

Conclusion and Reasons

45. In reaching our conclusions we've had regard to all the evidence, both written and oral and the skeleton arguments and oral submissions of both parties. We fully used our inquisitorial powers and at the conclusion of the case felt that we had a clear picture of the issues that we had to determine.

46. The case for CQC was detailed and cross-referenced to contemporaneous notes and the relevant Policy and Guidance. Overall our assessment was that each witness called by CQC was measured and fair and quick to acknowledge any change that has been made. We were concerned that amendments had to be made to their statements by Ms Alexander and Ms Church but a satisfactory explanation was offered. It is unfortunate that these errors could not have been corrected by the 'Factual Accuracy' process or before the hearing as Mr Barrett is a litigant in person and had spent time preparing to challenge those inaccuracies.

47. We were also assisted by the evidence of Mr Barrett and Dr Mohiuddin who were both also very frank. We judge both to be caring individuals with a genuine concern for the client group who attended the clinic. They however have different responsibilities. .They did not have a concerted plan for the future. We read the evidence of Dr Samantha Banbury who was clear change had happened and optimistic it could be sustained. For reasons which we now develop, this combination has not been able to drive sufficient change forward.

48. Ultimately it is the responsibility of the Registered Manager to ensure compliance with what are fundamental standards. We pay particular regard to the timeline. It is part of the case for the Appellant that they need more time. However, the Notice of Decision is dated as long ago as 3 August 2016. We pay particular regard to the Notice of Proposal dated 7 April 2016, so issued almost one year ago. It is very detailed and in our judgement cannot have failed to put the Appellant on notice as to what he had to address as a matter of urgency.

Findings of Fact

49. Overall we reach a conclusion that such changes as there are, are 'too little, too late'. We accept the view of Ms Ray that this is a provider 'who does not know what good looks like without being told. ' There was we find a fundamental misunderstanding of the role of CQC as the Regulator, not an adviser who would work with the clinic to guide them. .

50. The history shows a very concerning lack of understanding of what a compliant provider should be doing. That is clear from 145 points enumerated in the Notice of Decision. A doctor was in post who was unsafe but was kept in post for 18 months after concerns were first highlighted. The concerns led to a referral to the General Medical Council.

51. We have kept in mind that in particular Mr Barrett has faced a number of personal and professional challenges. He had intended to instruct a Consultant but was unable to afford to do so. We acknowledge that he has

found the proceedings and responding to them without the assistance of a lawyer, both stressful and diverting. However that cannot be a reason for non compliance one year on from when the concerns were first raised. He could see the problems and fairly acknowledged them in oral evidence but we saw no clear plan for how change was to be managed and sustained.

52. We now turn to the specific concerns. There is still no embedded system for the management of medicines. As late as February 2017 prescriptions were being generated by the receptionist in a batch and then given to the prescribing doctor. This appeared to be a standard practice in some private clinics but it does not make it safe. This area was the responsibility of the prescribing doctor. Even at the date of the hearing when the issue had been pointed out by Mr Brown there was a discrepancy as to whether Dr Mohiuddin was working off the Blue Card or the computer record. We had regard to the written notes of Dr Sharma who discussed the issues with Dr Mohiuddin in February 2017 who confirmed that he was aware of the issues in relation to the previous doctor. This should have acted as a further reminder of the need to ensure compliance with Guidelines in force.

53. Physical health checks remain outstanding. In the care record of SU 39 Dr Mohiuddin wrote to the GP in August 2016 and advised that blood tests and an ECG should be completed every six months and a physical health check annually. This was an example of a user being prescribed over 100 mls of methadone. Despite documentation to record that this person was at risk of prolonged QT interval - a potentially fatal heart condition associated with prescribing substitute medicines, and having a medical review with the doctor in December 2016, no physical health check had been undertaken. There is still no system embedded in a written policy of chasing up GPs who refuse to do the basic checks or arranging an alternative process. This may be a tension between the NHS and a private provider but nothing has been done to make sure these basic but necessary checks are carried out.

54. Only after CQC pointed out the dangers was the ‘GP waiver’ taken out of use. This was actioned in the first Action Plan. However even today there has been a failure to contact all GPs. Again there was a conflict of evidence on this point. Mr Barrett said that they would not always contact the GP if there was a minor change in medication Dr Mohiuddin said they must always contact the GP. That does not need to be unduly onerous, as Mr Barrett suggested, if there are embedded administrative systems. Again there is no written policy in relation to this. It is another example of over reliance on verbal communication with no thought as to what happens if key staff are not there.

55. Dr Mohiuddin appears to have put in extra hours unpaid. The patient reviews we read by him were thorough, but he is still to see three clients. It is not the quality of the reviews that is at issue but the frequency with which they can be carried out in the future and the lack of them being carried out initially. We do not accept Dr Mohiuddin’s estimate that he could do this every three months given his current hours and we were not persuaded by his answer that on the second occasion they could be less comprehensive. This appears

to be a capacity issue. It is also a resources issue as there was no clear plan as to his future hours and how they would be funded.

56. There is still no clear written policy about what would happen with missed appointments. An oral warning is insufficient as and when clients come in. Again that does not deal with situations where key staff are not there; it does not show an embedded practice.

57. Dr Mohiuddin readily acknowledged that anyone reading his notes should be clear as to how he balanced up risks in prescribing high doses of opiate substitutes or drugs not usually licensed in the United Kingdom for this purpose. We do not find it satisfactory to say this will now be remedied.

58. We find that there is still a lack of robust risk assessment and management plans. Mr Barrett's answer on this and other points that they knew their client group well is not satisfactory. In particular we read the note on the service user who diverted drugs to his wife. The note, as was acknowledged by Mr Barrett, is not a satisfactory risk assessment. It talks more about gaining his trust now that he had opened up and been honest about what he had done. In relation to a service user who drank more than double the recommended alcohol input there was no assessment of risk.

59. Only now is a new risk assessment tool being piloted. Staff training is yet to take place. This is not a robust monitored system that is up and running and in which we can have confidence

60. Mr Barrett frankly accepted that the issues of supervision and staff appraisal had been put on hold until after these proceedings had concluded.

Conclusion

61. We conclude that CQC have amply made out a case that there was a reactive response by the Appellants. They showed a lack of insight and operated within their own 'bubble'. By his own admission, at points Mr Barrett was overwhelmed. We reach no clear conclusion on whether this was a resources or a capacity issue, but it is telling that one year on there is still discussion on the Governance structure. We must look at the case at the date of decision. There was no clear plan from Mr Barrett, merely an aspiration to lead a better and more compliant service. This was not a plan with the level of detail we would expect. Instead a document entitled 'The way forward' was drafted overnight with a balance sheet attached. This is not a robust plan which goes anywhere near satisfying us that, with a little more time, this is a clinic that could achieve compliance.

62. Mr Barrett stressed at a number of points during the proceedings the harm that will be done to the clients if the Notice of Cancellation is upheld. The fact that this is a 'outlying' group described by Mr Barrett in his skeleton argument as *'an older entrenched client court cohort, who have fallen out of treatment many times and who for whatever reason have been unable or unwilling to access NHS or commissioned services often due to rigid policies and stringent protocols that they feel do not support their often complex needs'* cannot excuse a lack of compliance with what, we stress are

fundamental standards, especially when time was given to bring the service into compliance. .

63. We read the testimonials from the Service Users, some of whom travel a considerable distance into London to use this clinic. We have kept in mind that if this clinic is forced to shut, it will be difficult to find other treatment facilities willing to prescribe to the same level. There is a risk that some may resort to buying drugs on the street. This is a factor and one we accept was considered by the Respondent who initially considered going for immediate closure under s.30 HSCA. Instead, they decided against that course to allow clients to seek alternative treatment facilities and to give the clinic an opportunity to come into compliance. In weighing all these matters we have balanced such changes as we can in the Appellant's favour against a lack of compliance which is ongoing. These matters present a risk to the health and welfare of service users. Cancellation of Registration is an appropriate and proportionate sanction in all the circumstances of the case.

64. Practical arrangements are in place to receive Adastra's service users and we accept the submission that we should delay the effect of our order. We extend that to 10 working days rather than 7 days given the diverse home locations of the client group

Decision

1. The Notice of Decision to cancel the Registration dated 3 August 2016 Cancellation of Registration is upheld.

2. This decision shall not take effect until 10 working days after it is received by the Respondent.

APPEAL DISMISSED

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

Date Issued: 5 April 2017