First-tier Tribunal Care Standards Tribunal

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

[2024] UKFTT 001050 (HESC)
2024-01054.EA

Hearing held on 5, 6 and 7 November 2024 at the Royal Courts of Justice, London (deliberation on 8 November 2024)

Before

Ms S Brownlee (Tribunal Judge)
Ms Heather Reid (Specialist Member)
Dr Edward Yeates (Specialist Member)

Between:

PLL Business Solutions Limited

Appellant

-v-

Care Quality Commission

Respondent

DECISION

Preliminary note

1. Prior to the hearing, the Tribunal made an order pursuant to Rules 14(1)(b) of the Tribunal Procedure Rules 2008, prohibiting the disclosure and publication of any matter likely to lead members of the public to identify persons the Tribunal considers should not be identified. The Tribunal used an identification key for all service users and staff members.

The appeal

2. This is PLL Business Solutions Limited's ('the Appellant') appeal against a decision of the Care Quality Commission ('CQC' and 'Respondent') to cancel its registration as a provider in respect of the regulated activity of personal care carried out by PLL Care Services from Unit 7, North Leigh Business Park, Nursery Road, North Leigh, Witney, Oxfordshire, OX26 6SW ('the location'). Dr Lloyd Lukama, the nominated individual of the provider, brings the appeal, on behalf of the Appellant and is, in effect, also the Appellant. Dr Lukama appeals

the Respondent's decision of 23 January 2024 pursuant to section 32 of the Health and Social Care Act 2008 ('the Act') to the First-tier Tribunal ('the Tribunal').

The hearing

3. The hearing took place on 5, 6 and 7 November 2024. It had a time estimate of three days. The parties attended the hearing throughout. Dr Yeates attended the hearing remotely, on a video link. In advance of the hearing, the parties agreed, and the Tribunal subsequently directed that two witnesses could attend the hearing remotely, on the same video link. They were Ms Victoria Bragg and Mr Adam Tighe.

4. In advance of the hearing, the Tribunal had read the digital hearing bundle (running to 6458 digital pages) and skeleton arguments from both parties. The Tribunal had also read the late evidence sent by both parties in advance of the hearing, which is detailed below. At the beginning of the hearing, Dr Lukama provided the Tribunal with three documents, forming a further application to admit late evidence.

5. Some participants worked from hard copy hearing bundles and some from digital hearing bundles. All witnesses used the hard copy hearing bundles whilst giving their oral evidence.

6. Ms Natasha Ramgolam, newly appointed Specialist Member of the Primary Lists Tribunal, attended, to observe the first day of the hearing, for induction purposes. Neither party objected to Ms Ramgolam's observation of the public hearing.

Attendance

7. Dr Lukama represented himself. He had legal representation in place until the beginning of October 2024. Dr Lukama was assisted in representation by his wife, Dr Priscilla Lukama, who is the registered manager of the provider. There was no difficulty with this approach. Dr P Lukama had prepared a number of questions to ask Dr Lukama as he gave his initial oral evidence to the Tribunal. The Tribunal considered the overriding objective in the Tribunal Procedure Rules and the Equal Treatment Bench Book (July 2024) and ensured appropriate flexibility in the hearing process to ensure Dr Lukama could participate fully in the proceedings.

8. The Respondent was represented by Ms Mary-Teresa Deignan, counsel, instructed by Ms Winifred Carty, solicitor from CQC Legal Services.

9. The Tribunal heard oral evidence from:

   - Miss Emily Crossing, CQC assessor.
   - Miss Bridget Harrison, CQC bank inspector.
   - Mrs Amy Jupp, deputy director of operations in the south network of the CQC.

- Dr Lloyd Lukama, nominated individual of the provider.
- Mr Adam Tighe, care consultant at SRG Care Consultancy & Training.

10. The hearing was held in public. An order, made pursuant to Rule 14(1)(b), prohibited the publication of any matter likely to lead members of the public to identify any person who the Tribunal considers should not be identified. Accordingly, in this decision, staff members and service users are anonymised.

Late evidence and preliminary issues

11. On 23 October 2024, the Respondent applied to the Tribunal to admit late evidence. The late evidence consisted of a second witness statement from Miss Crossing, and witness statements of Miss Harrison and Mrs Jupp, along with exhibits. The Respondent put the Appellant on notice of the application on 15 October 2024. On 28 October 2024, Dr Lukama provided his views, which indicated that he opposed the application. Dr Lukama provided a second witness statement dated 28 October 2024 to set out his reasons for opposing the application. It was agreed between the parties that if the Tribunal decided to admit the Respondent's late evidence, it would also admit the linked second witness statement of Dr Lukama. Dr Lukama had also provided a copy of Mr Tighe's witness statement, which was admitted as late evidence, unopposed by the Respondent. There was no issue raised by the Respondent with Mr Tighe providing oral evidence remotely on the video link.

12. On 28 October 2024, the Tribunal issued an order admitting the late evidence from Dr Lukama. Dr Lukama's late evidence consisted of a number of documents he compiled in response to the Respondent's most recent assessment of the provider, which took place on 3 and 4 October 2024. The Respondent did not oppose the admission of the evidence, and it afforded the Respondent an opportunity to review the additional documents from Dr Lukama with its inspector/assessor witnesses.

13. The Tribunal heard Dr Lukama's reasons for opposing the admission of the witness statements of Miss Crossing, Miss Harrison and Mrs Jupp. He considered that the admission of the evidence would be unfair as the factual accuracy process in response to the assessment had not yet taken place and so their evidence had not yet been tested.

14. The Tribunal decided to admit the witness statements as late evidence. In the Tribunal's view, the evidence was highly relevant to its role, in making the decision afresh as to the proportionality of cancelling the registration of the provider. All three of the witnessed were ready to provide oral evidence to the Tribunal and to have their evidence tested in questions from Dr Lukama and the Tribunal. In the Tribunal's view, the hearing process provided a fairer forum than a factual accuracy process would have done. Dr Lukama had prepared the points he wished to challenge in the evidence, as the points were set out in his 12-page second witness statement. Furthermore, it would have been perverse and unfair not to admit the Respondent's evidence, in a context where the Appellant intended to provide updated evidence in response to the witness statements from the three Respondent witnesses. The Tribunal took into

account its role in the appeal – we make the decision afresh, examining relevant evidence about what has changed since the decision was made. In the Tribunal's view, the updated evidence from the assessors and reviewing decision maker are of equal importance to the updated evidence from Dr Lukama of changes implemented at the provider, including changes implemented in response to the feedback from the assessment in early October 2024. The admission of the late evidence came with the accompanying safeguard of the testing of all three witnesses' evidence. The Tribunal also admitted Dr Lukama's second witness statement and the three documents he shared with the Tribunal on the morning of the hearing, namely (1) certificate of registration for PLL Care Services, (2) a letter dated 24 October 2023 from Oxfordshire County Council to Dr Lukama, and (3) Mr Tighe's audit report dated 25 and 25 June 2024.

15. The Respondent had produced a summary Scott Schedule. The Tribunal established with Dr Lukama that he accepted there had been breaches of a number of the 2014 Regulations as a result of the August 2023 inspection and the March 2024 assessment. Dr Lukama's case is that the provider has made a significant number of improvements, since the assessment in March 2024. Furthermore, he considered that the assessments in March 2024 and October 2024 did not provide a full picture of the provider as they focused on a selected number of quality statements, without setting a new baseline. The Tribunal considered it fair and just to focus on the oral evidence from Miss Crossing, Miss Harrison and Mrs Jupp. Ms Emma Steele, an inspector who attended the inspection in August 2023 and the assessment in March 2024 and Ms Bragg, operations manager, who was an earlier decision maker, attended the hearing throughout and were available to provide oral evidence if required. Dr Lukama was content with this approach, proposed at the outset of the hearing. Once the oral evidence was completed from Miss Crossing, Miss Harrison and Mrs Jupp, Dr Lukama confirmed that he did not require Ms Steele or Ms Bragg to answer questions. The Tribunal didn't require them to provide oral evidence.

Background

16. The Appellant is currently registered to provide the regulated activity of 'personal care'. The Appellant has been registered with the CQC since the CQC's inception. In fact, the provider has been registered with the CQC and previously the Commission for Social Care Inspection since 26 September 2008. The Appellant's service is a domiciliary care agency which provides the regulated activity of personal care to older people, people with a learning disability and/or autistic people, people living with mental health needs, dementia and physical disabilities.

17. The Appellant was first inspected by the Respondent on 24 April 2018, which was a routine inspection. It was rated as 'requires improvement' in the domain of 'well-led' and 'good' in the remaining four domains, with an overall rating of 'good'. The Respondent had concerns about record-keeping and safeguarding.

18. In April 2023, the Home Office sent the Respondent an alert to indicate that it had revoked the Appellant's sponsor licence. At that time, it was established

that the decision to revoke the licence would have affected 91 staff members, who required the authorisation of the sponsor licence to work and remain in the UK. From April 2023 to August 2023, Oxfordshire County Council raised concerns with the Respondent regarding staff training and quality of care planning. As a result, the Respondent decided to inspect the provider. The inspection took place on 15 and 16 August 2023, carried out by Miss Crossing and Ms Jane Rowland, an inspector who has since retired from employment with the Respondent. At the time of the inspection, the provider was delivering personal care to 169 service users. After the inspection, it was determined that the provider was in breach of Regulations 9 (person centred care), 12 (safe care and treatment), 17 (good governance), 18 (staffing) and 19 (fit and proper persons employed) of the 2014 Regulations.

19. Following the inspection, the Respondent held a management review meeting on 5 September 2023. The decision maker, a deputy director, decided to propose cancellation of registration. An inspection report dated 17 October 2023 was published, in which the Appellant was rated as 'inadequate' overall. The Respondent received representations from the Appellant on 20 October 2023. The representations were reviewed by an independent representations team at the CQC and a decision reached to adopt the notice of proposal. The notice of decision was issued on 23 January 2024.

20. On 16 February 2024, the Appellant sent its appeal application to the Tribunal.

21. On 29 February 2024, the Respondent decided to carry out an on-site assessment in order to determine if the Appellant had improved since the previous inspection.

22. The on-site assessment used the Respondent's new methodology. From late 2023, the Respondent has implemented a new assessment methodology which it applies to all sectors, service types and levels. It is called the 'single assessment framework' and it requires the Respondent to assess services against five key question to determine compliance with the Regulations: is the regulated care or treatment safe?, is it effective?, is it caring?, is it responsive to people's needs?, and is it well-led? Each key question is assessed using quality statement, which are expressed as 'I' or 'we' statements of what good care looks like and the standard expected in delivering the regulated activities. The Respondent gathers its evidence from six categories: people's experience of health and care services, feedback from staff and leaders, feedback from partners, observations (on-site assessments), processes and outcomes. The evidence sources and the quality assessments are then scored and the scores generate the rating for each of the key questions which are then aggregated to give an overall rating for the service.

23. On 12 March 2024, the on-site assessment was carried out by Miss Crossing and Ms Steele. At that time, the Appellant was providing the regulated activity to 32 service users. The Respondent determined that the Appellant remained in breach of five of the Regulations which were found to be breached at the inspection in August 2023. It was found to be in breach of a further Regulation, Regulation 11 (need for consent). On 15 April 2024, a decision-making meeting

took place. The two inspectors attended, as did Ms Bragg and Mrs Jupp. The focus of the meeting was to determine if there had been sufficient improvement in the Appellant's service to warrant consideration of a different or no regulatory response. The decision reached was that cancellation of registration remained appropriate.

24. At some point in September 2024, the Respondent decided to carry out a second on-site assessment of the Appellant, in advance of this hearing. On 3 and 4 October 2024, Miss Crossing and Miss Harrison completed another on-site assessment, with Miss Harrison attending the provider's location and Miss Crossing speaking to staff and service users. Miss Harrison had not previously been involved inspecting the service provider. A further decision- review meeting took place on 10 October 2024 and a decision was reached to continue to defend the appeal, on the basis that there had been some minor improvements, but the Appellant remained in breach of Regulations 9, 11, 12, 17, 18 and 19.

The legal framework

25. Section 2 of the Health and Social Care Act 2008 ('the 2008 Act') invests in the Respondent registration and review and investigation functions. By virtue of section 3(1) of the 2008 Act, the Respondent's main objective is to protect and promote the health, safety and welfare of the people who use the health and social care services.

26. Section 4 of the 2008 Act sets out the matters to which the Respondent must have regard, including the views expressed by or on behalf of the members of the public about health and social care services, experiences of people who use the health and social care services and their families and friends and the need to protect and promote the rights of people who use health and social care services. Any action taken by the Respondent should be proportionate to the risks against which it would afford safeguards and is targeted only where it is needed.

27. Section 17 of the 2008 Act empowers the Respondent to cancel the registration of a service provider in respect of a regulated activity on a number of grounds, which includes on the ground of the regulated activity being carried out otherwise than in accordance with the relevant requirements and on any ground specified by regulations.

28. Under section 20 of the 2008 Act, the Secretary of State is empowered to make regulations in relation to the regulated activities by way of regulations. The Regulations made under this section are the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936 ('the 2014 Regulations') and The CQC (Registration) Regulations 2009.

29. Sections 26, 27 and 28 of the Act set out the procedural requirements in relation to notification of the Respondent's decision.

30. Section 32 of the Act provides for a right of appeal to this Tribunal against a

decision to cancel the registration of a service provider in relation to a regulated activity. The Tribunal may confirm the decision or direct that it is not to have effect. Under section 32(6), the Tribunal also has power to direct that any such discretionary condition as the Tribunal thinks fit shall have effect in respect of the regulated activity. A 'discretionary condition' means any condition other than a registered manager condition required by section 13(1) of the Act.

31. Part 3 of the Regulations sets out the Fundamental Standards that registered providers must comply with when carrying on a regulated activity, which includes Regulations 9, 11, 12, 17, 18 and 19 of the 2014 Regulations.

32. The Respondent bears the burden of establishing that it is more likely than not that the 2014 Regulations have not been complied with at the date of the hearing, including 'by having regard to' guidance issued under section 23 of the 2008 Act. The findings of fact are made on the basis of whether or not the Tribunal is satisfied as to the facts on the balance of probabilities.

33. The Tribunal is required to determine the matter afresh and make its own decision on the merits and evidence as of the date of hearing. Subject only to relevance and fairness, this can include new information that was not available or presented at the time when the decision under appeal was made and the information can be admitted as evidence in the appeal, even if it were not admissible in civil proceedings in England and Wales. The fresh determination in this appeal includes consideration of the detailed documentary evidence provided by both parties, as well as the oral evidence, subject to questioning over the three days of the hearing.

34. We have considered all of the evidence and the written submissions before us, even if we do not mention every point of it in our decision. We refer only to the parts of the evidence which were of particular importance in reaching our findings, noting that the proceedings were video recorded throughout the public hearing and both parties had made arrangements to take notes of the evidence.

The parties' positions

35. At the outset of the hearing, the Tribunal clarified the Appellant's position, in line with the summary Scott Schedule, completed by the Respondent. Broadly speaking, the Appellant's position was that the breaches of the Regulations identified by the Respondent at the inspections of August 2023 and March 2024 were reasonable and accepted by him. His position was that by the time of the October 2024 inspection, the Respondent had become too focused in its approach and had not been able to properly assess the extent of improvement made by the Appellant. It is fair to say that the Appellant was also concerned about the change in methodology by the Respondent and considered that the outcome of the assessment may well have been different if it has focused on the full number of quality statements, rather than a selected proportion.

36. The Appellant brought the appeal on the following grounds, which were set out in the grounds of appeal accompanying the appeal application of February

2024, the skeleton argument prepared by the Appellant and the closing arguments at the end of the hearing.

37. The Appellant contended that:

(a) He has accepted that there had been a significant number of issues at the points of the August 2023 inspection and the March 2024 assessment.

(b) He has provided evidence of significant improvement and demonstrated an ongoing commitment to high quality care and a proper response to the breaches identified by the Respondent.

(c) The Respondent did not undertake a fair and balanced assessment of the current service in October 2024 as it had not afforded the Appellant an opportunity to undertake the factual accuracy process and the assessment had unfairly focused on a proportion of quality statements, rather than all quality statements.

(d) There have been sufficient improvements to the service, which means it would improve its rating if assessed at the point of the hearing. Drs Lukama had demonstrated a commitment to improvement since using the services of an external consultancy company, including Mr Tighe.

38. The Respondent defended the appeal on the basis that its decision-making process and the decision subject to appeal have been fair, reasonable and proportionate at each stage. The Respondent relied upon the outcomes of the inspection and two assessments. The Respondent took the view that while some improvement had been noted – from August 2023 to March 2024 and from March 2024 to October 2024, it was not such a significant improvement such as to justify the Respondent considering a less serious regulatory response than cancellation.

39. The Respondent submitted that it reviewed its position each time new material was shared with it, but that it does not consider the improvements made to the service are sufficient to allay its evidence informed belief that the Appellant does not have the competence, skills, processes and systems to ensure any improvements are embedded, can be sustained and will demonstrate compliance with the 2014 Regulations in the near future.

Evidence

40. The Tribunal had the benefit of signed witness statements from all witnesses called to provide oral evidence and the two Respondent witnesses who were not required to provide oral evidence.

41. The oral and documentary evidence is referred to only as it is required to explain our findings and conclusions. The Tribunal noted that the public hearing was recorded and therefore we do not consider it necessary to set out a lengthy summary of the oral and documentary evidence.

The Tribunal's conclusions with reasons

42. For the reasons which follow, we have decided to direct that the Respondent's decision is confirmed pursuant to sections 32(5) of the Act.

43. As a starting point, it is important to note that Dr Lukama did not dispute that the service provider had not been compliant with all of the 2014 Regulations and, during oral evidence, accepted that the Appellant remained in breach of some of the 2014 Regulations as the Appellant was still working towards improvement. The Tribunal also took into account Regulation 8(2), which makes clear that the issue of lacking capacity (for service users aged 16 or over) under the 2014 Regulations is governed by the Mental Capacity Act 2005.

44. The Tribunal found the Respondent's witnesses to be clear, fair, detailed and reflective in their answers to questions. Their oral evidence was consistent with their witness statements. The Tribunal was impressed with the evidence from Mrs Jupp, as decision-maker and from Miss Crossing and Miss Harrison as 'on the ground' inspectors. Mrs Jupp acknowledged the personal and professional toll that the regulatory process can take on service providers. Furthermore, she reflected on criticisms levelled at the Respondent from recent external reviews and she did so in a thoughtful, and empathetic way. However, what was clear from Mrs Jupp's detailed witness statements and her oral evidence was that the statutory function of the Respondent had to be at the centre of its decision-making, which meant that if breaches of the Regulations continued, with limited progress towards coming into compliance, over a time period of more than one year, she would be unable to change her view on the proportionality of the regulatory response. Mrs Jupp explained, and the Tribunal accepted her evidence on this point, that at each point, when the Appellant submitted information or updated its position, the Respondent reviewed its position to decide if its response remained proportionate or could there be consideration of a lesser restriction. The Tribunal took into account that the Appellant's service was inspected as a result of information coming from the Home Office and a local authority, so by its very nature, it was a targeted inspection in the context where there was information which suggested an increase in risk to service users.

45. The Tribunal found Dr Lukama's oral evidence, at times, was evasive and unclear. As an example, the Tribunal found it unusual that Dr Lukama, in his position as the nominated induvial, was unsure as to the qualification which the registered manager at the service provider (who is also Dr Lukama's wife), Dr Priscilla Lukama, held, which entitled her to use the title 'Dr'. Furthermore, the Tribunal found Dr Lukama's understanding of the importance of capacity assessments was very limited. Dr Lukama relied upon the fact that the service provider had now undertaken checks with the Office of the Public Guardian to assure itself that lasting powers of attorney were in place for a number of service users that appeared to lack capacity. However, this information was of limited assistance in a context where there were insufficient capacity assessments in place. Dr Lukama sought to assure the Tribunal that he has completed all of the training that members of the caring team had completed, but his name did not appear on any of the records relating to completed training.

Furthermore, he stressed that there was an action plan in place for the service provider, which he was working towards, but the action plan was not submitted to the Tribunal amongst the more than 2000 pages of documentary evidence sent to the Tribunal on behalf of the Appellant. Further, there was no reference to the action plan in either of Dr Lukama's two witness statements. This was in a context where Dr Lukama had accepted, in questions from the Tribunal, that the leaders of any service provider, and in turn the Respondent, need to be assured that care is being delivered effectively and that assurance is sought from the integrity of the records kept by a service provider.

46. The Tribunal was concerned about Dr Lukama's assertion that the service provider provided care of 2000 hours per week for 30 service users. This was in a context where most staff members were not permitted to work more than 20 hours per week at the employer as it no longer has a sponsorship licence in place with the Home Office. This meant, on a purely mathematical basis, that there were some staff members appearing to work in excess of 300 hours per week in the delivery of care. On more than one occasion, Dr Lukama tried to explain how staff were deployed, including the staff providing 'live-in' care. The explanations were inconsistent and did not address the issue. Furthermore, 'live-in' staff appeared to be paid a fixed rate, per week, regardless of how many hours they worked.

Regulation 9: person-centred care

47. It was common ground that person-centred care involves care and treatment which is personalised and takes into account the service users' preferences and caring needs.

48. At the time of the on-site assessment in October 2024, Miss Crossing was assigned the role of speaking to service users and to staff. Service users reported back to her that staff changed too often and it appeared to service users that the staff who attended did not appear to know the services users' care needs or what they should be doing by way of delivering personal care. As an example, staff did not take the initiative to administer creams, unless they were on visible areas of the body. Service users had to direct staff to ensure creams were applied on the appropriate areas. Concerns reported back included that staff did not always attend on time and did not communicate to provide an update – updates had to be sought on the work of the service users. One service user reported that they had not received a face-to-face review of their care plan and they did not know anything about their care plan.

49. The second inspector, Miss Harrison, had not inspected the service provider before. The Tribunal noted that she took on the role of carrying on the on-site assessment, which involved reviewing the electronic documents held on the PASS system and the hard copies of documents kept at the location. It the Tribunal's view, Miss Harrison represented a 'fresh pair of eyes' if there was any concern that Miss Crossing's view of the service had become fixed. The Tribunal did not consider it had sufficient evidence before it to conclude, reasonably, that Miss Crossing had become fixed in her view of the service, but in any event, Miss Harrison's evidence was extremely helpful to the Tribunal as

she had no long-standing relationship with the Appellant prior to taking part in the October 2024 assessment.

50. The Tribunal considered carefully the records for service user I who lived with another service user, also receiving care from the Appellant. Service user I had vascular dementia. A care plan review had been completed by Dr P Lukama, in consultation with service user I's family member. Service user I's preferences had been recorded as no change and female carers only preferred. However, within the care plan for the service user, the information remained as 'I have no preferences and the staff rota reviewed by Miss Harrison showed that between 9 September 2024 and 6 October 2024, many staff provided care to service user I. As a further example in service user I's records, the care plan instructed staff to ask the person to go for a walk as a distraction when they became agitated, but in a mobility plan for the service user, it recorded that the service user was no longer mobile. There were no appropriate de-escalation instructions for staff when the service user became agitated or demonstrated challenging behaviour. In fact, the information recorded was lacking and contradictory – advising staff to accept me as a person regardless of my behaviour which may or may not be acceptable and advising staff to 'be consistent and firm yet gentle in your approach'. Staff were recording that PRN medication was administered to prevent agitation, when the PRN medication was prescribed so it could be administered for agitation rather than its prevention.

51. Dr Lukama provided an updated version of the 'customer file' for service user I which had been printed from the PASS system on 5 October 2024. Dr Lukama explained that he expected staff members to review all of the documents held on the customer file for the service user to understand updated risk assessments, for example, and how any updates might inform the delivery of care. Miss Harrison indicated that this approach was not acceptable. In some cases, the customer files ran to as many as nearly 100 A4 pages. In the Tribunal's view, this expectation on staff members, who were not required to be qualified healthcare professionals, was unrealistic and not manageable. It also left the process of interpreting records and what was acceptable and what was not open to intuition on the part of the staff member. This meant that instructions were unclear and there was a significant risk of delivering ineffective care.

52. The Tribunal noted the following, by way of example, in relation to service user I. At the beginning of the care and support plan (D1685), under 'please do and please don't', the instruction to staff members reads as follows: 'do not be tempted to restrain me unless you believe my behaviour is putting you at risk and I do not have the mental ability or capacity to make a decision in that instance. If my behaviour puts my partner or someone else at risk, carers need to intervene as calmly as possible but without physically restraining me'. Using Dr Lukama's guidance as to the expectations on staff members, the Tribunal then reviewed other sections of the customer file to satisfy ourselves on what staff members would understand about capacity and about restraint use. The Tribunal noted (at D1696) that staff members were required to seek consent before carrying out all care tasks. The customer file then goes on to record that

there are LPAs in place for health and welfare and finance. At D1768, the customer file records the 'behaviours that may challenge' risk assessment. In the Tribunal's view, at no point in that risk assessment does it record sufficient information to guide a staff member on how they should interpret the information at the beginning of the care and support plan. The level of risk is assessed as 'high' and there is a suggestion to distract the service user with something else to do. There is no information as to the use of restraint. In oral evidence, Dr Lukama indicated that staff members would only be allowed to use restraint in 'self-defence', but again, there was no information as to that in the customer file. Dr Lukama maintained his position that staff members would be required to read all of the documentation in the customer file and use it to inform their decision-making with care. The Tribunal did not consider this to be an acceptable process for delivering person-centred care. This is because the records in the customer file did not provide clear direction to staff members, who work under direction. The customer file for service user I required staff members to interpret directions on care and was not sufficiently detailed and clear to direct staff members on what to do in certain circumstances. Using Dr Lukama's example, it is not clear at all as to what a staff member should do if they were considering restraint to defend themselves in relation to an elderly, vulnerable service user who may not have capacity. The key reason this is not clear is because the risk assessment does not address the issue and so the care and support plan as it provides no direction to the staff member, based on the specific needs and risks for the service user. This is not person-centred and carries significant risk to the welfare of service users and staff members. It is a breach of Regulation 9.

53. The Tribunal reviewed the mental capacity and consent assessment for service user I. As of 20 June 2024, Dr P Lukama had assessed the service user as lacking capacity to make decisions as to their care. This assessment did not lead to updating the information about service user I at the beginning of the care and support plan, which left the issue of capacity unclear. In the Tribunal's view, a staff member reading the entirety of the customer file would not actually have a clear understanding of the care to be delivered and the needs of the service user. This represents a breach of Regulation 9.

54. The Tribunal reviewed the customer file for service user P who had a urinary catheter in situ. The catheter care instructions were incomplete, in that the instruction at the importance of hydration in the catheter care was set out in the falls risk assessment. There was then further detail for catheter care set out in the continence section. This was another example of Dr Lukama's expectation that staff members would read all of the various documents in the customer file before providing care to service users, in order to identify instructions to provide safe and effective care, including in documents which were not for the recording of such information. In the Tribunal's view, this was not a realistic and reasonable expectation on staff members – to request that they glean all important information from a number of sources, including sources which bear no relevance to the care to meet a specific need. The same was in place for service user L, as to clear instructions in relation to nutrition and diet, in a context where the service user has diabetes. Again, staff were expected to

review the entire customer file to glean all information to inform care. This is a breach of Regulation 9.

Regulation 11: need for consent

55. It was not disputed that the need for informed consent is an essential component of providing safe and competent care in the domiciliary setting. During oral evidence, Dr Lukama accepted that the work done to improve the service provider's system for confirming capacity and therefore valid consent to treatment and care was still lacking. The Tribunal took into account that this issue had first been set out as a breach of Regulation 11 in August 2023. By the time of the hearing, the process for assessing capacity and therefore ensuring valid consent to care was still not sufficient.

56. The Tribunal reviewed the service provider's mental capacity policy and procedure (D2067), submitted in the supplementary hearing bundle from the Appellant. The policy sets out that the service provider must ensure a mental capacity assessment is carried out where there is reason to believe the service user lacks capacity and Dr P Lukama will complete the assessment. The policy goes on to detail that the capacity assessment must clearly document the decision to be made and the domains of capacity that the service user is lacking (understanding, retaining, weighing and/or communicating) and details of how staff have attempted to maximise the service user's capacity. The policy then contains a template assessment form. The mental capacity assessment forms provided for service users did not comply with this template and did not assess the service users' ability to consent to different aspects of their care. As an example of how this impacted care, service user I's care plan recorded that restraint could be used if staff members felt they or others were at risk of harm. There was no mental capacity assessment in place for the service user and no information in the customer file as to the decision reached to restrain service user I in their best interests. There was no evidence that a best interests meeting had been held to decide upon the least restrictive option and who had been involved in the decision reached. At the hearing, Dr Lukama relied upon the fact that there were lasting powers of attorney in place for service user I and service user F. However, there were no mental capacity assessments in place to confirm that the service users lacked capacity to make certain decisions about their care, in order to activate the LPAs so that the named attorney(s) could make the decisions on the service users' behalf.

57. The Tribunal was struck by the fact that staff members were operating on the assumption that service users I and F lacked capacity because they had LPAs in place, even in the context of the use of restraint for service user I. The Tribunal did not consider that adequate Mental capacity Act assessments were in place even by the time of the hearing. As such, the Tribunal was not assured that there was valid consent in place from the service users who appeared to lack capacity to make certain decisions about their care. The service provider is still in breach of Regulation 11.

Regulation 12: safe care and treatment

58. Turning to service user K, who had a complex medical history relating to scoliosis of the spine, dysphagia and cerebral palsy. The Tribunal noted that K required bed rails. At the March 2024 assessment, the lack of a bed rails assessment had been highlighted and at the time of the most recent assessment in October 2024, there was still no bed rails assessment in place for the service user. This carried the risk of staff members not knowing what to do to mitigate the risk of the service user sustaining an injury due to unaddressed safety risks with the bed rails.

59. Service user K had been assessed as having a high risk of skin breakdown, which was detailed adequately in both the care and support plan and in the Waterlow risk assessment. The final piece of care planning and delivery remained missing at the point of the hearing – i.e. the need for a skin integrity plan so that staff members knew what steps to take to mitigate the risk of skin breakdown. It was Dr Lukama's position that the fact that the care and support plan noted that the staff members should 'reposition frequently to relive pressure areas' and 'continuous observation and monitoring at least once a day for any visual indications that a pressure ulcer is developing or that issues with tissue viability are arising, or any changes in need' was sufficient care planning. Miss Harrison, a registered nurse, did not accept this was sufficient. She explained that a skin integrity plan was needed for staff members to know, with certainty, the areas of the service user's body which were at highest risk and would therefore require specific care and with clear guidance on the frequency of the position changes. The Tribunal accepted Miss Harrison's evidence on this point. Staff members required clear direction on the actions to take, how often to take them and the points of service user's body that required particular attention. This was especially necessary in a context where the service user had been assessed as high risk of skin breakdown.

60. The service user was at risk of choking and information contained in the care and support plan directed staff members to turn the service user on their side if they were choking, whereas information in the choking plan directed staff members to bend the service user forward. A staff member, reading all of the documentation in the customer file, as per Dr Lukama's expectation of staff, would not have a clear understanding of what was required when the service user appeared to be choking. As to hydration, there was no target fluid intake record in place for the service user, but simply a direction to ensure that K has plenty of fluids to keep K hydrated. There was no clarity about what 'plenty' meant. Dr Lukama made the point that K's parent would always ensure there was a set amount of fluid available, but this does not resolve the issue of the care planning being clear on the expectations for safe care and to ensure a staff member, without the benefit of the service user's parent, could fulfil the required care.

61. There was a lack of clarity on the information about service user K's behaviour and service user K's risk of seizures. The information recorded in the behaviour plan and in the seizure plan was the same, which meant it would have been difficult for a staff member to differentiate between a behavioural need and a seizure.

62. Service user I's care and support plan contained information which contradicted the falls risk assessment. Again, applying Dr Lukama's expectations that staff members would read all of the customer file, it would not be clear if service user I was mobile or should no longer mobilise on their own.

63. The Tribunal took account of an incident report dated 27 July 2024 for service user I, which recorded that the service user had fallen and sustained a head injury. There was no further record on the head injury and the information appeared contradictory to the initial record of the fall, which recorded that the service user 'did not seem hurt'.

64. Service user L, has a learning disability and diabetes, as set out at paragraph 54 above. L's care and support plan referred to actions to be taken by staff members if L had high or low blood sugar, but there was no information as to the symptoms to help staff members recognise high or low blood sugar. Furthermore, the diabetes risk assessment made reference to what constitutes a low blood sugar level, but there was no clarity on whether or not staff members were expected to monitor the blood sugar levels and record them. Miss Harrison observed that there was no evidence that staff members had completed diabetes or blood glucose monitoring training, in order to assure the registered manager and, in turn, the Respondent, that staff members had the requisite skills and knowledge to support a service user with diabetes.

65. The records for service user F showed that F was prescribed Memantine 20 mg, to treat dementia. The medication was to be administered 'every other day'. However, staff had signed to confirm they had administered the medication on three consecutive days of 23, 24 and 25 September 2024. There were no records to indicate that this incident had been reported or steps taken to mitigate it. None of the medication audits had picked up this incident. There was no evidence to assure the Respondent that medications were being monitoring for stock balances, opening and expiry dates for topical creams and lotions. Dr P Lukama explained, at the time of the assessment in October 2024, that physical spot checks did take place, but there were no records in place to confirm the outcomes of the medication spot checking.

66. Taken cumulatively, the Tribunal finds that there are still ongoing issues with care planning and demonstrating assurance that care is planned and safely delivered. The Tribunal finds that the service is in breach of Regulation 12.

Regulation 17: good governance

67. This is one of the fundamental regulations, in the Tribunal's view. A service provider that can demonstrate good governance through its systems, processes and policies, will go some way to allaying concerns in relation to breaches of other 2014 Regulations.

68. The key tool for demonstrating good governance is the assurance systems a service provider implements. It was notable that in his first witness statement to the Tribunal, Dr Lukama explained that as at 3 June 2024, the service provider was carrying out an overarching audit on a monthly basis, using

Quality Care Systems auditing tool. During the assessment in October 2024, Miss Harrison noted that the service was not using the Quality Care Systems auditing tool. During a meeting between Miss Harrison and Dr Lukama, held on 16 October 2024, he confirmed that the service no longer used the Quality Care System auditing tool as the service wished to work digitally. As such, the service is currently planning to use PASS audit tools and forms. There was no evidence provided to the Tribunal, in the form of a plan for future auditing or in an up to date action plan, to provide assurance about the arrangements for audits.

69. The Tribunal considered the evidence as to audits which had taken place. The Tribunal had concerns about the integrity of the recent audits, which recorded that there was evidence of documents being in place, when, in fact, there was not. An example of this was a care plan core audit, recorded as having been completed on 26 September 2024. The auditor had ticked that the service was compliant for a malnutrition universal screening tool (MUST) (completed), but there was no evidence of any service users having MUST assessments/tools in their customer files. There were no names on audit records, which meant it was not clear to the reader as to which service user's records had been audited. Dr Lukama sent examples of audits dated 6 and 7 October 2024. The audit on 7 October 2024 related to mental capacity and Deprivation of Liberty Safeguards (DoLS). The audit identified that capacity assessments were being carried out and that more information needed to be added around the decision being made and that the policy had been shared with staff. It was concerning to note that an audit carried out after the on-site assessment was identifying issues which had previously been identified at the inspection of August 2023 and the on-site assessment of March 2024.

70. Miss Harrison reviewed the policies for the service, which included audit tools which were not being used by the service provider. There was sufficient evidence before the Tribunal to demonstrate that the auditing processes in place for the service, at the point when it was assessed in the month before the Tribunal, were not satisfactory. Furthermore, the evidence submitted by the Appellant, after the on-site assessment and in advance of the hearing, did not provide an updated, improved position on the assurance systems in place for the service.

Regulation 18: staffing

71. It was accepted that the service provides 2000 hours of care per week to its current service user group. It was confirmed that due to the revocation of the sponsorship licence, 23 of the 28 staff members employed were subject to a cap of 20 hours per week, on the basis that their sponsorship was provided by another (main) employer. As a result of this, it meant that the 23 staff members worked a total of no more than 460 hours per week. This left 1,540 hours of work to be covered by five staff members, which averaged out to each staff member having to complete 308 hours of work per week, which is a significant amount of additional hours over the 168 hours there are in one week.

72. It was not at all clear that staff members were not working above the cap of 20 hours per week at the service, which would have been a contravention of their visa arrangements. Furthermore, Drs Lukama were unable to provide documentation, at the time of the on-site assessment, and as part of the appeal, to demonstrate the arrangements for staff to provide care and the total number of hours they worked each week at the service. In the Tribunal's view, we could not be assured that the service was sufficiently staffed to safely provide the level of agreed hours of care to the service users.

73. There remained gaps in the training for staff. As previously identified, there was no evidence that staff had completed diabetes or blood glucose monitoring training. Further, there was no evidence of restraint training, in a context where Dr Lukama confirmed that restraint could be used by staff for self-defence purposes. Some staff members had completed training for dysphagia and choking, nutrition and hydration and epilepsy, but by no means all staff. By the point of the hearing, these gaps in the staff training remained.

74. Spot checks lacked detail on action taken to improve practice. For example, a spot check dated 17 July 2024 noted the need for immediate 'refresher moving and handling' training to take place, but no evidence as to when this was planned or completed. There were documents which demonstrated that two spot checks took place at two different locations at the exact same time and date by the same checker. It was not clear to the Tribunal as to how this was possible, which meant the integrity of the spot checks was undermined. Spot checks are an internal tool to assure the registered manager of staff's competence in a given moment. The Tribunal did not consider that the service had robust systems in place for assuring itself of its staff's competency in their roles. This amounts to an ongoing breach of Regulation 18.

Regulation 19: fit and proper person employed

75. With regards to this Regulation, the concern remains that the records for the hours worked by staff members demonstrated that those with a cap of 20 hours per week did not work more than 20 hours. There was no assurance from the system in place. There was no evidence that the service had checked the status of all of its staff members who were required to have a sponsoring employer in place, to assure itself that staff could validly work for the service. This demonstrated that the service did not have a robust recruitment process in place to assure itself that all relevant staff employed for no more than 20 ours per week had a sponsoring employed in place and that had been confirmed with the sponsoring employer.

76. The Tribunal was concerned to see that a reference was held on file for one staff member which referred to another staff member in the body of the reference.

77. There was no evidence provided to demonstrate that the service had any mechanism in place for preventing the relevant 23 staff members from working no more than 20 hours per week.

78. The Tribunal finds that the service continues to breach Regulation 19.

Improvements

79. The Tribunal took into account the actions taken by the Appellant to make improvements to the service. This included contracting with Mr Tighe and SRG Care Consultancy & Training to provide support for improvement. The Tribunal had the benefit of an audit report which Mr Tighe completed in June 2024. It was clear to the Tribunal that Drs Lukama had made some improvements at the service, to the extent that in Mr Tighe's view, the service would have been rated as 'requires improvement' overall, as a result of his audit report from June 2024. The Tribunal noted that Mr Tighe had produced an action plan template in his report, which detailed the issues identified and provided a grid to complete with details such as the RAG status of the action, the plan for completion and the evidence of completion, amongst other things. Mr Tighe confirmed, in his oral evidence, that this was advisory work and the 'owner' of the action plan is the service provider – the nominated individual and registered manager.

80. The Tribunal was not provided with the current action plan, to demonstrate the improvements made, when they were completed and the evidence to support completion. Dr Lukama explained, in his oral evidence, that the service had an updated action plan. From the Tribunal's perspective, this is a fundamental document, which would have provided some assurance to the Tribunal of the strategy for making improvements at the service provider. Its absence was conspicuous and supported the conclusion of Mrs Jupp, that despite the guidance from one inspection and two assessments, the service was still not complying with the Regulations. It further supported the conclusion of Mrs Jupp that despite Dr Lloyd and Dr Priscilla Lukama's dedication to wishing to improve, they do not possess the skills, relevant experience and competence to make the significant improvements and sustain them.

The Respondent's assessment methodology

81. The Appellant had concerns with the Respondent's change from its inspection methodology to its assessment methodology, which meant that the Respondent conducted a full inspection, based on information shared with it by Oxfordshire County Council and the Home Office. The Appellant submitted that because the Respondent had changed in methodology, it should have carried out a full assessment in March 2024 to provide a 'baseline' for its assessment. This argument would have had merit if the Respondent had fundamentally changed its model of assurance or its approach to decision-making. It is notable that the Respondent still uses the same enforcement policy and its enforcement decision tree. Furthermore, the assessment methodology is ultimately about establishing if the Regulations are being complied with or not. The quality statements identified by the Respondent for the two on-site assessments represented the issues identified during the inspection of August 2023. In that regard, the use of the on-site assessment was no different from the previous inspection process undertaken by the Respondent – a full inspection, followed by further, focused inspections which reinspected the areas of concern from the previous full inspection (or the areas in which the service provider was rated

inadequate). We do not consider that the failure to complete fact checking process of the most recent on-site assessment was a fundamental procedural failure on the part of the Respondent. As was made clear during the hearing, the Tribunal makes the decision afresh at the point of the hearing and takes into account all relevant evidence. It was highly relevant to the Tribunal's decision that the Respondent had completed a focused on-site assessment within one month of the hearing date. Any disputes as to the statements from Miss Crossing, Miss Harrison and Mrs Jupp were tested by the Appellant in his questioning of them, as well as questions from the Tribunal.

82. The Tribunal found all three witnesses to be credible, consistent and reflective in their evidence. Mrs Jupp acknowledged the impact the decision to defend the appeal had on Drs Lukama and on service users who still rely on the care provided by the service. The Tribunal accepted Mrs Jupp's oral evidence, which was sincere and even-handed – that the Respondent constantly reviews the proportionality of its decision as it does not wish to cancel registration – seeing it as a 'last resort' option. This is supported by the Respondent's approach to the appeal, in conducting two on-site assessments since the first inspection, which resulted in an inadequate overall rating and the initial decision to cancel registration.

Proportionality

83. The Tribunal took into account the fact that the service has made some improvements. However, the Tribunal has still concluded that as of today, the service remains in breach of a number of Regulations. The Tribunal could not be assured, on the quality of the evidence provided by the Appellant, that the service will be able to make further, significant improvements such as to come into compliance with the Regulations and to sustain compliance. The Tribunal noted that it has been approximately 15 month since the significant issues with the quality of care were first identified. The Tribunal also took into account that the service now provides care to a much reduced number of service users and even with the passage of time and a reduction in the pressure of a high service user volume, the service has not been able to comply with all of the fundamental regulatory requirements to assure this Tribunal that it can provide safe and effective care with stable, robust governance in place.

84. The Tribunal carefully considered its power at section 32(6) to direct that any such discretionary condition as the Trist-tier Tribunal thinks fit shall have effect in respect of the regulated activity. In light of the extent and nature of the breaches, the Tribunal concluded that workable, effective conditions would not appropriate in light of the limited improvements made over the past 15 months.

85. The Tribunal took into account the nine testimonials from family members of service users, noting their positive views on the service and acknowledging the impact a decision to cancel registration will have on them. However, the testimonials do not surmount the seriousness of the continued breaches of the Regulations or lead the Tribunal to conclude, on balance, that the decision to cancel is no longer proportionate.

It is ordered that:

1. The appeal is dismissed.

2. The Respondent's decision of 23 January 2024 is confirmed, pursuant to section 32(5) of the Health and Social Care Act 2008.

Judge S Brownlee
Care Standards & Primary Health Lists Tribunal
First-tier Tribunal (Health, Education and Social Care)

Date issued: 25 November 2024