Care Standards

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

Heard on 2nd September at Manchester Employment Tribunal & 28th and 29th October at Tameside Magistrates Court in Ashton-under-Lyne

[2019] 3774.EA-MoU

BEFORE
Mr G K Sinclair (Tribunal Judge)
Ms D Rabbetts (Specialist Member)
Ms M Tynan (Specialist Member)

BETWEEN:

ASC Healthcare Limited

Appellant

v

Care Quality Commission

Respondent

DECISION WITH REASONS

Before the Tribunal sitting at Tameside Magistrates Court on 28th & 29th October 2019

Representation
For the Appellant: David Pojour (Counsel)
For the Respondent: Rachel Birks (Solicitor, Ward Hadaway)

Preamble

1. This is a case which, in the tribunal's view, the CQC has done more to lose than the Appellant (save for its substantial financial input into improving the fabric and furniture) has done to win. The entrenched positions taken by certain witnesses and a reluctance to concede any point were profoundly unhelpful.

2. As Mersey Care NHS Foundation Trust had committed to ending its role as registered service provider at the Breightmet Centre on Tuesday 5th November 2019 the tribunal decided, pursuant to rule 30(2) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008, that as the parties needed to be able to make essential arrangements for future provision

the tribunal should deliver its decision as soon as possible, with reasons to follow as soon as practicable thereafter.

3. The tribunal met by telephone conference call to consider its decision during the evening of Wednesday 30th October 2019 and the initial draft of the decision was produced on the following day.

4. The tribunal's decision issued on Friday 1st November 2019 was to allow both appeals, direct that the conditions imposed by the two Notices of Decision should cease to have effect, and to impose fresh conditions governing the Appellant's provision of the service in the immediate future. Those new conditions are, for convenience, annexed to these reasons.

The appeals

5. The Appellant currently has two registered locations :
   a. Maryfield Court, Nettleford Road, Whalley Range, Manchester M16 8NJ, and
   b. The Breightmet Centre for Autism, Milnthorpe Road, Bolton BL2 6PD.

   It is a condition of its registration that regulated activity is restricted to those locations.

6. These appeals concern the second location only. The Centre is an independent hospital providing in-patient services for those with learning disabilities and severe autism.

7. The Appellant is appealing against :
   a. a Notice of Decision dated 3rd July 2019, served under section 31 of the Health and Social Care Act 2008, to impose nine additional conditions on its registration
   b. a second Notice of Decision dated 16th July 2019 to vary the scope of registration by varying the condition setting out the locations from which the Appellant may carry out the regulated activity by removing the Breightmet Centre for Autism as a location from which that activity may be provided.

8. The tribunal ordered that both appeals be heard together and, as the Memorandum of Understanding applied, they were listed for urgent hearing (with a time estimate of one day) at Manchester on Monday 2nd September 2019. The hearing that day was delayed by applications by the Appellant to debar the Respondent from participating in the appeals under rule 8(4), on the basis that there was no prospect of the CQC's case succeeding, and by both parties to adduce further evidence. The tribunal considered the Appellant's application under rule 8, ruling that :

   > ...while it may have formed some preliminary views concerning the Respondent's case, the tribunal cannot say that the Respondent has no reasonable prospect of succeeding at trial. The application under rule 8 is therefore dismissed.

9. For want of time the appeals were adjourned to the first available date, this time with a time estimate of two days. The earliest convenient dates were 28th and 29th October, one week before the revised date for Mersey Care to withdraw

from the Centre. The parties were granted permission to adduce further evidence and to revise their Scott Schedule of points in dispute. By further orders dated 18th and 22nd October the tribunal directed the production by the CQC of its notes of an unannounced focussed inspection of the premises that took place on 15th October and granted permission for the filing and service of further witness statements dealing with that inspection.

Material legal provisions

10. The material statutory provisions are to be found in the Health and Social Care Act 2008. The first Part of the Act deals with the establishment and role as regulator of the Care Quality Commission. This is divided into a number of Chapters and, in Chapter 2, section 8 defines "Regulated activity" as follows :

(1) In this Part "regulated activity" means an activity of a prescribed kind.

(2) An activity may be prescribed for the purposes of subsection (1) only if–

(a) the activity involves, or is connected with, the provision of health or social care in, or in relation to, England, and

(b) the activity does not involve the carrying on of any establishment or agency, within the meaning of the Care Standards Act 2000 ©. 14), for which Her Majesty's Chief Inspector of Education, Children's Services and Skills is the registration authority under that Act.

(3) For the purposes of subsection (2), activities connected with the provision of health or social care include, in particular–

(a) the supply of staff who are to provide such care;

(b) the provision of transport or accommodation for those who require such care;

(c) the provision of advice in respect of such care.

11. By section 10 any person who carries on a regulated activity without being registered under Chapter 2 of the Act in respect of the carrying on of that activity is guilty of an offence, and section 11 provides that a person seeking to be registered as a service provider must make an application to the Commission (the CQC).

12. By section 31:

(1) If the Commission has reasonable cause to believe that unless it acts under this section any person will or may be exposed to the risk of harm, the Commission may, by giving notice in writing under this section to a person registered as a service provider or manager in respect of a regulated activity, provide for any decision of the Commission that is mentioned in subsection (2) to take effect from the time when the notice is given.

(2) Those decisions are–

(a) a decision under section 12(5) or 15(5) to vary or remove a condition for the time being in force in relation to the registration or to impose an additional condition;

(b) a decision under section 18 to suspend the registration or extend a period of suspension.

(3) The notice must–

(a) state that it is given under this section,

(b) state the Commission's reasons for believing that the

circumstances fall within subsection (1),

(c) specify the condition as varied, removed or imposed or the period (or extended period) of suspension, and

(d) explain the right of appeal conferred by section 32.

13. By section 32(5), on an appeal against a decision to which a notice under section 31 relates, the tribunal may confirm the decision or direct that it is to cease to have effect. Additionally, by subsection (6), the tribunal also has the power:

(a) to vary any discretionary condition for the time being in force in respect of the regulated activity to which the appeal relates,

(b) to direct that any such discretionary condition is to cease to have effect,

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

(d) to vary the period of any suspension.

14. Subsection (7) defines "discretionary condition", in relation to registration under Chapter 2, as meaning any condition other than a registered manager condition required by section 13(1).

15. In seeking to impose or vary the conditions affecting the registration the Respondent has sought to rely upon a number of regulatory breaches found at the various inspections. These can be found in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[1], of which the Respondent has alleged breaches of regulations 9 (person centred care), 10 (dignity and respect),11 (need for consent),12 (safe care & treatment), 15 (premises & equipment) and 17 (good governance).

Hearing and evidence

16. When listed in Manchester on 2nd September 2019 the tribunal had two hearing bundles including witness statements by six witnesses: Stephen Brown, Sharron Haworth and Brian Cranna for the CQC and Nixon Amuntung, Jenna Timmins and Ayaz Vali for the Appellant. Even with a clean start it would have been difficult to hear all that evidence in one day.

17. By the time the case was heard at Ashton-under-Lyne at the end of October 2019 the evidence had increased to an extremely full three (or manageable four) lever arch files and eleven witnesses, of whom two (one on each side) did not or could not attend, and most of which now had produced more than one statement. The witnesses were :

For the Respondent CQC

a. Stephen Brown, CQC Inspector who inspected on 14th July only – one statement

b. Sharron Haworth, Inspection manager – five statements

c. Brian Cranna, Head of Inspection – two statements

d. Richard O'Hara, Inspector who inspected on 14th July only – one statement

e. Ishaq Mahmood, Inspector who inspected in June – one statement, but did not attend. (This statement added little, being mainly corroborative)

[1]SI 2014/2936

For the Appellant

f. William Martin Robinson, board chairman, non-executive director and proposed nominated individual – three statements
g. Elizabeth Cousins, retired hospital director, company director and proposed registered manager – two statements
h. Jenna Timmins, clinical nurse – two statements
i. Ayaz Vali, project manager – two statements
j. Dr Chris Carew, on-site doctor – one statement
k. Nixon Amuntung, former CEO, nominated individual and registered manager – two statements, but he did not attend as he had recently been dismissed by the Appellant company.

18. Insofar as Mr Amuntung's first witness statement contained non-contentious matters or referred to unchallenged documents it was accepted. His very short second statement exhibited voluminous and unhelpful documentation concerning care plans, etc, but also a very relevant letter from Mersey Care to the Appellant dated 30th August [K564], which it knew was likely to be put before the tribunal, concerning its involvement with the Centre.

19. Perhaps significantly, nobody from Mersey Care, which has been working at the Centre with some of the Appellant's staff from mid-July onwards, has provided any statement favouring either party. All we have is the letter dated 30th August 2019.

20. The witness statements were taken as their makers' evidence in chief, with oral evidence confined to cross-examination, re-examination and questions from the tribunal.

21. Stephen Brown gave evidence about his inspection on 14th July 2019. He had no other involvement in the case. When asked in cross-examination he said that his understanding was not that the premises are safe and well-led : it is that they are run by someone else. Shown some photographs of parts of the interiors of apartments that he had criticised he was unable to identify them, and professed an inability to say whether what they showed amounted to an improvement. Asked by the tribunal whether or not he could say that the items illustrated were at least in acceptable condition, he replied that they were in decent order. He said that he spent several hours in the same apartment, viz apartment 1 (which Mr Vali – whom he never met – later said was the one apartment that at the time had yet to be refurbished, and thus atypical). Concerned that it was a hygiene risk in a communal area, he drew the staff's attention to a blocked sink in a bathroom, which he regarded as something to be attended to immediately. In apartment 4 he noticed a mattress lying on the floor of one room, beneath part of the ceiling where damage had been caused by the patient bouncing on his bed. This he regarded as a failure to afford the patient an appropriate level of dignity.

22. Sharron Haworth was cross-examined principally about the recent inspection. She said that the inspection of June 2018 produced a rating of Good overall. The inspection of Mersey Care most recently in October 2019 was Safe and Well-led. She was emphatic that on this latest inspection she had not inspected ASC; the inspection was of Mersey Care. When she went on that inspection

she spoke with only one ASC staff member, Elizabeth Cousins. When the CQC went in it was not an inspection of ASC as it could not do that. The registered provider was Mersey Care, and she refused to accept that ASC played a part in providing the service.

23. It was put to her that the bulk of the staff working at the Centre were ASC staff, and that there were just four members of Mersey Care: Paul Thomas and Fran Cairns for four days a week, Amy Shaw for two days, and Ian Murphy one day a fortnight. By contrast, of the operational staff hours worked, 99% was by ASC staff and only 1% by Mersey Care. Of management time (including managerial, financial, psychiatry, psychology, medical, clinical lead, occupational therapy, speech and language therapy, HR and maintenance) 95% was ASC and only 5% Mersey Care. Ms Haworth declined to accept those statistics. If Paul and Fran are there four days per week, they are the leaders, Paul as the registered manager on a temporary basis. He, she said, is in charge.

24. It was put to her that the motive was to undermine ASC, by saying that all improvement was down to Mersey Care, and that the CQC was only aware of half the story, because she did not speak to ASC. She responded that colleagues of hers spoke to ASC staff; she just spoke to one. The inspectors asked the staff who had driven the improvements. They had spoken to three from Mersey Care MC and four from ASC. She said that she did a tour of premises with Mersey Care only. She did not exclude anyone, but agreed that she did not tell ASC staff that they could engage with the inspection.

25. Despite interviewing Ms Cousins none of what she said to her, as evidenced by the notes [H722–725], found its way into Ms Haworth's final statement dated 21st October 2019 [H672–676]. Her only comment, in paragraph 12, was:

> I also had an opportunity to speak to Elizabeth Cousins, ASC Director.

When put to Ms Haworth that the underlined comment at the foot of the notes at H724 that the achievement over 3 months was "down to Mersey Care" was not said by Ms Cousins, and that if she had then it would be a "dynamite point" for the CQC and would have been included in her statement, Ms Haworth denied it. She said she relied upon her notes and memory, but was under no obligation to let anyone fact check her notes.

26. Mr Pojour also put to her that if negative comments were made to her by Mersey Care staff about ASC she should have sought their comments. She rejected this. That was not how the CQC worked. The service provider would have the usual opportunity to check the draft report for factual accuracy before publication, but there was no requirement to allow ASC to comment. It was not the registered provider.

27. One example put to her was found in paragraph 8 of her latest statement [H674], where on the subject of ordering new equipment she stated (five lines from the bottom):

> I was told that ASC staff would automatically look at downgrading an order for a cheaper item which would then result it having to be sent back, causing delays.

Questioned about that she said that she did not discuss the subject with Ayaz Vali or any other ASC staff; just with Paul Thomas, Mersey Care's temporary

registered manager. Asked whether the issue concerned sofas being sent back because of inappropriate zips which could be a hygiene concern, she said Paul did not mention zips. She was told that stuff was being sent back as unsuitable. She did not explain or repeat her comment that ASC staff were automatically trying to downgrade orders for something cheaper.

28. Finally, when asked by the tribunal about ASC's investment of £250 000 in improvements to the fabric of the building and furniture despite the CQC's expectation that all of the patients would have been relocated by now and the Centre left empty, her response was that "our instruction was clear."

29. Richard O'Hara confirmed that, as of his recent inspection, the patients inspected are safe and the service provided well-led. This was the first inspection where there were two providers on site, but one not inspected, that he had carried out. He said that his role was to interview staff – four staff – all ASC staff. Because it was a safety concern he had to speak to four staff and two patients. Gleaning information from patients was difficult. The ASC staff were a team leader, a trained nurse, an occupational therapy assistant, and a psychology assistant. It was a focussed inspection on Mersey Care. He met with Fran Cairns and Amy Shaw, and was involved in the tour of the building. No ASC staff took part in the tour, but some were dealing with patients and the team were able to see the interaction between them. He said that he was able to speak with Gary from maintenance, but it was put to him that ASC employs no such person and that it is Ayaz Vali who is responsible for the refurbishment works.

30. Asked about governance documentation that Mersey Care was trying to introduce, Mr O'Hara commented that the impression he got from Paul Thomas was that this was the process they were trying to embed. He did not say to Mr O'Hara that if Mersey Care left the service would fall apart. Quoting from paragraph 7 of his statement [H679], he said that based on the inspection the team's findings were that the location was safe. The key word in that paragraph was "hopefully". He agreed that there was active input from ASC staff.

31. Put to him by the tribunal that a useful analogy for where are the ASC staff now was a comment made the previous weekend about how Warren Gatland had left the Welsh rugby team more motivated, in a much better place then when he arrived, and that it was now in a good place as he moves on, Mr O'Hara commented that it depends on who the new manager is; a matter of leadership.

32. Mr O'Hara said that he was led to believe that the service had improved since Mersey Care had come in. There was no need to dig deeper. The paperwork was provided to the CQC team by Mersey Care. It was not necessarily Mersey Care information, but referred to the service. He said that Tony Cliffe (of CQC) told them that care plans had markedly improved.

33. Asked about the motivation behind holding an inspection just a couple of weeks before Mersey Care leave the Centre, he said that it is the CQC's process. The report (which would not appear for some time) will still be relevant whether or not the service is in place.

34. Brian Cranna was at the material time interim head of inspection for mental health hospitals. He stated that the inspection process must look at care being provided by the registered provider. Asked what of care provided by another provider, he replied that if there is an agency situation then the agent is not the provider. In this case Mersey Care was the registered provider.

35. It was put to him that immediately following service of the 16th July notice ASC were carrying out unregistered care (a criminal offence), and yet the CQC was promising not to prosecute until Mersey Care were brought on board. He agreed that the Appellant was providing unregistered care but the potential risks involved in moving patients from care were higher than leaving them there. NHS England were overseeing the situation, and CCGs were conducting visits.

36. He was challenged on the issue of a section 64 request on 2nd July, so a fair assessment could be made. Despite that, and an expected response time of three days, the next day the first Notice of Decision was issued. He replied that as part of producing a report the CQC had to gather evidence. The section 64 notice was to read a fair judgment in the report. The management review meeting was on what action to take which was an entirely separate process. Emerging evidence from the latest inspection was affecting its decision. The section 64 request was to obtain information. It was put to him that, the reason given on the face of the document was so that a fair decision could be made. That is about enforcement. He responded that the CQC needed the full evidence to report and give a judgment against each element being looked at.

37. Finally, Mr Cranna was asked about the solidity of the alleged plans he mentioned to relocate all seven remaining patients. Were these firm plans or merely contingent upon the result of this appeal? He conceded that the CQC could not dictate to CCGs what steps to take; merely give advice. At the moment Breightmet was a registered location. It was up to the CCGs.

38. Day one concluded with the evidence of Dr Christopher Carew, an enthusiastic young doctor contracted to work two days per week at the Centre, including Wednesday when ward rounds are conducted by Dr Wasim Ashraf, responsible clinician. Otherwise Dr Carew works as a locum doctor in Salford, but ASC is his top priority. He had been recruited by the Centre on 14th August 2019, so was unable to comment on the state of the building and the service at the time the notices were served.

39. Asked about his learning difficulties experience, he described it as being in placements during his training, in psychiatry posts – for 4 months at the Norfolk & Suffolk Foundation Trust, around three years ago, and anything done while working as a locum GP. He had been doing that since the end of July this year. However, he revealed that he was also used to dealing with those with a learning difficulty from his own family background – his whole life. He also confirmed that he had read the CQC report into the Centre and had paid particular regard to those elements related to his role.

40. Re-examined about the CQC report, Dr Carew said that his view of the environment now is that it is completely unrecognisable from where it was at that time. He went on to say that it is rare for him to work at a place that he

would recommend to his family, and he would be happy for his brother to receive care at Beightmet. He commented that the CCGs are happy with patient progress, and the patients' families are also happy. As to the recent positive practice, a family member had said to him that this was the best they had seen the patient concerned in a year. He was confident that when Mersey Care withdraw things would go on as they are now, and he did not see why that would change when they leave.

41. Questioned by the tribunal, he said of the Appellant that it is those patients who would be moved if these appeals do not succeed that they would be most concerned about. If contingency plans exist the CCGs are happy with the care being provided, addressing problems not addressed at previous placements and where each patient is treated as an individual rather than a number. If moved, patients would have to get used to new staff who do not know how to communicate with them. It is not the same as knowing them: that takes time to get to that level.

42. William Robinson stated that he is a non-executive director and chairman of the board. He has no clinical background but is on the board of a health service provider. Including this one he has six board roles. They are all non-executive roles, so he commits one or two days a month. He told the tribunal that he first visited the Centre in July 2018, on more than one occasion, as part of his due diligence when asked to become involved. He asked for procedures, CQC reports, etc. His engagement by the company was in November 2018, his commitment being two days per month. He would attend board meetings. Since July 2019 he has devoted rather more time, about twenty hours a week.

43. His first tour of the premises was in April 2019. He went round all the departments, from the forecourt into the building; but not into the garden. He commented at that time that improvements were needed. Improvements had already been identified, but not yet implemented. He noticed damage to floors in apartments, damaged doors and door frames which did not fit properly, holes in ceiling, etc. Those things he identified were risks to patients included sharp objects being exposed, where people could harm themselves. Those were his immediate concerns.

44. He would have returned within weeks, if not days, attending meetings at the Centre on various dates. He sought assurance from the management team that changes were being made, and had revisited since then, prior to the CQC inspections, but not into the apartments. He could not recall if he had a tour of the building, but sought assurances from the people doing the work that it had been expedited.

45. On the recent proposal that he become nominated individual, he confirmed that he had never acted as a nominated individual before. He had read the guidance. He described his understanding of the role as being the point of contact between the CQC and the hospital management. He needed to inform the CQC of any points of concern, including serious incidents. An example had been quoted in the past of a patient in found in possession of a knife and using it as a weapon. The fact that the patient had access to the knife and could cause harm are matters to be brought to the attention of the CQC.

46. If there is an incident of restraint that has not been recorded in the care record, or not properly investigated, that should be reported to the CQC. He was not aware of other matters concerning restraint that need to be reported, but if a patient is injured during restraint the cause of the injury would need to be investigated to see if there was an incident that should be reported. If made aware of anything that caused him concern he would check to see if it needs to be reported. The sensible approach is to check. He admitted that he did not know the rule book inside out, but he just needed to be aware of matters that need to be investigated. He said he was aware of the need to inform the CQC of any police involvement.

47. Asked about the unsuccessful attempt to recruit both Paul Thomas and Amy Shaw on secondment from Mersey Care, he stated that the company saw secondment as a means of improvement, easier than recruiting permanent staff before regaining a Good rating. That would have been a good solution. They had done their due diligence as they were already working there. They had assisted the ASC staff to make improvements to the facility to address concerns in the CQC report. About two weeks prior to the dismissal of Nixon Amuntung as CEO in October he had become aware that Paul and Amy were not coming onboard. The company was starting to explore alternatives. The role of hospital manager had been advertised earlier, but the company had not found a suitable candidate from the interview process.

48. It was put to Mr Robinson that without Mersey Care staff present ASC could not have made the improvements needed. He agreed that they had helped. Without Mersey Care in post the facility would have had to be closed. Had ASC been able to retain registration and needed to seek external guidance then it could have gone to other sources. It did not have that opportunity.

49. Questioned about his ability to devote enough time to the role of nominated individual, Mr Robinson confirmed that his contract at present is for two days per month. The role of nominated individual is a new role, so would need a new contract. He demonstrated that he can provide twenty hours per week and would suggest an increase from two days to four days. None of his days are scheduled, save for specific meetings. This was just a proposal at the moment. He has the flexibility to take on additional days per week. Four days per month should be more than adequate for one facility, as he was aware of other individuals, eg at Mersey Care, where one person is nominated individual for thirty facilities – or one day per month; so he believed his proposed four days is more than adequate.

50. Asked by the tribunal about his knowledge of his proposed new role as point of contact with the CQC, he said that to get information ASC has external advisers, such as the solicitors representing it; and it has a firm of consultants to the health service industry. He can approach them as well. Also, he can consult the hospital manager and others about their interpretation of what the company had to do.

51. On the role of hospital manager, he said that the company had interviewed for that role. It was advertising that role, not Nixon's role as CEO, and had a

recruitment consultant looking for candidates. The company had not found anyone with sufficient experience, unlike Elizabeth Cousins or Paul Thomas. Autism and learning difficulties are particular specialisms.

52. Elizabeth Cousins gave evidence. A non-executive director and proposed registered manager, she holds a certificate and diploma in management. She has no clinical or autism qualifications, but her son is on the spectrum, which provides some knowledge. She had a thirty year career in health care, working in senior positions in management. She has basic life support training. It is not current, but needs to be. She last had training in 2016, in her last post. She has not had safeguarding training, or learning disability or autism training. She had been director of an animal hospital for two years, having retired early (at 55) and moved on from her (human) hospital post in September 2015. She has no experience of specialist or autism centres, but had been property manager at an acute surgical unit.

53. She became non-executive director in November 2018. In the beginning half of that month she visited the Centre and since then had been contracted to be at the hospital one day per week. She had been there most weeks and visited the apartments some of the time - about five times now. Her first tour was in the first month she was employed, and she spent time with the CEO and had a walk around with him. She thought she visited in springtime, as the company had already started the refurbishment of the premises.

54. Her thoughts on the condition of the premises observed on her first visit were similar to her colleague (Mr Robinson), and his comments to the board. She did not see anything that put patients at physical risk. There was a deterioration in the environment and she sought assurance from the CEO that no patients were at risk. She discussed with him the mattress on the floor, which she thought not normal, but Mr Amuntung said this was how the patient managed his environment. She had seen no sharp edges; but torn fabric, and foam exposed and coming out.

55. Asked about the proposal to have both a non-clinical nominated individual and manager, and how to ensure patient safety, she stated that this is a precedent set in many hospital leadership roles. She had managed many clinical departments, eg operating theatres, radiology, etc. This is about good leadership and compliance with all regulatory matters. She would be there four days per week, being deputised by a deputy manager, Anna. She will deputise for her at weekends. She has been at the hospital for three years and Ms Cousins believed she was promoted to that role. She was deputy manager in June, when the CQC inspected. The company is also recruiting a clinical lead. There is still a vacancy for that position. That is in addition to what is there now; a matron-type figure – the role Paul Thomas plays at present.

56. As for the note of her meeting with Ms Haworth [H724], Ms Cousins did not say what is alleged about all the improvement being down to Mersey Care, but she agreed that she did say that Paul and Fran were at top of their game and knowledgeable. She told the tribunal that she disagreed with the suggestion that it was all down to Mersey Care. She said that they both discussed the point that the hospital had improved and had an excellent future. That was the

view she believed both of them shared. She stated that during the meeting she had also clarified (at an earlier point) that on no occasion did the board deny any investment, and they were fully committed to the future of the hospital and its patients. Ms Haworth was writing in front of her but she could not read her notes, and was not asked to check their accuracy. For example, the bit she had just mentioned is not recorded in the notes.

57. She commented that she had retired early, at 55. She was not past it, as she had been involved in different projects and voluntary work in the period since. She had always worked alongside clinicians, be they surgeons or nurses, sat on committees and been responsible for the disciplines under her care. The fact that it is an autism hospital was not relevant to her management (although she then demonstrated her ignorance of the subject by showing a lack of understanding of what is meant by a "seclusion room"). She claimed that she will provide strong leadership and support, and that Mersey Care were relieved that she was there. Ms Cousins stated that Paul Thomas had said so, and at her handover meeting a week before the hearing Fran Cairns reiterated that as well.

58. Jenna Timmins started on 2nd January 2019 as a clinical nurse. She had previously worked in a mental health home for three years as a nurse, then as home manager, then moved to be turnaround manager for a failing dementia home (Lofton Grange), which had been inspected in 2014. She worked there in 2015 and was employed at Breightmet, first as nurse then nurse manager from March 2016 to September 2017. She then worked at Three Hour Care as lead nurse/deputy manager in brain injury care. The CQC carried out an inspection in August 2018, when it was rated Good. Her contract ended so she then left.

59. She had an opportunity to review the CQC report. Based on who they spoke to and the snapshot of staff, their understanding may have been limited. So far as Ms Timmins was concerned other nurses may have had issues with care plans, but she had none with hers at inspection this year. Risk needs to be managed on a daily basis. It changes daily. She had already raised issues in staff meetings with the manager before Mr Amuntung about environment, furniture and infection control – eg fabric being ripped and the exposure of materials. She sent it to the CEO (Mr Amuntung) by email on the previous manager's departure, on 24th March 2019. From start of her re-employment in January/February herself and other members of the clinical team raised concerns. She met Mr Amuntung and had a conversation. He said plans were in place for refurbishment. When she had reported concerns to the previous manager she was told they were being dealt with.

60. Ms Timmins, who worked in apartment 3, had concerns but not serious concerns. The service users and their challenging behaviour had caused ripped furniture and general untidiness of the grounds. Damaged furniture was removed from her apartment, but she couldn't say about others. She removed furniture from her apartment in March, when it was seen to be ripped, and with another nurse (apartment 2) wrote an email about their concerns about furniture and infection control. There was nothing particular about cleanliness. She did not note that as a concern. The staff she worked with maintained a

clean environment. She commented that infection control becomes an issue if it puts anyone in immediate danger. She did not see that there was a risk of infection or diseases being spread. Her staff undertook cleaning during the day.

61. As for the CQC's concern about staff handovers, her view was that nothing was wrong, but when reviewed the staff found that they could improve the system – mostly about communication on shift changes. There were other ways in which things could be picked up. Her view was that there was no problem, but they just tried to make it better. A lot of things have been addressed on CQC issues, overhauled – including systems that do work. She was aware that ASC had governance structures that could be improved, and these had now been put in place. As for care plans, she saw no risk from them. Hers were up to date. Any issues would be picked up by the care lead, and in her new role she does that.

62. Asked by the tribunal about reporting concerns to the CEO she said that staff had seen invoices for furniture being bought, decoration was booked, and painters and decorators were in. On the subject of the gardens, the gardeners were in, taking note of what staff had suggested about litter and untidiness.

63. Ayaz Vali, the estates and facilities manager, commented that prior to Mersey Care coming in audits relating to the environment were done by the hospital manager and care staff in place at the time; not by him. It did work to an extent, because they were on the shop floor, as he was restricted in his access to the apartments. Works were reported to his team to get implemented, with anything specialist escalated to outside contractors. Since Mersey Care's arrival he had taken on a new estates role, having full autonomy. He does the auditing himself, with one of the nurses, and is able to access all areas, subject to patients' wishes. He also has a maintenance meeting on Monday morning, immediately after the shift handover.

64. He had read the CQC report and the Notice of Decision to remove this location from the Appellant's registration. He did not think that was right. The inspector, Mr Brown, spent time only in one apartment, but the refurbishment programme was already in place. It started in apartment 2, then 4, and then apartment 3. When the CQC visited their focus was on apartment 1, which had yet to be done. Everything was getting actioned.

65. He could not comment on the dirty environment, as it was not his remit. As for broken doors, that risk assessment is on the internal portal. The hospital manager holds a file. He saw reports on the doors, flooring that had been damaged, the aesthetic appearance of walls, and dents or holes made in them. As for the risk from sofas, the ones damaged completely were removed. They could not remove everything as otherwise patients would be sitting on the floor. Used towels, etc were put over them as a temporary measure until new sofas arrived.

66. On practical issues Mr Vali was extremely knowledgeable and able to go into great detail about the internal doors, which are a bespoke size. The manufacturer had gone out of business. Despite what the CQC said, these were 60 minute fire doors, but patients will damage the handles. New handles

could then be fitted at a different point on the door and the original hole filled, restoring its fire proofing but not its appearance. There was a problem with sourcing alternatives, so the decision had been taken to replace all the door cases with thickened ones, allowing standard sized doors to be fitted. These could be replaced more quickly and cheaply from any builder's merchant.

67. When it came to repairing holes in ceilings patients would frequently become upset if a member of the maintenance team appeared, as they knew that the result would be an altered appearance to what they were used to – causing distress. Repairing bathroom floors with a smooth sealant involved clearing the whole apartment of users for an entire day. Now that there were fewer patients and one empty apartment this problem was easier to resolve, but the CQC had in its criticism not appreciated the difficulties and time involved in undertaking repairs in such an environment.

68. As for the criticism that boilers were in use despite having been condemned. He had not been concerned about that supposed heating problem. An engineer had been out to service them two weeks earlier and left lots of stickers around. Mr Vali believed that someone had put "Do not use" stickers on, either in jest or to discourage others from touching the boiler controls (although they are behind a locked door). An engineer came out the next day after this was discovered and said that nothing was wrong with them.

69. Another criticism was the gate between the garden and car park, where the lock had broken and it had been tied closed with bunged ropes. He explained that the gate had been damaged when trying to move a difficult patient earlier on Sunday 14th July, hours before the inspection. The next day, Monday, a locksmith attended to mend the gate.

70. On the refurbishment programme, he said that £80 000 had been invested between March and May, including new sofas, painting, and repairs to damaged floors and ceilings. At that time all apartments were in use, but since then apartment 3 became free, so work was done on that, costing roughly £160 000. Other work to the building has included installing tinted windows, and it is likely to cost £650 000 to complete all the other apartments. The board had virtually given his team an open chequebook, and he had also consulted with staff about the installation of air conditioning and providing a rest room for staff. On day one of the hearing they had moved users into apartment 3. The patients had been shown around over several days during the previous week and one user really liked the sound system. He was dancing as he was so happy.

71. Mr Vali said that he had discussions and good relations with Mersey Care, which he regarded as a second pair of eyes – saying how about doing this or that. Fran Cairns said to him that the CQC inspectors may want to speak with him. At the end of the day he was told that the CQC had come for a Mersey Care inspection and did not want to speak with anyone else. Days later he was told that there was a meeting to discuss feedback. Paul Thomas said that they were singing ASC's praises, but that the CQC team said this was a Mersey Care feedback, not for ASC.

72. In closing submissions Ms Birks for the Respondent stressed that although the

tribunal had to consider the issue of risk as at the hearing date it should not lose sight of the state of affairs at the time of the issue of the second notice of decision. She accepted that the current position was that staff and patients are not at risk of harm, but this was due to the considerable input from Mersey Care staff. There had been lots of attempts to muddy the waters over percentages of work, but the three individuals from Mersey Care had been central to driving the improvement. She drew attention to the fact that most of the Appellant's witnesses had been there at the time of the inspections and the problems had occurred on their watch. Those now proposed as nominated individual and hospital manager had no clinical knowledge. There had been a serious risk of harm, necessitating removal of the location from the registration, and imposition of conditions. There was no evidence that a strong, stable and knowledgeable management team was in place.

73. For the Appellant Mr Pojour criticised the CQC's approach to the case and argued that the appropriate test that it was purporting to apply was "safe and well-led". Applying that test, as of today, there is no risk to patients. The tribunal had heard from Dr Carew about how he treats patients, and from Mr Vali about how quickly the gate got repaired, and the significant efforts made to repair bedroom ceilings in apartments. When looking at the context of what staff are doing about keeping people safe, eg about the fire doors, what they are challenged with is keeping people safe.

74. What was Mersey Care's intention? The memorandum of Understanding is clear. It was to manage the Centre in the interim, while the Appellant sought the restoration of its registration. There is no evidence that CCGs are removing patients with a solid plan because of the CQC's view that the location is unsafe. Dr Carew says that the patients are happy, and parents are happy. Users are going into new apartments and thoroughly enjoying them. On a skewed basis, the CQC's approach is wrong about so many things; about the attitude of CCGs and of Mersey Care, and it had failed to provide evidence to divorce what Mersey Care had done and what ASC had done. There was no evidence from Mersey Care, and no notes of what Ms Haworth had discussed with Mersey Care.

75. The burden of proof is upon the Respondent, and the only way it could satisfy the test on the balance of probabilities would be to call witnesses from Mersey Care. Instead the Respondent's witnesses have filtered into the evidence what they say Mersey Care are saying. On 15th October the Appellant was excluded by CQC staff from a focussed inspection. The Respondent attacks a doctor for being junior, and a highly experienced lady – with 24 years experience as a registered manager of hospital settings – for being in retirement, instead of attacking the urgency of risk. Seven users have remained in the setting to this day, and it is clear that their CCGs have not accepted this decision-making process. The only evidence of how patients are doing comes from Dr Carew. Some are soon moving into community settings, but there is a risk to those required to move to other hospital settings, as they are flourishing.

76. At the conclusion of their submissions the parties were invited to withdraw to consider, were a middle way possible, what conditions it might be appropriate to impose. The Respondent argued for modification of some of the current

conditions, abandonment of others, but retention of condition 1 (which prevents new admissions without the CQC's consent). The Appellant argued that condition 1 was death by the back door, and that it was inappropriate as conditions are underpinned by criminal sanction, and the current ones are open ended.

Findings

77. The Breightmet Centre is a modern, purpose-built unit comprising 18 beds in four separate "apartments". First registered with the CQC in 2013, following an inspection in June 2018 it was rated Good. However, from the notes of a telephone conference call that NHS Bolton CCG held on 12th June 2019 with representatives of NHS England, of other CCGs placing patients at the Centre and CQC inspectors [bundle pages H156–162] it seems that Bolton's first involvement with it was in 2016/17. This was due to concerns raised about the use of anti-psychotic drugs. The Appellant's clinical lead and the line manager attended a joint meeting, which the local authority's safeguarding team also attended, and gave assurances that they were not misusing such drugs.

78. Despite the 2018 rating of Good the Centre again came to Bolton CCG's notice in December 2018 when a Bolton GP phoned regarding a patient who had attended the GP practice with four carers, became agitated, stressed and displayed frustration and then jumped over the reception desk, opened drawers and grabbed a pair of scissors. Following this an urgent professionals meeting took place in January 2019 between Bolton and the Centre, at which the CCG became concerned about Centre staff's lack of knowledge of the Mental Capacity Act and Best Interest Practice. Other issues raised at similar CCG meetings included inappropriate use of restraint, poor use of the MCA, poor safeguarding assurances, staff training and medicine management.

79. In about March 2019 the registered manager and another senior staff member resigned from the Centre, leaving the Chief Executive Officer (Mr Nixon Amuntung) to juggle three roles while advertising unsuccessfully for a replacement manager.

80. Following complaints by a whistle-blower, inspections took place on 6th, 14th and 20th June 2019 and the CQC wrote to the Appellant on 2nd July 2019 with a request for some quite detailed information. This was a statutory request made under section 64 of the Health and Social Care Act 2008. Addressed to the company secretary, it began:

> We are currently looking at our inspection findings. **In order to make a fair decision based on all the relevant information**, we require you to provide us with the following *[emphasis added]*

There then followed a list of 23 questions or pieces of information sought. The time limit for providing all this information was midday on Friday 5th July 2019 (two and a half days later), after which the letter included the following note:

> Please note : CQC may wish to use the information provided in civil or criminal enforcement action.

81. Without waiting for a reply to this request the CQC served a Notice of Decision the very next day. This imposed a series of nine conditions upon the

registration.

82. On 14th July the CQC conducted an unannounced focussed inspection, and on 16th July issued its second Notice of Decision. Of the serious concerns observed on this inspection those mentioned in the notice as reasons for its decision included:
    a. Poorly maintained and unclean environment, with various exposed hazards
    b. Failure consistently to protect patient dignity and privacy
    c. Failure to update risk assessments and management plans following incidents (one example being where a patient twice got hold of and hid a knife, on one occasion in May 2019 using it to stab a member of staff)
    d. Failing to understand and protect patients' rights under the Mental Capacity Act
    e. Failing to complete background checks on staff, including references and DBS checks, prior to them starting work at the hospital.

83. This was rather more serious than the first, as it prevented the Appellant from providing the regulated activity for its 14 patients at the Centre with immediate effect. This caused a problem not only for the Appellant but also the CQC and the CCGs that had placed patients at the Centre. Alternative placements for patients with very specialised needs are more limited and hard to find, so when informed that the second Notice had been served Mr Amuntung was told that he should expect a call from Margaret Kitching of NHS England and NHS Improvement.

84. That evening she informed him that she had been in contact with the CQC and would like to discuss how the Appellant could continue looking after the service users at the hospital. A meeting was arranged for the next day with Ms Kitching and Mersey Care, at which Mr Amuntung was informed that the Appellant either had to decide by 14:00 that day whether it wanted to work with Mersey Care (the latter in the lead role) or, if not, then they would line up ambulances to take the patients away; but due to the service users' complex needs they did not want to do that. Mersey Care wanted to put in a management team to work towards improvements.

85. In an email to Ms Kitching timed at 20:48 on 17th July 2019 [I 23] Jenny Wilkes, Head of Inspection – Hospitals Directorate at CQC, wrote :

> CQC served an urgent section 31 notice of decision to remove the location (The Breightmet Centre for Autism) form the providers registration. This took effect immediately when it was served. In most circumstances, CQC would usually expect that patients would be transferred to other providers of care at this time. However, in this instance CQC is fully appraised of the needs of the specific patient group and the challenges that will be faced in transferring them to alternative settings. As such we have agreed that we will take no further action against the provider. This is because we are aware of the local systems plans to either secure transfers in a safe and coordinated way for each individual patient to meet their specific needs, or for alternative management arrangements to be put into place. CQC would want to support both the patients and their families and the local system to

ensure that this happens.

...

CQC cannot dictate the contract arrangement but the staff do need to be under the direction of the registered provider. This would be best achieved through a service level agreement, if both parties agree, as this is most likely to be a temporary or short term arrangement.

So in effect a service provider makes use of staff from another organisation who are 'loaned' to it, through a service level agreement. The staff continue to be paid by provider B, but provider A is the provider who is carrying on the service. This arrangement does not make the delivery of the regulated activity a joint service (which might require both A and B to register for it). Instead, the staff member's original employer is acting as a staffing agency.

86. On 18th July 2019 Mr Amuntung met with representatives of Mersey Care to be introduced to key staff, and that provider began work at the Centre from 19th July onwards. On 22nd July it presented the Appellant with a Memorandum of Understanding to govern the working relationship [I 27]. This was signed on behalf of the Appellant by director William Robinson on 30th July, and on behalf of Mersey Care on the 31st. Very soon thereafter, on 2nd August 2019, an addendum [I 31] was signed to confirm that Mersey Care no longer considered it necessary for senior management representatives from ASC and Mersey Care to meet on a weekly basis. Instead they would do so at least once every four weeks. Each document confirmed that all support from Mersey Care would be withdrawn by 31st October 2019, although that had later been varied to 5th November shortly before the hearing in October.

87. From then on the Appellant's staff worked regularly with three members of Mersey Care at the Centre : Paul Thomas, Fran Cairns and Amy Shaw. With their guidance various governance and procedural changes were implemented. As this appeal was due to be heard on Monday 2nd September 2019 Mersey Care was asked and agreed to write a letter to the Appellant's chairman, Martin Robinson. The letter, dated 30th August [K562], is written by Trish Bennett, executive director of nursing and operations. In it she refers to the Memorandum of Understanding between the two organisations, the placement of a support team of three at the Centre, and to whom at Mersey Care they report. She refers to a section 31 action plan that Mersey Care had devised, and that :

> ...all actions identified in the plan have been allocated accountable owners from ASC, with progress being monitored by ASC management in conjunction with Mersey Care as part of the weekly meeting between senior managers and the clinical team at the Centre...
>
> ...
>
> Although progress has and continues to be made by ASC with the support of Mersey Care, a number of risks and challenges remain which the Support Team have brought to the attention of ASC through the weekly meetings, the monthly Clinical Governance meeting and the monthly Operations and Performance Meetings. A paper was shared with ASC colleagues on 20 August outlining these challenges and risks.

88. Work has continued apace at the Centre, with the Appellant engaging some new staff and investing heavily both in refurbishment of the fabric of the building and the replacement of furniture. It is likely that around £250 000 has been spent so far, with the budget for refurbishing all four apartments and ancillary works such as installation of air conditioning and tinted windows said by Mr Vali to be around £650 000. In a very recent change to the Appellant's plans Mr Robinson had agreed to assume the role of nominated individual and Ms Cousins that of registered manager (a role she had performed in previous jobs for a total of 24 years).

89. On 15th October 2019, as already discussed, a focussed inspection (said to be of Mersey Care's regulated activity at the Centre) took place just a fortnight before the intended date for its withdrawal under the terms of its Memorandum of Understanding with ASC. (That date was later extended to 5th November). ASC was not invited to participate or offered feedback, yet the findings from this inspection were later submitted as evidence at this hearing.

Discussion

90. Although Ms Timmins may think that matters under her direct control, whether care plans for her patients or the condition of her apartment 3, were of no cause for concern it is clear from issues raised at the conference call between CCGs and other interested parties on 12th June 2019 that as far back as 2016/17 there were some worrying signs at this service. A CQC inspection in June 2018 resulted in a rating of Good, but by the end of the year there was an alarming incident at a local GP practice. Quite why both the registered manager and another senior staff member handed in their notice in the spring is not known, but it certainly placed an increased load on the shoulders of the CEO and acting manager, Mr Amuntung.

91. The tribunal is satisfied that despite the efforts of Mr Robinson and Ms Cousins as non-executive directors (and at the time non-statutory ones on a supervisory board, as there was only one Companies Act director) when the location was inspected in June 2019 there remained service weaknesses that placed patients and potentially others at risk.

92. The CQC was entirely justified in serving the section 64 request on 2nd July, even though it allowed only two and a half days for ASC to gather and ensure that the CQC had received twenty three separate types of information. However, it was disingenuous of Mr Cranna to suggest that the section 64 process and enforcement action under section 31 were completely separate. The wording of the request makes clear that what was sought was needed "in order to reach a fair decision based on all of the relevant information", and that what was provided "may be used in civil or criminal enforcement action." It was therefore unfair for the CQC to serve the first Notice of Decision on 3rd July, when the recipient of the request had every expectation that it had at least until the 5th, following which the CQC would take time to consider what it had provided.

93. The second Notice of Decision was based on the findings of the 14th July inspection and on the Appellant's alleged failure to comply, in time or sufficiently, with the conditions imposed in the first Notice. Insofar as the

inspection may have criticised matters seen in the as yet to be refurbished apartment 1, the mattress on the floor of apartment 4, a blocked sink, and an insecure external gate this emphasis may have been unfair. The tribunal accepts Mr Vali's evidence on these issues.

94. Mersey Care having been imposed on the Appellant in a supervisory capacity, and so as to provide regulatory cover, the two organisations appear to have worked well under their Memorandum of Understanding, and as confirmed by Mersey Care's letter date 30th August 2019. That shows a distinct sharing of the burden of running the service; more so than any of the CQC witnesses were prepared to admit. So far as they were concerned all improvements at the Centre were due to the efforts of Mersey Care as registered provider. The extensive investment of funds and making of improvements by ASC were completely ignored.

95. Rather like Her Majesty's experience of the smell of fresh paint wherever she travels, the tribunal is very familiar with regulators conducting inspections of settings very shortly before a hearing. On occasions this satisfies them that circumstances have changed, resulting in a consent order allowing the appeal – often on terms. In this case, however, the reasons given for the focussed inspection that took place on 15th October are not convincing. Why spend time and effort on the inspection of a provider that would cease operations at the setting in two weeks time? Why, knowing that an appeal hearing was imminent, not seek to differentiate the efforts being made by Mersey Care and those by ASC, so that it could if necessary deploy in evidence some clear examples of behaviour by the Appellant which showed that patients would still be at risk of harm once Mersey Care pulled out?

96. Instead, the two inspectors studiously ignored senior members of ASC's staff who were present, such as Mr Amuntung and Mr Vali (whose responsibility for the refurbishment being undertaken might be considered relevant) and never sought to include them. The sole exception was Ms Cousins, with whom Ms Haworth did speak. However, although she took three and a half pages of notes of their conversation not one word appeared in her witness statement, she merely stating that she had the opportunity to speak with Ms Cousins. The tribunal prefers Ms Cousin's account of this conversation.

97. Ms Haworth's various explanations as to why she did not seek to engage with ASC staff, or ask them for their account of adverse comments ostensibly made by Mersey Care staff smacked of unfairness; a breach of one of the very basic principles of natural justice : *audi alteram partem*, or "hear the other side." One particular example is the allegation that ASC staff had deliberately attempted to downgrade items ordered to ones of a cheaper specification, which under cross-examination changed to her merely having been told that certain items were being returned as they were unsuitable.

98. Ms Haworth clung to the CQC's standard inspection and reporting procedures, which without modification do not fit a situation where two providers are present on site, one in a supervisory role. In such circumstances, if provider A makes adverse comments about provider B but the draft report is only sent to A for fact checking, then B never has the opportunity to have any input and/or correct

errors or misapprehensions. It was noteworthy that, when asked why input was not sought from ASC, she said "We had already received evidence from ASC at previous inspections." She was not interested in any role its staff – who formed the vast majority on site at any one time – were playing in the undeniable improvements that were taking place at the Centre.

99. The tribunal's role is to decide whether the Respondent has satisfied it that patients (or others) will be at risk of harm if the appeals were to be allowed. It is accepted that they are not currently at any such risk, but the CQC attributes this to the good management that Mersey Care is providing. This, it says, will all fail when Mersey Care pulls out. ASC has not got an established management team in place, with a change to its proposals being made only last week.

100. The tribunal must therefore consider Mr Robinson, Ms Cousins, and ASC's staff. It agrees that neither Mr Robinson nor Ms Cousins have any direct clinical knowledge, and Mr Robinson as a businessman has a lot to learn about the role of nominated individual. However, as chairman of a company that has shown its determination to achieve good results in this very specialist and under-supplied sector, and which has invested heavily in making significant improvements to the environment (as evidenced by Mr Vali) the tribunal believes that he will do all that is necessary to fulfil that role. Past efforts in the early part of this year were insufficient to avoid adverse inspection outcomes, but he will have learnt from that. He stated that he will seek advice from lawyers and consultants in the sector as and when needed, but he needs to acquire his own secure knowledge base. As chairman of the board he will also carry sufficient clout to ensure that any reforms will be implemented. The tribunal agrees that four days per month may suffice for this role in the long run, but the tribunal believes that more time is initially required to ensure a smooth transition of management and continued positive service.

101. Ms Cousins also lacks direct clinical experience, but she has proved acceptable to the CQC as registered manager for a combined total of twenty four years in many previous hospital management roles. Although her efforts as non-executive director to push through improvements also failed to avoid adverse findings made on inspection in June and July of greater importance is her ability to acquire knowledge when needed from the clinicians around her, which she appears to have demonstrated in the past, and to apply tried and tested systems to ensure that a safe and efficient service is being delivered.

102. The tribunal was also impressed by Dr Carew's evidence of the service now being provided, and especially the response by both patients and their families. It was also very impressed by Ayaz Vali's evidence, and has confidence in his ability to continue with the refurbishment and maintenance of the premises.

103. The tribunal takes into account all the evidence before it, including findings made at the inspections in June and July, undoubted improvements made under the supervision of Mersey Care support staff, and the Respondent's willingness even after service of the second notice to permit the Appellant to continue to provide the service illegally, as it was both more difficult and would involve more risk to this particular category of patients to attempt suddenly to

relocate them. Having assessed the above and formed a view of the ability and willingness of Mr Robinson and Ms Cousins to provide leadership in the immediate future it therefore determines that the Respondent regulator has failed to prove that any person will or may be exposed to the risk of harm, the appeals are allowed, and the two notices shall cease to have effect.

Judge Graham Sinclair
Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 10 November 2019

ANNEXE
SCHEDULE OF CONDITIONS ON REGISTRATION IMPOSED BY THE TRIBUNAL

Condition 1
During the six months beginning with the date of this decision the Appellant registered

provider must not admit more than one new patient every three weeks, subject to a maximum number of twelve patients being placed at the Breightmet Centre at any one time.

Condition 2
The registered provider shall, until the CQC considers it no longer necessary, submit a monthly report to the CQC providing details of the risk assessments and care plans for all newly admitted patients.

Condition 3
The registered provider shall, until the CQC considers it no longer necessary, submit a monthly report to the CQC on governance systems and processes that it has put in place, and/or any changes in such systems or processes that it has implemented, to ensure that care and treatment for each patient is safe, effective and responsive to their needs.

Condition 4
Within 3 months of the date of this decision the registered provider shall report to the CQC, using an appropriate quality audit toolkit, on the views of families, staff and other stakeholders on the quality of the service being provided.

NOTE:
The tribunal is confident that the CQC will be anxious to undertake an inspection of the service being provided at the Breightmet Centre within around 3 months of the Appellant resuming responsibility for the registered service. This should be undertaken by a fresh inspection team.