Care Standards

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

Heard on: 22-26 January 2018 at: Blackburn Magistrates Court

[2017] 2964.EA

BETWEEN:

RIAZ DESAI and CAREPATH RECRUITMENT LTD

Appellants

v

CARE QUALITY COMMISSION

Respondent

BEFORE:

Professor M Mildred – Judge
Mrs D Forshaw – Specialist Member
Mr J Churchill – Specialist Member

Background

1. This decision is in respect of two appeals heard together. One concerns a Care Quality Commission ("CQC") decision to cancel the registration of Mr Desai as a Registered Manager. The other is to cancel the registration of Carepath Recruitment Ltd as a Registered Provider of personal care. On 20 November 2015 Mr Riaz Desai was registered with the CQC as Manager in respect of the registration of Carepath Recruitment Ltd ("Carepath") of 27 Church Street, Preston, PR1 3BQ to provide the regulated activity of personal care.

2. The CQC inspected Carepath on notice on 18 August 2016 and found breaches of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 ("the Regulations") as follows: 9 (person-centered care), 10 (dignity and respect), 11 (need for consent), 12 (safe care and treatment), 17 (good governance) and 18 (staffing). After representations by Carepath following a request for assurances under s. 64 of the Health and Social Care Act 2008 ("the Act") a Notice of Proposal (NOP) to cancel Mr Desai's registration was issued in October 2016.

3. After a further inspection in October 2016 a Notice of Decision (NOD) was adopted to cancel Mr Desai's registration. Mr Desai made representations against this in November 2016 but in February 2017, following a review by a CQC senior manager unconnected with this case, the NOD to cancel his registration as a Registered Manager was adopted and confirmed. Mr Desai appealed against that decision on 14 March 2017.

4. On a further inspection in April 2017 the CQC found 15 breaches in total of Regulations 9, 11, 12, 13 (safeguarding), 16 (complaints), 17, 18, 19 (fit and proper person as RM) and 20 (duty of candour). A NOP to cancel Carepath Recruitment Ltd as a Registered Provider of personal care was issued on 5th June 2017.

5. In July 2017 Lancashire County Council cancelled its contract with Carepath with effect from 25 September 2017 but 2 of the adult and 3 of the children service users ("SUs") continued commissioning Carepath under the direct payments system.

6. On 10 July 2017 the CQC, after considering representations from Carepath Ltd, decided to cancel its registration as a registered provider of personal care.

7. In November 2017 there was a further inspection by CQC which found a total of 22 breaches of Regulations 9, 11, 12, 13, 14, 17, 18, 19 and 20. The 10 July 2017 decision was appealed by Carepath Recruitment ltd.

8. Carepath and Mr Desai have appealed against those decisions under Section 32 of the Act. The appeals (which have been heard together) are by way of redetermination.

The hearing

9. The appeal was heard by the Panel at Blackburn Magistrates Court from 22 to 26 January 2018. The Appellant was represented by Mr D Pojur, Counsel, instructed by Stephensons LLP and the Respondent by Ms A Wilkinson, Counsel, instructed by Mills & Reeve LLP.

The issues

10. The parties filed a Scott Schedule shortly before the hearing running to 24 pages. The tenor of the contents was that the Appellants accepted that there had been shortcomings in compliance with the Regulations, but that those had been remedied or were in the course of being remedied by new senior staff employed and revised policies and procedures introduced.

11. In the event the remaining issues are whether the registration of Carepath as a provider should be cancelled and whether Mr Desai is a fit and proper person to remain as RM at Carepath.

The evidence

12. The Panel had a bundle running to over 2,500 pages. Given the position outlined in paragraph 11 above much of this evidence was overtaken by events. We granted a late application by the Appellant's representatives to introduce the witness statement of Helen Fuller, Care Consultant, with 17 exhibits and the Respondent's application to introduce the 5th witness statement of Alison Martin with 11 exhibits including the draft CQC report following the November 2017 inspection.

13. A summary of the relevant evidence of the witnesses follows.

14. Katie Jones is an inspector for adult social care employed by the CQC. She confirmed that Carepath was registered on 17 May 2012 with Mr Desai as the sole director. He became the registered manager from 20 November 2015 in respect of regulated activities (the provision of personal care).

15. She was involved in the inspections of August 2016 and April 2017 after which conditions were imposed. The most important were that the Provider and Manager voluntarily undertook not to accept any new service users (September 2016) (C889) and later (by an urgent notice of a CQC Decision on 26 April 2017) was banned from doing so or from adding any additional hours to existing packages without the prior written permission of the CQC. Furthermore it was then required by CQC that a new care manager qualified at NVQ Level 4 in Adult Health and Social Care be appointed within 14 days; that the skills, training and competencies of Mr Desai be assessed and that a comprehensive set of assessments, audits and staff appraisals be carried out and reported to the CQC.

16. After the failure to comply with these conditions and the due notices the registration of Carepath as a registered provider was cancelled on 10 July 2017.

17. On a further inspection in mid-November 2017 Ms Jones found that a Care

Coordinator and a Compliance Manager had been appointed. In her second witness statement Ms Jones listed 3 examples of good care but 13 instances of poor care found at that inspection. She identified breaches of Regulation 11 in respect of 2 service users, failures effectively to operate the procedures introduced for good governance, lack of clinical oversight, lack of clarity in daily notes, lack of regular checks and reports to the CQC and an increase in the hours of care for SU2.

18. Ms Jones identified failures in respect of staff training records and appraisals, safeguarding training, inadequate specialist training to meet the needs of SU1 and SU8, incomplete or unavailable staff files, no or inappropriate references, two unexplored references saying the staff members were unsuitable for the role by reason of conduct, spoken English and mental health, no interview records and absent DBS certificates. Previous CQC ratings were not displayed on the Carepath premises and inaccurate claims of compliance with all CQC standards had made and, she said, are still to be found on the Carepath website.

19. Staff members 3, 11 and Mr Desai told the CQC that there were only 5 care packages in existence, but this ignored the complex package for SU8 which had been in place since September 2016.

20. In reply to cross-examination Ms Jones acknowledged that the Care Coordinator and a Compliance Manager were in place and that some systems had been changed but did not consider that the service had improved or that there were plans in place to achieve that improvement.

21. She had seen one care plan which had been improved, two sets of daily notes and one risk assessment. She had focused on staffing at the November 2017 inspection.

22. Ms Jones acknowledged that the staff plan and risk assessment documents that were shown to her were appropriately drafted but said that staff files at the time of the inspection were not up to date or not available for inspection. In general the documentation to which she was referred was in appropriate form.

23. Ms Jones said that supervisions were reactive to particular events rather than regular and that risk assessments concentrated on risks to staff rather than written from the service users' perspective. Medication documentation was lacking and should include the dose and time of administration.

24. The training matrix was supplied after the inspection but it contained no evidence that the training had taken place. Not all checks had been completed on staff recruitment including missing DBS certificates,

although the form itself was adequate.

25. Ms Jones described several of the new forms prepared since her inspections (D404, D406 and D260) as appropriate but with limitations, but the staff training report at D275 was inadequate as it did not specify who carried out the training or the mode of delivery and it lacked detail.

26. In re-examination Ms Jones confirmed that SU8 was receiving medication through a PEG tube administered by Carepath staff. The support plan index at D404 was not person-centered or tailored to the individual.

27. Ms Jones saw the same shortcomings, especially in relation to medications, through all 3 inspections. She thought the Registered Manager lacked an understanding of the Regulations, but that the service could improve with a new Manager with understanding of the Regulations and of the needs of service users, provided Mr Desai allowed that manager to run the service.

28. The witness statements of Naison Chaparadza who participated in the first inspection, of Julia Denham who was involved in the Notice of Proposal to cancel Mr Desai's registration and Notice of Decision in February 2017, of Rosalind Sanderson who as Regional Head of Inspection decided to resist these appeals and of Robert Tovey who authorized the issue of the Notice of Proposal were taken as read.

29. David Coop, Inspection Manager for the Central Lancashire Team, gave oral evidence. He described the CQC processes leading to the Notices of Decision.

30. He told us he believed a competent Registered Manager could manage the service and he used to believe that Mr Desai, supported by a competent RM with sufficient autonomy, could retain the registration but he now had concerns about Mr Desai's integrity since he had not declared 2 new SUs and he considered that Mr Desai should lose his registration and that cancellation was a proportionate response under the circumstances.

31. In cross-examination Mr Coop said that SU8 has complex needs and the CQC was not informed about his package for a long time after his care began. Ms Martin had discussed this issue with Mr Desai.

32. The two new senior staff had not made much difference to the standard of the care plans. It should not take long for changes to be bedded into such a small service. Little progress had been made to date and Mr Coop had little confidence that they could change things. The care coordinator began working at Carepath in March 2017 so more improvements should have

been made by now.

33. Mr Desai had only begun his NVQ Level 5 course in August 2017 despite assurances given in October 2015. There had been no improvement in the service's compliance through the course of 3 inspections and only minor improvements with the new staff. If a consultant were to be retained for a year, or even 6 months there might be improvements in compliance but there would still be concerns over Mr Desai's integrity.

34. In re-examination Mr Coop said that Mr Desai was under an obligation to declare to the CQC all service users from whatever funding source and that he was aware of this obligation. He had clearly undertaken not to take on new service users on 14 September 2016 but had breached that agreement on two occasions.

35. Katherine Holt, Contract Manager for Care and Public Health at Lancashire County Council, gave evidence. Notice to terminate the Council's contract with Carepath was given by telephone and email to Mr Desai on 26 June to expire on 25 September 2017. This was as a result of a review of the Council's intelligence concerning safeguarding and information received from the CQC and the Health Service and the Council's contract monitoring.

36. After a compliance visit to the Service on 18 May 2017 a report was completed on 20 June 2017 in which Carepath was scored as failing to achieve an acceptable standard in all 8 fields of assessment. After a 2-day assessment and a review with the Council's Legal Department a decision was taken to terminate the contract and after the service was suspended on 4 May 2017 the service was unable to take on any new care packages through the local authority route.

37. In cross-examination Ms Holt accepted that the CQC's NOP of April 2017 was a factor in the Council's decision, but the Council made the decision through its own procedures. The Council decision had used its own intelligence from service users and their families, the District Nurse service and the NHS as well as the CQC.

38. The number of safeguarding concerns was high for such a small service. The view of the Council's Legal Department was that the contract could have been justifiably terminated without notice due to the nature of the shortcomings found, but it was felt that the Council's social workers were better able to deal with finding suitable new care packages for the SUs over the longer notice period.

39. Two adult SUs decided to commission Carepath under the direct payments system. Ms Holt thought an established relationship between

the carers and the SU was the most likely explanation for this. There are 190 care agencies in Lancashire, mainly concentrated around Preston and there is a wide range of multicultural services available. There is an information sharing system for local authorities in the North West to which the contract termination was added.

40. Ms Holt met Mr Desai with Karen Thompson, the author of the Council report, to discuss the determination of the contract which Mr Desai wanted to challenge. The Council had requested an action plan from him but, although he was full of promises, none was provided.

41. Ms Holt was unable to tell us the exact number of safeguarding concerns but remembered there were 2 significant concerns in December 2016 which, together with later concerns, triggered the May 2017 inspection. Mr Desai seemed to struggle to understand the difference between the CQC Regulations and the contract with Lancashire County Council.

42. Alison Martin, CQC Inspector, was the principal witness for the CQC and had made 5 witness statements. She was not involved in the August 2016 inspection, but was involved in the April and November 2017 inspections as Lead Inspector.

43. A request for information was sent to Mr Desai on 5 September 2016 after identifying breaches of Regulations 12, 17 and 18. The response included an agreement to "take a voluntary restriction on new admissions to the service" (C891) dated 14 September 2016 in the light of which the CQC decided against taking urgent action.

44. SU7 was left alone by his carer at 2300 on 25 November 2016 as she was allergic to cats. The CQC had no prior knowledge of SU7.

45. On 30 November 2016 Mr Desai confirmed that he was providing 2 adult care packages to SU1 and AE. On 12 April 2017 Lancashire County Council confirmed it was funding care for KS (168 hours per week), II (6 hours per week), FP (12 hours per week), SP (24 hours per week) and his wife NP (7 hours per week) from Carepath (C926).

46. In addition the Council was then funding 2 children's care: KP (son of SP and NP) and MP. In addition SU1 was being transferred from a child to an adult care package.

47. SU8 was cared for by Carepath from September 2016 but not declared to CQC at the April 2017 inspection. The Panel was told this service user had come to the attention of the CQC through a whistle-blower.

48. Conditions were imposed by the CQC on Carepath's registration on 28

April 2017, after the second inspection, prohibiting Carepath from accepting any new service users or increases to hours of any existing packages. CQC required this condition because it had found the existing voluntary undertakings agreed by Mr Desai were not being honoured and so were clearly not sufficient.

49. In addition the conditions required the appointment within two weeks of an individual with NVQ Level 4 in Adult Social Care for the better governance and oversight of the service; the need to produce regular quality assurance reports and audits; a review of Mr Desai's competencies and regular appraisals of care staff and Mr Desai.

50. On the second inspection it became clear that no safeguarding alert had been raised after a carer fell asleep and SU3, an elderly SU with diabetes and Alzheimers, had been found in a communal area naked from the waist down. The SU's daughter complained in July 2017 that the same carer had again fallen asleep and left her mother sitting in her own faeces.

51. The incident report was found on the inspection not to have been notified to safeguarding. The Incident report form was dated 15 April 2017 (C115) and signed by the care coordinator although the incident actually took place in February 2017.

52. In addition it was alleged by the manager of the independent living scheme that SU2's carer's girlfriend had signed in during the evening and signed out the next morning. Carepath had suggested the girlfriend had just popped in when dropping the carer off or picking him up and failed to provide a risk assessment when requested. Carepath denied this happened (D12).

53. A further safeguarding episode of a carer borrowing £90 from SU1 who had fluctuating capacity had been properly dealt with by Carepath.

54. Staff member 8 had a caution for possession of cannabis, but was working with SU1 who had a prescription for liquid cannabis but no risk assessment was done. In addition there were concerns about medication recording, the recruitment process and DBS checks.

55. There were grave concerns about the recruitment of the care coordinator who told the CQC she had been in post since March 2017. The only application form on file was dated 7 May 2015 and was for a support worker post. The DBS check and references were received after her start date. One of the references purported to be from a service where the applicant had only worked for one week (and indeed only three shifts), whereas the reference said the period of work was 8 months. The reference purported to be signed by a team leader at an agency where the

applicant had previously worked but was in fact signed by an administrator not authorized to give references. When the telephone number given on the reference was dialed it was answered by Mr Desai as the referee now worked at Carepath.

56. Ms Martin concluded that the reference was fraudulent and that this cast doubt on her competence to fill the care coordinator role.

57. There was also a concern about the recruitment of the compliance manager as the DBS check provided was from an employer not mentioned on his CV. This recruitment had taken 3 months rather than the 2 weeks specified by the CQC. The CV supplied had gaps between 2003 and 2008 and 2012 to 2014 and no criminal history or health declaration. The last recorded salary was £8.39 per hour compared to the £18 to £22 per hour requested at interview.

58. The information on file did not include a second reference or DBS check. A DBS check dated 1 December 2016 was supplied with Preferred Care Solutions shown as the employer, although this company is not included on the CV as an employer. The second signature on the DBS check is Jencare Homes Ltd which used to manage Asmall Hall, which is no longer registered with the CQC and was not named on the CV.

59. The medication risk assessment form for SU1 at C190 refers to a medication container stored in a kitchen cupboard, “monitored by mum”. Ms Martin averred that cannot be correct as the service user lives alone.

60. On 18 August 2017 the Attorney of SU1 complained that the care coordinator had aggressively removed his essential care records including his care plan and blood sugar records from her filing cabinet without notice (C430). She said that no previous appointment had been made with her or other information given about the visit. This action was defended by the Mr Desai and by the care coordinator on the basis that notice had been given.

61. Ms Martin described the new Service User Assessment form introduced in September 2017 as high level and unclear in its purpose. The CQC had requested an audit of risk assessments and care plans and this document did not provide that.

62. On 8 November 2017 a whistle-blower informed the CQC that care was being provided to SU8 and a safeguarding alert was issued. Oldham Council was the commissioner and this package had been in place before the voluntary agreement of 14 September 2016.

63. The package was a nursing package which Carepath was not registered to

provide. Competent staff were TUPE'd from the previous provider but were not replaced with staff similarly trained in PEG feeding or specialist care when they left the job. This package was not referred to in Mr Desai's email of 30 November 2016 or in the compliance officer's email of 26 September 2017.

64. It was put to Ms Martin in cross-examination that the CQC had been informed of the package for SU8 before the November 2017 inspection. She denied that and referred to Ms Jones's note of the discussion on 16 November 2017 when Mr Desai first denied knowing of SU8's existence and then admitted providing care saying he had to run a business and provide for his family (C1109-1110).

65. Mr Desai was using 2 family members as carers for SU8 despite being explicitly told not to by Oldham Council as the Council had informed him of safeguarding issues with unspecified family members and having given his assurance that he would not.

66. Mr Desai also increased the hours of care for SU5 and CH2 (contrary to his assurance to CQC) on the basis that the direct payments available covered more hours of care.

67. At inspections the CQC were told that all staff were new, although some could be seen to have been in place for some time. Ms Martin felt this was to avoid the need to produce updated training records.

68. Ms Martin produced a timeline document to show that ascertained breaches had increased by the November 2017 inspection. An action plan promised at the September 2016 inspection had not been provided and little progress had been made in over a year. Normally special measures for a service were not intended to last more than a year and improvements were expected by CQC in 6 months.

69. Although some attempts at improvement had been made they fell short of the required standard and Ms Martin considered that neither Mr Desai nor the 2 new senior members of staff have the necessary experience or skills.

70. Her view was unaffected by Ms Fuller's report which concentrated on the June 2017 Notice of Proposal rather than the April or November 2017 inspections reports or the breaches of the Regulations.

71. In cross-examination Ms Martin confirmed that 3 adults and 2 children (3 of whom were in one family) continued to receive care from Carepath under the direct payments system after the contract with Lancashire County Council was terminated. This was usually because a positive relationship had developed between carer and client. In the case of this

family the care staff did not provide an adequate service and the mother guided the staff.

72. Since November 2017 the CQC has received an action plan most weeks, as required by CQC, but the content is mostly unhelpful as Ms Martin has told Mr Desai and the care coordinator.

73. Ms Martin was asked to comment on new forms developed since the last inspection. She described an entry in the Accident and Incident Log at D260 and a record of staff supervision at D262 as satisfactory, but inconsistent with other information. It was unclear whether the staff member who had abandoned SU7 mid-shift had been suspended and there was no mention of lessons learnt.

74. Ms Martin did not know whether the compliance officer had left the call logs behind when removing SU1's files.

75. The training matrix had no information regarding safeguarding or learning difficulty interest groups or services.

76. Ms Martin said there had been no ambiguity in her conversation with Mr Desai in April 2017 about not taking new SUs from other local authorities.

77. Ms Martin described the new risk assessment forms as generic and not person-centered but more staff-centered. For example, where a risk of choking had been identified, it was not explained why there was a risk and how to mitigate it.

78. Some of the information was inaccurate. For example the risk assessment for SU1 said no 'financial transactions involved' but this was the person whose money had been "borrowed" by the carer.

79. Ms Martin said that the Initial Assessment form was not a care plan or a risk assessment and was of uncertain value. There were no regular staff assessments, the medication risk information was generic and the support plan index unhelpful.

80. The care plan for SU8, who was non-verbal, was not clear and did not deal adequately with consent or involve the external local authority learning disability resources available.

81. Ms Martin described several forms as an improvement on the old material but insufficiently detailed. The very recent care plan for MP at D493 was appropriate, but the initial section was identically reproduced at D497 for SU8. It was wholly inappropriate to say that SU8 (who is 42) is "slower in development goals such as crawling, walking and talking".

82. The risk assessment for KP was an improvement but still jumbled, for example listing household products, rather than personal hygiene as a major risk.

83. In MP's risk assessment there were references to food being pureed or mashed: these are very different processes and the documents should be specific.

84. In summary, Ms Martin's view was that there had been attempts to improve the documentation where shortcomings had been pointed out, but the recruitment of new senior staff in March and July 2017 had not resulted in major improvements as they lacked the necessary skills. A consultant such as Ms Fuller could make permanent improvements, if she worked full-time for 6 months and was given complete autonomy. The existing senior staff did not have the skills to turn the service round. Although some process improvements had been made there were still shortcomings and inconsistencies.

85. In re-examination Ms Martin confirmed that an offer of input from the Oldham Adult Learning Disability Team of specialist support for SU8 had been ignored in early 2017.

86. In the Medication Risk Assessment Form for SU8 (D519) there is no early mention of PEG feeding although this was the most serious risk and one with which the Carepath staff were unqualified to deal.

87. On Wednesday 24 January 2018 we began to hear the Appellants' witnesses.

88. Mrs Helen Fuller, an experienced independent care consultant, was asked by Mr Desai to carry out an independent audit of Carepath on 8 November 2017. Her colleague Dave O'Connor visited Carepath on 14 November 2017 and produced an action plan addressing the issues raised by the contents of the NOP dated 5 June 2017.

89. Mr O'Connor's report found Carepath to be inadequate on the safe, effective and well-led standards and requiring improvement on the caring and responsive standards. The report concluded with 26 items where action was required in the light of his findings.

90. Mrs Fuller made a full-day visit to Carepath on 10 January 2018. On the basis of her findings she rated the service as requiring improvement on all 5 standards.

91. Mrs Fuller found that improvements had been made since the June 2017

NOP in relation to assessing and reducing risks and adapting care plans to identified risks as well as supervisions, staff spot checks, service user reviews, complaints, medication procedures and staff training. Her view was that these changes were sustainable as Mr Desai was committed to the service users and was prepared to invest in input from a consultancy.

92. In her oral evidence Mrs Fuller felt that support from a consultant for 1 day per week for 3 months then 1 day per fortnight for another 3 months would allow the agency to make significant progress in 3 to 6 months provided competent staff were employed.

93. Mr Desai would become more effective through his NVQ course and the care coordinator was person-centered, passionate, dedicated and knew the service users well and was well supported by the compliance manager. She believed the care coordinator had the authority to make changes.

94. She found the files were still confusing, but the training spreadsheet she had suggested had been adopted immediately and other reorganisations made following her advice. The addition of layers of new forms had resulted in more confusion for staff and a completely new and logical approach would have been more helpful. She said that all the necessary information was there, but it was difficult to find.

95. In cross-examination Mrs Fuller accepted she had not undertaken a mock inspection and that her report was limited to consideration of the June 2017 NOP.

96. Mr O'Connor was told there were 5 service users on direct payments and had not been told about SU8. Mrs Fuller was told there were 6 service users on direct payments and had been told about SU8. She felt the CQC should have been told about all the service users. She thought Mr Desai had been firefighting for months and the fact that Carepath had been in special measures for 15 months might indicate that he may not be a competent RM.

97. Although Mrs Fuller acknowledged progress in several areas her view was that these were still mostly work in progress needing more detail, fewer inconsistencies and a more person-centered approach.

98. Mr Desai gave oral evidence. He had experience in health and social care recruitment since 2002 and had run Carepath as a successful recruitment business since 2009 or 2010 and had a large number of registered workers whom Carepath had trained and then placed in residential jobs. He had then begun domiciliary care work to diversify the business.

99. Lisa Carmichael and then Mark Gahagan were Registered Managers of Carepath's domiciliary care business once Carepath was registered with CQC until Mr Desai became RM in November 2015. He considered the service had been running effectively until the CQC inspection in August 2016 when it was rated as Inadequate after the nature and intensity of the inspections changed.

100. He acknowledged the CQC's concerns and had enrolled on and was halfway through his NVQ Level 5 course, which was a big commitment but he was on track and the supervisor had visited the service. In addition Mr Desai had completed E-learning courses and practical training courses.

101. Mr Desai considered after the April 2017 inspection that non-compliance was largely caused by the lack of a suitable management structure. He had recruited a care coordinator in March 2017 and went on to recruit a compliance manager in July 2017 and a recruitment consultant in September 2017. The last 2 were recruited after the NOP to cancel the registration in June 2017.

102. In general Mr Desai acknowledged that there were shortcomings in the care provided and the documentation used by Carepath at the time of the April 2017 inspection, but maintained that these were substantially remedied by improved procedures and the appointment of these senior staff. He was confident that they, and in particular the care coordinator, were competent to turn the service round with the additional help of input from independent consultants.

103. He considered he was very 'hands-on" and highly involved in the service, engaging with service users and their families, being in the office and running the out of hours service.

104. Mr Desai did not accept the criticism of the removal of documents from SU1's premises when he changed his care provider. He said that it was Carepath's property that was collected and adequate information was left for the new provider.

105. In relation to SU8 Mr Desai told us that he thought his agreement in September 2016 not to take on any new service users only applied to contracts with Lancashire County Council. He initially explained his assertion in his first witness statement dated 13 October 2017 that Carepath had five service users as 'an oversight'. He then said it was not an oversight, but that he was only referring to service users under contracts with Lancashire County Council.

106. When asked about the notes of the November 2017 inspection (C1109) Mr Desai said he was asked whether he knew SU8 (identified by his real

name) and said he did not know who he was asked about, thinking it might be a staff member. When asked again "Are you sure?" he then explained that he was in receipt of a care package. According to Ms Jones's note of the meeting (C1110) Mr Desai than said that he needs to run his business and provide for his family.

107. The care staff TUPE'd over to look after SU8 in September 2016 were not nurses but care staff with training and as they left Carepath's own staff were trained up to meet his care needs. When asked about Oldham Council's instruction to him not to use family members because of safeguarding concerns, Mr Desai said there was no clear Oldham Council policy, that SU8's mother was his Attorney or Deputy and she had asked for family members to be used as care staff and that family members were only used in emergencies.

108. SU8's brother was trained in caring for him and was only used for a few nights in total. It was a very difficult situation because of the mother's demands that SU8's brother be used as a carer. The social worker who said that family members should not be used left shortly after making the request at the end of August 2016 and her replacement never mentioned the point again.

109. Mr Desai had not yet responded to the draft January 2018 CQC report sent after the November 2017 inspection) but considered that Mrs Fuller's report was a more accurate picture of the service currently. He considered that with input from a consultant the service could be turned round in 3 to 6 months.

110. In cross-examination Mr Desai said the he considered he was running Carepath competently in August 2016 and the service users were happy with it.

111. Although he undertook to the CQC to enroll on a NVQ Level 5 course in October 2015 he was let down by a course provider. He agreed he had only undertaken some Mental Capacity Act training in July or August 2017 despite a similar earlier undertaking. Mark Gahagan helped him in the office until December 2016 as his nominated person.

112. Mr Desai denied lying by omitting SU8 from his first witness statement. All documents relating to SU8 were in the file in the drawer and CQC could easily have found them. In retrospect he agreed he should have told CQC he had a case from Oldham.

113. When he agreed not to take on new clients he thought it was just a temporary thing for a few weeks.

114. SU7 was not a declared client and Carepath only provided a carer for one night shift as an emergency in an attempt to be helpful. The carer was unaware SU7 had cats and dogs and was allergic to them. After trying but failing to contact Mr Desai, the carer left the house at 23:00 and SU7 called later paramedics as he was cold and wet and on the floor. According to the safeguarding report Mr Desai considered the carer had handled the situation quite well and could not have done anything differently given the development of the rash.

115. When he told CQC on 30 November 2016 that there were only 2 adult packages Mr Desai thought he was only being asked about Lancashire cases.

116. The care coordinator and compliance manager were aware of SU8. They asked him whether they should mention him at the November 2017 inspection and Mr Desai said they probably did not have to.

117. The direct payments budget allowed extra hours of care to be provided to SU5 and CH2. This made it easier for the families and meant that Carepath did not just keep the money for no extra work.

118. Mr Desai accepted that SU3's carer falling asleep was not raised as a safeguarding issue, but said that it would now be after he attended a safeguarding course in August 2017. It was reported to the local authority but not to the CQC.

119. In relation to SU1 Mr Desai said that he accepted that the care plan and other documentation was removed from the client's premises on his instructions, but he thought the new provider had taken a copy and was unaware that they had not until he saw the complaint from the Attorney C432 for the first time at the November 2017 inspection.

120. Mr Desai discussed the matter with the care coordinator who said that the new carers were aggressive and swearing at her so that she had to leave the premises in a hurry as the situation was volatile.

121. Mr Desai said that the care coordinator was prompted to give the names of 6 service users at the April 2017 inspection rather than asked whom the service was supporting. He was unaware whether she knew they could not take on any new cases.

122. Mr Desai described the recruitment process to appoint the care coordinator as rigorous. Zoya had 2 interviews and brought a presentation to the second. She was appointed in competition with 4 others because of her passion and potential. She was working for Carepath as a carer and had received very good feedback.

123. Mr Desai accepted that the referee should not have signed the reference and that he did not check it. The referee worked for Carepath at the time and was subsequently dismissed for this and for other reasons unconnected with the reference. She had previously worked for the same agency as Zoya. He had only found out about the reference at the November 2017 inspection and did not know whether Zoya saw the reference.

124. Mr Desai accepted that he had not noted the reason given by the compliance manager for the gaps in his CV as he should have done and that he should have obtained a second reference. The manager is a qualified social worker registered with the HCPC who works 20 hours per week for Carepath. Mr Desai told the Attorney of SU1 that the carer had a caution for possession of cannabis and she had no concerns about this. SU1 had a supply of liquid cannabis on prescription on the premises for his own. He accepted that this had not been documented. The same individual carer is still working with SU1 through his new care agency.

125. Domiciliary staff often do residential work to supplement their income. Mr Desai sometimes uses residential care staff for domiciliary care in emergencies. Registration of these 2 groups is very similar but domiciliary workers' training has to be fitted to the client's needs.

126. Mr Desai was approached about taking over SU8's care by a social worker he had known for over 10 years and met SU8's family in about June 2015 before beginning to provide his care in September 2016.

127. The only relative of SU8 whom Mr Desai employed was RR, a brother, whom he only employed in emergencies. This carried on until after the November 2017 inspection when Oldham Council told him to stop.

128. Mr Desai was shown the rota for the week beginning 25 September 2017 during which RR was employed for the night shift 4 times. Mr Desai said these were 4 emergencies which had arisen suddenly and each day when there were no other suitable carers available. The rota was updated after each day to reflect which carers had actually been working with which service user.

129. Mr Desai denied all knowledge of SU8's sister-in-law and denied that the LB mentioned in the training records at C634 was her. He did the payroll for Carepath and was certain no other relatives of SU8 had been employed. There is one payroll which covers both residential and domiciliary services. The residential and domiciliary services each have their own rotas.

130. RR was trained by Carepath. Mr Desai was in a very difficult position because SU8's mother, who was his Deputy or Attorney, was insistent on family members being employed. Oldham Council had not specified about which family members there were safeguarding concerns. Rezaur only worked with SU8 (not on the residential side of the business) and only in emergencies.

131. Mr Desai denied all the allegations of 2 whistle-blower communications at C645 and C499 that he had employed 4 members of SU8's family as carers, tax was being avoided and poor care provided except insofar as he had employed RR. He said the letters were vindictive and contained lies. He had no knowledge of Habib R.

132. Mr Desai insisted that a reply had been sent to the LD team at Oldham Council in response to their offer of specialist communication support to SU8 but the letter had gone astray. This was confirmed by the Council (C1371) but the subsequent offer of support contained in that letter was never received by Carepath. Mr Desai said he saw it for the first time in the hearing bundle.

133. SU8's funding is from Oldham Council via the Court of Protection with no continuing care funding from the NHS. He goes swimming every Thursday, to the cinema weekly, goes on walks and has a sensory area at home. There has never been nursing care funding and no extra funding.

134. SU8 had a capacity assessment by his GP who had found that he had no capacity so that Mr Desai felt that there was no point in doing another one, although Carepath now has someone in place to do an assessment. The GP's assessment is not on the file in the Carepath office.

135. Mr Desai thought Mr O'Connor was doing an inspection of the service as well as a review of the NOP. He had had no consultant help before November 2017. It had been a very difficult time owing to the illness and subsequent death of his father.

136. Since the November 2017 inspection many changes had been implemented and senior staff recruited and training undertaken. Mr Desai took responsibility for the shortcomings in the service but was now aware of what needs to be done and has actions in place to achieve it.

137. On reflection Mr Desai agreed he should have checked the references for senior staff and would in future. What the care coordinator's referee had done was unacceptable.

138. The whistle-blower allegation that false names were entered in the payroll to disguise payments to family members of SU8 were untrue.

139. Mr Desai accepted that the Carepath website still said that Carepath complied with all CQC standards and that he had not got round to asking his IT consultant to change that. He thought it unimportant because everybody would check on the CQC website to which there was a link so that nobody would be misled.

140. On 25 January 2017 Omonzoya Iyobhebhe ("Zoya") gave oral evidence in support of her witness statement dated 13 October 2017. She has an MSc in Industrial Pharmacy and has completed a Management and Leadership course at the Open University. She is due to finish her NVQ Level 5 in Health and Social Care in July 2018.

141. Zoya aspires to be a Registered Manager after completing her NVQ Level 5. She has undertaken 2 Training the Trainers courses and 28 E-learning modules in topics relevant to her position at Carepath. She has studied and is proficient in writing risk assessments and undertaking audits.

142. Zoya has discussed with Mr O'Connor and Mrs Fuller their reports on Carepath and has understood from them areas for improvement and how to go about it, putting suggestions into immediate effect. She knows the Carepath service very well.

143. In cross-examination Zoya told us that she worked as a carer at Preferred Care Solutions for a short while, undertaking only 3 shifts, although she was registered for work with Preferred Care Solutions for some months. She left because she did not like the service and joined Carepath as a care assistant in May 2016. She was also registered at Serco Care Services and Interserve Healthcare but never worked for them. She became care coordinator for Carepath in March 2017 after 10 months as a carer. She had 2 interviews in the process of appointment, but there was no application form for the post of care coordinator.

144. Zoya's referee in her May 2016 application to be a care assistant was Fatima Vali, her line manager at Preferred Care Solutions. Zoya now accepted that Fatima was not in a position to give that reference, but she had not seen it at the time. No further references were required in March 2017 for the care coordinator post as she was known to and working at Carepath full-time. She has a contract in writing for the care coordinator post, but was not asked to produce it for this appeal.

145. She said Carepath now has 18 staff and the number quoted in her witness statement of 6 staff was wrong. Additionally, those twelve staff who work with SU8 were not mentioned in her statement (which says Carepath provides 5 domiciliary care packages). If she had included the

12 staff working with SU8, there would be 30 staff.

146. The rota for domiciliary staff used to be kept on Excel but a new system has been installed in the last 3 months. Zoya keeps the rota. Changes are made to it retrospectively to ensure it reflects accurately what actually happened. It is not often that changes are made to the rota.

147. The reason Zoya told CQC at interview on 20 April 2017 that Carepath was supporting 6, (later corrected on enquiry by Ms Martin by Zoya to 9) clients was that she thought CQC was focusing on clients funded by Lancashire County Council as she had been advised by Mr Desai. She did not mention SU8 because he was not funded by Lancashire County Council. She did not in April have access to his file and was still in her probationary period.

148. Zoya also said that she had been told by Mr Desai not to mention SU8, that she did know how SU8 was funded, that she was not sure whether she had to mention SU8, that she thought she only had to mention clients funded by Lancashire County Council and that she did not remember the actual question asked by Ms Martin.

149. When asked why she had not mentioned SU8 in April after Ms Martin advised that all packages had to be disclosed to the CQC and the notes of the meeting recorded that she (Zoya) had said she would provide a list of all packages provided by Carepath (C930), Zoya said that she understood that the CQC only wanted to look at packages funded by Lancashire County Council. It was her first CQC inspection and she was unsure what had to be declared.

150. Zoya also said that she only knew about SU8 after she finished her 3-months probation in June 2017 but did not work with him before then. After her probationary period she then had to do care plans for all people supported. She thought that the CQC did not regulate privately funded clients and Mr Desai had told her that the CQC was interested in the 9 packages that had been identified in the August 2016 audit.

151. Zoya said that Habib R who is SU8's brother comes to review meetings but does not work with him and the same was the case for Layla B, RR's wife.

152. RR only works with SU8 in emergencies or when the normal carers are unavailable. Zoya was at first unable to explain why her rotas showed RR as working on the nights of 26, 27 and 30 September 2017, 1 October 2017, 23, and 25 October 2017, 9,10 and 11 November 2017 and 13, 14 and 15 November 2017. She then said it was because the regular carer was away on a long holiday but was unable to recall that carer's name,

although the period ended only 2 months ago.

153. Zoya said that as far as she knew those were the only days Rezaur had worked with SU8. She was unaware that Oldham Council had directed that no family members should work with SU8. Zoya knew SU8 was funded by Oldham but was not aware that the previous agency had supplied nursing care. She was aware that SU8 used a PEG.

154. Zoya knew that the Communication Therapy Team (part of Oldham's Adult Learning Disability Team) had offered assistance with SU8's communication. She received the letter dated 24 March 2017 offering to reopen SU8's file, if his care staff identified communication needs. She could not remember whether she had responded to that but confirmed that SU8 had not been referred back to the Team.

155. When SU7 was left by his carer at Carepath's office, Zoya rang Riaz and SU7 was taken home.

156. Zoya disputed the account given by SU1's Attorney when the care package was transferred to new advisers. She agreed that she had removed all Carepath's property from SU1's premises. She took the diabetes and ketone monitoring records to do the end of package audit. She did not remove the current week's records. She did not have time to ask whether a copy of the care plan had been taken because she was treated aggressively and sworn at and left promptly.

157. Zoya said that she had given a week's notice of her visit to the Attorney. She had thought the Attorney would have taken a copy of the care plan because she was very "hands-on". In retrospect Zoya accepted the care plan should not have been removed. Zoya denied she had behaved aggressively in the way described by the Attorney in her complaint to CQC at C430-C433.

158. Zoya accepted that Carepath was administering medication to SU8 when she said in her statement (dated 13 October 2017, para 23) that no medication was being administered. The reason that her statement said this was because she was unaware that Carepath was caring for SU8 and so did not know medication was being provided.

159. Zoya's view is that significant improvements had been made in Carepath's practice by the date of her statement as care plans and risk assessments had been introduced and improved. In her opinion Carepath should be rated as Requiring Improvement rather than Inadequate.

160. Zoya described the manual handling assessment form at D463 as appropriate for the time, but said that the form was now improved. She

considered that it focused adequately on the service user.

161. Zoya defended the 14 page long Medication Risk Assessment Form she had created for SU8 (at D519-D533) by saying that it was most important to place reference to the medication he was administered first and that it was appropriate not to mention the fact that the medications were administered by PEG until the 9th page.

162. Zoya defended the Care Audit and Action Plan for SU8 (C761-C763) where everything was scored 5 out of 5 on the basis that items which appeared to be missing were to be found in other documents. She accepted that there had been no capacity assessment and said that she was preparing to commission one.

163. In Zoya's view Mr Desai is a very dedicated and user-focused RM who is determined to provide the correct care staff for the users and to ensure a good service is provided on a teamwork basis. She is allowed by Mr Desai to make independent decisions and to have input at regular team meetings.

164. The hearing bundle contained 2 further statements from witnesses on behalf of the Appellant who were not called to give oral evidence and whose statements were not agreed by the CQC.

165. Oye Oshoremor has been employed by Carepath since April 2017, first as a part-time carer and then from July 2017 as a compliance and assessment officer, 10 hours per week.

166. He audits care plans, highlighting changes needed using an audit tool of his own design. As a result significant changes have been made to support plans, accident and incident reports, medication administration documentation, training schedules, consent forms and recruitment files. The statement is also dated 13 October 2017 and contains the assertion that Carepath is "not currently administering medication to any service users and is limited to checking that medication has been administered correctly in its current packages".

167. Riaz Hasmi worked as a health recruitment consultant at a care agency from September 2016 and joined Carepath as a compliance and assessment officer in September 2017. His statement outlines the recruitment procedures now in force at Carepath including reviewing applications, interviews, DBS checks, references and suitability assessment. He considers Mr Desai and Zoya to be suitable in their positions

Findings of fact

168. In the light of the evidence contained in the hearing bundle and the oral evidence given by the witnesses we make the following findings of fact.

169. Mr Desai has worked in health and social care recruitment since 2002.

170. From 2009 or 2010 he has been the owner and sole director of Carepath.

171. Carepath is a recruitment business that has trained and placed a large number of care workers mostly in residential jobs.

172. In about 2012 Mr Desai decided to diversify the business by providing domiciliary care employing workers on zero hours contracts.

173. Carepath was registered with the CQC on 17 May 2012.

174. The CQC inspections in November 2012 and January 2014 found the service to be compliant.

175. The first RMs were Lisa Carmichael, then Mark Gahalan, with Mr Desai then as the registered provider.

176. Mr Desai passed his 'fit and proper person' interview and became RM in November 2015 after he had he given 3 assurances to CQC in October 2015. These were that he would attend a L5 Manager qualification, would attend advanced Mental Capacity Act training (and implement it) and he would have suitable oversight from another person or body with appropriate knowledge and skills.

177. Despite undertaking to enroll on a NVQ Level 5 course in October 2015 Mr Desai in fact enrolled on 31 July 2017.

178. No evidence was provided to the tribunal of Mr Desai ever having attended advanced MCA training. On the matter of implementation of such training - in his statement on 24 November 2017 Mr Desai said "We have identified a need to improve training and understanding in relation to the Mental Capacity Act and intend to facilitate specific training in this respect moving forward."

179. After a CQC inspection in August 2016 breaches were identified of Regulations 9, 10, 11, 12, 17 and 18 and the service was rated as Inadequate and placed into special measures. It has remained in special measures ever since.

180. We are uncertain of exactly when Mr Desai took on the care of SU8 in September 2016. This was a large package (366 hours weekly, dwarfing all other care packages provided) of complex care (PEG feeding, advanced communication skills needed) to a severely disabled person. By accepting this package for SU8 Mr Desai was certainly ignoring the Section 64 letter sent to him by CQC dated 5 September 2016 requesting an "immediate voluntary restriction on new admissions" (C882).

181. On the last possible day to respond to the Section 64 letter, 14 September 2016, Mr Desai undertook (C891) to the CQC not to take on any new admissions to the service. We reject his suggestion that this undertaking was to last only a couple of weeks.

182. In breach of the undertaking II, FP and SP were taken on as new service users.

183. Mr Desai also breached his undertaking not to increase the hours of existing care packages by adding to the hours of the packages supplied to CH2 and SU5.

184. We do find that Mr Desai must have accepted the demanding package of care for SU8 in full knowledge of CQC's concerns about Carepath's ability to 'provide safe care for all service users' and their request for such a voluntary undertaking.

185. On 27 October 2016 a NOP to cancel Mr Desai as RM was sent out.

186. A NOD to cancel Mr Desai as RM was sent out on 15 February 2017.

187. Mr Desai did not inform the CQC of 2 substantiated safeguarding incidents in November 2016.

188. One of the substantiated safeguarding incidents was in respect of a new client.

189. On 30 November 2016 Mr Desai falsely told the CQC that Carepath had 2 adult care packages.

190. On 12 April 2017 Lancashire County Council informed the CQC that they had commissioned 4 adult and 2 children's care packages with Carepath.

191. On 20/21 April 2017 the CQC inspected Carepath under its new inspection methodology and found breaches of Regulations 11, 12, 17 and 19.

192. A NOD was served on 26 April 2017 restricting new additions to Carepath, prohibiting additions to hours of existing packages and requiring recruitment of a person qualified to NVQ Level 4 standard to carry out proper governance and oversight of the business and secure compliance and to provide reports and audits to the CQC.

193. A NOP to cancel Carepath's registration was issued on 5 June 2017 and a NOD was sent, in the absence of representations, on 10 July 2017.

194. On 20 April 2017 Zoya told the CQC Carepath had 6 service users which she then conceded should be 9 service users.

195. We find that her expressed reason not to disclose the care package of SU8 (who we find had been cared for by Carepath since September 2016) was that she thought she only had to disclose clients funded by Lancashire County Council was disingenuous and the real reason was that she had been told by Mr Desai not to reveal SU8's existence.

196. Zoya was told in unambiguous terms by Ms Martin in April 2017 that all service users should be disclosed to CQC and she had undertaken to provide a complete list but failed so to do.

197. Mr Desai was instructed by Oldham Council not to permit any of SU8's family to provide care for him.

198. Mr Desai asked for a reason to be provided in writing "just in case any family members come back to us and so we have something to go back with" (C1362) and received an email on 31 August 2017 informing him it was for safeguarding reasons owing to the possibility of the abuse of SU8 and referring to a conversation 3 months earlier in which Mr Desai had assured the Oldham social worker that "no family members have worked with SU8".

199. Notwithstanding this we find that SU8's brother RR was regularly employed to look after SU8 on night shifts. This was not an emergency arrangement and not a substitution at the last minute for a staff member who cancelled his or her shift: it was organized in advance.

200. Of the many weekly shift records in the hearing bundle only 5 weeks are relevant to this service user's care (C622, C1196, 1198, 1200, 1202) and they each show that RR worked with SU8 between 2 and 4 nights per week for those 5 weeks during September and November 2017. The remaining shift records for this period were not supplied.

201. We reject Zoya's evidence that this was the result of a long holiday by a member of the non-family care staff whose name she could not remember as untruthful.

202. Due to the lack of evidence to support the suspicion raised by 2 reports from whistle-blowers we are unable make any finding on the question whether or not any other members of SU8's family were employed by Carepath to look after him.

203. Although there is no evidence that SU8 required or was entitled to nursing care we find that the care provided by Carepath was not of the standard appropriate to a service user with SU8's level of disability.

204. The failure of Zoya to follow up the offer of communication specialist input from the Learning Disabilities was reprehensible and not justified by the fact that some Carepath staff may have had communications training.

205. Carepath failed to have regard to the requirements of the Mental Capacity Act 2005 in its dealings with SU8.

206. Zoya's actions in removing care documentation relating to SU1 without ensuring that adequate copies were left behind for the subsequent care organisation displayed an unprofessional approach to the provision of care and fell far short of what would be expected.

207. Zoya was not prevented from finding out whether SU1's Attorney had taken a copy of the care plan she removed by the behavior of the Attorney or the carer Alison. It was open to her to ascertain this information prior to or subsequently by a phone call or by other means and she should have done so.

208. When Mr Desai and Zoya made their witness statements on 13 October 2017 they were unaware that the CQC had been informed that Carepath was providing a package for SU8.

209. They each stated that Carepath had 5 service users knowing that to be false.

210. On 16 November 2017 Mr Desai denied to Ms Martin of the CQC that he knew who AR (SU8) was and then, on further questioning by CQC, admitted that Carepath was providing SU8 with care.

211. There is a discrepancy between Mr Desai's witness statement that Mr Oshoremor worked 20 hours per week and Mr Oshoremor's statement that he worked 10 hours per week.

212. Zoya signed a witness statement saying that Carepath had a staff of 6 which she said in oral evidence was wrong.

213. The draft CQC report sent to Mr Desai for comment on 18 January 2018 rated Carepath's performance as Inadequate in the safe, effective, responsive and well-led domains and Requiring Improvement in the caring domain.

214. Mr Desai engaged consultants after the November 2017 inspection.

215. Mr O'Connor rated Carepath's performance as Inadequate in the safe, effective and well-led domains and Requiring Improvement in the caring and responsive domains.

216. Mrs Fuller rated Carepath's performance as Requiring Improvement in all domains.

217. Mr Desai intends to engage an independent consultant to provide leadership for Carepath on a part-time, limited duration basis yet to be determined.

218. Some improvements have been made to Carepath's systems since the August 2016 CQC inspection.

219. The recruitment processes for Zoya and Oye Oshoremor were lacking in rigor, especially given Mr Desai's experience in recruitment.

220. In Zoya's case a false reference on her application to be a care assistant was accepted without checking and no references or other enquiries were sought or made on her promotion to care coordinator.

221. The appointment of these persons and Mr Hashmi is an inadequate response to the gravity of the shortcomings in Carepath's service.

222. On Carepath's website it is said that "We are registered as a domiciliary care provider with the Care Quality Commission's (CQC), the regulatory body for the sector, and are fully compliant with all standards'. This has been untrue since at least August 2016.

Discussion

223. Although the evidence bundle and oral evidence was concerned with 2 appeals we must examine and decide each appeal separately. We consider first Mr Desai's appeal against cancellation of his registration as RM.

224. We find it beyond belief that a person with 20 years experience in the social care business would not understand that the CQC is a national regulator with national jurisdiction, a body with a different function and geographical remit from a local authority commissioner of care. At all relevant stages Mr Desai and his staff were asked for details of all their care packages. This was not limited by area and there was no coherent basis for anyone to believe it was.

225. We do not accept Mr Desai's evidence. The fact that files relating to SU8 were stored on the premises is no valid reason for failing to report the existence of his care package to the inspectors. Mr Desai's pretended ignorance of SU8 at the November 2017 inspection is in our view further evidence of his bad faith.

226. In our judgement Mr Desai also instructed Zoya to hide the existence of SU8's package from the inspectors: it could not have been made clearer by the inspectors that all packages should have been disclosed.

227. We also deplore Mr Desai's action in permitting RR to provide night care to SU8 contrary to the instructions of Oldham Council. He took the trouble to obtain an explanation in writing from the Council why relatives should not be employed in providing SU8's care and then flouted its instructions. The reason for the prohibition given by Oldham was an important safeguarding reason: in our judgement that makes the failure worse as a vulnerable SU was knowingly placed at risk for well over a year.

228. Mr Desai was at liberty to disclose all the rotas for SU8's care. Only 5 weeks data were supplied and in each of those weeks from 25 September to 15 November 2017 RR provided care on 2, 3 or 4 nights. Mr Desai's own evidence that emergency cover after a cancellation was a rare necessity. His case on this matter is entirely without logic or merit.

229. Our clear conclusion was that RR cared for SU8 as a matter of course and on a regular basis despite the pressing reason why he should have been disqualified from so doing. A RM who allows a Deputy's wish, perhaps spurred on by a financial incentive, to prevail over a reasoned objection is failing in his professional duty.

230. Mr Desai obtained his registration as a RM only after giving the CQC three clear separate undertakings but showed no compunction in breaking his undertaking to enroll promptly on a NVQ Level 5 course. This was a solemn undertaking and not a matter of enrolling on a course only at his convenience. He did not promptly complete advanced MCA training, did not implement it in his business, and did not obtain suitable oversight of how Carepath operated until very late in the day.

231. On 14 September 2016 Mr Desai gave an undertaking to the CQC not to take any more clients and this was later made a formal condition. He had no compunction in breaking this condition when it suited him and when it was open to him to disclose any request to take on a new client to and seek permission from the CQC.

232. Mr Desai's disregard for the need for compliance with the regulator and his lack of integrity are further demonstrated by him allowing a claim on his website that Carepath was fully compliant with all CQC standards are being met to be left in place. Mr Desai admitted that he had not changed the text even though CQC had told him to.

233. Mr Desai saw Carepath's performance decline under his management. After 2 successful CQC inspections performance declined so drastically that within 9 months of his registration as RM Carepath was in special measures. Two inspections and the (albeit interim) report of the third suggest that by some measures performance over time has declined rather than improved.

234. This cannot be explained by the change of inspection regime: if it could, one would expect the change adversely to affect the ratings of all providers which has manifestly not been the case.

235. Nor was the CQC the only body to rate the service so badly. Lancashire County Council scored the service so low in June 2017 that its Legal Department advised that immediate termination of the contract was an option. Mr O'Connor rated 3 out of 5 domains as inadequate at the end of 2017 and even Mrs Fuller on 10 January 2018 could only rate it as requiring improvement.

236. When Mr Desai bowed to the need to recruit senior staff in 2017 the procedures put in place were strikingly informal and sparse for an expert in recruitment.

237. Many criticisms were made in evidence of the standard of care and office procedures. We accept that these have improved to some extent from a very low base. In relation to the first appeal we are content to leave this area of criticism on the basis that Mr Desai realizes that further improvements and consultant inputs are necessary, however late in the day that realization has come to him.

238. In the light of all these considerations and in particular because of his lack of integrity we refuse Mr Desai's appeal against the cancellation of his registration as the RM of Carepath Recruitment Limited.

239. Although the second appeal is different, it is inevitable that our findings of fact and conclusions set out above will influence our approach to the second appeal.

240. Mr Desai is the sole director and (we imagine – as we were not told different at the hearing) the sole shareholder in Carepath. He is in sole ownership and control of the company.

241. When action to strengthen the procedures by taking on supervisory staff was forced upon him he showed a cavalier approach to putting them in place in a manner remarkable for an experienced and apparently successful recruitment professional.

242. The staff he has recruited have neither the experience nor the authority to turn the company around. We have found that he was able to direct Zoya to mislead the CQC about SU8 and she was unable or unwilling to refuse him.

243. It has always been open to Mr Desai to engage independent consultants. It was 14 months and 3 inspections before he took this step. Even then he did not inform the first consultant about SU8's package, which effectively devalued the accuracy of the first report as the consultant was unaware of a package which constituted 80% of all the care the company then provided, leaving the report to be based on the 20% of activity disclosed to him. He could have come to the hearing with a concrete plan in place for external professional expertise to achieve a turnaround but he did not.

244. Mr Desai's evidence was that he wished to continue as RM and was capable of fulfilling the role successfully: appointing an outsider to the role would be a last resort. This appears to us a true reflection of his attitude to the company.

245. It is clearly Mr Desai's right as owner of the company to deal with it as he thinks fit. His best offer appeared to be putting in place a consultant one day per week for 3 months and then one day per fortnight for another 3 months. We regard it as improbable that such a process would displace the approach Mr Desai has to running the company or achieve compliance with the CQC standards.

246. The domiciliary care activities are only part of Carepath's business. In our view the long lasting and deep-rooted failures in the conduct of this section of the business are irremediable while Mr Desai is in sole charge of it. Put simply, he "is" the company and has brought before us no plans to change that.

247. Integrity is an essential characteristic in the owner of a care business and, for the reasons set out above, our view is that Mr Desai lacks it.

248. For all these reasons the appeal against the cancellation of the registration of Carepath Recruitment limited is refused.

Mark Mildred
First Tier Tribunal Judge
First-tier Tribunal (Health Education and Social Care)
Date: 05 February 2018