

The Nottingham Inquiry

First Witness Statement of Chris Dzikiti

I, Chris Dzikiti, will say as follows: -

Introduction

1. I am employed by the Care Quality Commission (CQC) as Interim Chief Inspector of Mental Health and Executive Director for Operations, a post I started in November 2025. Prior to this I was CQC's Director of Mental Health, joining CQC in October 2022, before becoming Interim Chief Inspector of Healthcare in May 2024 and then the Interim Executive Director for Operations and Executive Lead for Mental Health in March 2025.
2. I have a background in healthcare, having qualified as a registered mental health nurse in 2002. Between 2002 and 2013 I managed mental health services in London followed by working for a commissioning team at NHS England. In 2017 I joined an Integrated Care System in London leading on mental health transformation and returned to NHS England in 2019 as Deputy Director of the National Retention Programme. Between 2017 and 2021 I also worked as a Global Healthcare Consultant for Health Education England in India.
3. This statement is provided in response to the request from The Nottingham Inquiry ('the Inquiry') dated 16 June 2025, made under Rule 9 of the Inquiry Rules 2006.

Governance of CQC

4. I have been asked to set out an overview of the CQC, covering its establishment, role and function.

Board

5. CQC has a unitary Board made up of Non-Executive and Executive members.

The Chair and other Non-Executive Members, who must make up a majority of the Board, are appointed by the Secretary of State. Legislation sets out requirements governing these arrangements, including Schedule 1 of the Health and Social Care 2008 Act (as amended) (the 2008 Act), the Care Act 2014 and the Care Quality Commission (Membership) Regulations 2015. The Care Quality Commission (Membership) Regulations 2015, which came into force in September 2015, include a requirement for the Board to have no fewer than 6 and no more than 14 members (not including the Chair). The Board is supported by a number of established committees, which provide assurance and advice to the Board on areas such as risk management and internal control, risks specific to the regulatory programme, and senior pay and succession planning. During the relevant time period covered by the Inquiry's Terms of Reference (ToR) (2019 to December 2023), the membership of the Board has changed. CQCM0029016 shows the current membership of CQC's Board as at 3 November 2025.
6. The Board ordinarily met monthly (save for August) in both public and private session from 2019 to 2023. As from February 2023, the frequency of Board meetings was varied. The Board now has six formal meetings a year as well as meeting for two Board Strategy Days a year.

Executive Team

7. Our Executive Team (ET) meets formally twice a month. Membership (as at 31 October 2025) of the ET is listed on our website [CQCM0029017]. Committees of ET meet to consider matters such as strategic oversight, operational performance, and people, financial, and commercial resources.

Corporate Governance Framework

8. CQC has a corporate governance framework [CQCM0016454]. This sets out the responsibilities and procedures that we use to make sure we govern our organisation to a high standard. This framework was refreshed in 2021, and again in 2022.

Framework Agreement

9. In addition, a signed Framework Agreement is in place between CQC and the Department of Health and Social Care (DHSC) [CQCM0016455]. This sets out our governance, as well as accountability, management and financial responsibilities and reporting procedures. It includes the Accounting Officer's accountability responsibilities to Parliament. It was last reviewed in 2021 and is currently in the process of being updated in consultation with DHSC.

Overview of CQC and its functions

CQC's Duties and relevant Regulations

10. CQC was established on 1 April 2009 by the 2008 Act as the independent regulator of health and adult social care in England. CQC is an executive non-departmental public body, sponsored by the DHSC, and accountable to Parliament through the Secretary of State for Health and Social Care.
11. Our functions, statutory duties and powers, which extend to England only, are set out principally in section 2 of the 2008 Act. They can also be found in the

Health and Social Care Act 2012 (the 2012 Act), the Care Act 2014 (the 2014 Act), the Health and Care Act 2022 (the 2022 Act), as well as in further primary and secondary legislation. In summary, we are responsible for the registration, monitoring, inspection, assessment, and regulation of services which fall within our regulatory remit.

12. We have a duty to conduct reviews of the carrying on of prescribed regulated activities and service providers, assess performance following the review, and to publish a report of our assessment as set out in section 46 of the 2008 Act.
13. The 2022 Act received Royal Assent on 28 April 2022 and added to the list of regulatory duties owed by CQC. Section 31 and 163 of the 2022 Act inserted sections 46A and 46B into the 2008 Act, which extended CQC's duties to conduct reviews, assess performance and to publish reports relating to, among other things, the provision of relevant health care, and adult social care, within the area of each Integrated Care Board (ICB) and the exercise of regulated care functions by English Local Authorities.
14. We have a duty, under the Mental Health Act 1983 (MHA), to monitor how services exercise their powers and discharge their duties when patients are detained in hospital, subject to community treatment orders or guardianship. In addition, we monitor how the Mental Capacity Act 2005 (MCA) is being used by health and adult social care providers and how they use the Deprivation of Liberty Safeguards (DoLS).
15. Our objectives when fulfilling these functions are set out in section 3 of the 2008 Act. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to

encourage care services to improve. We report on how care is being delivered in England in our annual State of Care report which is available on our website.

Requirements for registration with CQC (CQC's regulatory remit)

16. Providers of 'regulated activities' must be registered with CQC unless a specified exemption or exception applies, as set out in Section 10 of the 2008 Act and defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These regulated activities are:

- personal care.
- accommodation for persons who require nursing or personal care.
- accommodation for persons who require treatment for substance misuse.
- treatment of disease, disorder or injury (TDDI).
- assessment or medical treatment for persons detained under the 1983 Act.
- surgical procedures.
- diagnostic and screening procedures.
- management of supply of blood and blood derived products.
- transport services, triage and medical advice provided remotely.
- maternity and midwifery services.
- termination of pregnancies.
- services in slimming clinics.
- nursing care; and
- family planning services.

17. It is an offence to carry on a regulated activity without being registered, and we can prosecute those who do this. Registered persons can be an individual, a partnership or an organisation. CQC will register the relevant legal entity that will be carrying on the regulated activity.

Registration with CQC

18. When CQC decides whether to grant or refuse an application for registration of a service provider we must apply the test set out in section 12 of the 2008 Act. This provides that we must be satisfied that the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (“2014 Regulations”), and the Care Quality Commission (Registration) Regulations 2009 (“2009 Regulations”), and any other enactment which appears to us to be relevant, are being and will continue to be complied with in relation to the regulated activity for the application to be granted, otherwise we must refuse it. Prior to 2014, providers were required to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have the power to grant an application subject to conditions and the power to impose, vary or remove conditions on the registration.
19. At the point of registration, we are required to issue a certificate of registration. This sets out the regulated activities that the provider is permitted to carry on, and the locations at which the provider may carry on the regulated activities by means of a locations condition which forms part of the conditions of registration. Other conditions may be placed on the registration of providers, depending on the type of provider and the type of service being operated.
20. Following registration, we monitor and inspect services in accordance with our published guidance and inspection framework.
21. Providers can apply to us to be registered to carry out one or more regulated activities. As an example, acute NHS trusts may be registered to carry on regulated activities such as treatment for disease, disorder or injury (TDDI), surgical procedures, diagnostic and screening procedures, maternity and midwifery services, depending upon the trust. It is for the provider to determine

which regulated activities it carries on and therefore which activities it requires registration for. CQC's Scope of Registration (which is published on CQC's website) offers guidance to providers to help them decide whether they need to register with CQC and explains what we mean by regulated activities, who and what needs to be registered, and which regulated activities they are most likely to need to register for.

Meeting the requirements of the Regulations

22. Throughout the lifetime of a registration registered persons are required to comply with the 2014 Regulations and the 2009 Regulations. In line with our responsibilities under section 23 of the 2008 Act, CQC has issued guidance to help providers to comply with the requirements of the Regulations. Our guidance covers many aspects of CQC's inspection and monitoring powers and responsibilities including registration, notifications, enforcement and inspection.
23. Our guidance for providers has been updated several times since 2010 and reiterates the fact that providers are responsible for meeting the regulations and deciding how to do this. It is not CQC's role to tell providers what they must do to deliver their services. However, where providers choose not to follow the guidance, we ask them to provide evidence that their approach enables them to meet the requirements of the regulations.
24. The guidance clearly sets out: a copy of the actual text of the regulation; a summary of the intention of the regulation; and guidance on the requirements of specific components of the regulation. It is intended to assist providers, to understand the specific regulations in delivering safe services and regulated activities.

25. Copies of the guidance for providers dated March 2010 [CQCM0016489], March 2015 [CQCM0016446] and May 2025 [CQCM0016449] are exhibited to this statement.

Notifications and reporting patient safety incidents

26. Registered providers and/or registered managers are required to submit notifications to us about certain incidents, events or changes that affect a service, or the people using it. These are called 'statutory notifications.'
27. The statutory notification framework is set out in regulations 12, 14-18, and 20-22 of the 2009 Regulations. These regulations also state the timescales within which we must be notified, and these vary depending on the type of notification. CQC uses information from statutory notifications to:
- be aware of what is happening in a service.
 - identify issues of concern.
 - inform whether we need to take regulatory action; and
 - monitor trends across health and care.
28. Regulation 25 of the 2009 Regulations states that it is an offence not to notify CQC when a relevant change, event or incident has happened, specifically in relation to regulations 12 and 14 to 20. Failure to notify under regulation 21 (death of a registered provider) is not in and of itself an offence, however, in this event, the service will no longer be registered, and it is an offence to operate as an unregistered provider.
29. The information that must be provided to CQC varies depending on the type of notification being submitted. We hold a range of forms to enable providers to submit statutory notifications to us and there is a specific form for each different type of notification. Examples of this are set out below.

30. Registered persons are required to notify us of the death of a person accessing their service under regulation 16 of the 2009 Regulations. Regulation 17 of the same Regulations requires registered persons to notify us about unauthorised absences and deaths of people detained or liable to be detained under the MHA.
31. Regulation 18 of the 2009 Regulations sets out a range of events or occurrences of which registered persons must notify us of so that, where needed, we can take follow-up actions. Registered persons must send these notifications directly to us unless the provider is a health service body and it has followed the below process. A health service body, as defined by the 2009 Regulations, includes an English NHS body, which is defined in section 97 of the 2008 Act as a National Health Service trust all or most of whose hospitals, establishments and facilities are situated in England; NHS England; an integrated care board; an NHS foundation trust; or a Special Health Authority performing functions only or mainly in respect of England.
32. Registered persons must notify us of incidents that affect the health, safety and welfare of people who use services. The list of notifiable incidents includes: certain types of injury; abuse or allegations of abuse; incidents involving the police (not applicable to an English NHS body); applications regarding deprivation of liberty; and events which could prevent the provider's ability to continue to carry on the regulated activity safely. Some examples of events which have necessitated a Regulation 18 notification include: staff shortages; utility access; damage to the premises; and malfunction or failure of safety devices such as fire alarms.

33. The 2009 Regulations state that in some circumstances, where the provider is a health service body, notifications about the death of a service user and other incidents impacting on the health or safe care and treatment of a service user do not need to be submitted to CQC. For this to be the case, the provider must have already submitted the information to the NHS Commissioning Board (now NHS England (NHSE)). In practice this would have been through the National Reporting and Learning System (NRLS) which was in use from 2005.
34. This would include those notifications relating to: deaths of people using the service (Regulation 16); allegations of abuse (Regulation 18(2)(e)); events that stop or may stop the service from running safely and properly (Regulation 18(2)(g)); or serious injuries of people using the activity (Regulation 18(2)(a) and (b)).
35. The notifications to NHSE via NRLS are shared with us under a data sharing agreement and are incorporated into our intelligence and monitoring. NRLS has now been replaced by the Learn from Patient Safety Events (LFPSE) service with effect from the end of June 2024 (although some trusts submitted data to LFPSE from 2022). Our Data Sharing Agreement continues to apply to the LFPSE service.
36. CQC requires providers to have suitable policies and processes in place to enable the reporting of statutory notifications. A failure to comply with the requirements of Regulations 12 and 14 to 20 of the 2009 Regulations is an offence. These apply to all of the regulated activities within CQC's remit, including mental health inpatient facilities.
37. Serious incidents were previously investigated by providers using the NHSE Serious Incident Framework. This framework describes the circumstances in

which a heightened level of response to a serious incident may be required, and the processes and procedures for achieving that response. Any cases that met the criteria of serious incident were required to be reported on the Strategic Executive Information System (STEIS). This was to ensure that serious incidents were identified correctly, investigated thoroughly and learned from in order to prevent similar incidents happening again. This framework was replaced by NHSE's Patient Safety Incident Response Framework in Autumn 2023. CQC previously had access to STEIS data and continues to have access to data from the revised framework.

Monitoring the Mental Health Act 2009 to 2025

38. As stated in paragraph 14 above CQC has certain statutory duties in relation to the monitoring of mental health services. These duties were previously conducted by the Mental Health Act Commission (MHAC) and were subsequently incorporated into CQC's functions in 2009. The visiting regime in place in 2009 has continued to apply to date and remains the same currently.
39. Under the MHA, we have a duty to monitor how services exercise their powers and discharge their duties when patients are either detained in hospital, subject to community treatment orders or subject to guardianship orders. We also have duties to review, and powers to investigate, MHA complaints raised by or on behalf of individuals, and to provide a Second Opinion Appointed Doctor Service (SOAD) to review or certify treatment.
40. MHA monitoring visits focus on monitoring the use of the formal powers of the MHA, the exercise of duties under the MHA and the experience of detained patients. Unlike our inspections of health and care providers, our reviews

under the MHA focus on individual wards within a location. Standard ward visits focus on speaking with detained patients, seeing the environment in which they are detained and reviewing records relating to detention and treatment.

41. MHA reviewers conduct the MHA monitoring visits and are integrated into our wider mental health inspection teams. Any information we gather from our MHA activities, including monitoring visits will inform our broader monitoring and inspection activities of providers of mental health services. Inspection teams will assess how the MHA is applied and review the discharge of relevant duties under the MHA. Any MHA activity will inform the judgements made about a service. This will be reflected in our inspection reports.
42. Our MHA reviewers visit all places where patients are detained under the MHA and meet with them in private. Where requested, arrangements can also be made to meet patients who are on a community treatment order. We also look at the day-to-day operation of powers and duties under the MHA. If we identify concerns this can trigger further monitoring or inspection activity.
43. The frequency with which standard MHA monitoring visits are carried out varies, up to a maximum period of two years for individual wards that treat detained patients. Focused or thematic MHA monitoring visits are carried out in response to risks or concerns. An MHA monitoring visit report is written following each monitoring visit and was sent directly to the service provider of the ward. The visit report includes a summary of our findings and raised actions arising from the visit. Providers are required to provide an action statement in response to our reports advising of the action they would take/had taken in response to the issues raised.

44. From 2009, MHA reviewers conducted the MHA monitoring visits and were integrated into our wider mental health inspection teams in April 2014, reporting directly to mental health inspection managers. The MHA Operations teams then moved into National Operations in October 2022. MHA reviewers share intelligence and findings with the mental health inspectors in their teams.
45. CQC has a statutory duty to publish an annual report on its monitoring of the MHA. In this we report on data on deaths of detained patients. This data is also routinely shared with the Ministerial Board of Deaths in Custody.
46. Our role in relation to monitoring under the MHA is set out in more detail in paragraphs 127 to 130.

Care Quality Commission Inspection Framework 2014 to 2023

Approach to Registration

47. CQC's current Scope of Registration guidance (updated in May 2022 and applicable since 2014) outlines the regulated activities set out in Schedule 1 of the 2014 Regulations (See Paragraph 16). [CQCM0016450]

Fundamental Standards

48. Central to the manner in which CQC regulates is the application of 'fundamental standards.' These are the standards which everybody receiving care has the right to expect and below which care must never fall. Introduced following the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Sir Robert Francis KC, they impose obligations that registered providers must meet in order to be registered with CQC.
49. There are 14 fundamental standards. These are set out in the 2014 Regulations and listed below. Regulations 5 and 20 came into force in December 2014

whilst all other provisions of these regulations came into force on 1 April 2015, save for Regulation 9A which came into force on 6 April 2024. They replaced the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which set out the previous 16 essential standards. Since 2015, the relevant Trusts have been required to meet the various fundamental standards.

50. The fundamental standards, as summarised on CQC's website (<https://www.cqc.org.uk/about-us/fundamental-standards>), are:

- Regulation 9 - Person centred care.
- Regulation 9A – Visiting and accompanying in care homes, hospitals and hospices.
- Regulation 10 - Dignity and respect.
- Regulation 11 – Need for consent.
- Regulation 12 – Safe care and treatment.
- Regulation 13 - Safeguarding services users from abuse and improper treatment.
- Regulation 14 – Meeting nutritional and hydration needs.
- Regulation 15 - Premises and equipment.
- Regulation 16 – Receiving and acting on complaints.
- Regulation 17 - Good governance.
- Regulation 18 - Staffing.
- Regulation 19 - Fit and proper persons employed.
- Regulation 20 - Duty of candour.
- Regulation 20A – Requirement as to display of performance assessments display of ratings.

Notifications and reporting patient safety incidents

51. Reporting requirements and notifications to CQC during this period remained as stated in paragraphs 26-37 above.

Inspection Framework and Methodology

52. In April 2014, comprehensive inspections were commenced which used Key Lines of Enquiry (KLOEs) to help inspectors direct the focus of inspections and help them form a judgement about the quality of a service and award a rating. These inspections were first piloted in the autumn of 2013.

53. In accordance with section 23 of the 2008 Act, CQC produced guidance to help providers to comply with the regulations made under the Act. In April 2015, CQC issued 'Guidance for providers on meeting the Regulations' [CQCM0016446]. The guidance was developed with the help of people who use services, organisations that represent them, health and adult social care providers, other regulators and professional bodies.

54. CQC's mental health directorate was established in April 2014 to have specialist inspectors and inspection teams undertaking inspections of mental health services (both in the NHS and independent providers).

55. Following the introduction of the 2014 Regulations, core services were introduced by service type (for example wards for older people, wards for adults of working age etc.). The comprehensive inspections undertaken during this period were large in scale and all core services at all mental health trusts were inspected and rated.

56. Inspection teams began to include Experts by Experience and Specialist Advisors (who were specialist to the core services they helped inspect). The former are patients, people who use services and carers who have experience of a service; the latter are akin to peer reviewers, who provide specialist advice

to support our regulatory activity in an ad hoc role undertaken alongside their existing employment. Providers were given 'Must do' and 'Should do' actions following inspections to ensure they were in compliance with the regulations or took action if they were not.

57. In early 2015, updated guidance was developed for providers [CQCM0016446] on meeting the new regulations and applied from 1 April 2015. Internally, CQC developed brief guides and core service frameworks to help both inspectors and providers. These were shared on the CQC website.

58. In May 2016, CQC's Shaping the future strategy for 2016 to 2021 was launched with the aim of being more targeted, responsive and collaborative in our approach to regulation. CQC sought views from providers in relation to the evolution of the assessment framework and regulatory model. The consultation document dated December 2016 set out specific proposals in relation to the regulation of new models of care and complex providers; changes to the assessment framework across all sectors; and how NHS trusts would be regulated from April 2017. [CQCM0016490]

Health Framework

59. 'How CQC monitors, inspects and regulates NHS trusts' (updated November 2022) sets out how CQC monitored and inspected NHS trusts, the ways in which we shared information and the steps taken post-inspection [CQCM0016447]. This guidance is updated regularly, and at the outset of the relevant period, this document had most recently been updated in March 2018 [CQCM0016431]. Alongside this we had various inspection frameworks, depending on the core service. These documents confirm the approach of inspectors in relation to mental health care in acute trusts and the 11 mental

health core services. Page 17 of the 2022 guidance refers to mental health care in acute trusts and pages 21-23 refer to mental health core services: pages 19 and 23 to 25 respectively in the 2018 guidance.

60. CQCM0016433 (dated January 2019), CQCM0016492 (dated May 2019) and CQCM0016434 (dated August 2021) confirm the approach that inspectors took when inspecting mental health care in independent health providers, both at the outset of the relevant period and towards the end of the same.

61. Our five key questions are central to our approach. These are the things we ask of all care services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

62. Structured around the five key questions, these frameworks covered the following:

- areas to inspect
- interviews / focus group observations
- service-specific considerations
- KLOEs and related prompts for inspectors.

63. Each of the five key questions was broken down into a subset of questions, called Key Lines of Enquiry (KLOEs). Throughout the relevant period, CQC used KLOEs during inspections to help decide what we needed to focus on and to ensure consistency. For example, the inspection team might have

looked at how risks were identified and managed to help them understand whether a service was safe. We used different KLOEs in different sectors.

64. 'Key lines of enquiry, prompts and ratings characteristics for healthcare services' was first published in 2015. The document was subsequently updated to simplify the process and the revised assessment framework for NHS trusts was introduced in June 2017 [CQCM0016432].

Adult Social Care Framework

65. 'How CQC monitors, inspects and regulates adult social care services' (updated November 2023) [CQCM0016494] sets out how CQC monitored and inspected residential and community adult social care services, the ways in which we shared information and the steps taken post-inspection, during the relevant period. This guidance is updated regularly, and at the outset of the relevant period, this document had most recently been updated in January 2019 [CQCM0016491].
66. In the same way as the Healthcare Framework above, the original version of 'Key lines of enquiry, prompts and ratings characteristics for adult social care services' (first published in 2015), was replaced in November 2017. [CQCM0016493]
67. It is worth noting that a person being supported by an adult social care service, including people living in a care home or receiving care in their own home, might have their needs met by a number of different services. For example, a person could be living or staying in a care home and also be under the care of a mental health team, who lead on their clinical or medical care. We would make a distinction between the care that the adult social care provider

delivered, and the care and treatment delivered by the mental health provider. We would however consider how the adult social care provider ensured they worked in partnership with the mental health provider.

68. That said, the following KLOEs and prompts under the adult social care framework in use at the time would be of particular note in this context:

- E1 Are people's needs and choices assessed, and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?
 - i. E1.1 Are people's physical, mental health and social needs holistically assessed, and is their care, treatment and support delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies, to achieve effective outcomes?
- E4 How well do staff, teams and services within and across organisations work together to deliver effective care, support and treatment?
 - i. E4.1 How do staff work together to ensure that people receive consistent, timely, coordinated, person-centred care and support when they are referred to, use, leave, or move between, different services?
- E5 How are people supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support?
- R1 How do people receive personalised care that is responsive to their needs?
 - i. R1.2 How does the service make sure that a person's care plan fully reflects their physical, mental, emotional and social needs, including

on the grounds of protected characteristics under the Equality Act?
These should include their personal history, individual preferences, interests and aspirations, and should be understood by staff so people have as much choice and control as possible.

- W.5 How does the service work in partnership with other agencies?
 - i. W5.1 How does the service work in partnership with key organisations, including the local authority, safeguarding teams and clinical commissioning groups and multidisciplinary teams, to support care provision, service development and joined-up care? Does it do so in an open, honest and transparent way?

69. There are also KLOEs and prompts included which relate to mental capacity and to medicines optimisation.

Inspection approach

70. The inspection approach in force from April 2014 to 2023 can broadly be described across three main phases:

- a) Monitoring and Information Sharing – This involved the review of information we had collected on a service via various sources. The exact information reviewed varied depending on service type but generally included a review of CQC Insight (a tool used by CQC from October 2016 until May 2022 which was the last point at which Insight reports were exported and shared with NHS Trusts, to monitor potential changes to the quality of care), information gathered from providers, local and national organisations and the public as well as any experiences shared directly with CQC through our website, helpline or social media channels.

- b) Inspection – The frequency of inspections varied depending on the previous CQC rating of the service. For example, services rated as good or outstanding were normally inspected within 30 months of the publication of the last comprehensive inspection report whereas services rated as inadequate were normally inspected within six months of the publication of the last comprehensive inspection report.
- c) After Inspection – The report which was drafted by the lead inspector, contained a description of the good and outstanding practice found, as well as any concerns we may have had. The report included the findings in relation to the key questions that were inspected and what this meant for the people who use the service.

71. Prior to undertaking an inspection, we would review the information we held on a service. The exact information reviewed varied depending on service type. 'CQC Insight' (discussed further at paragraphs 98-101 below) was used to monitor quality of care. There were specific Insight tools for the different health and care sectors which aimed to: bring together information from people who used services, knowledge from our inspectors and data from our partners; indicate where the risk to the quality of care provided was greatest; monitor change over time for each of the measures; and point to services where the quality may have been improving.

72. We also continued to gather information directly from a service via statutory notifications as well as information from national, regional and local stakeholders and until 2023, relationship management meetings.

73. In our pre-Single Assessment Framework approach, frequency principles, based on a service's existing rating, were the primary trigger for inspection.

Information of concern received through the monitoring and information sharing phase could also trigger a smaller focused inspection to examine specific KLOEs. More significant concerns could also have prompted a comprehensive inspection. More recently, notably since the start of the Covid-19 pandemic, we have adopted a risk-based approach to triggering an inspection. Regulatory history continues to play an important part in making the decision to inspect a provider.

74. The different types of inspections were as follows:

a) Comprehensive inspections:

- An in-depth and holistic view was taken across the whole service.
- Inspectors looked at all five key questions to consider if the service was safe, effective, caring, responsive and well-led. A rating of either outstanding, good, requires improvement or inadequate was given for each key question, as well as an overall rating for the service.
- These were carried out:
 - (1) within the timescales set out above; or
 - (2) where there was a risk to the safety or wellbeing of people who use the service, or there had been a significant deterioration in the quality of the service; or
 - (3) where there was a substantial improvement in quality that could increase the overall rating.
- These were usually unannounced, although there were circumstances where the provider was notified of the inspection in advance (for example, we may have contacted a small residential service within 48 hours of the start of the inspection to check that people were home, or given up to a

week's notice to very complicated community services where careful planning was needed).

b) Focused inspections:

- These were more targeted than comprehensive inspections and were conducted in response to specific information received or to follow up on findings from a previous inspection.
- We did not necessarily look at all five key questions; however, we would always look at the well-led key question, plus any other key question that was relevant to the information that triggered the inspection.
- Focused inspections could be converted into comprehensive inspections if the scope needed to be broadened.
- These were structured with a variety of factors in mind, which may have included:
 - (1) Risks or concerns raised.
 - (2) Timing, evidence or engagement required.
 - (3) Resources entailed, including use of Experts by Experience and/or Special Advisors.
- They were smaller in scale than a comprehensive inspection.
- They broadly followed the same process as a comprehensive inspection.
- They could have resulted in a change to the overall rating of a service at any time by using key question ratings from the focused inspection as well as the remaining key question ratings from the last comprehensive inspection.
- Focused inspections were normally unannounced.

c) Combined inspections:

- These were aimed at those providers who delivered services across the health and social care sectors (for example, mental health, community health and care homes).
 - Where possible, we aligned the inspection process.
 - Each service was inspected by a specialist inspector.
75. Most inspections were either unannounced or have a short notice period (normally two weeks). In some cases, inspections were announced, for example an inspection of the Well-Led key question across an NHS Trust, which necessitated interviews and discussions with all senior board members and therefore required a degree of coordination.
76. The size of an inspection team varied according to the provider and service type, but broadly continued to be made up of our inspectors and be supported by Specialist Advisors and Experts by Experience.
77. The report and the ratings of each type of service were provided in a comparable way by using a combination of different inspection approaches. Overall ratings were aggregated from the ratings for all of the services of that provider that were inspected.
78. Following an inspection, we could ask for additional information from the provider to confirm evidence gathered during the inspection. After a period of quality assurance and factual accuracy review with the provider, a written report was published on our website. This continues to be the case. In most cases, our inspection reports continue to include ratings.
79. The written reports typically included:
1. Contextual information about the service and the inspection.
 2. A description of the inspection team's findings.

3. Ratings for each key question inspected and the overall rating given.
 4. Evidence about any breaches of the regulations, the action we told the provider to take, and any enforcement activity that CQC may have taken.
 5. Recommendations made to the provider about improvements to their service; and
 6. A summary section for the provider to share with each person using their service, their family and carers, and staff.
80. If the inspection identified regulatory breaches, further regulatory action may have been taken following the inspection, as appropriate. The regulatory action available for CQC to take in these circumstances is explained in detail in the Enforcement section of this statement from paragraph 134.
81. It is important to note that we have now undergone wide organisational change and in November 2023, commenced the transition to a Single Assessment Framework. As discussed at paragraph 88 below the Single Assessment Framework approach was rolled out over a transition period, from November 2023 to March 2024. Where relevant, we will refer to this new Framework.

Changes to Mental Health Act Visits in 2020 as a result of the Covid-19 pandemic

82. As a result of the Covid-19 pandemic, the decision was taken within CQC to pause routine inspection activity and take a revised approach to regulation. Given our unique role in supporting those people detained under the MHA, our view was that visits should be continued wherever possible. However, we moved routine visits to a digitally enabled format, including remotely monitoring mental health wards through contact with staff, patients, carers and advocates, virtual tours of wards, remote Second Opinion Appointed Doctor (SOAD) assessments and electronic certification by SOADs. Throughout the

pandemic, where we had specific and urgent concerns, we engaged with services and continued to carry out on-site visits.

83. Where we believed there were risks of harm, ill-treatment or human rights breaches for people detained in services then, with oversight from the Chief Inspector, we carried out additional activity which may have included a site visit to a service.

84. From 11 May 2020, we began prioritising inpatient complaints, to ensure that during the pandemic we were focusing on protecting the human rights of the most vulnerable people, redirecting them to our MHA reviewers to seek immediate resolution. These interventions provided an opportunity for MHA reviewers to identify services for remote monitoring activity where a serious concern or high number of concerns had been raised.

85. Our teams collected data remotely from a range of sources, and where we identified risks of harm, ill-treatment, or human rights breaches we carried out additional activity, which could include on-site MHA visits.

86. This remote-led approach continued through 2020 and 2021, with routine on-site MHA visits restarting in July 2021, and direct SOAD visits restarting in February 2022. Some elements of the remote review methodology were retained in a blended approach, in particular, continuing to contact carers and advocates outside of the physical visit. We have found that these contacts increased in remote reviews and provided a more well-rounded picture of services.

CQC Inspection Framework – Post 2023

New Inspection framework – the Single Assessment Framework

87. . In 2019, CQC embarked on a transformation programme. As part of this, in May 2021, CQC published a new strategy setting out our ambition to regulate in a smarter way, which was one of the four themes of that strategy (“smarter, more dynamic and flexible regulation that provides up-to-date and high quality information and ratings, easier ways of working with us and a more proportionate response”). Following this, plans for change were initiated with 3 key components. These were the development of a Single Assessment Framework and a new methodology for inspections; changes to the organisational structure; and changes to IT systems, with a new regulatory platform and provider portal replacing existing systems.

88. The Single Assessment Framework is a redesign of our approach to regulating services. In July 2022, we published an update on our website on the developing work on our new approach to regulation and the Single Assessment Framework, with a further update in December 2023 [CQCM0016495 and CQCM0016496]. We started the rollout of this new assessment framework in the South region and with 'early adopter' providers that volunteered to take part (a small number of providers across various types of services and sectors). Planned assessments and subsequent feedback from these providers helped to shape our approach as we rolled out this new Framework.

89. Whilst quality ratings and the five key questions continue to be central to our approach to regulation, we have replaced our KLOEs and prompts with new 'quality statements'. Quality statements are the commitments that providers, commissioners and system leaders should live up to, expressed as 'we'

statements that show what is needed to deliver high-quality, person-centred care. For example, under the 'safe' key question there is a quality statement relating to safe and effective staffing: 'We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.' These were intended to reduce the duplication in our current separate assessment frameworks and allow us to focus on specific topic areas under each key question. Our assessments across all types of services at all levels will be based on this Single Assessment Framework. Assessments of local authorities and integrated care systems will use a subset of the quality statements.

90. The principle of our on-site and off-site work, analysing data, and the approach to incorporating the opinions of those who work in and use services continues, but with a more structured approach to scoring and rating individual quality statements, rather than scoring only the five key questions. The new approach is intended to help providers take a structured approach to improvement, take less time to carry out, and provide the public with clearer comparisons with other services and offer a more granular view than the single word judgement offers.

91. The evidence we now collect falls into six categories:

- people's experiences.
- feedback from staff and leaders.
- observations of care.
- feedback from partners.
- processes; and

- outcomes of care.

92. For each quality statement we state which evidence we will always need to collect and look at, although this may vary by the type of service under assessment. It may also depend on the level at which we are assessing, for example a newly registered service.

Current position in relation to the Single Assessment Framework

93. The Single Assessment Framework was a redesign of our approach to regulating services which was introduced in November 2023.

94. Despite the well-intended strategic intent of the transformation programme, its implementation resulted in significant problems for CQC and caused concern amongst staff, providers, and stakeholders about our ability to fulfil our role as a regulator. The reviews of Dr Penny Dash (the Dash Review) and Professor Sir Mike Richards cover these matters more in detail. CQC is now undertaking urgent work to get back to delivering effective regulation.

95. Although our current methodology is still the Single Assessment Framework, we are currently developing our new clearer, simpler, assessment approach, and making sure our inspectors, led by our newly appointed Chief Inspectors, will be able to conduct more inspections and share feedback on the findings more quickly – so that we can support providers to make faster improvements and the public have timely information about care. We have committed to retain the five key questions in inspections across all sectors but will amend the 34 quality statements to ensure clarity and relevance to each sector and remove duplication. We have also stated we will stop scoring individual evidence categories.

96. We launched our consultation on our proposals to evolve and improve our approach to assessing and rating health and care providers on 16 October 2025 and closing on 11 December 2025.

97. Central to this work was a review of our culture and purpose, values and ways of working encapsulated in 'the CQC Way' the most relevant aspects of which are outlined in paragraphs 185-192.

Data

Data collated by CQC – CQC Insight and 'Give Feedback on Care'

98. We used CQC Insight until May 2022 to monitor potential changes to the quality of care. CQC Insight brought together in one place the information we hold about services, and analysed it to monitor services at provider, location, or core service level. This helped us to decide what, where and when to inspect and provided analysis to support the evidence in our inspection reports. CQC Insight produced monitoring reports, which we shared with Trusts. We also shared the reports with other key partners including NHSE, clinical commissioning groups and Healthwatch.

99. Until May 2022, our inspectors and assessors regularly checked CQC Insight. If it suggested an improvement or decline in the quality of care for a service, we may have followed this up between inspections. Depending on the report generated using CQC Insight, we may have been prompted to ask the Trusts for further information or to discuss issues at our regular relationship management meetings which were held until late 2023. We may also have decided to re-inspect that service.

100. For all NHS trusts, CQC Insight gave inspectors:

- Facts and figures: contextual and descriptive information such as levels of activity, staffing and financial information.
- A ratings overview: the trust's latest CQC ratings with information about the direction of potential change suggested by the performance monitoring indicators.
- Intelligence overview: a summary of the analysis of the indicators selected to monitor performance. It is presented at provider, key question and, where available, core service level.
- Performance monitoring indicators: these show a trust's performance compared with national standards or with other providers. They also indicate changes in a trust's performance over time, including benchmarking from 12 months before. All indicators are mapped to our five key questions and quality statements (previously KLOEs).
- Featured data sources: this might include, for example, the findings from national surveys, incident reports, mortality ratios and outliers. We coordinate our monitoring activities for 'complex providers' that operate across sectors and, where possible, combine information about each of their services within our Insight model.

101. Copies of CQC Insight relating to Nottinghamshire Healthcare NHS Foundation Trust (NHFT) between January 2019 and May 2022 are attached as exhibits CQCM0016497; CQCM0016498; CQCM0016499; CQCM0016500; CQCM0016501; CQCM0016502; CQCM0016503; CQCM0016504; CQCM0016505; CQCM0016506; CQCM0016507; CQCM0016508; CQCM0016509; CQCM0016510; CQCM0016511;

CQCM0016512; CQCM0016513]. May 2022 was the last point at which Insight reports were exported and shared with NHS Trusts.

102. 'Give Feedback on Care' is part of our approach to gathering peoples' experiences as part of assessments. We ask providers to print and display assessment posters that promote our 'Give Feedback on Care' service. The posters signpost members of the public to an online form where they can share information about poor care, abuse and neglect. People can also share information about good care, which adds to our picture of the overall standard of care and by sharing good examples which we can use to help all providers to improve.

103. CQC uses information shared via 'Give Feedback on Care' alongside information from the service itself or what we found when we last inspected them. CQC can take a number of actions in response to the reports, including: asking the care provider to give us their response to the information, meeting with management at the care provider, sharing information with other relevant agencies that need to know about it, carrying out an urgent inspection or bringing forward a planned inspection, and warning, fining, or placing conditions on how a care service operates.

Data collected by providers

104. CQC expects providers to submit the following national data returns:
- a. safety of mental health services statutory reporting requirements, such as the notifications that registered providers are required to submit to CQC;
 - b. national datasets created to support quality initiatives, for example, Mental Health Services Data Set (MHSDS);

- c. routine national data collections, including submissions to defined commissioning datasets run by NHSE, for example Hospital Episode Statistics (HES); and
- d. information relating to people's experience, for example, any data collection of experiences of service users of mental health services or their families.

Monitoring and inspecting mental health services

105. CQC inspects mental health services against the 2014 Regulations (as described earlier in this statement). Prior to the introduction of the Single Assessment Framework, CQC inspected and rated against core services; following the key lines of enquiry, CQC rated each of the five key questions (Safe, Effective, Caring, Responsive and Well-led) and provided an overall rating for the core service and provider. The mental health core services were as follows: Acute wards for adults of working age and psychiatric intensive care units; Long stay or rehabilitation mental health wards for working age adults; Forensic inpatient or secure wards; Child and adolescent mental health wards; Wards for older people with mental health problems; Wards for people with a learning disability or autism; Community-based mental health services for adults of working age; Mental health crisis services and health-based places of safety; Specialist community mental health services for children and young people; Community-based mental health services for older people; Community mental health services for people with a learning disability or autism.

106. CQC published the following topic area brief guides to support inspectors in making judgments:

- Brief guide: Patient and carer race equality framework (PCREF)
[CQCM0029018]
- Brief guide: Care of children and young people in appropriate settings
[CQCM0029019]

- Brief guide: Mandatory training requirement on learning disability and autism [CQCM0029020]
- Brief guide: Digital contactless patient monitoring technologies in mental health in-patient services [CQCM0029021]
- Brief guide for inspection teams: Use of 'blanket restrictions' in mental health wards [CQCM0029022]
- Brief guide for inspection teams: Smoke free policy for mental health inpatient services [CQCM0029023]
- Brief guide for inspection teams: Crisis response lines – NHS 111 (select mental health option) [CQCM0029024]
- Brief guide for inspection teams: Assessing mental health in the emergency department [CQCM0029025]
- Brief guide for inspection teams: Mental Health Units (Use of Force Act) 2018 [CQCM0029026]
- Brief guide for inspection teams: Physical healthcare in mental health settings [CQCM0029027]
- Brief guide for inspection teams: Covert medicines in mental health services [CQCM0029028]
- Brief guide for inspection teams: Ligature Anchor Points and Ligatures [CQCM0029029]
- Brief guide for inspection teams: Staffing levels on mental health wards [CQCM0029030]

- Brief guide for inspection teams: Psychotropic Medication [CQCM0029031]
- Brief guide for inspection teams: discharge planning from assessment and treatment units for people with a learning disability [CQCM0029032]
- Brief guide for inspection teams: Schizophrenia – assessment of concordance with NICE guidance [NHFT0011231]
- Brief guide for inspection teams: Bipolar Disorder – assessment of concordance with NICE guidance [CQCM0029033]
- Brief guide for inspection teams: Physical Healthcare in inpatient eating disorder services [CQCM0029034]
- Brief guide for inspection teams: Long-term segregation [CQCM0029035]
- Brief guide for inspection teams: Call systems in mental health inpatient services for patients/service users and visitors [CQCM0029036]
- Brief guide for inspection teams: Immediate Life Support training for services that may use restrictive interventions [CQCM0029037]
- Brief guide for inspection teams: Shared sleeping arrangements on mental health wards ('dormitories') [CQCM0029038]
- Brief guide for inspection teams: Good communication standards for people with a learning disability or autism. [CQCM0029039]
- Brief guide for inspection teams: Substance misuse services – same-sex provision [CQCM0029040]
- Brief guide for inspection teams: Substance misuse services – workforce qualifications [CQCM0029041]

- Brief guide: Staffing in Emergency Departments that treat children [CQCM0029042]
- Brief guide for inspection teams: Restraint (physical and mechanical) rooms [CQCM0029043]
- Brief guide for inspection teams: Functional assessment of behaviour in people with learning disabilities [CQCM0029044]
- Brief guide for inspection teams: Psychoactive medicines (LD) [CQCM0029045]
- Brief guide for inspection teams: Capacity and competence to consent in under 18s [CQCM0029046]
- Brief guide for inspection teams: Monitoring the physical health of people with a learning disability and/or autism on admission to a ward [CQCM0029069]
- Brief guide for inspection teams: Substance misuse services – detoxification or withdrawal from drugs or alcohol [CQCM0029047]
- Brief guide for inspection teams: Substance misuse services – Ligature risks [CQCM0029048]
- Brief guide for inspection teams: Substance misuse services – People in vulnerable circumstances [CQCM0029049]
- Brief guide for inspection teams: Substance misuse services – use of blanket restrictions [CQCM0029050]

- Brief guide for inspection teams: Sexual Safety in Mental Health wards [CQCM0029051]
- Brief guide for inspection teams: inspecting safeguarding [CQCM0029052]
- Brief guide for inspection teams: Waiting times for community child and adolescent mental health services [CQCM0029053]
- Brief guide for inspection teams: Assessing how well mental health services support carers [CQCM0029054]
- Brief guide for inspection teams: Assessing how providers use the Mental Health Act [CQCM0029055]
- Brief guide for inspection teams: Out of area placements in rehabilitation units [CQCM0029056]
- Brief guide for inspection teams: Seclusion rooms [CQCM0029057]
- Brief guide for inspection teams: Same-sex accommodation [CQCM0029058]
- Brief guide for inspection teams: Assessing how providers implement the Mental Capacity Act [CQCM0029059]
- Brief guide for inspection teams: Assessing quality improvement in a healthcare provider [CQCM0029060]
- Brief guide for inspection teams: Education in CAMHS [CQCM0029061]
- Brief guide for inspection teams: Inpatient mental health rehabilitation services – assessment, treatment and care [CQCM0029062]

- Brief guide for inspection teams: Inpatient mental health rehabilitation services – discharge. [CQCM0029063]
- Brief guide for inspection teams: Recovery orientated practice [CQCM0029064]
- Brief guide for inspection teams: Same sex provision in mental health hospitals. [CQCM0029065]

The brief guides on electroconvulsive therapy and positive behaviour support for people with behaviours that challenge, are under review and not currently published on CQC's website.

107. Under the Single Assessment Framework, as discussed earlier in this statement, CQC assesses against the five key questions using quality statements.

108. CQC collects and monitors information from a range of sources, including:

- Direct notifications: Providers must notify CQC about certain changes, events and incidents that affect their service or the people who use it. CQC publishes guidance to providers on notification and a list of notifications. [CQCM0016489 and CQCM0029066]
- Incident reports made by NHS trusts via the National reporting and learning system, and its replacement the Learn from Patient Safety Events service.
- Directly from the public and people working in services via CQC's contact centre or website.
- Data and Insight indicators. These include information from a range of sources, such as the Mental Health Services Data Set (<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set>), community mental health survey (<https://www.cqc.org.uk/publications/surveys/community-mental->

health-survey) and NHS staff survey (<https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-staff-survey-in-england/>).

- Inspectors will also review publicly available information, such as Trust board minutes.
- Engagement meetings with NHS Trusts.

109. During an inspection, inspectors, Specialist Advisors and Experts by Experience will complete the following tasks: observations of care; speaking to patients; interviews with staff; review of patient records; review of environment; review of management records and audits.

110. CQC assesses primarily against the 2014 Regulations, but in making its judgements, CQC will consider guidance issued from other relevant bodies. These include NHS England, e.g. the guidance on the Patient Safety Incident Response Framework; the National Institute for Health and Care Excellence; and Royal College guidance e.g. from the Royal College of Psychiatrists.

111. CQC will not assess all areas on all inspections. Inspectors will include a key question or quality statement depending on risk and the information available to them.

112. Staffing is considered under the Safe key question, and caseloads will be reviewed in inspections of community services. Inspectors review information to consider whether patients are having their needs met. We have access to the 'NHSE Mental Health Staffing Framework' [CQCM0029067] which is designed to equip leaders in mental health with the skills and knowledge to plan and deliver safe staffing, with the skill mix and staffing numbers appropriate for safe, compassionate care. In addition we use our 'Brief Guide: safe staffing levels on all mental health and learning disability wards' [CQCM0029030] which includes how we identify signs that there might be a problem with staffing levels.

113. The bed occupancy rate will be considered as part of inspections. NHSE publishes information on bed occupancy, collected from all NHS organisations that operate beds and publishes information on the average daily number of beds that are available and occupied by sector. High levels of bed occupancy in mental health trusts is an important indicator of pressure in other parts of the system (the Royal College of Psychiatrists recommends a maximum bed occupancy of 85%). We would look at whether staffing was sufficient to meet the needs of patients.
114. CQC will consider a Trust's use of out of area placements when completing a Trust-level assessment of well-led. CQC does not have powers to inspect commissioning and would not necessarily inspect the reason for the placement of people out of area. NHS Digital collects and publishes information on out of area placements in mental health services. During inspections of long stay or rehabilitation mental health wards for working age adults, inspectors would consider how the provider is working to ensure patients are linked to local services.
115. CQC inspects community mental health care provision under the following assessment service groups ("ASGs"): Community-based mental health services for adults of working age; Mental health crisis services and health-based places of safety; Specialist community mental health services for children and young people; Community-based mental health services for older people; Community mental health services for people with a learning disability or autism. CQC is inspecting all providers of 'Community-based mental health services for adults of working age' and 'Mental health crisis services and health-based places of safety' as part of its adult community mental health programme. Early intervention in psychosis teams are inspected under the 'Community-based mental health services for adults of working age' ASG. When inspecting this ASG, inspectors will sample services. This is due to the size and number of services provided by NHS Trusts.
116. Care planning is reviewed under the Effective key question. A member of the inspection team will review a sample of care records and the evidence

collected will be corroborated with observations of meetings, such as multi-disciplinary meetings and interviews with members of staff and people using the service.

117. Assessing risk in mental health patients will be inspected as part of the Safe and Effective key questions. We will look to see whether staff had completed risk assessments for each patient on admission/arrival using a recognised tool, and this was reviewed at regular intervals including after any incident.
118. Assessing capacity in mental health patients was previously inspected under the Effective key question but is now inspected as part of the Safe key question. We will look to ensure that staff have given patients support to make specific decisions for themselves before deciding a patient did not have capacity to do so; that staff assessed and recorded capacity to consent each time a patient need to make an important decision; and that when staff assessed patients as not having capacity, that they made decisions in the best interests of patients and considered their wishes, feeling, culture and history.
119. In relation to the detention of mental health patients, as outlined earlier in this statement, CQC's MHA reviewers complete monitoring visits to review the application of the MHA. The application of the MHA will also be considered during inspections as part of the Safe key question. It was inspected under the Effective key question previously.
120. Inspectors will consider how services are seeking to engage with non-engaging mental health patients, including those requiring intensive and assertive support. However, CQC inspections are focused on the regulated activity being provided by the service being inspected and there is limited opportunity to consider those who are not accessing the service.
121. In relation to monitoring mental health patients, the provision of ongoing care, support and treatment would be reviewed during inspections.
122. Inspectors may consider the usage levels of Community Treatment Orders (CTO) by an organisation when completing a Trust-level assessment of well-

led, but usage is not assessed in inspections of assessment service groups routinely. CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship, and its most recent Monitoring the Mental Health Act report contains some references to the use of CTOs. MHA reviewers have completed specific pieces of work reviewing CTOs previously. We currently have an ongoing improvement project to update our CTO visit methodology and pilots are planned.

123. The use of depot medication is reviewed under the Safe key question. CQC has pharmacy specialists in its medicine management team. These inspectors join all inspections in the adult community mental health programme to review medicine management.

124. CQC will look at matters such as lengths of stay but it is very difficult to assess patient outcomes in mental health due to the variabilities inherent in the diverse range, background, and circumstances of mental health patients.

125. In relation to incidents of violence against third parties by mental health patients, CQC will review incidents either notified to it directly or via the learning for patient safety events service. Inspectors will review incidents and consider a regulatory response. This may include seeking assurance from the provider or undertaking a responsive inspection. CQC will consider whether to prosecute where there has been any provider-level failure that led to the harm occurring.

126. Information sharing amongst mental health service teams and other agencies is reviewed under the Responsive key question.

Monitoring through Mental Health Act Visits

127. The Mental Health Act 1983 (MHA) and its Code of Practice (2015) apply to all providers that are registered with CQC to assess and treat patients who are detained under the MHA. We are responsible for reviewing and monitoring

how these organisations apply the MHA when providing services. CQC has a role in providing an effective safeguard for people who are subject to detention under the MHA in hospital and community settings. This includes our MHA monitoring roles, supporting our inspection and regulation of a provider's application of the MHA and how we meet our responsibilities in hospitals under the National Preventative Mechanism (an independent monitoring body to carry out regular visits to places of detention to prevent torture and other ill-treatment).

128. The purpose of MHA monitoring activity is to provide independent specialist review of the way the MHA is being applied across places of detention using a human-rights based approach. We consider how the dignity of patients is respected and protected by staff and services and identify improvements needed in order to protect patients, promote their rights and increase the quality of their care and treatment.

129. Our MHA activities are informed and planned using a range of information and guidance on the expected care and treatment of people subject to the MHA.

This includes:

- The regulations and key standards we use in our inspection activity including the five key questions.
- The MHA duties and powers or the statutory guidance set out in the MHA Code of Practice.
- Human Rights Act and Equality Act.
- Best practice guidance available including NICE standards and guidelines.

130. Our approach to monitoring the MHA involves activities which deliver across the following four areas:

- Visiting: our primary monitoring activities involve visits by MHA reviewers (MHARs) to meet with patients and look at the day-to-day operation of powers and duties under the MHA. These visits are unannounced and include reports and actions from providers to improve issues identified, whether current or emerging, that impact on patients. Monitoring activities during a visit may include a tour of the ward; meetings with individual patients; meeting with the ward manager or staff member in charge; carrying out observations of activity and interactions on the ward; and reviewing MHA documentation such as audits and sample documents.
- Regulation: this is time spent supporting regulation with MHA expertise. This includes attending engagement, reviewing mental health insight intelligence, joining inspections and well-led reviews, participation in management review meetings/enforcement or other activities that require MHA knowledge and insight. MHA reviewers can help support the management of those statutory notifications that relate specifically to the MHA, such as deaths of detained patients, notification of absence without leave and the admission of minors to adult mental health wards.
- Contacts and complaints: reviewing contacts or investigating concerns and complaints from people who are or have been subject to the MHA (where they have been detained in hospital, been subject to a CTO or subject to guardianship). Section 120 of the MHA sets out a duty for CQC to investigate any complaint from or on behalf of a patient detained under the provisions of the Act with regard to the use of powers or the way in which duties have been carried out under the Act.

- Focused activity: dependent on need, risk or request and may include themed visits, work with inspection colleagues or reviewing appeals from patients in high secure hospitals. Themed visits may include focused, planned visits to look at specific issues or types of service, such as CTOs, Admission and Assessment, records checks, long-term segregation or seclusion practices. This can be locally identified if the evidence and information collated suggests there is a specific regional need; as part of a national programme of work; or of there is a requirement because of a national policy change.

Community Treatment Orders

131. A typical MHA monitoring visit is usually to an inpatient mental health ward and on these visits we may see a person who has previously been on a CTO or who has had a CTO revoked but the focus of that visit is not on CTOs or any other community use of the MHA specifically. Our section 120 MHA monitoring duties include visiting and speaking with people subject to the formal powers of the MHA in community settings such as people on CTOs, but CQC's priority has been to visit regularly the inpatient mental health services that treat those detained under the MHA.

132. We have carried out CTO-focused visits. We undertook 11 CTO-focused visits between February 2019 and November 2021 to explore how CTOs were being used in 9 boroughs across London. There has not been a focused CTO visit in Nottingham in the last 10 years and currently there is not one planned as there has been a high volume of inspection activity.

Challenges CQC encounters in its monitoring and inspection of mental health services

The provision of mental health services in the community.

133. CQC can encounter a range of challenges to differing degrees in the monitoring and inspection of mental health services, whilst working as the regulator within the scope of the wider system:

- i. Multi-agency and partnership working is an area that is reviewed during Trust well led inspections. CQC will normally liaise with other agencies as part of that activity and does not see this as posing specific or substantial challenges.
- ii. The number of mental health services provided in the community are significant and when those services sit within an NHS Trust CQC may encounter challenges in identifying the number of services and where they are located. This is because at the point of registration for NHS Trusts all community services would be registered to the Trust's headquarters.
- iii. In 2019 NHS England commissioned the Royal College of Psychiatrists to develop a new place-based community mental health model that provided more support care and treatment for adults. The focus of that model was that there should be an integrated, single core community mental health service. As the model began to be rolled out, many services removed assertive outreach teams as they were not in line with the new model of care. At around the same time as the roll out of the model to implementation, the Covid 19 pandemic began and the focus for NHS Trusts and other providers shifted significantly. As a result, the model was implemented at different times across provider organisations, with some much further ahead than others, and implementation of integrated care varies

significantly. In light of the above, CQC can encounter challenges in understanding where an organisation is in terms of implementation of, and fidelity to, the model.

- iv. Monitoring and inspection of in-patient mental health services normally poses less of a challenge. CQC will know through a provider's Statement of Purpose the locations of the in-patient mental health services. However, the regulation for the Statement of Purpose does not detail what needs to be included and Trusts in particular regularly change ward names/service provision in wards, and do not routinely keep us updated. Therefore it follows CQC can sometimes encounter challenges (in relation to large NHS Trusts) in identifying the number of sites provided and (in relation to both NHS Trusts and independent health providers) knowing how many wards are at each site. CQC previously asked for Provider Information Returns ('PIR') which asked the Trust (or independent provider) to submit details of all its sites and wards. We previously stopped requesting PIRs to reduce the burden on the providers.
- v. It should be noted that identifying, assessing and managing risks of violence is for the provider rather than for CQC: CQC's role is to review how a provider has addressed the identified risks. However, on inspections CQC can review risk assessments, risk management plans and Datix to identify some of the issues. CQC may encounter challenges in obtaining data relevant to identifying, assessing, and managing risks of violence posed by mental health patients. CQC has been unable to rely on data from the Mental Health Services Data

Set (MHSDS)/NHS England. The supply of this data was disrupted by the change from Version 4 to Version 5 in October 2021 in addition to technical and contractual issues. This meant the data was next received in June 2024. MHSDS data cannot be used to identify issues relevant to individual patients as its use is subject to confidentiality and suppression rules (to address the data disclosure risk inherent in the presentation of small numbers). Data on assaults by community patients is not available at present; data on assaults on staff used to be collected by NHS Protect but this stopped when they were replaced by the NHS Counter Fraud Authority in November 2017.

Enforcement

134. Enforcement is one of the core components of the operating model that CQC uses to achieve our purpose and perform our role.

135. The 2008 Act gives CQC both civil and criminal enforcement powers to address issues of non-compliance with the 2014 Regulations and with the 2009 Regulations. We also have powers to undertake civil and criminal enforcement action against registered persons who fail to comply with a condition of their registration or the relevant Regulations.

Enforcement action and other steps that can be taken by CQC

136. CQC's civil enforcement powers, as set out in the 2008 Act (as amended by the 2014 Act), include powers to cancel or suspend a registered person's registration (sections 17, 18 and 30 to 31), to impose, vary or remove conditions of registration in respect of a registered person (sections 12 (5), 15

(5), and 31) or to serve a “warning notice” where the test set out in sections 29 and 29A is met.

137. Criminal enforcement action can be taken, in response to breaches of certain regulations and sections of the 2008 Act, against any registered person, and against any unregistered person where they are carrying out regulated activities without registration. It can also be used against any person who obstructs us during an inspection and against registered or unregistered persons where they have made a false or misleading statement in any application to us. CQC’s criminal enforcement powers include cautions, fixed penalty notices and prosecution. CQC also has powers under section 91 of the 2008 Act that enable us to consider the actions of an individual director, manager or secretary of the body corporate, where there is evidence that they have committed an offence or with their consent, connivance or neglect allowed an offence to be committed.

138. We can issue Requirement Notices where we identify breaches of regulation that have not placed people using the service at immediate risk of harm. The Requirement Notice requires the provider to send us a report detailing what action is being taken by them to comply with the relevant regulation(s) and the timeframe they will do this in. Under the new Single Assessment Framework, Requirement Notices have been named ‘Action Plan Requests.’

Enforcement Policy

139. Our Enforcement Policy sets out the principles and approach we will follow when using our enforcement powers under the 2008 Act, as amended by the 2014 Act, and is intended to be a general guide to good practice when carrying out or considering carrying out enforcement action.

140. Several versions of our Enforcement Policy have been in existence during the relevant time period. We have set out below the versions that we have been able to locate following a search of our document repositories:
- a. February 2015 - [CQCM0016436] This policy is discussed in more detail below.
 - b. November 2023 - [CQCM0016441].
141. Following the changes to our enforcement powers in 2015, which meant that we were able to bring criminal prosecutions against health and social care providers for failing to provide care and treatment in a safe way, in addition to prosecuting specified breaches of the Regulations, a new Enforcement Policy was introduced in 2015. From 1 April 2015 to 21 November 2023, we used the 2015 version of our Enforcement Policy (dated February 2015, effective from 1 April 2015) [CQCM0016436], which was replaced with an updated Enforcement Policy on 21 November 2023.
142. For the purposes of this statement, we will focus on the Enforcement Policy (as amended) which was in place from April 2015 onwards as it contains details of our updated prosecution powers.
143. All versions of the Enforcement Policy operated alongside the following other key guidance documents:
- Our enforcement decision tree for selecting appropriate enforcement powers, (applicable from 2015 and explained in greater detail below);
 - Our provider handbooks that described our approach to inspecting, regulating and, where applicable, rating each of our sectors; and
 - Our guidance for providers on meeting the regulations.

144. As set out in our 2015 Enforcement Policy, we have two primary purposes when using our enforcement powers:

- To protect people who use regulated services from harm and the risk of harm, and to ensure they receive health and social care services of an appropriate standard; and
- To hold providers and individuals to account for failures in how the service is provided.
- When a service falls below the required standards, we will consider both purposes.

145. In addition, the 2015 Enforcement Policy set out the five principles which guided our enforcement decision making as follows:

- Being on the side of people who use regulated services.
- Integrating enforcement into our regulatory model.
- Proportionality.
- Consistency; and
- Transparency.

146. We updated our Enforcement Policy in 2023 to bring it in line with our new regulatory approach and the new version took effect from 21 November 2023 [CQCM0016441]. The changes included, but were not limited to, removing principle (ii); *'integrating enforcement into our regulatory model'*, as we considered that this requirement was no longer relevant. Therefore, the 2023 Enforcement Policy refers to the remaining four principles referred to above to guide the use of our enforcement powers.

147. Our current Enforcement Policy was updated in 2024 (taking effect from 23 December 2024). The changes in 2024 noted updates to terminology as a

result of the introduction of the Single Assessment Framework. We have included reference to the 2024 Policy for the sake of completeness as we recognise that it falls outside of the time period of relevance to the ToR.

148. Since 2015, the 'Enforcement Decision Tree' has been at the core of how we apply our Enforcement Policy. This describes the process that guides how CQC makes decisions on the use and selection of appropriate enforcement powers to ensure consistency and proportionality. From 2017, we were using the 2017 version of the Enforcement Decision Tree [CQCM0016430]. We updated our Enforcement Decision Tree in 2023 to bring it in line with the amended 2023 Enforcement Policy [CQCM0016439].

149. The Enforcement Decision Tree sets out a four-stage decision-making process which we use to select the appropriate enforcement power. Below is a high-level summary of the process:

a. Initial assessment:

- Before commencing enforcement action, the first stage is to consider the case at a Management Review Meeting (MRM) (these are now known as Decision Review Meetings (DRM)). In the overwhelming majority of cases, the MRM will be followed up through standard direct checks such as a focused inspection. Urgent cases may proceed directly to evidence collection for potential urgent action or prosecution.

b. Legal and evidential review:

- At this stage we check that the evidence we hold demonstrates a breach of the regulations or relevant requirements. We also ensure that we take account of our statutory guidance and any other relevant legislation. The purpose of this stage is to check that the evidence is sufficient to enable

us to proceed to take enforcement action, and that the initial logging and registering of evidence has been done correctly.

c. Selection of the appropriate enforcement action:

- Stage 3A looks at the seriousness of the concern and the facts that gave rise to it. It does not take account of other incidents that may have taken place nor the provider's response to them. It is an assessment of the likelihood of the concern happening again, and if it were to happen again, the impact it would have on the people using the service.
- Stage 3B takes account of other incidents that may have taken place relating to the provider and their response. It requires inspectors to consider whether there is sufficient evidence of systemic failings in the quality of care and/or management which may result in recurrent issues. The outcome of assessment at stage 3B can result in an increase or decrease to the severity of the enforcement action we decide to take, as well as determining whether we need to hold a provider and/or individual to account through criminal sanctions.

d. Final review:

- The final decision about which enforcement action to take is made at an MRM meeting where CQC's sector enforcement priorities are considered. These are the priorities set by CQC's Board and agreed in our business plan. They set expectations for our overall approach to enforcement, providing a transparent message to the sectors as well as to our inspectors. Consideration of these priorities could result in a change to the type or severity of the planned enforcement action. At the final review stage, we also check that the recommendation is in line with

the enforcement policy and that the decision-making process has been followed properly.

150. There are three enforcement actions that we use in order to 'require' a provider to protect people who use regulated services from harm and the risk of harm, and to ensure that the services they receive are of an appropriate standard. These are:

- Requirement Notices (now known as Action Plan Requests)
 - Where a registered person is in breach of a regulation or has poor ability to maintain compliance with the regulations, but the people using the service are not at immediate risk of harm, we may use our power to require a report from the provider by serving a Requirement Notice. The response from the provider must show how they will comply with their legal obligations and must explain the action they are taking or propose to take to do so. Failure to send us a report in the timescales set out in the Requirement Notice is an offence and could lead to us using other enforcement powers.
- Warning Notices
 - Warning Notices notify a registered person that we consider they are not meeting a condition of their registration, a requirement in the 2008 Act, a regulation, or any other legal requirement that we think is relevant. We cannot issue Warning Notices against unregistered persons. We can serve Warning Notices about past failures or about a continuing breach of a legal requirement. If a registered person does not comply with the Warning Notice we will consider further enforcement action under civil or criminal law. The regulations allow us to publish Warning

Notices as long as registered persons are given the opportunity in advance to make representations about the proposed publication.

- Section 29A Warning Notices
 - Section 29A of the 2008 Act make provision for Warning Notices that are addressed to NHS Trusts or foundation trusts. We may issue such a notice where we find that an NHS trust requires significant improvement.

CQC Civil Enforcement Powers

151. We may use the following discretionary civil enforcement powers to ‘force’ a provider to protect people who use services from harm and the risk of harm, and to ensure that they receive services of an appropriate standard:

- Impose, vary or remove conditions of registration.
- Suspend a registration.
- Cancel a registration.
- Urgent procedures; and
- Special measures – a time limited approach ensures inadequate care does not continue and co-ordination with other oversight bodies.

152. A high-level explanation of each of these powers is provided below.

Impose, vary or remove conditions of registration.

153. As explained above, registered persons may have conditions attached to their registration. Imposing, varying or removing conditions of registration is a flexible enforcement process that we can use in a variety of different ways to ensure that providers comply with their legal obligations. For example, we may use a condition to stop a regulated activity at one location but allow the provider to continue providing services at its other locations. This allows us to remove the condition if, and when, the concern has been addressed. We can apply conditions at whole-provider level and/or at certain targeted geographic locations.

154. We can also use conditions to require a registered person to take some action where further improvement is necessary. We design and communicate these conditions so that they explain what we require to be achieved but leave the provider to decide exactly how that will be delivered. We will not define precisely how a provider should operate or manage its service. It should be the provider's choice to decide precisely how to operate its business, provided it complied with all relevant legal requirements.

155. We will consider imposing conditions on the provider's registration if we assess that by imposing a condition it is likely to result in the provider addressing the matters of concern within an acceptable timescale.

Suspend registration.

156. We can suspend the registration of a registered person for a specified period of time. This period can also be extended if necessary. This power allows us to compel the provider to address a specific concern within a fixed period, for example, to hire new staff.

157. This power is rarely used as suspension affects all the locations where the registered person carries on or manages the relevant regulated activity. We will therefore pay particular attention to the likely outcomes of suspending registration before taking this action. If a provider carries on providing a regulated activity following suspension, we may prosecute this as a criminal offence.

158. We will consider suspending a provider's registration if we assess that suspension is reasonably necessary to prevent the breaches of the provider's legal requirements but that the provider will be able to provide a lawful service at an identifiable time in the future.

Cancellation of registration

159. One of our most powerful civil enforcement powers is to cancel a registration. As with suspension, this will affect all the locations where the provider carries on or manages the relevant regulated activity. Cancellation normally follows considerable efforts to get the registered person to meet the legal requirements. However, where appropriate we will use the cancellation process without following other processes first.

160. If a provider carries on providing a regulated activity following cancellation, we may prosecute this as a criminal offence.

161. We will consider the cancellation of a registration if we assess that the registered person does not have the capability or the capacity to substantially comply with regulations or is likely to fail to do so.

Urgent procedures

162. In certain circumstances we can use our powers to impose, vary or remove conditions or suspend a registration on an urgent basis with immediate effect.

Section 31 of the 2008 Act states that we can use urgent procedures where the evidence demonstrates that unless there is an urgent use or amendment of conditions, or urgent suspension of registration, a person will or may be exposed to harm.

163. Under section 30 of the 2008 Act, we can apply to a magistrate for an order to immediately cancel a registration. We can apply for these orders if not cancelling the registration would pose a serious, immediate risk to a person's life, health or wellbeing.

164. Providers are entitled to appeal against the use of these urgent powers, but this does not prevent the conditions, suspension or cancellation from taking effect immediately.

165. Urgent procedures are an important part of our enforcement powers so that we can act quickly to protect people using a registered service. We expect urgent procedures to be a significant element of our enforcement activity and we will also consider criminal sanctions in serious cases.

Special measures/Recovery Support Programme

166. Special measures were an administrative framework which helped CQC to manage providers who were failing to comply with their legal requirements and required a higher than usual level of regulatory supervision. For these providers, special measures helped us to deliver our statutory functions.

167. For NHS trusts, this gave us powers to require NHSE to appoint an administrator and thereby place the trust in 'special administration'. This was a form of time-limited, rules-based administration that resulted in an administrator making recommendations designed to ensure that the NHS body improved its standards to provide secure, sustainable and high-quality

services. To use these powers, we first had to have issued a section 29A Warning Notice and be satisfied that the provider had not complied with it. Before requiring the appointment of an administrator, we would consult the Secretary of State for Health and Social Care and NHS England and NHS Improvement (NHSEI).

168. Part of any special measures regime was the effective use of enforcement powers to ensure that improvements were made to the standard of care provided by the registered provider. A provider that was operating under special measures might also be working under the close supervision of another oversight body. Where appropriate, we would work closely with relevant oversight bodies to ensure that the registered provider made improvements to the standards of service provision.

169. From 2021, the Special Measures framework was replaced by the Recovery Support Programme ('RSP'), under the new System Oversight Framework. The RSP differed in that it was system oriented (while still providing focused, intensive support to individual organisations), focused on the underlying drivers of the problems identified, was time-limited with clear exit criteria, and focused on system resilience with transfer of knowledge and skills.

170. The RSP is now in the process of being replaced by the Provider Improvement Programme and CQC's processes will be updated accordingly.

CQC's Criminal Enforcement Powers

171. Failure to comply with the steps required when we use certain civil enforcement powers is a criminal offence and may result in a prosecution.

172. Our Enforcement Policy provides lists of the specific regulations in respect of which a prosecution may be brought directly if the offences listed in the

regulations are breached; and the regulations in respect of which further qualification is required before CQC can prosecute (which are that the breach results in people who use services being exposed to avoidable harm or significant risk of such harm occurring or suffering a loss of money or property as a result of theft, misuse or misappropriation).

173. CQC can use a variety of methods to hold providers and individuals to account for failures in how the service is provided. Our criminal powers include using:

- Simple cautions.
- Fixed Penalty Notice; or
- Prosecutions.

174. Each of these methods is briefly described below.

Simple Caution

175. A simple caution ensures that there is a formal record of an offence when a person has admitted to it but is not prosecuted. There is no obligation on a provider to accept a caution and, where the offer of a caution is refused, we will consider prosecution. We will consider using a simple caution when:

- We have evidence of an offence and that evidence is sufficient that we would be able to bring a criminal prosecution.
- Although we could prosecute, we consider that achieving improvements without initiating lengthy and costly proceedings is a realistic alternative and is more proportionate than proceeding with a prosecution.
- The provider has demonstrated to us that they will be able to put these improvements in place within a reasonable timescale.

- The Code for Crown Prosecutors indicates that this option would be appropriate; and
- The offence has an insubstantial impact on people using the service.

Fixed Penalty Notices

176. Our power to issue Fixed Penalty Notices (FPNs) is set out in sections 86 and 87 of the 2008 Act, and in Regulation 28 and Schedule 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A FPN requires a provider or individual to pay a specified amount of money to CQC, which is then passed on to the Secretary of State for Health and Social Care. Paying a FPN enables a registered person to avoid a potential prosecution for an offence. It is only appropriate to issue a FPN where CQC would have been entitled to prosecute.

177. We have discretion over whether to serve a FPN as an alternative to a prosecution. There is no obligation on a registered person to pay the sum under a FPN and, if a registered person decides not to pay the penalty, we will consider using other enforcement powers. The failure to pay sums under a FPN will normally lead to a prosecution.

178. We will consider using the power to issue a FPN when:

- We have evidence of an offence and that evidence is sufficient to bring a criminal prosecution.
- Although we could prosecute, we consider that achieving improvements without initiating potentially lengthy and costly proceedings is a realistic alternative and is more proportionate than proceeding with prosecution; and

- The offence has an insubstantial impact on the people using the service.

Prosecutions

179. Prosecution can be used to:

- hold a registered person to account for breaches of prosecutable fundamental standards (those regulations with prosecutable clauses that specifically relate to harm or the risk of harm), or for failing to comply with conditions of registration.
- enforce the offence of carrying on a service without registration (in which case we may prosecute the person who appears to be carrying it on).
- ensure accountability for any person who obstructs us during an inspection, or any person who makes a false or misleading statement in an application to be registered with us.

180. Where appropriate, we may prosecute at the same time as taking other enforcement action, for example, alongside urgent procedures. We may also prosecute more than one offence at the same time. There may be occasions where, even if the above criteria are satisfied, we will decide to serve a Warning Notice as an alternative to immediate prosecution. However, we will generally prosecute providers where there are serious, multiple or persistent breaches of the fundamental standards (those regulations with prosecutable clauses that specifically relate to harm or the risk of harm) without issuing a Warning Notice first. Failure to make the improvements set out in a Warning Notice is likely to lead to a prosecution.

181. Although we are not required by law to publish details of all criminal law procedures that we undertake, we have a general power to publish this type of information and will normally do so. We must publish information about any offence for which a registered person has been convicted.

182. We are required to carry out all investigations of criminal offences in accordance with the Police and Criminal Evidence Act 1984 (PACE) principles and Codes of Practice. Where another regulator has the power to prosecute, we will coordinate our activity with them at an early stage to ensure the right action is taken, to avoid inconsistency, and to ensure that any proceedings taken are for the most appropriate offence. Where we successfully prosecute, the court will decide on the penalty to be imposed and we must publish information about any offence for which a registered person has been convicted. The court may impose a prison sentence as well as, or instead of, a fine following conviction for carrying on a regulated activity without being registered.

183. We will consider using our powers to prosecute where:

- the breach of legislation is assessed by us to be serious and there are multiple or persistent breaches; or
- we have sufficient evidence so there is a realistic prospect of conviction; and
- we assess that it is in the public interest for us to use our powers of prosecution.

184. In making decisions about whether to prosecute, we will be guided by the Code for Crown Prosecutors.

CQC's ongoing review of its regulatory approach

Review of Single Assessment Framework

185. The CQC board commissioned Professor Sir Mike Richards (former Chief Inspector of Hospitals at CQC between 2013 to 2017) to undertake a review of the Single Assessment Framework to address concerns identified in the interim report of the Dash Review. The review was initially proposed by CQC leadership before release of the interim Dash report and was announced by DHSC to coincide with publication of the interim report of the Dash Review.
186. Findings from the first part of the review were published on 15 October 2024. The report makes 35 recommendations based on Sir Mike's informed opinion following engagement with relevant parties including current and former staff, and representatives of NHS and adult social care providers. These recommendations are organised in relation to five key areas being organisational structure, the inspection assessment framework, data and insight, staffing, and prioritisation of future inspections. When making his conclusions, Sir Mike noted the report is intended to complement the work of the Dash Review and that his overall findings are in line with those of Dr Penny Dash.
187. For the next phase of this review, CQC worked with Professor Vic Rayner (Chair of the Care Provider Alliance and Chief Executive Officer of the National Care Forum). Professor Rayner gathered further feedback from adult social care providers on their use of the assessment framework, to build on Sir Mike's findings to date. Additionally, Sir Mike and Professor Rayner have supported CQC in determining what good regulatory assessment looks like in different sectors and services, an understanding of what providers want from an inspection and the inspection reporting process and reports. The ToR for the

second phase of their review were published in January 2025. The report was published on 11 February 2025 [CQCM0016514].

CQC's Response to the Dash Review

188. CQC published a response to the interim findings of the Dash Review on 26 July 2024, accepting the findings and recommendations in full. Many of the areas identified in the report as requiring urgent improvement aligned with CQC plans and priorities.

189. On 3 October 2024, CQC published a detailed announcement on our website titled "Re-building a trusted approach to our regulation" which outlined the immediate changes being made in response to the interim report of the Dash Review [CQCM0016515].

190. CQC also published a response to the final report of the Dash Review and the review of the Single Assessment Framework by Professor Sir Mike Richards on 15 October 2024 accepting all high-level recommendations [CQCM0016516].

CQC's Programme of Priorities

191. This section outlines Single Assessment Framework element of CQC's programme of priorities and our future strategy in response to recommendations of the Dash Review and the review of the assessment framework.

192. It should be noted this work is ongoing and will continue to evolve as further phases of these reviews are completed.

CQC Reports

Monitoring the Mental Health Act reports

193. Our Mental Health Act reports published during the relevant period highlight a number of issues which on touch matters relevant to the terms of reference of this Inquiry. We reported on our findings that there was disproportionate detention under the MHA, and use of CTOs, in Black and minority ethnic groups. There were concerns that people were not getting the help they needed in a timely manner when they needed it, including making adequate community provision, and there were issues around discharge planning. We found that workforce and staffing issues presented the greatest challenge for the sector with gaps in community care adding to the pressures on inpatient services; we had concerns about the use of bank and agency staff to fill gaps in staffing. We noted systemic issues with community mental health care, including a shortage of mental health staff and a lack of integration with other health/social services. An increased demand for inpatient beds highlighted the risk that patients would be discharged too soon without appropriate support in place.

State of Care Reports

194. Our State of Care reports during the relevant period found concerns with a lack of mental health community care, and poor care in inpatient wards for people with a learning disability and/or autism. We found that many people were being sent far from home for treatment, and those cared for by independent providers were staying longer in hospital than those in NHS services. There was an increased risk of closed cultures in mental health services, and particularly where treatment was provided far from the patient's home. We found there to be poor co-ordination and joint working between acute and mental health services, and delays in assessments and securing

beds. Recruitment and retention of staff was noted to be one of the biggest challenges for the mental health sector, with the high use of bank and agency staff causing concern. A shortage of qualified mental health staff meant a system-wide approach was required to ensure a continual 'pipeline' of trained mental health professionals. High bed-occupancy rates were a known indicator of pressure in other parts of the system. The reports also noted that access to mental health services was challenging for people in deprived areas, women and 'other' ethnic groups, and again found disproportionate detention (and use of CTOs) among Black and Black British men.

Community Mental Health Survey 2024

195. The survey received feedback from over 14,000 people who received treatment for a mental health condition between 1 April and 31 May 2024. It found people were continuing to have poor experiences of NHS community mental health services, particularly around crisis care support. In key areas for improvement, nearly a quarter of all respondents said they did not get the help they needed when they made contact out of hours. There had, however been some positive changes for support accessing care and about some aspects of medication.

Section 48 Review

Background

196. I have been asked to set out the context and actions undertaken by CQC in undertaking the s.48 rapid review of NHFT.

197. CQC has powers under s.48 of the 2008 Act to conduct a 'special review or investigation'. The CQC has a duty to undertake a special review or

investigation where the Secretary of State requests. Under s.48 of the 2008 Act, CQC must publish a report.

198. A s.48 review looks at the exercise of functions and provision of NHS care, the provision of adult social services and the carrying on of regulated activities and may relate to;

- the overall provision of NHS care or adult social services, or
- the provision of NHS care or adult social services of a particular description, or
- the overall exercise of functions, or
- the exercise of functions of a particular description, or
- the provision of care or services or the exercise of functions generally or by particular bodies or persons.

199. Whilst undertaking a s.48 review CQC must consider whether it raises anything about the exercise of functions and provision of NHS care, the provision of adult social services and the carrying on of regulated activities on which it ought to give advice to the Secretary of State.

200. Following the conviction of VC in January 2024, the Secretary of State for Health and Social Care commissioned CQC to carry out a special review of NHFT, where VC was treated for paranoid schizophrenia, in response to concerns about the safety and quality of mental health services. We were asked to complete the review in approximately three months. This is much shorter than our previous s.48 reviews which have been carried out over period of approximately 12 months. Due to the short timescale the review was termed a rapid review.

201. As part of our review, we were asked to look at 3 specific areas:

- A rapid review of the available evidence related to the care of VC
- Assessment of patient safety and quality of care provided by NHFT
- An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity

202. This led to the publication of two reports [CQCM0016517 and CQCM0016518.

Part 1 (areas (b) and (c) above), published 26 March 2024, providing:

- (i) An assessment of patient safety and quality of care provided by NHFT
- (ii) An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity alongside a small number of benchmarking cases to consider wider patient safety concerns or systemic issues.

203. Part 2 (area (a)) published 13 August 2024, providing:

- (i) A rapid review of the available evidence related to the care of VC

204. The review was carried out and supported by a variety of CQC and specialist colleagues, including: CQC Operations Managers, Assessors, Inspectors, Regulatory Coordinators, Analysts, CQC Senior Specialists, Clinical Experts, Specialist Advisors, and Experts by Experience.

The scope of the review

205. As noted above, the Review was set up to look at three major elements. The scope of these were set out in the Terms of Reference set by the Government, published 26 March 2024 [CQCM0016519].

- “A rapid review of the available relevant evidence related to the care of [VC], including available evidence made public during the criminal trial, alongside a small number of other cases (to enable benchmarking), to determine whether this evidence indicates wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire. This

rapid review is intended to be complementary to the Independent Mental Health Homicide Review which will be conducted by NHS England over a longer timeframe and will provide more detailed scrutiny of [VC]'s interaction with mental health services [NHSE0000298].

- An assessment on patient safety and quality of care provided by Nottinghamshire Healthcare NHS Foundation Trust, drawing on CQC's latest inspection findings and other available intelligence. This will include CQC's recent inspections of Rampton Hospital and acute wards for adults of working age and wards for older people with mental health problems at the trust. CQC will also assess care for patients in the community who are presenting with risk to public safety, and the extent to which there is sufficient oversight from the provider. This will consider the trust's discharge processes and approaches, including assessment of patient risk and engagement and working with other local partners.
- An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity to offer an up-to-date assessment of care provided at the hospital.

Engagement

Throughout the review CQC will continue to engage the families affected by this work, and will draw upon the experience of the NHS, people using services, and other key stakeholders they may identify during the review."

Limitations

206. **Timeframe:** The timeframe set for the completion of the whole review at the start of 2024 was challenging and therefore CQC needed to approach this

work with that context in mind. The first Report was published within the timeframe initially set, in March 2024. Permission was later given to extend the timescales for Part 1 of the review and this report was published in August 2024.

System working

207. The scope of Part 1 of our Review was limited to the care (VC) received from NHFT mental health services, from his first point of contact in May 2020 to his discharge back to his GP in September 2022. DHSC were clear that we should focus only on the NHFT, and this was then widened to include other healthcare providers within Nottinghamshire.
208. The Terms of Reference for our s.48 review focused on the safety and quality of care provided by NHFT and care for patients in the community who are presenting with risk to the public as well as oversight of the provider.
209. The Review was to consider how VC engaged with services, but not look more widely at services across the system.
210. We were also keen to avoid any crossover work with the NHSE-commissioned Theemis 'Independent investigation into the care and treatment provided to VC' which was due to be published in January 2025. The Theemis report's Terms of Reference included the systemic approach to the communication of risk across the healthcare system for patients with severe mental health problems; and to consider and comment on the key 'touch point' in the system, identifying any weaknesses in systems and processes both within organisations and across systems and the extent to which those factors may have influenced the responses to VC.

Speaking to staff

211. In Part 1 of the s.48 review, which focussed on the available evidence related to the care of Valdo Calocane, CQC spoke to 87 members of staff.

212. The Terms of Reference relating to Part 2 of the s.48 review, focussing on assessing patient safety and quality of care provided by NHFT, stated we would carry out a desktop review of VC's care and treatment. We were given access to the transcripts from VC's criminal trial which meant we had access to what staff had disclosed, although we were unable to use details concerning individual clinicians within our report. We also had access to the Trust's own Serious Incident investigation where staff were interviewed (although again we were unable to use details of individual decisions with our report).

Medicines management

213. With reference to medicines management, Part 1 of the review included how staff at Rampton reviewed patient medicines regularly as part of the multidisciplinary meeting and provided specific advice to patients and carers about the medicines.

214. In Part 2 of the review we considered the balance between VC's preference and wishes around the choice of medicine and treatment regime, against other information such as his pattern of not taking medication while in the community (this was compared to benchmarking cases where we also found issues with medicine monitoring).

Part 1 Methodology

215. The Part 1 report was informed by information gathered from onsite visits, reviews of the Trust's services, data from previous inspection and ratings, along with information and personal experiences, including those from people

who use services, their families and carers, to inform our judgements about the quality of care within the trust.

216. CQC reviewed data, reports and policies, drew on findings from surveys, and analysed publicly available datasets to assess the patient safety and quality of care provided by the Trust. Where possible in the report, we compared data from NHFT with other trusts or national data. However, in many places this was not possible due to a lack of standardised data collection. For example, this included:

1. Feedback to CQC - we reviewed information that has been shared with us from people who use services, families and carers, feedback from staff and from partner organisations. This feedback is collected through our Give feedback on care webform, as well as phone calls and emails to our National Customer Service Centre. Between 18 July 2023 and 5 February 2024 there were 247 records referring to NHFT, of which 173 provided information on quality and safety of care to support the report. Some cases concerned the Trust as a whole, while others related to the service. Analysis is presented at trust or 'setting' level (for example, inpatient, secure setting), except for Rampton Hospital, which was included in trust level analysis as well as reported separately.
2. Surveys – we carried out quantitative and qualitative analysis of responses to 2023 Community Mental Health Survey for NHFT. Our analysis did not include national figures or compare results with other participating trusts. Unless otherwise stated, people's experiences used in this report are based on a combined analysis of qualitative comments from the

community mental health survey analysis and all other feedback received by us.

3. Prevention of future death reports - We analysed 15 Prevention of Future Death reports for NHFT, which were sourced from both the courts and tribunals judiciary websites. These reports highlight the most serious concerns relevant to a service. The sample contained reports published after 1 January 2021, but some dates of death pre-date this, owing to the time taken to conduct an inquest. Reports such as those relating to acute healthcare provision not relevant to the review and some of historic concern were not included in the analysis.
4. Healthwatch - In November 2023, Healthwatch produced a report on specialist mental health services in Nottingham and Nottinghamshire [CQCM0016521]. We reviewed this report and summarised the key points in order to corroborate findings from this rapid review. The response from NHFT to the report was not reviewed or included in the report.
5. MHA Reviews – Following MHA reviewer visits to locations, a letter is sent to report on findings. There were 20 letters from MHA reviewers relating to different locations in Nottinghamshire, issued between July 2023 and November 2023. Each of the MHA reviewers' letters ends with any actions that the provider must carry out (under Section 120B of the MHA). Analysis of these letters focused on the actions raised by MHA reviewers to give us an overview of issues raised.
6. Data sources - We used data and insight gained through our routine monitoring of and engagement with NHFT. Where data was sent directly to CQC from NHFT this was analysed and, where possible, benchmarking

analysis is referenced in the report. This included, for example, staffing data (levels, sickness, training), bed occupancy rates, discharge information, and out of area placements data.

7. Observations, interviews, and visits - To assess patient safety and the quality of care at NHFT, we visited and assessed a number of services in the Trust, including community health services for adults of working age, crisis services and the University of Nottingham Health Service, due to their involvement with VC. During these visits we spoke with 37 members of staff including doctors, nurses, care assistants and allied health professionals.

We were able to observe the care that patients receive, and directly speak to 34 people using services, 10 carers, relatives and loved ones. In addition, we were able to review 30 records of care and treatment provided to people using these services.

217. Conclusions drawn in our report were not solely based on the findings of the rapid review but took into account findings from previous inspection activity at NHFT and Rampton Hospital over the previous 5 years. We have then looked at these findings within the context of our wider understanding and evidence around the challenges facing mental health services. This includes drawing on evidence from our statutory State of Care and Mental Health Act annual reports, and other thematic reviews [CQCM0016464; CQCM0016465; CQCM0016466; CQCM0016467; CQCM0016468; CQCM0016456; CQCM0016457; CQCM0016458; CQCM0016459; CQCM0016460].

Summary of main findings and recommendations of Part 1

Main findings:

218. The report set out our findings around safety and quality of care provided by NHFT in 5 areas, drawing on a range of evidence sources, including findings from our October and November 2023 inspections.
219. Access to care - High demand and long waiting times at NHFT meant that people were not able to access care when they needed it. People's mental health was not monitored for signs of deterioration. Too many people did not have an allocated care coordinator, and the crisis teams did not always respond to people's immediate needs to minimise discomfort, concern, or distress, or provide care and treatment to people quickly. The flow to inpatient beds was ineffective.
220. Quality of Care - Most people said staff had treated them with kindness, compassion and dignity. However, people in inpatient services were less positive and described concerns around the attitudes of staff, and restrictions. The quality of care planning, risk assessment and involvement of patients and their families and carers was inconsistent, and assessments were not always personalised. NHFT had redesigned its community mental health teams in line with national guidance, but pathways of care were unclear and size of teams did not meet the needs of the local populations. Discharge planning across community mental health and crisis services was not robust, with people describing concerns around being discharged too soon or leaving inpatient services in a worse state than when they arrived.
221. Safety of services - We were concerned about the safety of services at NHFT. The Trust did not have enough staff to keep patients safe. High demand for services and complex staffing arrangements meant that staffing levels were

not equitable to caseload sizes. We found that the approach to risk assessment was varied and inconsistent.

222. Leadership and governance - There had been a lot of changes in leadership in recent years, with 3 out of the 7 executive directors having taken up post since 2023. Leaders were aware of some of the current risks in safety and quality of services, but we were concerned senior leaders did not appear to have clear oversight of these risks. We were concerned that trust activities are predominantly reactive.

Recommendations of Part 1 of the review.

223. **Recommendation one** - NHFT is required to do more to provide safe care and treatment to protect patients, families and the public from the risk of harm.

This includes but is not limited to:

- Ensuring patients receive ongoing assessment of their risks and escalations in risk are identified; appropriate and effective risk management plans are implemented; patients can access crisis services without delay with timely access to appropriate inpatient care; reviewing waiting times in community mental health services and setting measurable targets to ensure deterioration in people's conditions are monitored and equity of care across services.
- Ensuring patients receive timely and equitable access to the full range of evidence-based care and treatment through multidisciplinary teams with clear pathways regardless of where patients live.
- Ensuring services, including GP practices, are integrated and use shared systems to provide seamless transitions in care and treatment
- Ensuring incidents and the level of harm caused are identified and investigated by appropriately trained and competent staff in a timely way, ensuring lessons

are learnt and are immediately shared appropriately with all services to improve safety.

224. Recommendation two (community mental health services for working age adults) –

- NHFT is required to change the current approach to providing community mental health services to ensure evidence-based care and treatment is provided through clear pathways with cohesive and equitable multidisciplinary teams and ensure that community mental health teams' approach to risk management is reviewed to ensure that teams are able to monitor, mitigate and respond to people at risk of harm to themselves or others.
- NHFT is required to ensure that staff are appropriately trained and that mandatory training is available to support staff in working with autistic people and people with a learning disability and that joint working protocols are in place with GP practices, which ensure that patients with complex mental health needs have joined up care. NHFT is required to improve their responsiveness to people's immediate needs by ensuring 4-hour and 24-hour targets for calls to the crisis line are answered and met more often and consistently.

225. Recommendation three (Rampton Hospital) - It is recommended that:

- NHFT pair Rampton Hospital with another high secure hospital as a 'critical friend' to include regular oversight and monitoring by senior staff from a different NHS trust, and commissions an independent review of staffing. Clear processes should be implemented to ensure continued safe staffing levels.
- The medication audits and medication governance process should be reviewed by a dedicated team to bring about positive and sustainable change for the

application of section 58 of the MHA, administration of high dose antipsychotic therapy and controlled drugs.

- Nursing staff numbers on the wards are increased to enhance the therapeutic offer to patients.
- British Sign Language (BSL) trained staff are ringfenced to only work with deaf patients to increase support and communication of deaf patients within Rampton Hospital.
- The IT equipment is fit for purpose and used effectively to record patient information.

226. **Recommendation four** - It is recommended that NHS England:

- Recommends to the Secretary of State for Health and Social Care that Rampton Hospital is relicensed for a period of no more than 12 months, to allow for expected improvements at the Trust to continue.
- Works with DHSC to agree clear standards in waiting times for community mental health services and with CQC to establish what datasets are needed for monitoring the quality and safety of community mental health services around waiting times, unexpected deaths and suicide, crisis response times, incidents of serious harm to the public involving people using mental health services and treatment outcomes.
- Should define standards for answering calls to mental health crisis lines and work with the Royal College of Psychiatrists and DHSC to review the community mental health framework for adults to standardise pathways of care and assertive support where people may be hard to engage.

Part 2 Methodology

227. For Part 2 of the s. 48 review, CQC commissioned 2 consultant psychiatrists and 2 senior community mental health nurses, who have experience of community mental health teams and early intervention in psychosis services, to review VC's medical records (for the duration he was under the care of the Trust and the independent hospital) and to carry out a review of all medical records for benchmarking purposes. Ten cases were selected at random from a list of 2,528 patients who had been patients of the early intervention in psychosis services at NHFT between April 2020 and February 2024. Reviewers looked at all interactions that patients had with the Trust.

228. VC's care and treatment and the benchmarking cases were compared against each other to identify if any themes and trends existed between them. These were further compared against the wider Part 1 review of the Trust completed previously to identify any similarities.

229. For both VC and the benchmarking cases, reviewers looked at all interactions that patients had with the Trust including, but not limited to:

- observations
- risk assessments
- care plans
- discharge plans
- Mental Health Act assessments
- multidisciplinary team meeting notes.

230. Reviews were completed using a template of best practice guidelines, the Trust's policies and procedures and national guidance, to form a judgement about the care and treatment delivered [CQCM0006196; CQCM0006427].

VC's care and treatment and the benchmarking cases were compared against each other to identify if any themes and trends existed between them. These were further compared against the wider review of the Trust completed previously to identify any similarities.

Summary of main findings and recommendations of Part 2 of the review

Main findings

231. A core part of our review was to consider whether the evidence we gathered from VC's care records indicated wider patient safety concerns or systemic issues in Nottingham. While we did not find any widespread patterns with 10 other cases that we reviewed as a benchmark, many of the issues we have identified are consistent with the problems we found in our wider review of the quality of care and safety of services at NHFT. Our key findings are set out below.
232. Risk assessment and record keeping - Inconsistent approaches to risk assessment was an issue in both VC's case and the 10 benchmarking cases and reflected findings from our wider review of NHFT. Other issues particular to VC's case included: risk assessments were minimised or omitted key details and did not outline the seriousness and the immediate threat; risks around VC's capacity to consent may not have been managed adequately; there does not appear to have been an updated risk summary before VC was discharged back to the GP in September 2022.
233. Care planning and engagement - VC received a timely referral into mental health services after his first arrest and was allocated a care co-ordinator from the early intervention in psychosis (EIP) team promptly. Teams did not always identify risk factors and create person-centred care plans. There were issues

with VC's engagement with services, and we found similar issues in 3 out of the 10 benchmarking cases. While VC's family contacted NHFT services to raise their concerns, the information they provided was not consistently acted on. VC mostly received timely admission to hospital but delays around his third admission led to VC being admitted to an out-of-area psychiatric intensive care unit (PICU) bed. VC was discharged back to his GP in September 2022 due to non-engagement. There was no evidence that VC's family was consulted or that the GP, police or university were consulted.

234. Medicines management and optimisation - VC's preferences were at the forefront in decisions around the choice of medicine and treatment regime but VC's decisions and wishes were not always balanced with other information. There was an obvious pattern of VC not taking his medicine while in the community. In 3 of the 10 benchmarking cases we looked at we found issues with medicines monitoring. NICE guidelines that require people with schizophrenia whose illness has not responded adequately to treatment and should have their diagnosis and treatment reviewed, were not followed.

235. Discharge planning - No problems were identified for the first 2 discharges between local NHS hospitals and community services for VC. In relation to the third discharge in October 2021 there were differences between the records we reviewed from the Trust and the independent hospital. VC was unable to access specialist crisis team care. There is no evidence of discussion around the value of depot medicine or a community treatment order (CTO) until his fourth admission. As he was being held under section 2 of the MHA it was not legally possible to discharge him using a CTO. The evidence indicated beyond any real doubt that VC would relapse into distressing symptoms and

potentially aggressive and/or intrusive behaviour. The decision to discharge VC back to his GP in September 2022 did not adequately consider or mitigate the risks of relapse and violence or his lack of engagement with services.

Recommendations of Part 2 of the review:

236. **NHFT must:**

- Review treatment plans regularly to ensure it is in line with national guidelines specifically when it relates to treatment of schizophrenia and medicines optimisation.
- Ensure clinical supervision of decisions to detain people under section 2 or section 3 of the MHA and regularly carry out audits of records for people, which are reported to the NHFT board.
- Ensure that regular auditing of medicines monitoring takes place within community mental health teams to identify any themes, trends and required learning.
- Ensure that, in line with national guidance and best practice, staff involve and engage patients' families and carers in all aspects of care and treatment and discharge, with patient consent. The Trust should ensure that where patients do not give consent, this is reviewed on a regular basis and on all the available information available to the multidisciplinary team.
- Have a robust policy and processes for discharge that consider the circumstances surrounding discharge and whether discharge is appropriate.
- For community mental health services for working age adults, NHFT must:
 - i. Ensure regular medicines monitoring takes place within the community and address issues identified quickly.

- ii. Ensure all practicable efforts are made to engage patients who have disengaged from the early intervention in psychosis service.
- iii. Ensure there is a standard operating procedure in place for early intervention in psychosis and community teams to follow when a patient does not attend for appointments and follow-up actions are defined.

237. We recommended that NHS England:

- Appoints a named individual to take ownership for the delivery of these recommendations.
- Ensures that providers' boards understand their role in the oversight of the needs of patients who have a serious mental illness and who find it difficult to engage with services.
- Ensures every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis who present with high risk.
- Within the next 12 months, provides evidence-based guidance setting out the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.
- Within 3 months of the publication of the national standards, ensures every provider and commissioner develops and delivers an action plan to achieve these.
- Through the providers' boards, ensures delivery of the actions within 12 months of the national standards being published.
- Together with the Royal College of Psychiatrists:

- i. reviews and strengthens the guidance to clinicians relating to medicines management in a community setting.
- ii. reviews how legislation is used in the community to deliver medication for those patients who have a serious mental illness and where it is known they are non-compliant with medication regimes.

Conclusions

238. Our review suggests that in VC's case there was no single point of failure, but a series of errors, omissions and misjudgements. The scope of our review has not allowed us to explore this further.

239. While our s.48 review focused on NHFT, the issues we have identified are not unique. Both parts of our review have highlighted systemic issues with community mental health care which require immediate action to mitigate inherent risk to patient and public safety.

240. We are committed to looking in depth at the standard of care in community mental health across the country to fully understand the gaps in quality of care, patient safety, public safety, and staff experience in community mental health services. This is set out in more detail in paragraphs 241-242. There also needs to be national action to ensure that people most in need get the care, treatment and support they need at the right time in the most suitable environments.

Adult Community Mental Health Programme

241. We currently have a dedicated programme of work, developed specifically out of the s.48 review, called the Adult Community Mental Health Programme. This is a comprehensive inspection programme of all 51 providers delivering community mental health services for adults of working age. We will assess

all quality statements across all five Key questions within two ASGs: Mental health crisis services and health-based places of safety; and community-based mental health services for adults of working age.

242. The programme launched a pilot phase in March 2025 and from September 2025 we have begun the full programme which is expected to last approximately two years. We will update ratings for those two ASGs at every provider, but we will also be reviewing the evidence collected to inform our independent voice and produce a final national report. We have been delivering face-to-face and virtual provider engagement events throughout the programme to bring all trusts together to share what works, what challenges there are and how CQC can support change in this area.

Closed Cultures – Observing and Improving Cultures

243. Further to our existing approach to identifying and responding to closed cultures (<https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures>), CQC has piloted an enhanced observation process on selected mental health inspections: Observing, Understanding and Improving Cultures. The pilot was developed and adapted to CQC's new Single Assessment Framework as part of the transformation process. The pilot Observing and Improving Cultures (OIC) guidance was developed to be used in conjunction with existing CQC closed culture guidance [CQCM0029068]. The OIC process allowed inspectors more time on site to actively observe care delivery, the environment, interactions and behaviours and to speak with people using services, advocates and friends and family members.

244. Following completion of the OIC framework pilots on inspections, the project was reviewed and suggestions made to complete more pilots at upcoming inspections. Further work is planned with CQC policy colleagues to discuss how observation guidance could be added to quality statement guidance as the assessment service groups are being reviewed.

Progress made against recommendations

Recommendations for Nottinghamshire Healthcare NHS Foundation Trust

245. It should be noted that, whilst CQC published recommendations as part of both the reports, the Secretary of State requested that NHSE supported NHFT to develop an action plan in response to these and has primary oversight of this.

246. CQC continues to monitor quality and performance at NHFT as part of our ongoing monitoring and inspection framework, as set out above. The last comprehensive inspection of the Trust under the previous methodology took place, as set out above, in March and April 2022 and the report was published in November 2022. There were subsequent inspections of relevant services delivered to the Trust, including High Secure Hospitals (September 2022, June/ July 2023), Wards for adults of working age and PICUs (October 2023), Wards for older people with mental health problems (November/December 2023) [CQCM0016478; CQCM0016523; NHFT0002106; NHFT0000581; CQCM0016525].

247. There have also been assessments using the new Single Assessment Framework of the below elements of the Trust. Each of the Assessment Service Groups (formerly Core Services) listed below were assessed and

reported on separately. There have been 33 published assessments for the Trust since July 2024.

248. Please note that some of these ASGs have been assessed multiple times in the same publication period. This is because under the Single Assessment Framework, these Assessment Service Groups were assessed under a selection of between three and five quality statements at each assessment. These have provided us with oversight of the Trust's performance against the recommendations.

249. This is an enhanced level of oversight of NHFT under our current approach and was supported by a dedicated CQC operational team. CQC has recently undertaken a Well-Led inspection of the Trust to assess their current performance and quality, with reference to the recommendations made. We aim to publish this early in the new year. We would be happy to provide an update to the Inquiry in regard to this in future.

250. We would be happy to provide the following assessment reports if they would assist the Inquiry. The Assessment Service Groups assessed are listed below:

- Published July 2024: High Secure Hospitals.
- Published August 2024: Wards for people with learning disabilities or autism; Specialist eating disorder services; Perinatal services; Child and adolescent mental health wards.
- Published September 2024: High secure hospitals; Community-based mental health services for adults of working age.
- Published November 2024: Long stay or rehabilitation mental health wards for working age adults; Forensic inpatient or secure wards; Perinatal services.

- Published December 2024: Community health inpatient services; Acute wards for adults of working age and PICU; Child and adolescent mental health wards; Forensic inpatient or secure wards.
- Published January 2025: High secure hospitals; Community-based mental health services for adults of working age; Mental health crisis services and health-based places of safety; Community mental health services for people with a learning disability or autism
- Published February 2025: Specialist community mental health services for children and young people; Community-based mental health services for older people; Community health services for adults.
- Published April 2025: Acute wards for adults of working age and PICU; Community health services for children, young people and families.
- Published May 2025: Wards for older people with mental health problems; High secure hospitals; Community end of life care.
- Published July 2025: Community health inpatient services; Forensic inpatient or secure wards.
- Published August 2025: Perinatal services.
- Published October 2025: Wards for people with learning disabilities or autism; Long stay or rehabilitation mental health wards for working age adults.
- Published December 2025: Wards for older people with mental health problems; Child and adolescent mental health wards.

Recommendations for NHS England

251. On 13 June 2025, we met with NHSE colleagues who provided an update regarding progress made against the recommendations contained in the two section 48 reports. From that meeting we understand the following:

252. NHSE have accepted all recommendations from CQC across the two section 48 reports. In addition, the Independent Homicide Review (IHR) that was carried out made a specific action for NHSE to complete all recommendations from CQC with additional other actions for them to complete.
253. NHSE commenced action on the recommendations from the s48 review prior to the publication of the IHR report. This included writing to all Trusts requesting an action plan and information about what additional help they would need to complete relevant actions.
254. Once the IHR was published, NHSE re-wrote to Trusts to ask them to update their original action plans to consider the additional actions. All Trusts should be reporting on and publishing these action plans at their separate Board meetings by July 2025.
255. ICBs were also expected to give updates on their action plans by July and publish these via Board meetings.
256. In relation to recommendations around updating guidance for Trusts, this guidance has been developed in line with national partners, including the Royal College of Psychiatrists, and published. That said, NHSE have identified notable variation across regions for Trusts' implementation of the updated guidance – the biggest pressure being resource. NHSE resourcing remains a live discussion.

Nottinghamshire Healthcare NHS Foundation Trust

Overview and registration

257. I have been asked to set out the history of CQC's monitoring and inspection of NHFT's mental health services in the relevant period.

258. NHFT is an integrated healthcare provider and provides community health care and mental health care including high secure services across over 100 individual locations. It was first registered with CQC on 1 April 2010 and serves a population within Nottingham City and Nottinghamshire with some services offered nationally (England and Wales) or regionally (East Midlands and South Yorkshire).

259. The Trust provides the following core services:

260. Mental Health

- i. High secure hospitals
- ii. Wards for older people with mental health problems
- iii. Acute wards for adults of working age and PICUs
- iv. Mental health crisis services and health-based places of safety
- v. Forensic inpatient or secure wards
- vi. Child and adolescent mental health wards
- vii. Perinatal services
- viii. Long stay or rehabilitation mental health wards for working age adults
- ix. Specialist eating disorder services
- x. Wards for people with learning disabilities or autism

261. Community Health

- i. Community end of life care
- ii. Community health services for children, young people and families
- iii. Community health services for adults
- iv. Community-based mental health services for older people
- v. Specialist community mental health services for children and young people

- vi. Community mental health services for people with a learning disability or autism
- vii. Community-based mental health services for adults of working age
- viii. Community health inpatient services

262. It currently has the following registered locations (excluding prison services):

- Duncan Macmillan House (Trust Headquarters)
- Rampton Hospital
- Bassetlaw Hospital
- Arnold Lodge
- Mansfield Community Hospital
- Blossomwood
- Hopewood
- John Eastwood Hospice
- Wells Road Centre
- Highbury Hospital
- Lings Bar Hospital
- Thorneywood Unit
- Nottingham University Hospital
- Wathwood Hospital Regional Secure Unit
- Sherwood Oaks Hospital

It is registered to provide the regulated activities listed below, although not all locations listed are registered for all activities listed. Full details of which locations are registered

for which activities can be found on the Trust's registration page of the CQC website (<https://www.cqc.org.uk/provider/RHA/registration-info>):

- Personal care
- Transport services, triage and medical advice provided remotely
- Nursing Care
- Family planning
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures

263. During the relevant period the service or parts of the service have been inspected on 6 occasions. The Trust was inspected in January to March 2019; Lucy Wade Unit was inspected in February 2020; Acute wards for adults of working age PICUs were inspected in July 2020; Seacole ward, Wells Road Hospital – Forensic inpatient or secure wards was inspected in January 2021; Forensic inpatient or secure wards were inspected in February 2022; and the Trust was inspected again in March to April 2022. These are set out in greater detail below. We would be happy to share the relevant information underlying these reports as part of further upcoming disclosure.

2019 Inspection

264. The 2019 inspection was a comprehensive inspection forming part of CQC's routine inspection program, informed by ongoing monitoring and previous inspection outcomes [CQCM0016473]. Between 22 January and 7 March 2019 it evaluated the Trust's performance across all five domains, with

particular attention given to services that had previously been rated as requires improvement or where concerns had been raised.

265. The inspection was led by a Head of Hospital Inspection who was supported by a multidisciplinary team which included executive reviewers, inspection managers, inspectors, pharmacy specialists, Mental Health Act reviewers, and specialist advisers with expertise in mental health services.

266. The inspection covered six core services provided by the Trust. These included: acute wards for adults of working age and PICUs, community-based mental health services for adults, child and adolescent mental health wards, community mental health services for people with learning disabilities or autism, forensic inpatient or secure wards, and mental health crisis services including health-based places of safety.

267. The overall rating for the Trust was downgraded from Good to Requires Improvement. The domains of Safe, Responsive, and Well-Led were all rated as Requires Improvement, while Effective and Caring retained a Good rating. The inspection found that leadership instability, particularly during a transition between chief executives, had negatively impacted governance and strategic focus. Staff morale was low, and there were concerns about the ability of staff to raise issues without fear of retribution. Safe staffing levels were not consistently maintained, and medication management was found to be inconsistent across several services. Despite these challenges, some services demonstrated good practice and maintained high standards of care.

268. The inspection identified 25 breaches of legal requirements under nine of the 2014 Regulations. These breaches were spread across multiple services and related to key areas such as person-centred care, dignity and respect, safe

care and treatment, premises and equipment, good governance, staffing, and complaints handling. In response, the CQC issued Requirement Notices. The Trust was expected to demonstrate progress through follow-up inspections and ongoing monitoring.

269. These breaches reflected systemic issues in the Trust's ability to deliver safe, effective, and respectful care. The specific regulations breached were:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 15: Premises and equipment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 18: Staffing

270. Specific examples of breaches included:

- Inadequate monitoring of patients' physical health following rapid tranquilisation, poor medication storage and handling practices, and failure to maintain patient privacy.
- In some wards, patient information was visible to unauthorised individuals, and dormitory-style accommodation compromised dignity.
- Care planning was inconsistent, with some patients not receiving copies of their care plans or being involved in decisions about their treatment.
- Staffing shortages and lack of supervision were also noted, particularly in forensic and acute mental health services.

February 2020 inspection

271. The Lucy Wade Unit, within the Millbrook Mental Health Unit, is a 16-bedded mental health acute inpatient unit for women, providing care, assessment, treatment, and support to women who cannot be safely supported in the community [CQCM0016474]. This inspection was conducted on 12 February 2020 as an unannounced focused inspection of the Acute wards for adults of working age and PICUs core service in response to concerns raised anonymously following a serious incident on the ward. The inspection focused on the Safe, Caring, and Well-led domains, and comprised one CQC inspection manager, three CQC inspectors, and a specialist advisor.
272. The Lucy Wade Unit was rated as Inadequate overall. The Safe and Well-led domains were rated as Inadequate, while the Caring domain was rated as Requires Improvement. The inspection identified serious concerns regarding staffing levels, observation practices, incident reporting, and the overall governance of the ward. The unit was later closed in 2022.
273. CQC issued a Letter of Intent and subsequently served a Notice of Decision under section 31 of the Health and Social Care Act 2008, requiring the Trust to stop all admissions to the ward until further notice. [CQCM0018101 and CQCM0017639] Weekly updates were required to monitor progress. The inspection identified breaches of Regulations 12 (Safe care and treatment), 17 (Good governance), and 18 (Staffing) of the 2014 Regulations.
274. Specific examples of breaches included:
- Staff failed to follow observation policies and procedures, with numerous records showing incomplete or incorrect entries.

- Emergency medical bags were not sealed with tamper-proof seals, and ligature cutters were stored in a locked cupboard with a keypad code that staff were not always aware of.
- Incident reporting was inconsistent, with many incidents documented in clinical notes but not recorded in the electronic reporting system.
- Staff deployment did not ensure sufficient numbers of suitably qualified and experienced staff, and preceptorship nurses were not adequately supported.
- Staff attitudes were not always respectful or supportive, and patients reported feeling unsafe.

July 2020 Inspection

275. The inspection of NHFT acute wards for adults of working age and PICUs took place from 19 to 29 July 2020 [CQCM0016475]. This was a focused responsive inspection, following up on concerns identified in previous inspections.

276. The inspection aimed to assess whether improvements had been made since the previous comprehensive inspection published in May 2019. The inspection focused on three domains: Safe, Caring, and Well-led. The inspection covered four acute inpatient wards for adults of working age and one psychiatric intensive care unit (PICU). These included B2, Rowan 1, Rowan 2, and The Willows. The inspection assessed the quality of care, staffing, medication safety, and governance processes within these services.

277. The inspection team included one CQC inspection manager and one CQC inspector who conducted the on-site inspection. Four additional inspectors and one Expert by Experience supported the inspection remotely through

desktop reviews and telephone interviews. The inspection team visited four wards and conducted both on-site and remote assessments.

278. The overall rating for the service remained as Requires Improvement. The Safe and Well-led domains were rated as Inadequate, while the Caring domain was rated as Requires Improvement. The inspection found that while some improvements had been made, there were still significant concerns regarding medication safety, access to electronic records for temporary staff, and governance oversight of staffing levels.

279. The inspection identified continued breaches of legal requirements under the 2014 Regulations. These included breaches of Regulation 12 (Safe care and treatment); Regulation 17 (Good governance), and Regulation 18 (Staffing).

280. Specific examples of breaches included:

- Staff did not ensure that medications such as insulin pens and emergency EpiPens were correctly labelled or stored, posing a risk of medication errors.
- Patients prescribed high-dose antipsychotics were not supported by care plans documenting the monitoring regime, despite physical health monitoring being carried out.
- Not all bank and agency staff had access to electronic patient records or the incident reporting system, which placed additional burden on substantive staff and risked incomplete documentation.
- Some staff were unaware of how to access ligature cutters in an emergency, and one patient did not have a personal emergency evacuation plan (PEEP) in place.

281. The Trust was required to take action to address the identified breaches. This included ensuring proper medication storage and labelling, providing all staff

with access to electronic records, care planning for high-dose antipsychotic monitoring, and improving governance systems to monitor staffing fill rates. The Trust was also expected to ensure that all clinical staff could access emergency equipment and that PEEPs were in place where required.

January 2021 Inspection

282. The inspection of Seacole Ward at Wells Road Hospital, part of NHFT, was carried out on 30 and 31 January 2021 [CQCM0016476]. This focused responsive inspection was prompted by an anonymous whistleblowing report raising concerns about the safety and quality of care on the ward. Seacole Ward is a 15-bed low secure ward for women. The inspection assessed the five domains. The inspection was limited in scope and did not result in a full re-rating of each domain, but the overall rating for the core service was downgraded to Inadequate.

283. The inspection team comprised a CQC lead inspector and two additional CQC inspectors. The inspection was overseen by an inspection manager. The inspection focused solely on Seacole Ward, a low secure forensic inpatient ward for women. No other forensic or secure wards were inspected during this visit.

284. The overall rating for the service was Inadequate. The Safe and Well-led domains were rated as Inadequate, while the other domains were inspected but not rated. The inspection found serious concerns regarding staff conduct, supervision, physical health monitoring, and the ward culture. Although some improvements had been made, governance processes remained weak and previous recommendations had not been fully implemented.

285. The inspection identified breaches of legal requirements under the 2014 Regulations. A Section 29A Warning Notice was issued to the Trust, requiring urgent improvements [CQCM0019771]. Breaches included:

- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

286. Specific examples of breaches included:

- Whilst staff told us about incidents staff had failed to report or escalate incidents of inappropriate and offensive language used by colleagues when engaging with patients.
- Ligature cutter usage logs were not consistently updated, and blind spots on the ward had not been addressed. Infection control procedures were not always followed, with staff failing to comply with bare-below-the-elbow policies.
- Patients did not receive regular one-to-one sessions with their named nurse, and physical health monitoring was not carried out in line with trust policy.
- Supervision compliance was low, and staff reported feeling unsupported and disconnected from leadership.
- Complaints were not accurately recorded, and lessons from incidents were not routinely shared.

287. The Trust was required to address issues related to staff conduct, supervision, physical health monitoring, governance, and ward culture. The Trust was also expected to ensure that all staff had access to appropriate training and electronic systems necessary for their roles.

February 2022 Inspection

288. This inspection took place between 8 and 10 February 2022 and focused on NHFT's forensic and secure inpatient services [NHFT0000567]. The service includes 268 beds across 17 wards at three hospital sites: Wathwood Hospital Regional Secure Unit (Rotherham), Arnold Lodge (Leicester), and Wells Road Centre (Nottingham). The inspection followed up on previous requirement and warning notices issued in 2019 and 2021.
289. This was an unannounced, focused inspection triggered by the need to assess progress against previous requirement notices (May 2019) and warning notices (February 2021). The inspection covered all key lines of enquiry and included visits to 13 of the 17 wards across the three sites. Wards visited included assessment, ICU, continuing care, rehabilitation, and low secure units.
290. The inspection team included a CQC lead inspector, two additional CQC inspectors, a consultant psychiatrist specialist advisor, two nurse specialist advisors, and three Experts by Experience. The team was overseen by an inspection manager and a Head of Hospital Inspection.
291. The overall rating for the service improved to Good. The Safe domain was rated as Requires Improvement, while Effective, Caring, Responsive, and Well-led were all rated Good. The inspection found that the Trust had addressed all previous warning notices and most requirement notices, with significant improvements in governance, staffing, and patient care.
292. The inspection identified two continued breaches of legal requirements of the 2014 Regulations. These related to Regulation 12 (Safe care and treatment), and Regulation 15 (Premises and equipment).
293. Specific examples of breaches included:

- At Wathwood Hospital Regional Secure Unit, toilets showed limescale staining that could harbour germs, and one shower room on Thornton Ward had been out of action for over two months, leading to long waits for patients.
- At Wells Road, unlabelled food items were found in patient fridges.
- At Arnold Lodge, there were occasions when only one staff member was available to monitor two seclusion rooms, contrary to policy.
- Additionally, closed-circuit television had not yet been installed in some courtyard and low stimulus areas, and some sanitary ware required maintenance.

294. The Trust was issued with Requirement Notices under Regulations 12 and 15 of the 2014 Regulations. It was required to ensure that all bathrooms and shower rooms were in good working order, that sanitary ware was free from limescale, and that CCTV was considered to reduce blanket restrictions. The Trust was also expected to ensure that seclusion rooms were monitored by two staff and that food items were properly labelled.

March 2022 Inspection

295. The inspection of NHFT wards for adults of working age and PICUs took place on 1 and 2 March 2022. [NHFT0000590] This was an unannounced focussed inspection to see if improvements had been made since the 2020 inspection.

296. The inspection covered all the key lines of enquiry. The inspection was led by a CQC inspection manager alongside two CQC inspectors, two specialist advisors and two experts by experience. The inspection visit covered four wards at the Highbury hospital, one ward at Bassetlaw hospital and one ward at Millbrook hospital. It included observing group therapeutic activity sessions and a specific check of the medication management and prescribing practice on three wards.

297. The overall rating remained the same at Requires Improvement. The Safe and Well-Led domains were rated Requires Improvement, while the Effective, Caring and Responsive domains were rated Good. The inspection found that while improvements had been made since the 2020 inspection, there were concerns regarding shared sleeping arrangements that did not comply with national guidance. There were also concerns regarding clinical supervision, mandatory staff training and failing to record whether some patients had been offered a copy of their care plan.

298. The inspection identified breaches of legal requirements under the 2014 Regulations. These included breaches of Regulation 9 (Person-centred care), Regulation 10 (Dignity and respect) and Regulation 17 (Good governance).

- Making alternative arrangements for service users to improve their experiences whilst residing in dormitory-style accommodation.
- Ensure all patients were offered a copy of their care plan and that was to be recorded in the patient record.
- Ensure mandatory training compliance rates (including Mental Health and Mental Capacity) were above 75%.
- Ensure all staff received regular supervision and an annual appraisal.

299. The Trust was also expected to ensure that all ligature risks were recorded in the ligature risk assessment.

300. A section 29A Warning Notice was subsequently issued to the Trust in relation to the breach of Regulation 10 and required significant improvements to be made in relation to dormitory style sleeping arrangements [CQCM0019835].

March – April 2022 Inspection

301. This comprehensive inspection of NHFT was conducted between 22 March and 28 April 2022 as part of CQC's routine programme [CQCM0016478]. It was triggered by the need to reassess services not inspected since 2014 or 2018 and to follow up on previous concerns, including those raised in warning and requirement notices issued in 2019 and 2021.

302. It included a Well-led review at Trust level, alongside detailed inspections of seven core services across mental health and community health domains. During the Well-led review, 33 senior leaders were interviewed, and a wide range of governance documents were reviewed. The inspection was unannounced for inpatient services and announced 24 hours in advance for community services.

303. The inspection team included a Head of Hospital Inspection, an Inspection manager, CQC inspectors, Specialist Advisors and Experts by Experience. The seven inspected core services included are listed below. These services span across multiple sites and include both inpatient and community-based care.

- Long Stay Rehabilitation Mental Health Wards for Working Age Adults
- Wards for Older People with Mental Health Problems
- Community-Based Mental Health Services for Older People
- Community Health Inpatient Services
- Community Health – End of Life Care
- Community Health Services – Children, Young People and Families
- Community Health Services – Adults

304. The Trust's overall rating remained Requires Improvement, with Requires Improvement for the Safe, Effective, Responsive, and Well-Led domains, and an outstanding rating for Caring. An Outstanding rating under Caring is used to reflect consistently compassionate, respectful, and person-centred care across services.

305. The inspection noted Outstanding practice in the following areas:

- John Eastwood Hospice created welcome and exit packs for patients and a dedicated space for grieving families.
- Children's Services were rated Outstanding for Caring, with staff going "above and beyond" to support families.
- Community Health Services for Adults demonstrated exceptional compassion and innovation in care delivery.

306. Feedback was overwhelmingly positive in most services. Patients described staff as kind, respectful, and supportive. Carers appreciated being involved in care planning and praised communication. Some concerns were raised about communication delays and lack of access to complaints procedures in certain services.

- Areas for improvement identified on inspection included:
 - Eliminate dormitories and improve ward environments
 - Improve medicines safety and audit processes
 - Ensure all staff receive regular supervision and appraisal
 - Increase visibility of senior leadership
 - Improve access to training and digital tools
 - Ensure consistent use of ReSPECT forms and MCA compliance

307. The inspection identified multiple breaches of the 2014 Regulations. These included:

- Regulation 10: Dignity and respect
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse
- Regulation 15: Premises and equipment
- Regulation 17: Good governance

- Regulation 18: Staffing

308. Specific examples of breaches included:

- 80 patients across nine wards were still in shared sleeping arrangements, despite previous commitments to eliminate dormitories.
- Outdated or unlabelled medicines, poor audit trails, and insecure storage were found in several services.
- Patients at Thorneywood Mount lacked up-to-date crisis or contingency plans.
- Compliance with mandatory training and supervision was below target in several services. Inadequate staffing levels, particularly at night, affected patient care and safety.
- Delays in implementing Electronic Prescribing and Medicines Administration (EPMA) and governance dashboards.

309. The Trust was required to: embed governance structures across all divisions; improve equality impact assessments; ensure GDPR compliance and fit and proper persons checks; address staffing shortages and training gaps; complete the elimination of dormitories; improve medicines management and crisis planning; and implement and monitor the digital strategy and EPMA.

The Role of Mental Health Act Reviews at NHFT

310. As set out above in paragraphs 38-46 and 127-130 CQC has a duty, under the MHA, to monitor how services exercise their powers and discharge their duties when patients are detained in hospital.

311. Between 1 January 2018 and 31 December 2023 CQC's Mental Health Act Team undertook 63 review visits of wards at 10 locations overseen by the Trust (excluding Rampton Hospital). These included (Ward types):

- Arnold Lodge (Forensic)
- Bassetlaw Hospital (Acute inpatient, Older persons)
- Blossomwood (Acute inpatient, Older persons)
- Highbury Hospital (Acute inpatient, Older persons, Psychiatric Intensive Care Unit – PICU, Learning Disabilities)
- Hopewood (Mother and baby unit, Child and Adolescent Mental Health Services)
- Mansfield Community Hospital (Learning Disabilities, Rehabilitation)
- Sherwood Oaks Hospital (Acute inpatient)
- Thorneywood Unit (Rehabilitation)
- Wathwood Hospital Regional Secure Unit Regional Secure Unit (Forensic, Rehabilitation)
- Wells Road Centre (Forensic, Rehabilitation)

312. These produced findings specific to each individual ward which were set out in unpublished MHA reports for providers. Please find the list of review visits undertaken at the Trust during the above period at [CQCM0016526]. As noted above the findings of these visits were also used to inform broader CQC inspections and published inspection reports of the provider [CQCM0016473; CQCM0016474; CQCM0016475; CQCM0016476; NHFT0000567; CQCM0016478]. These were considered in greater detail above.

313. CQC also produces an annual report entitled 'Monitoring the Mental Health Act' which sets out our activities and findings over the year from visits and inspections, at a national level, along with key themes [CQCM0016464 ; CQCM0016465; CQCM0016466; CQCM0016467; CQCM0016468]. The most recent of these reports (2023/24) for example highlighted the Mental

Health Bill; pressures on systems; workforce; inequalities; children and young people; and environment.

Management Review Meetings in relation to NHFT

314. We have identified Management Review Records ('MRR') spanning January 2019 to May 2023 (based on the date that the MRR was opened). We have reviewed the Management Review Meetings ('MRM') that form the meeting review record in order to identify examples of themes and concerns that arose during this period.
315. Staff Issues – we found, for example, a shortage of nurses and a lack of experienced staff on wards. There were findings of high usage of agency staff and a lack of staff with knowledge of patients on the ward. We also found issues relating to staff behaviours and culture.
316. Governance – we found there to be issues with a weakened leadership at the Trust and we recommended initially to feedback to NHSE/NHSI to let them provide support and monitor governance arrangements. We found that the Trust did not always take action on identified risk.
317. Incident reporting/Investigation – we found examples of problems with incident reporting, including discrepancies in evidence, and insufficient investigation into incidents. We discussed with the Trust that we were concerned that we were not being informed of serious incidents in a timely way. We noted that a Coroner's Prevention of Future Deaths ('PFD') report found that the Trust's incident investigation had failed to identify themes of concern, contained false/inaccurate statements and failed to challenge false assumptions and introduced false information. A further PFD report found concerns about the Trust's serious investigation process.

Nottingham City Council

318. I have been asked to set out an overview of CQC's Local Authority Assessment process.

Background

319. In April 2023 the CQC assumed a new duty to assess local authorities' performance in delivering their adult social care responsibilities under Part 1 of the 2014 Act. We do not assess against Mental Health Act duties as part of this process.

320. In preparation for this CQC worked with partners to coproduce our assessment framework. During the summer of 2022 we carried out a test and learn exercise with two local authorities to test our plans for assessment and refine our approach. We then launched a pilot with five local authorities in May 2023 to further test our approach. The pilot led to a published evaluation [CQCM0016424], and we then further refined this.

321. The current methodology was signed off by the minister in December 2023 and we rolled out a programme to baseline assess all 153 local authorities, including those that were part of the pilot, over a two-year timeframe from December 2023. Within this timeframe we intend to assess each relevant local authority once. However, in exceptional circumstances, we may need to carry out more than one assessment if there are issues of concern. For example, if we believe that people are or may be at risk of harm, or where we have previously carried out an assessment where we have identified serious risks to people and need assurance that improvements have been made.

322. We currently anticipate that all the site visits that are part of these assessments will be completed by end December 2025 and the reports

completed by the end of March 2026. When we have carried out an initial formal assessment of all local authorities, we will be able to understand how well they are meeting their Care Act duties as a starting point. We will then begin our longer-term approach to regular ongoing assessments. Our post baseline approach will commence in April 2026.

323. As part of our assessment of Local Authorities and included in our report is an overall and underlying ratings against certain criteria, see below for more detail. In brief, the ratings are between 1 (Evidence shows significant shortfalls) to 4 (Evidence shows an exceptional standard). We set out how these scores are determined on our website [CQCM0016527].

324. We do not currently have an ongoing engagement and monitoring role as part of the assessment programme. At present our role is focussed on completing the first assessments. Regular engagement is planned for after the baselining is completed.

325. CQC does not have enforcement powers in this area. Local authorities are not registered with CQC for this regulatory purpose. If CQC considers that a local authority is failing to perform its functions under the Care Act to an acceptable standard, then, pursuant to s50(2) HSCA 2008, we must inform the Secretary of State for Health and Social Care. This notification will be triggered where a local authority scores 1 in a quality statement (in any quality statement other than those that sit under the leadership theme) or is rated Inadequate overall.

Assessments

326. Our assessments start when we send an information return to local authorities with adult social care functions, and end when we publish our reports. During the assessment we intend to look at evidence that relates to the 12 months

preceding the start of the assessment (when we send the information return) [CQCM0016528]. This is the period to which the assessment relates. However, we may look at evidence outside of the 12-month period. For example, where relevant data is published every two years, or when looking at organisational strategies and policies.

327. In exceptional circumstances, it may be appropriate for us to look at information of concern that is several years old. We will only consider this if it is significant and relevant to our current assessment. Our assessment teams will consider each individual case to make these decisions. If we identify serious risks to people during an assessment, we will follow these up in a further assessment.

328. Our assessment teams have a breadth of experience in health, social care and regulation. Teams include social workers, nurses, occupational therapists, commissioners, and people who have delivered and run services. Our teams work alongside executive reviewers and specialist advisors who will be substantively or recently employed as senior leaders such as directors of adult social care services within a local authority or other relevant organisation. This will help ensure our judgements are informed by up-to-date professional knowledge and experience.

329. Our assessments use an Assessment Framework which uses a subset of nine of the CQC's quality statements from our Single Assessment Framework, set out under four themes [CQCM0016529; CQCM0016530]. This is because local authorities are being assessed against a different set of statutory duties to registered providers. These include:

- Working with people

- Providing support
- How the local authority ensures safety within the system
- Leadership

330. To assess against these, we use five of our six standard evidence categories, including:

- People's experience
- Feedback from staff and leaders
- Feedback from partners
- Processes
- Outcomes (we will not use this category in the initial formal assessments)

331. We do not use the observation evidence category as it does not apply to the specific context of a local authority. In addition, the Department of Health and Social Care has requested that we include financial information in our assessment reports; we do not consider this in our assessment, and it is presented for the purposes of information only.

332. We will use the most appropriate options to gather evidence for a quality statement through both on-site and off-site methods.

333. Each assessment starts with sending a request for information to local authorities with adult social care functions. This is called an information return. The information return requests the documentary evidence and key information that we need to carry out an assessment. The information return also includes a request for a self-assessment. This is an item of evidence in the 'Feedback from staff and leaders' evidence category.

334. We use a range of approaches to gather evidence before we carry out an on-site visit. We corroborate the evidence to ensure our judgements are robust.

Nottingham City Council Assessment

335. Nottingham City Council was one of the five local authorities which formed part of the pilot programme and was assessed under this approach in May 2023. The report was published in November 2023 and provides a detailed summary of the findings [CQCM0016426].

336. They were rated as Requires Improvement overall, which is indicative of the evidence demonstrating some shortfalls. They were scored as follows:

- Working with people
 - i. Assessing needs – 2 – evidence shows some shortfalls
 - ii. Supporting people to live healthier lives – 2 – evidence shows some shortfalls
 - iii. Equity in experience and outcomes – 2 – evidence shows some shortfalls
- Providing support
 - iv. Care provision, integration and continuity – 3 – evidence shows a good standard
 - v. Partnerships and communities – 2 – evidence shows some shortfalls
- How the local authority ensures safety within the system
 - vi. Safe systems, pathways and transitions – 2 – evidence shows some shortfalls
 - vii. Safeguarding – 3 – evidence shows a good standard
- Leadership
 - viii. Governance, management and sustainability – 2 – evidence shows some shortfalls

- ix. Learning, improvement and innovation – 3 – evidence shows a good standard

Cygnets Victoria House Hospital

337. I have been asked to set out the history of CQC's monitoring and inspection of Cygnets Victoria House Hospital's mental health services in the relevant period.

338. Cygnets Victoria House (previously Cambian Victoria House Hospital) is a 26-bed mental health inpatient service for men who are experiencing an acute episode of mental illness and require an emergency admission. It provides Acute wards for adults of working age and PICUs units as a core service. It was first registered with CQC on 17 November 2010. Since first registering there have been 4 registered managers of the service, two of which during the period, as well as one nominated individual.

339. It is registered to provide the below regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

340. During the relevant period the service has been inspected three times, on 29 October 2018, 21 April 2021, and 6 September 2022.

October 2018 Inspection

341. The 2018 inspection was planned as part of the then ongoing mental health inspection programme. It was an unannounced comprehensive inspection. The service was rated as Requires improvement overall, and across all domains other than Caring, which was rated as Good.

342. The rationale for these judgements can be found in the inspection report published 11 February 2019 and summarised there on page 2 [CQCM0016538]. In summary, the inspection identified concerns relating to restrictions on the environment, blanket restrictions (including on the use of plastic cutlery, on high caffeine drinks, on lighters, and on locked bathroom doors), insufficient care planning around risks, minimal uptake of structured activity, staff not being up to date on mandatory training and reduced supervision rates, failure to clearly document discharge decisions, lack of clarity over storage of records, and medicines not always being authorised in line with the MHA.

343. The inspection identified 3 breaches of the 2014 Regulations:

- Regulation 12 (Safe Care and Treatment) in relation to choking risks & care planning around these risks, and prescription of medicines not in accordance with the MHA.
- Regulation 18 (Staffing) in relation to out of date mandatory training.
- Regulation 9 in relation to lack of patient centred care and use of blanket restrictions that were not reviewed.

344. These were considered at a Management Review Meeting (MRM)

April 2021 Inspection

345. The 2021 inspection was a focussed responsive inspection in response to a rise in safeguarding notifications regarding racial abuse, as well as one incident where inappropriate restraint had been used by a member of staff. The inspection considered the Safe and Well-Led domains; however, the service was not rerated as the service type had changed since the previous inspection.

346. The rationale for these judgements can be found in the inspection report published 25 June 2021 and summarised there on page 2 [CQCM0016428]. In summary, the inspection identified concerns relating to the environment limiting staff oversight of patients, limited communal space, unreflective risk assessments, failures to uphold Covid-19 infection control principles, errors in multiple forms of documentation including incident recording and cleaning records, and monthly incident review meetings had not identified all areas for improvement in the use of restraint, or errors in documentation.

347. The inspection identified two breaches of the 2014 Regulations:

- Regulation 17 (Good governance) in relation to lack of effective processes to ensure appropriate record keeping regarding service users, management of the regulated activity, or evaluation and improvement.
- Regulation 12 (Safe care and treatment) in relation to premises used not being safe for the intended purpose or used in a safe way.

348. These were considered at an MRM.

September 2022 Inspection

349. The 2022 inspection was an unannounced comprehensive inspection to determine if the regulatory breaches identified on the previous two inspections had been addressed. The service was rated as Good overall and across all domains. No breaches of regulations were identified.

350. The rationale for these judgements can be found in the inspection report published 18 October 2022 and summarised there on page 2 [CQCM0016429]. In summary, whilst rated Good, the inspection identified areas for improvement relating to the presence of large numbers of staff outside of seclusion review meetings, potential concerns around the acoustics

in the seclusion room for clear communication, patient concerns around the clarity of staff communications, and lack of a system for patients to be able to speak with managers above hospital director level.

Management Review Meetings in relation to Cygnet Victoria House Hospital

351. We identified MRMs between May 2019 and November 2021 and found the following examples of themes/concerns (a management meeting was not required in relation to the September 2022 inspection as no regulation breaches were identified and therefore it was considered that an MRM was unnecessary in the circumstances).

352. Staff Issues: we identified concerns relating to the skills and experience of staff, and concerns about the ability of the service to manage a new ward opening. There were also issues of staff struggling to deal with the patient group, with a reliance on involving police to defuse situations, or to move patients. We also identified concerns about staff training and culture: staff training was found to be out of date in some instances.

353. Governance: we noted issues with governance at the service, including issues with patient risk assessments and ward audits, and the presence of old ligature maps on wards.

354. Investigation Processes: we had concerns that the service's incident data was not complete and accurate, and about their investigation processes and lessons learned following incidents.

Priory Arnold Hospital

355. I have been asked to set out the history of CQC's monitoring and inspection of Priory Arnold Hospital's mental health services in the relevant period.

356. Priory Arnold Hospital (previously Calverton Hill prior to 2020) is an inpatient acute and PICU in Nottingham, for males and females struggling with a wide range of mental health conditions. It consists of 8 male and 24 female acute beds and 10 male and 10 female PICU beds.

357. It was first registered with CQC in December 2010 and provides the Acute wards for adults of working age and PICU units core service.

358. It is registered to provide the below regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- The service has the following service specialisms:
 - Mental health conditions
 - Learning disabilities
 - Caring for adults under 65 yrs
 - Caring for adults over 65 yrs
 - Caring for people whose rights are restricted under the Mental Health Act

359. During the relevant period the service or parts of the service have been inspected or assessed on eight occasions. Calverton Hill (as was then) was inspected in October 2019 and in February 2020; Priory Arnold was inspected in October 2020, March 2021, June 2021, December 2021, August 2022, and January 2023 [CQCM0016480; CQCM0016481; CQCM0016482; CQCM0016483; CQCM0016484; CQCM0016485; CQCM0016486; CQCM0016487]. These are set out in greater detail below.

October 2019 inspection

360. The 1 - 2 October 2019 inspection was a routine comprehensive inspection as part of CQC's then ongoing programme. Please note at this time the service included an additional core service, wards for people with learning disabilities or autism, provided in Clumber Ward for women with learning disabilities. The inspection team consisted of CQC inspectors, Specialist Advisors, and an Expert by Experience.

361. The service was rated as Requires Improvement overall, as well as under the Effective, Caring Responsive, and Well-Led domains. The Safe domain was rated as Inadequate.

362. A number of serious concerns were noted across all domains. The inspection identified 17 breaches against 6 of the 2014 Regulations. The specific regulations breached were:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

363. Specific examples of breaches included:

- Care plans not being personalised or collaboratively developed.
- Physical health monitoring was inconsistent and poorly documented.
- Discharge planning was not initiated on admission.
- Female patients lacked access to sanitary bins.
- Patients' capacity to consent was not clearly recorded.

- Advocacy information was not readily available to patients.
- Staff recruitment and retention strategies were inadequate.
- Restricted items were not properly monitored.
- Blanket restrictions were in place without individualised risk assessments.
- Observations were not completed in line with policy.
- Cleaning records were incomplete and ward areas were visibly dirty.
- Medicines were not always available or stored safely.
- Multiple record systems led to fragmented and outdated patient information.
- Clinical audits were not routinely conducted or used to drive improvements.

Staff training in key areas was below required levels.

364. CQC served a s.29 Warning Notice to the Provider in relation to a breach of Regulation 12 Safe care and treatment of the 2014 Regulations.[CQCM0019618] This related to the monitoring of restricted items, the blanket search rules for patients, observations not being carried out in line with policy, ward cleanliness, record keeping, and a lack of a sufficient quantity of medicines to ensure the safety of patients.

February 2020 Inspection

365. The 4 February inspection was a focussed inspection carried out to assess progress against a warning notice issued in October 2019. The Safe, Effective, and Well-Led were considered. The inspection focused solely on the acute mental health wards (Newstead and Bestwood) each with 16 beds. Clumber Ward was due to close at the time of inspection. The inspection team included CQC inspectors and a Nurse Specialist Advisor.

366. The Safe domain was rated as inadequate, and both the Effective and Well-Led domains were rated as requires improvement. While some improvements

were noted, the CQC concluded that changes were not yet embedded and that several areas of concern persisted.

367. The inspection identified 3 breaches under 3 of the 2014 Regulations and Requirement Notices were issued. The specific regulations breached were:

- Regulation 9: Person-centred care
- Regulation 12: Safe care and treatment
- Regulation 17: Good governance

368. Specific examples of breaches included:

- Risk assessments not being detailed or regularly updated following incidents.
- Staff did not consistently monitor or record patients' physical health, including after rapid tranquilisation.
- Blanket restrictions were in place without individualised risk assessments.
- Cleaning records were incomplete, and tasks were not completed to the required frequency.
- Staff were unclear about restricted items and how to document searches.
- Patient information was stored across multiple systems, leading to gaps and inconsistencies.
- Audits did not lead to clear actions or improvements, and outcomes were not always recorded.

October 2020

369. The 14, 15 and 16 October inspection was an unannounced focussed inspection carried out in response to concerns raised anonymously about unsafe staffing levels, poor risk management and a culture of bullying. At the time of inspection, the hospital operated three female wards: Newstead and

Bestwood (acute wards), and Rufford (PICU). Plans to open a male PICU on Clumber Ward were on hold due to staffing concerns.

370. The Safe and Well-Led were considered. The inspection focused on the acute mental health wards (Newstead and Bestwood). The visit included both on-site and remote interviews with patients, carers, and staff. The inspection team included CQC inspectors a Specialist Advisor, and an Expert by Experience.

371. Although the hospital had previously been rated as Requires Improvement overall in October 2019, this inspection was not rated due to its limited scope. Significant concerns remained regarding safety and governance.

372. The inspection identified breaches of Regulation 12: Safe care and treatment of the 2014 Regulations and a Requirement Notice was issued in respect of this particular Regulation. Specific examples of breaches included:

- The alarm system not functioning effectively, and staff lacking confidence in receiving timely assistance during emergencies.
- A fault on the Newstead Ward alarm system had not been resolved at the time of inspection.
- Ligature anchor points on ensuite doors had been identified but not yet fully addressed, despite a patient death.
- Risk assessments were incomplete or missing in several patient records. Staff did not consistently monitor or record patients' physical health observations.
- Staff shortages and reliance on untrained locum staff affected continuity and safety of care.

March 2021 Inspection

373. The 9-12 and 16 March inspection was an unannounced focussed inspection of the Safe, and Well-Led domains. This was prompted by serious concerns raised anonymously regarding safety and cleanliness on wards, inappropriate use of restraint and seclusion, and a lack of staff confidence in reporting safeguarding issues. It included all four wards, including Rufford (female PICU), and Clumber (male PICU) which had opened in 2020, as well as remote interviews with patients, carers, and staff. The inspection team included CQC inspectors, a specialist advisor, and an Expert by Experience.

374. Both the Safe and Well-Led domains, as well as the Overall rating were rated as inadequate, and the service was placed into special measures. The inspection identified breaches of 4 of the 2014 Regulations, specifically:

- Regulation 12: Safe care and treatment
- Regulation 15: Premises and equipment
- Regulation 17: Good governance
- Regulation 18: Staffing

375. Specific examples of breaches included:

- Wards and seclusion rooms being dirty, with bodily fluids and graffiti left uncleaned for extended periods.
- The alarm system was unreliable, and staff lacked confidence in its use.
- Ligature risks were not fully assessed or mitigated, including in areas previously linked to patient harm.
- Infection control procedures were not followed, and antibacterial supplies were not readily available.
- Staff lacked training and support to work safely in PICU environments.

- Risk assessments were incomplete or missing, and seclusion practices were not always safe.
- Audits failed to identify or resolve risks, and actions were not taken even when issues were known.
- Staff shortages led to missed breaks and long observation shifts, increasing the risk of harm.

376. Requirement notices were issued in relation to the breaches of Regulations 12, 15, 17 and 18 of the 2014 Act. Additionally, in relation to the breach of Regulation 12, CQC issued a Letter of Intent and subsequently served a Notice of Decision under Section 31 of the Health and Social Care Act 2008 [CQCM0019944 and CQCM0021649]. The Notice of Decision imposed conditions that there be no new admissions without prior agreement from CQC, that work be undertaken to assess and mitigate ligature risks and that weekly reports be provided setting out actions taken to ensure an effective system for environmental risk management. A written record of staff training on ligature risk management was also requested.

June 2021 Inspection

377. The 15 and 16 June inspection was an unannounced focused inspection looking at the Safe and Well-Led domains. At the time of inspection, only Bestwood and Rufford Wards were open, with Newstead and Clumber Wards closed. The inspection included site visits to the open wards and a review of the seclusion and de-escalation rooms on the closed Clumber Ward. The inspection team included CQC inspectors and an inspection manager.

378. Although the hospital was not re-rated, the findings indicated that significant issues remained, particularly around ligature risks, environmental safety, and governance processes.

379. The inspection identified breaches against 3 of the 2014 Regulations, specifically:

- Regulation 12: Safe care and treatment
- Regulation 15: Premises and equipment
- Regulation 17: Good governance

380. Specific examples of breaches included:

- Ligature risks previously identified not having been addressed, and no clear timescales were in place for their resolution.
- Staff lacked confidence in the alarm system, which continued to produce false alerts and delayed responses.
- Governance systems failed to identify or act on safety risks, including gaps in observation records and broken equipment.
- Staff did not consistently report incidents or conduct post-incident debriefs.
- Environmental repairs and equipment maintenance were delayed or lacked clear timelines.

December 2021 Inspection

381. The 7 and 8 December inspection was a comprehensive inspection looking at all five domains. The inspection was prompted by ongoing concerns about patient safety, risk management, and governance. At the time of inspection, three wards were open: Bestwood, Newstead, and Rufford. Clumber Ward remained closed. The inspection team visited all open wards, and included interviews with patients and staff, observation of care, and review of clinical

records and governance documentation. The inspection team consisted of CQC inspectors, an inspection manager, a Nurse Specialist Advisor, and an Expert by Experience.

382. The hospital remained in special measures, with the overall rating and domains of Safe and Well-led rated as Inadequate, Effective and Responsive as Requires Improvement, and Caring as Good.

383. The inspection identified breaches against three of the 2014 Regulations, specifically:

- Regulation 12: Safe care and treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

384. Specific examples of breaches included:

- Medicines not being administered at the prescribed times, and staff failing to monitor the effects of rapid tranquilisation.
- Ligature risks created by maintenance work were not identified or mitigated.
- Emergency equipment was not tested at the required frequency.
- Staff failed to follow policies on restricted items and patient observation, leading to serious incidents.
- Risk assessments were vague and did not provide clear guidance for managing patient risks.
- Staff did not consistently record or monitor patients' physical health, including for those with diabetes or at risk of pressure sores.
- Patients' feedback, particularly about food and activities, was not acted upon.

385. Governance systems failed to identify or address ongoing risks, and learning from incidents was not embedded. Requirement notices were issued in relation to the breaches of Regulations 12, 17 and 18 of the 2014 Act. CQC also served s.29 Warning Notices on the provider in relation to Regulations 12 and 17 [CQCM0018796 and NHNB0011905].

August 2022 Inspection

386. The 2 – 4 August inspection was a comprehensive inspection looking at all five domains. The inspection was prompted by concerns following incidents at the hospital. At the time of inspection, three wards were open: Bestwood, Newstead, and Rufford. Clumber Ward remained closed. The inspection team visited all open wards and reviewed care records, staff training, governance systems, and patient feedback. The inspection team comprised of three CQC inspectors, one specialist advisor who was a registered nurse and had experience of these settings and an Expert by Experience.

387. The hospital remained in special measures, with the overall rating and domains of Safe and Well-led rated as Inadequate, and Effective, Caring, and Responsive all rated as Requires Improvement.

388. The inspection identified breaches against 6 of the 2014 Regulations, specifically:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 12: Safe care and treatment
- Regulation 15: Premises and equipment
- Regulation 17: Good governance
- Regulation 18: Staffing

389. Specific examples of breaches included:

- Sanitary disposal bins not being available in female bedrooms, compromising dignity.
- Staff were not trained in managing personality disorders, despite this being a known gap.
- Restricted items were not consistently managed, leading to repeated incidents of harm.
- Staff did not use least restrictive practices when searching patients.
- Medical equipment in clinic rooms was not always in working order.
- Governance systems failed to identify or act on risks, including maintenance issues and training gaps.
- Staff were not trained in immediate life support, despite the use of restraint and rapid tranquilisation.
- Activities were not tailored to patient needs, and community engagement was limited.

390. Requirement notices were issued in relation to the breaches of Regulations 9, 10, 12, 15, 17 and 18 of the 2014 Act. CQC also issued a Letter of Intent to the provider following concerns that service users will, or may, be exposed to the risk of harm. [CQCM0016717] No enforcement action was subsequently taken in relation to this matter.

January 2023 Inspection

391. The 24 January 2023 inspection was an unannounced focussed inspection looking at the Safe and Well-led domains. It was prompted by serious incidents, including a patient death following unauthorised leave and another incident involving a patient accessing the roof and sustaining injuries. At the

time of inspection, the hospital operated four wards: Bestwood and Newstead (acute), Rufford (female PICU), and Clumber (male PICU).

392. The inspection team visited Bestwood and Newstead Wards unannounced during the night and early morning. The review focused on patient safety, staff training, risk management, and governance processes. The inspection team consisted of CQC inspectors.

393. The service was not re-rated due to the limited scope of the inspection – the previous Inadequate rating remained in place.

394. The inspection identified breaches against 3 of the 2014 Regulations, specifically:

- Regulation 12: Safe care and treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

395. Specific examples of breaches included:

- Staff failing to manage restricted items consistently, leading to repeated incidents involving contraband.
- Post-leave searches were not conducted in line with care plans, and staff were unaware of relevant policies.
- Observation records were inaccurate and contradicted section 17 leave documentation.
- Staff lacked training in managing high-risk behaviours and did not carry out enhanced observations correctly.
- Mandatory training compliance was below target in key areas, and new staff were not adequately prepared.

- Governance systems failed to identify or address risks, and lessons learned were not embedded in practice.
- Staff were unclear on how to respond to absconsion incidents, and the absconsion pack was not known or used by most staff.

396. Requirement notices were issued for the breaches of Regulations 12, 17 and 18 of the 2014 Act. Additionally, CQC issued a Letter of Intent and subsequently served a Notice of Decision under Section 31 of the Health and Social Care Act 2008 imposing conditions relating to staff training on absconsion risk and the policies and procedures on patient record keeping [CQCM0024082 and CQCM0016763].

Management Review Meetings in relation to Priory Arnold Hospital

397. We identified MRMs between February 2019 and January 2023 and found the following examples of themes/concerns.

398. Staff Issues: we noted concerns around the use of locum nurses, with staff retention an issue. A review of staffing information prior to the opening of the PICU ward showed insufficient staffing to cover the wards, together with insufficient ward leadership. We received whistleblowing on three occasions in the space of two weeks regarding staffing levels with noted high usage of agency staff. There were also concerns noted regarding staff behaviours and training, for example responding to absconsion incidents and a lack of awareness of the missing persons policy.

399. Governance: we noted concerns around the management's awareness of risks and the capacity to learn lessons following incidents. We also found the

service was not reactive enough to reassess risk assessments following the death of a patient. Governance processes were not sufficiently thorough in identifying risks from ligature points, and there were also failures in processes around omissions and discrepancies in patient records.

Recommendations

400. I have been asked to set out CQC's position with regards to recommendations for changes and improvements that we consider should be made to existing standards and guidance, and to multi agency working, which will help to prevent similar attacks in the future.
401. CQC continues to endorse the recommendations made as part of our Section 48 Review of NHFT and to the extent that it is possible, and depending on the evidence received by the Inquiry, we would encourage the Inquiry to adopt any recommendations which have not yet been fully implemented by the relevant bodies.
402. We would also refer the Inquiry to our annual Monitoring the Mental Health Act reports, referred to at paragraph 193, and previous publications are exhibited to this statement. These set out CQC's activity and findings from engagement with people subject to the MHA and review of services registered to assess, treat and care for people detained using the MHA. These reports raise key areas and concerns CQC has identified about the sector.
403. Similarly, we would refer the Inquiry to our annual State of Care reports, referred to at paragraphs 15, 194 and 217, and previous publications are exhibited to this statement. The 2023/2024 report in particular included section entitled 'Black men's mental health', following on from our findings in the previous year's report.

404. We would also note CQC’s work and publication of the Mental Health Act Code of Practice 2015: Evaluation in 2019 [CQCM0016463], and Community Mental Health Survey in 2024 [CQCM0016453] referred to at paragraph 195, the latter of which included NHFT [CQCM0016531; CQCM0016532; CQCM0016533; CQCM0016534].

405. In terms of additional recommendations, CQC is keen to ensure that lessons are learned and wishes to engage fully in the Inquiry process. We confirm that we will monitor the Inquiry evidence carefully and should any supplementary recommendations be identified as a result of our review, we will notify the Chair.

406. CQC reiterates our commitment set out in the Section 48 Review of NHFT to look in depth at the standard of care in community mental health across the country as set out in paragraphs 241-242, given that we continue to see issues with quality and with patient and public safety. CQC continues to develop and embed our work around observing and understanding cultures where there is a risk of people receiving poor treatment and/ or care as a result of factors associated with a closed culture as set out in paragraphs 243-244. We will combine any insights from this work with our ongoing monitoring of the Inquiry evidence and provide any suggested recommendations to the Inquiry.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

GRO-B

Dated: 18/12/2025

No.	Inquiry URN	Document Description
1	CQCM0029016	Policy Document, Re: Our Board, CQCM 3 November 2025
2	CQCM0029017	Policy Document, Re: Our Executive Team, CQCM 31 October 2025
3	CQCM0016454	Policy Document. Re: Corporate Governance Framework, CQC June 2022
4	CQCM0016455	Policy Document Re: Framework Agreement, DHSC and CQC. October 2020
5	CQCM0016489	Policy document compiled by CQC RE: Essential standards of quality and safety - What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008 March 2010
6	CQCM0016446	Policy Document Re: Guidance for providers on meeting the regulations, CQC March 2015
7	CQCM0016449	Policy Document. Re: Notifications: guidance for providers 20 May 2025
8	CQCM0016450	Policy Document Re: Registration under the Health and Social Care Act 2008. The scope of registration. May 2022
9	CQCM0016490	Policy Document, Re: Our next phase of regulation A more targeted, responsive and collaborative approach Cross-sector and NHS trusts, CQC

		December 2016
10	CQCM0016447	Policy Document Re: How CQC monitors, inspects and regulates NHS trusts. November 2022
11	CQCM0016431	Policy document Re: How CQC monitors, inspects and regulates NHS trusts, CQC March 2018
12	CQCM0016434	Policy document Re: How CQC monitors, inspects and regulates independent healthcare services, CQC August 2021
13	CQCM0016433	Policy document Re: How CQC monitors, inspects and regulates independent healthcare services, CQC January 2019
14	CQCM0016432	Policy document re: Key lines of enquiry, prompts and ratings, characteristics for healthcare services, CQC
15	CQCM0016491	Policy document Re: How CQC monitors, inspects and regulates adult social care services, CQC January 2019
16	CQCM0016492	Policy document Re: How CQC monitors, inspects and regulates independent healthcare services May 2019
17	CQCM0016493	Policy document Re: Key lines of enquiry, prompts and ratings characteristics for adult social care services
18	CQCM0016494	Policy document Re: How CQC monitors, inspects and regulates adult social care services, CQC November 2023

19	CQCM0016495	Policy document Re: Our new single assessment framework, CQC
20	CQCM0016496	Policy document Re: Our new assessment approach: update December 2023 6 December 2023
21	CQCM0016497	Report dated 22/01/2019, compiled by CQC, Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services - Nottinghamshire Healthcare NHS Foundation Trust
22	CQCM0016498	Report dated 30/03/2019, compiled by CQC, Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services - Nottinghamshire Healthcare NHS Foundation Trust
23	CQCM0016499	Report dated 23/05/2019, compiled by CQC, Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services
24	CQCM0016500	Report, dated 19/12/2019, compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services.
25	CQCM0016501	Report dated 18/02/2020, compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services dated 18/02/2020
26	CQCM0016502	Report, dated 30/04/2020, compiled by CQC RE:CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services dated 30/04/2020

27	CQCM0016503	Policy document. Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services, NHFT. 26 June 2020
28	CQCM0016504	Report dated 23/08/2020, compiled by CQC, Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services - Nottinghamshire Healthcare NHS Foundation Trust
29	CQCM0016505	Report dated 27/10/2020, compiled by CQC, Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services - Nottinghamshire Healthcare NHS Foundation Trust
30	CQCM0016506	Report dated 16/12/2020 compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services (NHFT)
31	CQCM0016507	Report dated 20/02/2021 compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services (NHFT)
32	CQCM0016508	Report, dated 27/04/2021, compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services dated 27/04/2021
33	CQCM0016509	Report dated 28/06/2021 compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services (NHFT)
34	CQCM0016510	Policy document compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services dated 25/08/2021

35	CQCM0016511	Policy document. Re: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services - Nottinghamshire Healthcare NHS Foundation Trust, CQC 18 October 2021
36	CQCM0016512	Report dated 14/02/2022 compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services (NHFT)
37	CQCM0016513	Report dated 16/05/2022 compiled by CQC RE: CQC Insight for NHS Trusts and Community Interest Companies that provide Mental Health Services (NHFT)
38	CQCM0029018	Guidance document, Re: Brief guide: Patient and carer race equality framework (PCREF), CQCM 13 November 2025
39	CQCM0029019	Guidance document, Re: Brief guide: Care of children and young people in inappropriate settings, CQCM 13 October 2025
40	CQCM0029020	Guidance document, Re: Brief guide: Mandatory training requirement on learning disability and autism, CQCM 8 September 2025
41	CQCM0029021	Guidance document, Re: Brief guide: Digital contactless patient monitoring technologies in mental health in-patient services, CQCM 20 August 2025
42	CQCM0029022	Guidance document, Re: Brief guide: the use of 'blanket restrictions' in mental health wards, CQCM

43	CQCM0029023	Guidance Document, Re: Brief guide: Smokefree policies in mental health inpatient services, CQCM
44	CQCM0029024	Guidance Document, Re: Brief Guide: Crisis Response Lines - NHS111 'select mental health option', CQCM
45	CQCM0029025	Guidance, Re: Brief guide: Assessing mental health care in the emergency department (ED), CQCM
46	CQCM0029026	Guidance, Re: Brief Guide: Mental Health Units (Use of Force Act) 2018, CQC
47	CQCM0029027	Guidance, Re: Brief guide: Physical healthcare in mental health settings, CQCM
48	CQCM0029028	Guidance, Re: Brief Guide: Covert Medicines in Mental Health Services, CQCM
49	CQCM0029029	Guidance, Re: Brief Guide: Ligature anchor points, ligatures and other means of self-harm using fixtures and furniture, CQC
50	CQCM0029030	Guidance, Re: Brief guide: safe staffing levels on all mental health and learning disability wards, CQC
51	CQCM0029031	Guidance document, Re: Brief guide: Psychotropic medication in intellectual and development disability, CQCM
52	CQCM0029032	Guidance document, Re: Brief guide: discharge planning from learning disability assessment and treatment (or similar) units, CQCM
53	NHFT0011231	Policy Document, RE: Brief guide: Schizophrenia - assessment of concordance with NICE guidance, CQCM
54	CQCM0029033	Guidance Document, Re: Brief guide: Bipolar disorder - assessment of concordance with NICE guidance, CQCM

55	CQCM0029034	Guidance document, Re: Brief guide: Physical healthcare in inpatient eating disorder services, CQCM
56	CQCM0029035	Guidance document, Re: Brief guide: Long-Term Segregation, CQCM
57	CQCM0029036	Guidance document, Re: Brief guide: Call systems in mental health inpatient services for patients/service users and visitors, CQCM
58	CQCM0029037	Guidance document, Re: Brief guide: Immediate Life Support training for services that may use restrictive interventions, CQCM
59	CQCM0029038	Guidance document, re: Shared sleeping arrangements on mental health wards ('dormitories'), CQCM
60	CQCM0029039	Guidance document, Re: Brief guide: good communications standards for people with a learning disability or autism, CQCM
61	CQCM0029040	Guidance document, Re: Brief guide: substance misuse services - same-sex provision, CQCM April 2018
62	CQCM0029041	Guidance document, Re: Brief guide: substance misuse services - workforce qualifications, CQCM
63	CQCM0029042	Guidance document, Re: Brief guide: Staffing in emergency departments that treat children, CQCM
64	CQCM0029043	Guidance document, re: Brief guide: Restraint (physical and mechanical) rooms, CQCM
65	CQCM0029044	Guidance document, Re: Brief guide: functional assessment of behaviour, CQCM

66	CQCM0029045	Guidance document, Re: Brief guide: psychoactive medicines (LD), CQCM
67	CQCM0029046	Guidance document, RE: Brief guide: capacity and competence to consent in under 18s, CQCM
68	CQCM0029069	Guidance document, Re: Brief guide: monitoring the physical health of people with a learning disability and/or autism on admission to a ward, CQCM
69	CQCM0029047	Guidance document, Re: Brief guide: substance misuse services - detoxification or withdrawal from drugs or alcohol, CQCM
70	CQCM0029048	Guidance document, Re: Brief guide: substance misuse services - ligature risks, CQCM
71	CQCM0029049	Guidance document, Re: Brief guide: Substance misuse services - People in vulnerable circumstances, CQCM
72	CQCM0029050	Guidance document, Re: Brief guide: Substance misuse services - use of blanket restrictions, CQCM
73	CQCM0029051	Guidance document, Re: Brief guide: Sexual safety on mental health wards, CQCM
74	CQCM0029052	Guidance document, Re: Brief guide: inspecting safeguarding, CQCM
75	CQCM0029053	Guidance document, Re: Brief guide: waiting times for community child and adolescent mental health services, CQCM
76	CQCM0029054	Guidance document, Re: Brief Guide: Assessing how well mental health services support carers, CQCM
77	CQCM0029055	Guidance document, Re: Brief guide: Assessment by inspectors of how a provider applies the Mental Health Act, CQCM

78	CQCM0029056	Guidance document, Re: Brief guide: Out of Area Placements in Rehabilitation Units: The responsibilities of NHS trusts for people under their care who are placed in an mental health rehabilitation ward outside of the local area, CQCM
79	CQCM0029057	Guidance document, Re: Brief guide, Seclusion rooms, CQCM
80	CQCM0029058	Guidance document, Re: Brief guide: Assessment of same-sex accommodation, CQCM
81	CQCM0029059	Guidance document, Re: Brief guide: assessing how providers implement the Mental Capacity Act 2005, CQCM
82	CQCM0029060	Guidance document, Re: Brief guide: assessing quality improvement in a healthcare provider, CQCM
83	CQCM0029061	Guidance document, Re: Brief guide: education arrangements for children in Tier 4 CAMHS settings, CQCM
84	CQCM0029062	Guidance document, Re: Brief guide: inpatient mental health rehabilitation services - assessment, treatment and care, CQCM
85	CQCM0029063	Guidance document, Re: Brief guide on inpatient mental health rehabilitation services: access and discharge, CQCM
86	CQCM0029064	Guidance document, Re: Brief guide: recovery orientated practice, CQM
87	CQCM0029065	Guidance document, Re: Brief guide: substance misuse services - same-sex provision, CQCM July 2019
88	CQCM0029066	Guidance, Re: Notifications, CQC 22 February 2024

89	CQCM0029067	Guidance, Re: Mental Health Staffing Framework, NHS
90	CQCM0016436	Policy document, Re: Enforcement Policy, CQC February 2015
91	CQCM0016441	Policy document, re: Enforcement policy, CQC 2023
92	CQCM0016430	Policy document Re: Enforcement Decision tree, CQC January 2017
93	CQCM0016439	Policy document Re: Enforcement decision tree, CQC 2023
94	CQCM0016514	Report dated [unknown] compiled by The Care Provider Alliance RE: Care Provider Alliance CQC Single Assessment Framework Review – Final Report
95	CQCM0016515	Policy document compiled by CQC RE: Re-building a trusted approach to our regulation 13 January 2025
96	CQCM0016516	CQC responds to reviews by Dr Penny Dash and Professor Sir Mike Richards, CQC, dated 15/10/2024
97	CQCM0016517	Report compiled by CQC, Re: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (Full Book)
98	CQCM0016518	Report compiled by CQC, Re: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 (Full Book)

99	CQCM0016519	Guidance RE: Review into Nottinghamshire Healthcare NHS Foundation Trust: terms of reference, DHSC 26 March 2024
100	NHSE0000298	Report dated January 2025, compiled by Theemis Consulting Ltd, Re: Independent investigation into the care and treatment provided to VC
101	CQCM0016521	Report, dated November 2023, compiled by NHFT and Healthwatch Nottingham & Nottingham Shire. RE: Specialist Mental Health Service.
102	CQCM0016464	Report dated 2020 compiled by CQC. Re: Monitoring the Mental Health Act in 2018/19
103	CQCM0016465	Report dated 2020 compiled by CQC. Re: Monitoring the Mental Health Act in 2019/20. The Mental Health Act in the COVID-19 pandemic
104	CQCM0016466	Report dated 2022 compiled by CQC. Re: Monitoring the Mental Health Act in 2021/22
105	CQCM0016467	Report dated 2023 compiled by CQC. Re: Monitoring the Mental Health Act in 2022/23
106	CQCM0016468	Report dated 2025 compiled by CQC. Re: Monitoring the Mental Health Act in 2023/24
107	CQCM0016456	Report dated 15/10/2020 compiled by CQC. Re: The state of health care and adult social care in England 2019/20
108	CQCM0016457	Report dated 21/10/2021 compiled by CQC. Re: The state of health care and adult social care in England 2020/21

109	CQCM0016458	Report dated 20/10/2022 compiled by CQC. Re: The state of health care and adult social care in England 2021/22
110	CQCM0016459	Report dated 19/10/2023 compiled by CQC, re: The state of health care and adult social care in England 2022/23
111	CQCM0016460	Report dated 24/10/2024 compiled by CQC. Re: The state of health care and adult social care in England 2023/24
112	CQCM0006196	Blank Care Record Review Template compiled by CQC
113	CQCM0006427	Report template (undated) compiled by CQC re Review of the involvement of services into Valdo Calocane's care to identify if the care and treatment he received was appropriate and in line with trust policies and national guidance or if there were missed opportunities to manage his care
114	CQCM0016478	Report dated 25/11/2022, compiled by CQC, Re: Nottingham Healthcare NHS Foundation Trust
115	CQCM0016523	Report, dated 24/02/2023, compiled by CQC. Re: High secure hospitals Inspection report - Rampton Hospital
116	NHFT0002106	Report dated 17/01/2024, compiled by Nottinghamshire Healthcare NHS Foundation Trust Re: Inspection Report of Rampton High Secure Hospital
117	NHFT0000581	Report dated 01/03/2024, compiled by CQC Re: Nottinghamshire Healthcare NHS Foundation Trust, Acute wards for adults of working age and psychiatric intensive care units Inspection report
118	CQCM0016525	Report, dated 01/03/2024, compiled by CQC. Re: Wards for older people with mental health problems Inspection report compiled by CQC

119	CQCM0016473	Report dated 24/05/2019, compiled by QCQ, Re: Nottingham Healthcare NHS Foundation Trust.
120	CQCM0016474	Report dated 25/03/2020, compiled by QCQ, Re: Acute wards for adults of working age and psychiatric intensive care units
121	CQCM0018101	Letter from Karen Bennett-Wilson to Dr John Brewin re Possible Urgent Enforcement Action – Section 31 of the Health and Social Care Act 2008 14 February 2020
122	CQCM0017639	Letter from Kevin Cleary to Chief Executive of NHFT re Health and Social Care Act 2008 - Notice of Decision to impose conditions on your registration as a service provider in respect of a regulated activities 18 February 2020
123	CQCM0016475	Report dated 23/09/2020, compiled by CQC, Re: Acute wards for adults of working age and psychiatric intensive care units
124	CQCM0016476	Report dated 31/03/2021, compiled by CQC, Re: Forensic inpatient or secure wards
125	CQCM0019771	Letter from Jenny Wilkes [CQC] to Dr John Brewin [NHFT], Re: The Care Quality Commission The Health and Social Care Act 2008 Section 29A warning notice 19 February 2021
126	NHFT0000567	Inspection Report Dated 20/05/2022 Compiled by CQC Re: NFT Forensic inpatient or secure wards

127	NHFT0000590	Report dated 25/11/2022, compiled by CQC Re: Inspection report - Nottinghamshire Healthcare NHS Foundation Trust, Acute wards for adults of working age and psychiatric intensive care units Inspection report
128	CQCM0019835	Letter from Craig Howarth [CQC] to Dr John Brewin [NHFT] re: The Care Quality Commission The Health and Social Care Act 2008 SECTION 29A WARNING NOTICE: Provider: Nottinghamshire Healthcare NHS Foundation Trust 27 May 2022
129	CQCM0016526	CQC list of review visits undertaken at NHFT between 01/01/2018 and 31/12/2023
130	CQCM0016424	Report dated December 2023, Compiled by CQC Re: Evaluation of CQC's local authority pilot assessments
131	CQCM0016527	Guidance re: How we determine ratings, CQC 8 July 2025
132	CQCM0016528	Guidance re: An Introduction to our assessments of local authorities, CQC 30 June 2025
133	CQCM0016529	Policy document, re: Assessment framework for local authority assurance, CQC November 2023
134	CQCM0016530	Guidance, re: How we assess local authorities, CQC 8 July 2025
135	CQCM0016426	Policy document dated 17/11/23 Compiled by CQC Re: Nottingham City Council assessment

136	CQCM0016538	Report dated 11/02/2019, compiled by CQC. Re: Cygnet Victoria House Quality Report
137	CQCM0016428	Inspection Report dated 25/06/21 Compiled by CQC Re: Cygnet Victoria House Quality Report
138	CQCM0016429	Report dated 18/10/22 Compiled by CQC Re: Cygnet Victoria House Quality Report
139	CQCM0016480	Report dated 13/12/2019, compiled by CQCM, Re: Calverton Hill
140	CQCM0016481	Report dated 17/03/2020, compiled by CQC, Re: Calverton Hill
141	CQCM0016482	Draft Report, compiled by CQC, Re: Priory Hospital Arnold
142	CQCM0016483	Report dated 05/05/2021, compiled by CQC, Re: Priory Hospital Arnold
143	CQCM0016484	Report dated 22/07/2021, compiled by CQC, Re: Priory Hospital Arnold
144	CQCM0016485	Report dated 15/03/2022, compiled by CQC, Re: Priory Hospital Arnold
145	CQCM0016486	Report dated 25/01/2023, compiled by CQC, Re: Priory Hospital Arnold
146	CQCM0016487	Report dated 23/06/2023, compiled by CQC, Re: Priory Hospital Arnold
147	CQCM0019618	Letter from Surrinder Kaur [CQC] to Company Secretary/Clerk of Partnerships in Care Limited, re: The Care Quality Commission The Health and Social Care Act 2008 WARNING NOTICE 10 October 2019
148	CQCM0019944	Letter from Jenny Wilkes (CQC) to Caroline Taylor (PAGR) re Possible Urgent Enforcement Action – Section 31 of the Health and Social Care Act 2008 11 March 2021

149	CQCM0021649	Letter from Stuart Dunn to Trevor Torrington, Warren Irving, re: Care Quality Commission Health and Social Care Act 2008 Notice of decision to impose conditions on your registration as a service provider in respect of regulated activities 17 March 2021
150	CQCM0018796	Letter from Brian Cranna (CQCM) to Company Secretary or Clerk (Partnerships in Care Limited), re: The Health and Social Care Act 2008 Warning Notice 17 December 2021
151	NHNB0011905	Letter from Craig Howarth to Company Secretary or Clerk at Partnerships in Care Limited re: Warning Notice re failure to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 re Priory Hospital Arnold 22 December 2021
152	CQCM0016717	Letter from Sarah Duncanson to Partnerships in Care Ltd; Re: Possible Urgent Enforcement Action – Section 31 of the Health and Social Care Act 2008 5 August 2022
153	CQCM0024082	Letter from Greg Rielly [CQC] to Rebekah Cresswell (Nominated individual) [PAGR], re: Possible Urgent Enforcement Action - Section 31 of the Health and Social Care Act 2008 25 January 2023

154	CQCM0016763	Letter from Greg Rielly to Partnerships in Care Limited re: Care Quality Commission, Health and Social Care Act 2008, Notice of decision to impose conditions on your registration as a service provider in respect of regulated activities 30 January 2023
155	CQCM0016463	Report (Undated) compiled by CQC. Re: Mental Health Act. Code of Practice 2015. An evaluation of how the Code is being used
156	CQCM0016453	Report dated 04/04/2025 compiled by CQC. Re: Community mental health survey 2024
157	CQCM0016531	Report compiled by CQC, Re: NHS Community Mental Health Survey Benchmark Report 2024
158	CQCM0016532	Report compiled by CQC, Re: NHS Community Mental Health Survey Benchmark Report 2024 (PowerPoint version)
159	CQCM0016533	Report compiled by CQC RE: NHS Community Mental Health Survey Assessment Service Groups (ASG) Benchmark Report 2024
160	CQCM0016534	Report compiled by CQC RE: NHS Community Mental Health Survey Assessment Service Groups (ASG) Benchmark Report 2024 (PowerPoint version)
161	CQCM0029068	Observing and Improving Cultures (OIC) Approach Form