The Nottingham Inquiry

Third 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 13 April 2026, made under Rule 9 of the Inquiry Rules 2006.

How CQC rates and scores health providers in England

4. This section should be read in conjunction with my first statement to the Inquiry dated 18 December 2025 which sets out CQC's inspection framework at paragraphs 87 to 97.

5. CQC is currently using a scoring framework in assessments. We score each quality statement that has been assessed, use those quality statement scores to calculate a score for each key question, and translate those scores into the four ratings of Outstanding, Good, Requires Improvement and Inadequate. We introduced evidence categories to make our judgements more structured and consistent. To assess a specific quality statement we will consider the evidence we have in each relevant evidence category (since 2 December 2024 we no longer score and report findings at evidence-category level, and now score at quality statement-level only. This change was so that we could carry our more, and better quality, assessments so that assessments were done in a timely way to give an up-to-date view of quality for the public and providers). There is further information on evidence categories at paragraphs 91 to 92 of my first statement dated 18 December 2025.

6. The process for providing ratings to services and providers is set out in the 'Assessing quality and performance' section of our website [CQCM0016437].

7. Following the introduction of the Single Assessment Framework ('SAF') our ratings and 5 key questions are still central to our approach and are based on a set of 34 quality statements, which are set out in our Assessment Framework [CQCM0016438]. They are arranged under the 5 key questions and describe what good care looks like, while reducing the previous duplication across the Key Lines of Enquiry ('KLOE'). We use the quality statements, or a sub-set of

them, in our assessments of all sectors and service types and at all levels. We continue to use our 5 key questions (are services safe, effective, caring, responsive and well-led) and the 4-point ratings scale (outstanding, good, requires improvement and inadequate). The quality statements sit under each key question and are mapped against the fundamental standards of quality and safety.

8. After we complete an assessment, we use a scoring system to produce a rating for that service. We provide ratings at different levels for different types of service, using professional judgement and a set of principles to help us determine the final ratings.

9. The levels we rate are:

- Level 1: a rating for every key question at service level. For example a rating for how effective the surgery service at a hospital is.
- Level 2: an aggregated overall rating for the service. For example, the rating for a surgery service at a hospital.
- Level 3: an aggregated rating for each key question at location level. For example, the rating for how safe a hospital is.
- Level 4: an aggregated overall rating for the location. For example, the rating for a hospital.
- Level 5: an overall rating for an NHS trust. This is based on the trust-level assessment of the quality statements under the well-led key question [WITN0091004] and moderation (see paragraphs 35 to 37 below).

10. We rate services at the following levels:

    i. Adult social care services: levels 1 and 2

    ii. GP services: levels 1 and 2

iii. Independent doctors and clinics: levels 1 and 2

iv. Independent health single speciality services: levels 1 and 2

v. Independent health hospital: levels 1, 2, 3 and 4

vi. Online primary care: levels 1 and 2

vii. Urgent care: levels 1 and 2

viii. Non-acute NHS trusts: levels 1, 2 and 5

ix. Acute NHS trusts: levels 1, 2, 3, 4 and 5

11. If we identify concerns during an assessment, we will use our professional judgement to decide whether to depart from applying our ratings principles. We will do that particularly where we need to aggregate ratings that range from Inadequate to Outstanding. When we do this, we will consider the extent of the concerns and the impact of those concerns on people who use services, the risk to quality and safety of services, our confidence in the provider to address the concerns and whether the provider has already taken action.

12. Prior to the SAF, our previous approach did not allow us to rate in a flexible way that reflects how services change over time and how people experience those services. We developed a set of provider service definitions to determine and deliver the principles and levels at which we assess and rate.

13. The provider service definition sits at a level below a location and is a subset of the information to be captured about all providers in all sectors, including:

- The care services offered.
- The settings in which they are offered.
- The population groups they support.

14. Settings and services are grouped together into 'assessment service groups' ('ASG'). These form the basis of the units we apply ratings to, for example a core service in our NHS Trust approach.

15. Mental health services include:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with a learning disability or autism
- Community based mental health services for adults of working age
- Community based mental health services for older people
- Community based substance misuse services
- Forensic inpatient or secure wards
- Gender identity services
- High secure hospitals
- Hospital inpatient-based substance misuse services
- Liaison psychiatry services
- Long stay or rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Perinatal services
- Personality disorder services
- Residential substance misuse services
- Services for people with acquired brain injury

- Specialist community mental health services for children and young people
- Specialist eating disorder services
- Substance misuse services
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism.

Ratings principles for health services

16. These principles determine how we aggregate and combine ratings. The overarching aggregation principles apply when we are aggregating ratings:

    - The 5 key questions are all equally important and we give them equal weight when aggregating.
    - The services are all equally important. We give them equal weight except where they are significantly small.
    - We treat all ratings equally when aggregating unless one of the principles (below) applies. We can adjust the following principles for combinations where it is not appropriate to treat ratings equally.

Aggregating ratings

17. We use the following principles as the basis of aggregation. We use our professional judgement to apply them to the specific combination of lower-level ratings that we are aggregating. These are 'underlying ratings.'
18. The aggregated rating will normally be outstanding where:
    - The following number of ratings are outstanding:
        i. 1 or more where there are 1-3 underlying ratings in total.
        ii. 2 or more where there are 4-8 underlying ratings in total.

iii. 3 or more where there are 9 or more underlying ratings in total.

- The remaining underlying ratings are good.

19. The aggregated rating will normally be no higher than requires improvement where the following number of underlying ratings are requires improvement:

    - 1 or more where there are 1-3 underlying ratings in total.
    - 2 or more where there are 4-8 underlying ratings in total.
    - 3 or more where there are 9 or more underlying ratings in total.

20. The aggregated rating will normally be no higher than requires improvement where the following number of underlying ratings are inadequate:

    - 1 where there are 4-8 underlying ratings in total.
    - 2 where there are 9 or more underlying ratings in total.

21. The aggregated rating will normally be inadequate where the following number of underlying ratings are inadequate:

    - 1 or more where there are 1-3 underlying ratings in total.
    - 2 or more where there are 4-8 underlying ratings in total.
    - 3 or more where there are 9 or more underlying ratings in total.

22. The ratings for NHS trusts have been simplified by publishing a single trust-level rating rather than multiple levels of aggregated trust-level ratings. The single rating is the rating for the well-led key question for a trust. The trust-level rating for the well-led key question is based on the eight quality statements under that key question (see the section below on assessing at trust-level paragraphs 31 to 34). This ensures a focus on leadership, culture and governance in our assessments.

Scoring

23. We introduced a scoring framework into our assessments to support the transparency and consistency of our judgements. When we assess evidence, we assign a score for each quality statement that we are assessing. Ratings will then be based on building up scores from quality statements into an overall rating. The score also indicates a more detailed position within the rating scale which allows us to see if quality performance is moving up or down within a rating. For example, for a rating of Good, the score will tell us whether this is either in the upper threshold (nearing Outstanding) or the lower threshold (nearer to Requires Improvement).
24. To assess a specific quality statement, we consider the evidence we have in each relevant evidence category, which will vary depending on the type of service or organisation. Evidence can be information that we already have (e.g. from statutory notifications), or we actively look for (e.g. from an on-site inspection).
25. We then give a score for each quality statement that we have assessed on a scale of 1 to 4:

    - Evidence shows significant shortfalls.
    - Evidence shows some shortfalls.
    - Evidence shows a good standard.
    - Evidence shows an exceptional standard.

26. Inspectors use their professional judgement to assign the score, based on the evidence categories they have looked at for each quality statement. As we have moved away from assessing at a single point in time, we aim to assess

different areas of the framework on an ongoing basis, meaning we can update scores for different quality statements at different times.

Calculating key question scores

27. We use the quality statement score as set out above to give us an updated view of quality at key question level and calculate a percentage score. We divide the total of the quality statement scores by the maximum possible score, i.e. the number of quality statements under the key question multiplied by the highest score for each statement (which is 4).
28. At key question level, we translate this percentage into a rating rather than a score using these thresholds:

    - 25 to 38% = Inadequate.
    - 39 to 62% - Requires Improvement.
    - 63 to 87% = Good.
    - 88% and above = Outstanding.

29. If the key question score is within the Good range, but one or more of the quality statement scores is 1, the rating is limited to Requires Improvement. Similarly, if the key question score is within the Outstanding range, but one or more of the quality statement scores is 1 or 2, the rating is limited to Good.
30. For services that have not previously been inspected or rated we will need to assess all quality statements in a key question before we publish the rating. For newly registered services, we will usually assess all quality statements within 12 months.

Approach to trust-level assessments of the well-led key question in NHS trusts

31. We assess the well-led key question using quality statements at both assessment service group and at trust level and refer to our 'Trust-level Well-Led Assessment Handbook [WITN0091004]. At trust level, the focus is on the trust's board and senior leaders with trust-level responsibilities in the context of wider organisational performance. We award a single rating at the trust level, replacing the previous complicated structure of aggregated trust-level ratings. The single trust-level rating will be the well-led rating and will be based on the trust-level assessment process.

32. The first trust-level assessments under the single assessment framework will cover all eight quality statements under the well-led key question, plus moderation (please see paragraphs 35 to 37 below). The eight quality statements are:

    - Shared direction and culture
    - Capable, compassionate and inclusive leaders
    - Freedom to speak up
    - Workforce equality, diversity and inclusion
    - Governance, management and sustainability
    - Partnerships and communities
    - Learning, improvement and innovation
    - Environmental sustainability – sustainable development

33. We have initially prioritised service-level inspections using the single assessment framework which allows us to focus on risks to patients and to update our overall view of service-level ratings. Service-level quality is important to inform a holistic view of quality at trust level. This approach will

enable us to reflect and update our view of quality in the trust-level assessment and rating. This also allows more time for the new transition and assessment approach for NHS trusts to be understood externally before we award new ratings for trusts, and existing trust-level Key Question ratings are removed from display on our website.

34. CQC and NHS England have agreed that both organisations will work together to assess Trust level. NHS England will assess the financial and resource governance in the trusts that CQC inspects, and ahead of the trust-level assessment NHS England will undertake a risk assessment to determine the level of its involvement.

Moderation

35. There is a moderation process we carry out as part of our quality assurance checks to ensure that we accurately reflect the trust's overall performance, sustainability and direction of travel. This process is driven by the aggregation principles, allows for flexibility and professional judgement, and ensure that we are fair and proportionate. It will consider the balance and proportionality of the scores for the eight quality statements under the well-led key question (including taking account of NHS England's oversight of trusts as described in paragraph 34 above), the evidence of quality and safety at the trust's services and locations, and consider a wider picture of service-level ratings, including change over time.

36. There are two principles we will consider when confirming the trust-level well-led rating:

- Does the initial trust-level well-led rating align with and reflect the provider's current level of quality and direction of travel at service level?
- Does our planned trust-level well-led rating appropriately take account of NHS England's view of the quality, safety and financial performance of the trust?

37. The moderation principles are considered at the end of the trust-level assessment process and reviewed as part of our quality assurance checks. Ratings can be moderated both positively and negatively.

Publishing our findings

38. The information is published in a different format to the inspection reports under the previous inspection model. The information is published as web content on our website rather than in a PDF document (publishing this way means the information is easier to use on a mobile device and more accessible to people using assistive technology).
39. For hospitals and other services where we previously reported on multiple core services, there will also be a section of the report with information about the location overall and we will continue to publish aggregated information about the location overall.
40. For services that receive a rating, for each of the key questions we have assessed, we will publish a rating, score and summary of our findings. The score we publish for a key question will be out of 100 and will be calculated from the scores awarded for the quality statements within that area (please see paragraphs 23 to 26 above). The score is used to help us reach the rating and ensures this is done consistently.

Frequency of Inspections

41. There is no set frequency for when assessments are carried out and ratings are updated. We schedule our assessment activity based on a range of factors including risk, data and information received, current ratings and age of rating since last rated.

42. The CQC Mental Health assessment teams are scheduling assessments using the following priorities which are designed to strike a balance between risk, strategic and planned approaches to assessments:

Priority Level	**Type**	**Risk, Strategic or Planned activity**
1	Extreme risk (in accordance with the decision tree)	Risk
2	Very high risk	Risk
3	Information of concern received and indicates urgent prioritisation and High Risk	Risk
4	Adult Community Mental Health Programme ASGs	Strategic
5	Inadequate and Aged over 12 months	Planned
6	Never rated and over 2 years	Planned

7	Outstanding and Aged over 8 years	Planned
8	Requires Improvement and Aged over 3 years	Planned
9	Good and Aged over 5 years	Planned

43. The Adult Community Mental Health Programme ('ACMHP') is a strategic commitment we have made externally to deliver inspections of community mental health services and crisis and will be delivered as a sector-wide approach.

44. In our Section 48 report, CQC committed to look in depth at the standard of care in community mental health services across the country. To achieve this CQC is inspecting mental health trusts in England, assessing community mental health services and crisis services. A specialist team of inspectors is supporting the delivery of inspections in this programme, with the aim of considering patient safety, health inequalities, and system capacity and integration.

45. To meet this commitment, CQC is working with providers and stakeholders to adapt and improve our approach, ensuring that we are responding to the issues and improvements in quality and safety.

46. We continue to report updates on the delivery of this programme through the following:

    - Inspection reports published for each trust.
    - Findings reported in the annual State of Care report.

- Ongoing engagement plans with both providers and Experts by Experience, through an Expert Advisory Group.
- Delivery of provider engagement events. Two events have been held so far and focused on areas where providers are particularly struggling; the aim is also to encourage the sharing of experiences and good practice.

47. We are highlighting certain ASGs as priorities due to the amount of never rated, minimal contact currently and/or significantly aged ratings or ones that carry significant risk:

    - Older people Inpatient.
    - Learning disability and Autism Community and Inpatient.
    - Substance Misuse Detox and Residential Services.
    - Children and Young People.
    - Community Mental Health Services for Working Age Adults (through the Adult Community Mental Health Programme).
    - Crisis and Health Based Places of Safety (HBPOS) (through the Adult Community Mental Health Programme).
    - Psychiatric liaison (through the Winter Pressures programme).

48. As set out in my first statement (at paragraph 241) the Adult Community Mental Health Programme was developed following the findings in CQC's Section 48 Review into NHFT.

<u>New draft frameworks</u>

49. Following on from the review of the Single Assessment Framework by Professor Sir Mike Richards (to address concerns identified in the interim report of the Dash Review), it was agreed that CQC would return to a sector-

based approach to regulation (as part of CQC's 2021 strategy it was decided to bring together the 3 sector teams (adult social care, hospitals and primary care services) into one Operations group. Professor Sir Mike Richards recommended reverting to the previous structure with separate sector-based inspection directorates led by Chief Inspectors). We gathered insight from consultation, operational feedback from across the inspectorates, and learning from engagement with providers and partners. Information relating to the findings of the Dash Review etc and CQC's next steps are set out in my first statement to the Inquiry dated 18 December 2025 at paragraphs 185 to 190.

50. On 25 March 2026 CQC published the draft separate assessment frameworks that are more specific to the health and care sectors that we regulate. There are draft assessment frameworks for each of the following sectors:

- Adult social care [WITN0091005].
- Mental health care [WITN0091006].
- Primary care and community services [WITN0091007].
- Hospitals (secondary and specialist care) [WITN0091008].

51. Each of the frameworks has 4 components:

i. The 5 key questions we ask of all providers (safe, effective, caring responsive and well-led).

ii. Key lines of enquiry that indicate what we will assess with each key question.

iii. Rating characteristics that describe what outstanding, good, requires improvement and inadequate look like in each sector.

iv. 'I statements' that describe the outcomes and experiences that people who use services tell us they expect from a good quality service.

52. Taken together these components form the 'quality indicators' that we are required to set out by section 46 of the Health and Social Care Act 2008.

53. The rating characteristics are intended as a guide, rather than a comprehensive list of everything that might be relevant under each key question or key line of enquiry. They will sit alongside best practice standards and sector-specific guidance, and we expect providers and inspectors to use these together. Not every element of the rating characteristics will apply to every service, and so services will not need to demonstrate every characteristic to meet a particular rating. Our approach to ratings aggregation will not change.

54. We are asking for feedback on whether the draft frameworks will guide CQC in carrying out assessments and make clearer, more transparent judgements about quality; help providers understand what CQC will be looking for and improve the quality of care they deliver; help CQC and providers identify and address the inequalities in care; and reflect the range of services and sectors that we regulate.

55. After this feedback period, which will close on 12 June 2026, we will carefully consider all feedback to refine each framework before we pilot and test them.

Community-based mental health services for adults of working age

56. We exhibit a spreadsheet which lists all CQC-registered NHS Trusts that have been assessed and rated for their service 'Community-based mental health services for adults of working age' [WITN0091009]. This sets out those NHS Trusts with a published latest rating for 'Community-based mental health

services for adults of working age and latest trust-level rating; all service ratings for 'Community-based mental health services for adults of working age' from 13 June 2023 onwards; all trust-level overall ratings from 13 June 2023 onwards (using the pre-SAF methodology) and all Well-led ratings from 13 June 2023 onwards (using the SAF methodology)

57. There are only two trusts that have undergone more than one assessment of 'Community-based mental health services for adults of working age' since 13 June 2023. Nottinghamshire NHS Foundation Trust had assessments published on 24 September 2024 and then on 8 January 2025. However, at both assessments the overall rating for that service was the same (Good) and therefore there had been no change in the rating since 13 June 2023. Leicestershire Partnership NHS Trust had assessments published on 13 January 2026 and 27 April 2026 where the overall rating for that service changed from Requires Improvement to Good.

58. We are unable to directly compare ratings produced under different methodologies in order to be able to comment on whether there has been a national improvement or decline since June 2023. CQC began implementing the SAF in January 2024 and ratings are not directly comparable with previous years for a number of reasons:

    - Our assessment activity during this time has been based on risk to people using those services, so they are unlikely to be representative of all services in a sector.
    - For some services, the number of assessments completed using the SAF are still too low to be representative of all services in that sector.

- Alongside the introduction of the SAF, we also made changes to some aspects of our assessment methodology, such as differences in the levels at which we rate providers.

Community Mental Health Survey 2025

59. CQC published a document on 31 March 2026 titled 'Community mental health survey 2025' ('CMH') [CQCM0029655]. The CMH is an annual national survey of people's experiences of using NHS community mental health services and asks about people's experiences of accessing services, interactions with staff, involvement in care planning etc. For the 2025 survey, 50 providers of NHS community mental health services took part. The survey received feedback from 12,319 people aged 16 or over who received treatment for a mental health condition between 1 April and 31 May 2025. This is set out in the '2025 Community mental health survey: statistical release' [WITN0091010].

60. The CMH is one of the surveys that sits within the NHS Patient Survey Programme, which was initiated in 2002 by the Department of Health and is now overseen by CQC. It is delivered across three levels: CQC (the programme owner), a Survey Co-ordination Centre contracted to an external partner who co-ordinates the programme on CQC's behalf, and approved contractors/individual NHS trusts who run the individual surveys (for this survey all 50 providers used an approved contractor). National results from the CMH are accredited official statistics, as the survey is developed (and results recorded) in accordance with the UK Statistics Authority's Code of Practice for Statistics, which sets the standards for producing and releasing official statistics.

62. Development of the survey, which is set out in full in the Survey Development report [WITN0091011] includes the following:

    i. Early stakeholder consultation to understand the priorities for the survey.

    ii. Service-user consultation to ensure the questionnaire remains relevant to service-user experiences.

    iii. Survey design, including reviewing questions to ensure the questionnaire is up-to-date and reflects current policy. A stakeholder advisory group has input during the design period.

    iv. Cognitive testing interviews with recent service users to ensure questions are understood.

    v. Production of all materials and guidance to support running the survey.

    vi. Application to the Confidential Advisory Group at the Health Research Authority to process confidential patient information without consent.

63. The fieldwork for the CMH survey includes:

    i. Sampling, where each provider draws a sample of service users from their patient administration systems.

    ii. Sample checking for errors by, firstly, approved contractors and then the Survey Co-ordination Centre.

    iii. Distribution of the survey to the selected sample by approved contractors.

    iv. Data entry of the returned surveys/responses by approved contractors.

64. Analysis and reporting of the resulting information:

    i. Collation of all responses from all providers for submission to the Survey Co-ordination Centre.

ii. Creation of the full dataset: data is compiled and analysed by the Survey Co-ordination Centre.

iii. Delivery of data and analytical outputs to CQC, including the full respondent-level dataset, national tables, benchmarked data and reports, and multi-variate analysis (which analyses differences in experiences by demographic and care characteristics).

iv. Production of statistical release reports (produced by the CQC and set out national results).

v. CQC quality assurance of all outputs in line with its analytical quality assurance policy: all outputs are subject to quality control and sign-off before the next stage of analysis and reporting.

65. Full details of the steps and methodology for each stage of the survey are published on the NHS Patient Surveys website: Survey development report [WITN0091011]; survey handbook [WITN0091012]; sampling instructions [WITN0091013]; final questionnaire [WITN0091014]; quality & methodology report [WITN0091015].

Analysis approach and reporting format

66. In line with the Official Statistics code of practice, analysis of the CMH survey is undertaken in line with the published methodology as set out on the NHS Patient Surveys website. All the national findings and underlying data are set out on our website (www.cqc.org.uk/publications/surveys/community-mental-health-survey). The national tables provide results for each question in the survey, specifically the number and percentage of respondents who ticked each response option. The findings were informed from all 50 NHS providers who took part in the survey.

67. The statistical release presents national results from the survey and sets out information about the survey process including the analysis methodology. It includes findings by theme and by service, with statistically significant changes highlighted based on statistical testing that compares the survey results obtained in 2025 with those from 2024 and 2023 (results from earlier years are not comparable due to the change in the way we collected data and significant changes made to the questionnaire and sampling method). It also presents multi-variate analysis of subgroups which explores how mental health service-user experiences are associated with demographic and care characteristics and can highlight inequalities in care experiences.

68. Results are also produced that show each trust's results in comparison with the range of scores achieved by all trusts taking part in the survey. The interpretation of the data obtained is set out in the Technical Document [WITN0091016]. Each patient's response to a question is converted to a score representing how positive people's experiences were (save where the options provided did not have any bearing on the trust's performance in terms of people's experience, or where respondents stated that they could not remember). Results are based on standardised data, which adjusts for certain demographic characteristics so that results for trusts can be compared more fairly.

69. The 'better/about the same/worse' categories are based on the 'expected range' within which we would expect a particular trust to score if it performed about the same as most other trusts in the survey. The expected range statistic is used to arrive at a judgement of how a trust is performing compared with all other trusts that took part in the survey. The data only show performance

relative to other trusts: we do not set out absolute thresholds for good or bad performance.

70. In terms of addressing the national picture facing Community-based mental health services for adults of working age, CQC considers the following:

    i. We recognise that the failure is systemic and national and the focus should not only be on individual providers' responsibilities to improve care. These failures predominantly arise from staffing shortages, poor system working, rising demand, and a lack of digital and commissioning integration. These issues undermine patient and public safety.

    ii. CQC should continue to ensure that it is a key lever for national change. Through the Adult Community Mental Health Programme ('ACMHP') and our ongoing work involved in our State of Care reports, Independent Voice pieces and other mechanisms, CQC should continue to support improvements and learning by using its influence to bring system leaders together, enabling and accelerating improvement across providers via inspections, and identifying and spreading good practice nationally.

    iii. There is a requirement for clearer national standards and expectations. We have seen through inspections and provider engagement events an absence of clear national standards in community mental health. There is a need for defined standards on safe staffing levels, caseloads and skill mix, with clear expectations and accountability for managing risk within recovery-focused care. There ought to be national guidance on medicines management, patient engagement, assertive outreach and digital records. CQC would be the organisation responsible for checking providers' compliance with the standards.

iv. More generally, CQC accepts that traditional inspection approaches need reviewing in line with the NHS 10-year plan, and increased integration across systems. CQC needs to continue to develop: greater flexibility in inspection methodology; a better understanding of system pressures and how they are presented in our findings; work is being undertaken to restore the system of relationship owners/managers to maintain continuity and organisational understanding.

Inspections of Nottinghamshire Healthcare NHS Foundation trust

71. We exhibit a spreadsheet [WITN0091017] which sets out the inspections undertaken of mental health services at Nottinghamshire Healthcare NHS Trust Foundation since 1 January 2020.

72. The first tab on the spreadsheet titled 'Inspections' sets out the inspections since 1 January 2020 for Nottinghamshire Healthcare NHS Foundation trust, including the core services that were inspected, and the Trust overall rating. Columns F to K set out the individual ratings for the 5 key questions and the overall rating. These inspections were carried out under CQC's previous inspection framework, i.e. prior to the implementation of the SAF.

73. The second tab on the spreadsheet titled 'Assessments' sets out those inspections of Nottinghamshire NHS Foundation Trust since 1 January 2020 that have been carried out under the SAF. Column E sets out the Assessment Service Group that was assessed at that time; Columns G to L confirm the rating for each key question and the overall rating for that service.

Inspection of January 2026

74. CQC carried out an unannounced inspection of the Acute wards for working-age adults ASG at Highbury and Sherwood Oaks hospitals between 27 - 29

January 2026. We inspected Redwood 2, Rowan 1 and The Willows Psychiatric Intensive Care Unit wards at Highbury Hospital, and Fir and Elm wards at Sherwood Oaks Hospital.

75. At the time of the inspection, we found a number of concerns relating to the management of risk. The following were raised with the Trust in our Letter of Intent (see paragraph 77 below):

- We were not assured that staff had the knowledge and information needed to keep patients safe from harm. We found issues with the management of risk items on the ward, with risk items missing from patient lockers and no assurance of who removed them or when. We also found extra items of risk in lockers which were not recorded.
- We found concerns with the management of ligature risk. There had been recent incidents of ligature on Fir Ward and we were not assured that these had been addressed. We also found exposed cables which posed a ligature risk on Fir Ward which were not included on the ward's ligature risk assessment.
- We were not assured that staff were able to manage patient risks. We heard from patients on Elm Ward who said they did not feel safe and raised this with staff, who took no action. This was also raised during our observation of a community meeting and we were not assured that those concerns would be addressed. Care records did not detail whether harm had actually been sustained following an incident on Cedar Ward. Physical restraint had been used when it was not required.

- We were not assured that staff understood and were able to respond to the needs of individual patients, for example with regard to food allergies and managing reactions to certain medication.

76. We reported the issues of risk items and ligature risks to the ward managers at the time of the inspection.

77. Following the inspection, we held a decision review meeting on 30 January 2026 to consider whether further action should be taken. It was decided to issue a Letter of Intent setting out our concerns. We held a Teams call with Diane Hull, the Trust's Director of Nursing, on 30 January to advise that we would be issuing a Letter of Intent, and this was sent to the Trust on 30 January 2026 [WITN0091018] indicating that CQC was considering urgent enforcement action under its powers pursuant to the urgent procedure (for suspension, or imposition or variation or removal of conditions of registration) under Section 31 of the Health and Social Care Act 2008. We exhibit a copy of the post-inspection Decision Tree [WITN0091019] where the options were considered and the decision made to issue a Letter of Intent requiring assurances from the trust on the points listed above.

78. We requested an action plan from the Trust in response by 2 February 2026 and received a copy of the Trust's action plan [WITN0091020] and covering letter [WITN0091021] on that day.

79. The action plan set out what steps the Trust had taken and were going to take in response to the concerns raised in our Letter of Intent, including:

    i. An immediate and comprehensive review of all lockers on every mental health ward to provide assurance that the recorded inventory reflected each locker's actual contents.

ii. A daily audit process for locker inventories across all adult mental health wards.

iii. Comprehensive review of the Risk Items Procedure following best practice guidance.

iv. Detailed review of ligature risks for those patients identified as at risk on Fir Ward, and a full review of all care and safety plans on that ward.

v. Enhanced oversight and review processes across all adult mental health wards and enhanced daily audit.

vi. Strengthened existing post-incident review systems implemented to ensure every ligature-related incident triggers immediate review of care plan and environmental risk assessment.

vii. Renewed environmental ligature risk assessment on Fir Ward and all adult mental health wards.

viii. Daily bite-size training on relational security and ligature risk management and complete a training needs analysis for all adult mental health ward staff to identify gaps in knowledge/competence in ligature risk assessment and management.

ix. Comprehensive review of CCTV footage in relation to an identified incident.

x. Investigation into presence of dinner knives on the ward and to undertake a structured learning event and critical incident analysis covering all incidents referenced.

xi. CCTV reviews of restraint incidents to be completed within one working day. Review of all new restraint incidents to ensure proportionality and appropriateness.

xii. Daily community meetings to be facilitated to ensure patients have meaningful opportunities to share views, experiences etc.

xiii. Comprehensive review of all care plans on Fir Ward; Electronic Prescribing and Medicines Administration (ePMA) system updated to reflect all recorded medication/food allergies on Fir ward.

xiv. Allergic reaction guidance provided to staff on all adult mental health wards.

xv. Enhancing daily governance at care unit level to assure safety with numerous daily checks and processes in place.

80. CQC held a Decision Making Meeting (DMM) on 2 February 2026 to consider the Trust's response and action plan in relation to our Letter of Intent to determine whether we should proceed to exercise our powers under Section 31 of the Health and Social Care Act 2008. We were assured by the Trust's action plan and decided that, as a result of the action taken by the Trust, urgent enforcement action was no longer required. CQC is currently drafting its assessment report setting out the findings of our inspection. Consideration will be given to whether further regulatory action is required during this process and we are reviewing potential breaches of Regulation 10 (Dignity and Respect), Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance). In accordance with our normal procedures we will send the draft report to the Trust to check for factual accuracy and provide it with the opportunity to respond with any factual accuracy comments. We will then review this in line with our process and proceed to finalise the report and subsequently publish it on our website when it will be available to the public.

Recommendations

Recommendation 1: establish mandatory national standards for community mental health services with clear expectations for providers.

81. The Inquiry should recommend that DHSC (or the National Quality Board) ensures national bodies are convened to define mandatory national standards to address:
    - Safe staffing levels and caseload limits.
    - Competency thresholds for senior decision-making roles.
    - Risk management within recovery-focused models.
82. This process should include, and the standards should address, collaborative working between key agencies (commissioning bodies, regulators and clinical bodies). Transformation of service provision and delivery has increased the impact of inconsistent standards. Varying approaches to implementation by local and national agencies have been repeatedly identified as a root cause of unsafe care and fragmented risk-management in engagement with patients, representatives and providers.

Recommendation 2: Strengthen accountability for risk-management and shared care.

83. The Inquiry should recommend clearer accountability frameworks requiring:
    - Explicit professional responsibility for decisions about risk.
    - Robust, multi-disciplinary decision-making for patient discharge and disengagement.
    - Mandatory learning from deaths and serious incidents across systems.
    - Quality assurance approaches to ensure that these processes are embedded across providers and systems.

84. Providers have highlighted a lack of capacity to understand and manage risk, compounded by unmanageable caseloads and poor cross-service working in many areas.

Recommendation 3: Require improved system integration and information-sharing.

85. The NHS 10-year plan sets out goals to improve system integration and information-sharing. Poor information sharing and lack of digital integration have been identified by providers as among the biggest contributors to unsafe care. Consideration should be given to developing specific recommendations and guidance for mental health services, with particular attention to community care to prevent individuals falling through gaps in care. This may include the following:

- Urgent investment in digital systems which improve access to information.
- Shared access to medication records, risk information and care plans.
- Clear expectations on data sharing between mental health services, primary care and social care.

Recommendation 4: Reinforce named responsibility for patients in the community.

86. Concerns have been raised by providers that moving away from the Care Programme Approach has left patients without a single, accountable professional which increases risk. There should be a review, and strengthening, of the keyworker/care co-ordinator role, ensuring:

- Each patient has a clearly identified professional lead.
- Families and carers know who is responsible.

- There is continuity across transitions in care.

Recommendation 5: Use CQC's Adult Community Mental Health inspection programme as a learning and improvement mechanism.

87. CQC is viewed by providers as uniquely positioned to drive national learning and improvement if inspections move beyond narrow compliance. The Inquiry should recommend that CQC:
    - Continues its thematic, learning-focused inspection approach.
    - Publicly shares good practice and system learning.
    - Uses its influence to shape national investment and strategy in collaboration with NHSE and DHSC.
    - Review the impact of commissioning and neighbourhood health on community and crisis care as part of the Adult Community Mental Health Programme of inspections.

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 May 2026

Index to Third Witness Statement of Chris Dzikiti

No.	Inquiry URN	Document Description
1	CQCM0016437	New assessment approach
2	CQCM0016438	Assessment framework
3	WITN0091004	How we regulate: an overview of our assessment framework and approach to trust-level well-led assessments
4	WITN0091005	Draft adult social care assessment framework V9
5	WITN0091006	Draft mental health care assessment framework
6	WITN0091007	Draft primary care and community services assessment framework V 6.0
7	WITN0091008	Draft Hospitals (secondary and specialist care) assessment framework V 6.0
8	WITN0091009	Spreadsheet – NHS Trusts community health for adults and Well-led
9	CQCM0029655	Community mental health survey 2025, dated 27 March 2026, CQCM
10	WITN0091010	CQC/NHS 2025 Community mental health survey – statistical release
11	WITN0091011	Survey Development Report. 2025 Community Mental Health Survey
12	WITN0091012	CQC – Survey Handbook. 2025 Community Mental Health Survey
13	WITN0091013	CQC – Sampling instructions. 2025 Community Mental Health Survey
14	WITN0091014	CQC – NHS Community Mental Health Questionnaire
15	WITN0091015	2025 Community mental health survey – Quality and Methodology Report
16	WITN0091016	2025 Community mental health survey – technical details for analysing trust level results
17	WITN0091017	Spreadsheet of inspections undertaken of mental health services at Nottinghamshire Healthcare NHS Foundation since 1 January 2020
18	WITN0091018	Letter of intent sent 30 January 2026 to NHFT
19	WITN0091019	Enforcement Decision Tree dated 30/01/2026
20	WITN0091020	Trust Action plan 02 February 2026
21	WITN0091021	Covering letter from NHFT sent 2 February 2026 to CQC