Summary of the evidence of the Healthcare Professional Regulators and Care Quality Commission

1. This is a summary of the evidence provided to the Inquiry by the General Medical Council (GMC), Nursing and Midwifery Council (NMC), and Healthcare Professions Council (HCPC) and the Care Quality Commission (CQC). That evidence has already been disclosed to Core Participants.

2. This is a summary and does not represent the totality of the evidence provided. It should be noted that the Inquiry anticipates receiving further evidence from these bodies in the course of the Inquiry and that there are further enquiries which remain outstanding. Where practical these are identified in this summary.

3. At this stage the Inquiry will not be going into the detail of any specific case identified by these regulators. However, this will be revisited as the Inquiry's investigation progresses.

4. The purpose of this summary is therefore limited to providing an initial overview of the roles of these regulators and steps taken in respect of healthcare professionals or providers of mental health inpatient care at the Essex Trusts during the relevant period. As set out, the information is not complete and should not be taken to represent the final picture.

Starting with the GMC [and the witness statement, Shaun Gallagher, director of strategy and policy CB 223]

5. The GMC is the independent regulator of doctors within the UK. Their powers are provided by the Medical Act 1983.

6. Under the Act the GMC must act to:
    a. protect promote and maintain the health, safety and wellbeing of the public;
    b. promote and maintain public confidence in the profession;
    c. promote and maintain proper professional standards and conduct for members of the profession.

7. A concern relating to a doctor can only be taken forward if it falls within one of the following categories:
    a. misconduct;
    b. deficient professional performance;
    c. a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales);
    d. adverse physical or mental health;
    e. not having the necessary knowledge of English;
    f. a determination (decision) by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.

8. The GMC will only take action where the concern raised is sufficiently serious to raise a question about the doctor's fitness to practise. Concerns can be raised by anyone including patients, families, employers or other doctors.

9. In 2012 the GMC set up a team of Employer Liaison Advisors (ELAs) to enable more effective working between the GMC and healthcare providers. ELAs work with employers and offer advice on whether thresholds for referral of concerns to the GMC are met. Many local concerns can be resolved without referral to the GMC.

10. On receiving a concern the GMC will triage this against their threshold for investigation. This will include consideration of the doctor's overall fitness to practise, the seriousness of the concern, its context and how the doctor has responded. Where a matter is investigated, a decision on whether to refer the matter for a hearing before the Medical Tribunal Practitioner Service (MPTS) is made by the GMC's Case Examiners. If a case is not referred by the Case Examiners for a hearing, the case can be closed with no action, a warning or with undertakings agreed with the doctor about their future practice.

11. The MPTS is a tribunal service created in June 2012 to separate the GMC's adjudication function from its investigations. Where a doctor's fitness to practise is found to be impaired the MPTS has the power to restrict a doctor's practise by imposing a sanction of conditions, suspension or erasure.

12. Since 2015 the GMC has used provisional enquiries to obtain limited and targeted information at triage in order to help inform a decision about whether a full investigation is required. This includes where a doctor subject to a complaint has a history of whistleblowing and where concerns relate to a single clinical incident or course of treatment.

13. From 2010 the GMC assumed responsibility for setting and maintaining the standards of postgraduate medical education and training.

14. In response to the Inquiry the GMC has carried out a search of their electronic management system, introduced in April 2006, for complaints with a recorded connection to the Essex Trusts and relevant to mental health inpatient care. There have been limitations to the ability to search that material and further searches are being conducted using a list of known providers of inpatient care by unit location.

15. The results initially provided have been where there is a 'recorded connection' to the Trusts by way of referring body, incident location, doctor's designated body or employment history.

16. The initial search has identified 29 complaints or concerns in respect of doctors. None of these have to date resulted in any action being taken against the registered doctors concerned, although some remain subject to ongoing investigation.

17. In summary:
    a. These complaints took place between 2013 and 2024.
    b. Fourteen cases were closed at the enquiry stage without a further investigation. Reasons for this included concerns not being sufficiently serious to call into question a doctor's fitness to practise, issues being of a systemic rather than individual nature, and failings or concerns not being attributable to an individual doctor.
    c. Fifteen cases were investigated after meeting the relevant threshold. Of those which are not ongoing:
        i. Ten cases were closed by Case Examiners. Reasons for this commonly included expert evidence that the care provided either did not fall short of the relevant standards

or if it did, that it did not fall seriously below the relevant standards such as to reach the threshold for misconduct.

ii. Two cases where undertakings were deemed appropriate.

iii. One case was referred to hearing but then reviewed and closed with no further action.

Next the NMC [and the witness statement of Paul Rees, interim chief executive and registrar, CB 242]

18. The NMC is the independent regulator responsible for nursing and midwifery professionals in the UK. This includes responsibility for mental health nurses. The NMC is a statutory body, established and governed by the Nursing and Midwifery Order 2001. Their overarching objective is protection of the public and the 2001 order requires that the NMC:

    a. Protect, promote and maintain the health, safety and wellbeing of the public;
    b. Promote and maintain public confidence in the nursing and midwifery professions, and
    c. Promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions.

19. In regulating the nursing profession, the NMC seeks to set, monitor and promote high educational and professional standards in nurses and midwives across the UK.

20. When a concern is raised about a nurse's conduct, health or competence, this will be investigated through the NMC's fitness to practise process. Similar to the GMC, the NMC has the power to take action where a nurse's fitness to practise is alleged to be impaired by:

a. Misconduct;
b. Lack of competence;
c. Criminal conviction or caution;
d. Physical or mental health;
e. Not having the necessary knowledge of English; or
f. Where other relevant organisations have determined that their fitness to practise is impaired.

21. Concerns can be raised by patients, their families and members of the public. Information is provided publicly to support those wishing to raise concerns.

22. Employers can also raise concerns and can engage with the NMC through their Employer Link Service. The NMC advises that referrals should be made to them where:
    a. Concerns pose a serious risk to people who use services and would be difficult to put right;
    b. Local action cannot effectively manage any ongoing risks to people who use services;
    c. Concerns require the NMC to take action to protect public confidence in the professions and uphold standards.

23. The NMC can also investigate matters of its own volition without a concern being referred by a third party.

24. In outline the NMC's fitness to practise process contains the following stages:
    a. Screening. This will consider whether the concern relates to a nurse, whether the concern is sufficiently serious and whether

there is clear evidence to show whether a nurse is fit to practise. This stage can include further enquiries to enable a decision.

b. Investigation. Evidence will be gathered and the nurse will be asked to respond to the concerns.
c. Case Examiner decision. This will involve reviewing the information gathered during an investigation and deciding whether it is likely to be found by the Fitness to Practice Committee that there is a case to answer based on the facts alleged and that the nurse's fitness to practise is currently impaired. If it is found that there is no case to answer on facts or impairment the case will be closed with no further action. If it meets this threshold it will be referred to the Fitness to Practice Committee or undertakings can be proposed and agreed. Prior to 2015 this function was performed by the Investigating Committee.
d. Adjudication. Cases referred by the Case Examiners will be adjudicated on by the Fitness to Practise Committee at a meeting or hearing. Factual allegations will be decided on the balance of probabilities before impairment of fitness to practise is then decided. If a nurse's fitness to practise is found to be impaired then the following sanctions are available:
    i. Caution order. This lasts between one and five years.
    ii. Conditions of practice order. These last between one and three years.
    iii. Suspension order. These can be between one and 12 months.
    iv. Erasure or Striking off order. This removes a nurse from the NMC's register, meaning that they are no longer allowed to practise.

25. In response to the Inquiry the NMC have provided details of fitness to practise cases thought to relate to mental health nurses and provision of mental health inpatient care by the Essex Trusts. Challenges in providing that data have meant that the information provided may not be complete for the following reasons:
    a. Employer data was not recorded in fitness to practise referrals prior to 2017.
    b. Prior to 2008 cases were not recorded on the current system meaning that it has not been possible to provide details of cases from this period.
    c. Recording systems do not include a specific marker for mental healthcare provision which means care from mental health nurses and at inpatient units cannot easily be identified.
    d. The data often does not show the context and nuance relevant to decisions taken in all fitness to practise cases.

26. The current list provided has also not been cross referenced against the list of specific locations and hospitals identified to the NMC by the Inquiry as providing inpatient care. It is therefore not clear that all those referrals listed necessarily relate to mental health inpatient care.

27. The Inquiry therefore recognises that further analysis will need to be undertaken to refine those cases which will fall within its scope, and which may be relevant.

28. Set against those caveats the current data provides the following information from 2008 onwards:
    a. There have been 149 referrals concerning 133 nurses between 2010 and 2023.
    b. 146 received an initial assessment and this has resulted in 65 cases being closed at initial screening. Across the cases that

were closed at screening and did not progress to investigation, the NMC recorded reasons for the case closure in 50 cases (the remaining 15 cases do not have reasons recorded). Of those with reasons recorded, 49 cases were closed either due to insufficient evidence to substantiate the concerns, or because the concerns were not considered to be serious enough to meet the threshold for potential Fitness to Practise impairment. In six cases, the investigation was not progressed either because the individual subject to allegations could not be identified or was not on the NMC register. In three cases, the concerns were seen to have been remedied, meaning that the NMC considered that there was clear evidence to show that the individual was currently fit to practise.

c. Of those cases which progressed to investigation:
    i. 3 await an assessment decision.
    ii. In 30 cases, the Case Examiners or the Investigating Committee acted as the final decision-maker and did not refer the case on to the Fitness to Practise Committee.
    iii. 36 were referred for a hearing and 29 have concluded. Of those concluded, fitness to practise was found impaired in 24 cases. This has resulted in 4 cautions, 4 orders for conditions of practice, 13 suspensions and 6 orders for striking off.
d. Overall, there remain 24 cases which remain open awaiting a decision at some stage within the fitness to practise process.

Moving now to the HCPC [and the witness statement of Bernie O'Reilly, chief executive, CB 273]

29. The HCPC is the statutory regulator of 15 health and care professions within the United Kingdom. The HCPC (previously the Health Professions Council) was established in April 2002 with its register coming into effect on 9 July 2003. Its role and functions are substantially governed by the Health and Professions Order 2001.

30. The HCPC maintain a register of professionals, set standards for entry to the Register, approve education and deal with concerns that a professional may not be fit to practise. Their main role is to protect the public.

31. Each of the following professions is regulated by the HCPC and must be registered to legally practice under the following titles:
    a. Arts therapists;
    b. Biomedical scientists;
    c. Chiropodists/ podiatrists;
    d. Clinical scientists;
    e. Dietitians;
    f. Hearing aid dispensers (since 1 April 2010);
    g. Occupational therapists;
    h. Operating department practitioners (since 18 October 2004);
    i. Paramedics;
    j. Physiotherapists;
    k. Practitioner psychologists (since 1 July 2009);
    l. Prosthetists/orthotists;
    m. Radiographers; and
    n. Speech and language therapists.

32. Between August 2012 and 2 December 2019 the HCPC also acted as the regulator for social workers, who are now regulated by Social Work England.

33. Where concerns are raised, fitness to practise can be found impaired on a similar basis to doctors and nurses by reason of:
    a. Misconduct;
    b. Lack of competence;
    c. A criminal conviction or caution;
    d. Physical or mental health; or
    e. A determination by another health or social care regulator or licensing body.

34. Similar to the GMC and NMC, any concern must be sufficiently serious to establish that a HCPC registrant's fitness to practise is impaired and that they require restrictions on their practise.

35. Since 2020 the HCPC has used the Professional Liaison Service to work with employers to assist their decision making in respect of referrals of local concerns.

36. Following a concern being raised about an HCPC registrant, the following procedure is followed:
    a. Stage one, concern received. A decision is then made whether this falls within the types of case which the HCPC consider.
    b. Stage two, an investigation begins. Where a case falls within the HCPC's remit, information is gathered, and the registrant is notified.
    c. Stage three, threshold assessment. This is carried out against the relevant grounds for establishing fitness to practice. As with

the GMC and NMC this includes an assessment of the seriousness of the complaint.

d. Stage four, Investigating Committee Panel. If the concern meets the threshold for referral, allegations will be drafted, and the Investigating Committee will decide if there is a case to answer or whether further investigation is needed.
e. Stage five, Healthcare Professions Council Tribunal Service (HPCTS) hearing. This will be where the Investigating Committee determines there is a case to answer. The HPCTS will determine the allegations and whether fitness to practise is currently impaired. If impaired the HPCTS has available to it similar sanctions to the NMC, which are: a caution order, conditions of practice order, suspension order, or striking the registrant off the register.

37. The Inquiry requested that the HCPC provide details of fitness to practise cases concerning relevant providers of mental health inpatient care in Essex during the relevant period. The HCPC conducted a search using relevant locations identified by the Inquiry to match location name against details held of employer name, employer address, current employer and previous employer. Cases unrelated to mental health, solely related to the registrant's health, not related to their work environment, or from outside of Essex were excluded.

38. From the data available from the HCPC's commencement in 2003 there have been referrals concerning 12 professionals (8 psychologists and 2 occupational therapists). This has resulted in one case where the registrant was voluntarily removed from the register on health grounds, and 11 cases which were closed without referral to fitness to practise proceedings due to failing to meet the relevant threshold.

39. It should be noted that this data does not include records from pre-2005, which are paper based and have not therefore been electronically searchable. The HCPC have also not been able to provide details of cases concerning practitioner psychologists prior to 2009 as the profession was regulated by the British Psychological Society up to this point.

And moving finally to the CQC [and the witness statement of Sir Julian Hartley, chief executive, CB 286]

40. The CQC was established on 1 April 2009 by the Health and Social Care Act 2008 as the independent regulator of health and adult social care in England. Since then, it has been responsible for the registration, monitoring, inspection and regulation of services which fall within their regulatory remit.

41. Providers of regulated activities, such as those providing mental health inpatient care, must be registered with the CQC unless exempt. The CQC has identified the following as having provided mental health inpatient care in Essex during the relevant period:
    a. Mid Essex Hospital Services NHS Trust – registered 1 April 2010, most recently inspected in November 2019;
    b. North Essex Partnership University NHS Foundation Trust (NEPT) – registered 1 April 2010, most recently inspected in September 2016;
    c. South Essex Partnership University NHS Foundation Trust (SEPT) – registered 1 April 2010, most recently inspected June/July 2015;
    d. North East London NHS Foundation Trust (NELFT)– registered 1 April 2010, most recently inspected in June 2022;

e. Essex Partnership University NHS Foundation Trust (EPUT) – formed by the merger of SEPT and NEPT; registered 1 April 2017, most recently inspected in December 2024 and January 2025.

42. The CQC's main objective in fulfilling its functions is set out in section 3 of the Health and Social Care Act 2008. This is to "*protect and promote the health, safety and welfare of people who use health and social care services*". Further, it has the general purpose of making sure health and social care services provide safe, effective, compassionate, high-quality care and to encourage care services to improve.

43. The CQC has a duty to conduct reviews of these regulated activities and service providers, to assess their performance following the review, and to publish a report of the assessment. This is further to section 46 of the Health and Social Care Act 2008.

Outline of predecessor organisations

44. Prior to the CQC the following organisations were responsible for functions now within its remit:

a. Mental Health Act Commission. This was previously responsible for considering the legality of detention and rights of detained individuals under the Mental Health Act 1983.
b. Commission for Health Improvement. This was the health sector regulator dealing with safety, quality and standards up until 2004.
c. Healthcare Commission. This took over from the Commission for Health Improvement and operated until the CQC took over this function in 2009.

Approach to regulation

45. Central to the way in which the CQC regulates is the application of 'fundamental standards'. These are identified as the standards which everybody receiving care has the right to expect and below which care should never fall. These were introduced following the Mid Staffordshire NHS Foundation Trust Public Inquiry and impose obligations that registered providers must meet in order to be registered with the CQC.

46. There are 13 fundamental standards which are contained in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It is against these standards that healthcare providers are assessed as part of the CQC's functions. They are:
    a. Regulation 9 - Person centred care;
    b. Regulation 10 - Dignity and respect;
    c. Regulation 11 – Need for consent;
    d. Regulation 12 – Safe care and treatment;
    e. Regulation 13 - Safeguarding service users from abuse and improper treatment;
    f. Regulation 14 – Meeting nutritional and hydration needs;
    g. Regulation 15 - Premises and equipment;
    h. Regulation 16 – Receiving and acting on complaints;
    i. Regulation 17 - Good governance;
    j. Regulation 18 - Staffing;
    k. Regulation 19 - Fit and proper persons employed;
    l. Regulation 20 - Duty of candour;
    m. Regulation 20A – Requirement as to display of performance assessments.

47. Between 2010 and 2014, there were previously a set of 28 regulations setting standards of quality and safety of which 16 related to quality and safety of care.

48. Since 2013, inspections by the CQC have used five key questions to assess services from registered providers:

a. Are they safe?
b. Are they effective?
c. Are they caring?
d. Are they responsive to people's needs?
e. Are they well-led?

49. In 2014 the mental health directorate was established to provide specialist inspectors and inspection teams for the purpose of undertaking inspections of Mental Health Services. All core services at all Mental Health trusts would be inspected and rated. Following inspections 'Must do' and 'Should do' actions were given to providers.

50. From 2014 to 2023 the inspection approach fell into three main phases:

a. Monitoring and Information Sharing. This would involve the review of information collected on a service prior to an inspection.
b. Inspection. This varied depending on the previous CQC rating following comprehensive inspection. This would normally be within 30 months of the previous report if good or outstanding, or within six months if inadequate.
c. After inspection. A report would be drafted including findings on the five key questions.

51. Different types of inspection included:
    a. Comprehensive inspections where an in depth and holistic view across the whole service would be considered. This resulted in a rating of inadequate, requires improvement, good or outstanding. In addition to being based on timescales dictated by previous performance, this could also be where a risk to safety or a significant deterioration in service had been identified.
    b. Focused inspections. These would be more targeted inspections in respect of specific information or previous findings.
    c. Combined inspections. These would be aimed at those delivering services across health and social care sectors.

Information in respect of the Essex Trusts

52. At the Inquiry's request the CQC has provided details of inspections of the Essex Trusts and those services providing mental health inpatient care [Exhibit JH12A].

53. Although not possible to summarise all of these at this hearing, it is of note that more recent inspections of EPUT have included the following:
    a. Willow Ward and Galleywood Ward, acute wards for adults of working age and psychiatric intensive care units, were inspected on 5 and 6 October 2022. The report dated 3 April 2023 graded the service as "inadequate" and included findings that the ward did not have enough permanent nursing staff to keep patients safe from avoidable harm. It also found instances where staff were asleep whilst meant to be undertaking observations.

b. Acute wards for adults of working age and psychiatric intensive care units were visited between November 2022 and January 2023. The report dated 12 July 2023 graded these as "Requires improvement". This applied to all areas except for "Are Services Caring?". It found that previous breaches identified in 2019 and 2022 had yet to be addressed.

Enforcement

54. In addition, and distinct to its role in registering and inspecting healthcare providers the CQC also has substantial statutory powers to take both civil and criminal enforcement action against registered persons who fail to comply with conditions of registration and CQC regulations aimed at ensuring safe and adequate care.

55. Civil enforcement powers include being able to cancel or suspend registration, imposing, varying or removing conditions or serving a warning notice.

56. The CQC describes itself as *"the primary enforcement body at a national level in England for ensuring that people using health and social care services receive safe care of the right quality"*.

57. Where breaches of regulations do not constitute a criminal offence, the CQC can enforce standards using civil enforcement powers. Failure to comply with the steps required using civil enforcement powers is a criminal offence and can result in prosecution.

58. There are three enforcement actions which the CQC has available to require a provider to protect service users from harm and the risk of harm. These are:

a. Requirement Notices. These are used where there is not an immediate risk of harm.
b. Warning Notices. These notify a registered person that the CQC consider that they are not meeting their relevant regulatory obligations. If a registered person does not comply with a Warning Notice, consideration will be given to enforcement action under civil or criminal law.
c. Section 29A Warning Notices. These are provided for by section 29A of the 2008 Act and make provision for Warning Notices to be addressed to NHS Trusts or foundation trusts.

59. It is stated by the CQC in their witness statement at [170] that "*we have not identified any civil enforcement action taken by CQC against any of the relevant Trusts.*"

60. The Inquiry is however aware of details of a Warning Notice issued to North Essex Partnership University NHS Foundation Trust in 2016. Clarity as to the extent and reasons for the issue or not of Warning Notices or other civil enforcement action will be subject to further investigation by the Inquiry.

61. Criminal enforcement can also be undertaken for breach of certain regulations and sections of the 2008 Act by use of fixed penalty notices, cautions and prosecutions.

62. Since April 2015 the CQC has also been able to bring criminal prosecutions against health and social care providers for failing to provide treatment in a safe way.

63. In their witness statement at [186] the CQC confirm that they have not "*identified any prosecutions brought by CQC against any of the*

relevant Trusts". The CQC acknowledges that cases may be identified where prosecution was considered but the relevant threshold was not met.

64. As with the civil enforcement action, the Inquiry will continue to seek further information and clarity as to the extent of the use of criminal powers and the basis of any decisions concerning these.

Notifications and reporting of patient safety incidents

65. Under the Care Quality Commission (Registration) Regulations 2009 registered providers and/or registered managers are required to submit notifications about certain incidents or events which are referred to as statutory notifications. These are set out in regulations 12, 14-18, and 20-22. These regulations are said to be relied on by the CQC to be aware of activity within a service, identify issues of concern, to inform whether regulatory action is needed, and to monitor trends. Failure to notify the CQC of certain incidents, changes or events will be an offence.

66. In overview:
    a. Regulation 16 requires notification of the death of a person accessing their service.
    b. Regulation 17 requires notification of unauthorised absences and deaths of those detained or liable to be detained under the Mental Health Act 1983.
    c. Regulation 18 requires notification of a range of incidents including:
        i. serious injuries to service users;
        ii. abuse or allegations of abuse of a service user;

iii. any event which prevents or appears likely to threaten or prevent safe carrying out of the regulated activity. This would include staff shortages, issues relating to the physical premises and malfunctioning of alarms or safety devices;

iv. The placement of a service user under the age of 18 in adult services where this lasted over 48 hours.

67. Up until Autumn 2023 (when replaced by the Patient Safety Incident Response Framework) any cases which met the criteria of a serious incident were required to be reported on the Strategic Executive Information System. Serious incidents were governed by the NHSE Serious Incident Framework which describes the circumstances in which a heightened response would be required.

Monitoring the Mental health Act 1983 – from 2009 to date

68. Since its creation in 2009 the CQC has had a duty under the Mental Health Act 1983 (MHA) 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. The CQC also have duties to review and powers to investigate complaints raised by or on behalf of individuals, and to provide a Second Opinion Appointed Doctor Service to review or certify treatment.

69. Visits from the CQC would focus on monitoring the use of formal MHA powers and the exercise of duties under the MHA. This is said to include ward visits and speaking with detained patients, seeing the environment in which they would be detained, and reviewing records related to detention and treatment.

70. MHA monitoring visits ought to have been carried out to individual wards treating detained patients on a regular cycle of 18 or 24 months. There could also be focused or thematic visits in response to identified risks or concerns. Such visits would result in a report including a summary of findings and actions raised during the visit.

71. The CQC reports annually on deaths of detained patients in its MHA Monitoring the Mental Health Act annual reports.

28 April 2025

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