

Witness Name: Dr Michael Mulholland (on
behalf of the Royal College of General
Practitioners)

Statement No: WITN0227001

Dated: 17 November 2025

THE NOTTINGHAM INQUIRY

FIRST STATEMENT OF DR MICHAEL MULHOLLAND

I, Dr Michael Mulholland, will say as follows:

INTRODUCTION

1. I am a practising GP and a Partner in the Unity Health practice, which has 5 surgeries in the Thames Valley region. For the purposes of this evidence, my professional address is 30 Euston Square, London, NW1 2FB. My professional qualifications are: BSc, MB, ChB, DRCOG, MSc (Med Ed), FRCGP.
2. I qualified as a doctor in 1994 and as a GP in 1998. I joined the practice now known as Unity Health Buckinghamshire in 1999. I had roles in Health Education England (HEE) as an Associate GP Dean until November 2018, when I was seconded to RCGP. I was also a Continuing Professional Development (“CPD”) /Workforce Tutor until November 2021, at which point I

left HEE. I was RCGP Vice Chair for Professional Development and Standards from November 2018 to 2021 and am now the Honorary Secretary of the College.

3. As Honorary Secretary I work at RCGP for 4 half-day sessions per week.
4. My role as Honorary Secretary is to be a RCGP council representative for the College's Clinical Policy portfolio and to support the RCGP Trustee Board in ensuring proper governance of the College across all four UK nations. Unless individual nations are specifically referred to, the information in this statement relates to the position across all UK nations. My fixed-term appointment as Honorary Secretary will come to an end in November 2025.
5. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 16 June 2025 (the "Request").

BACKGROUND TO THE ROYAL COLLEGE GENERAL PRACTITIONERS

6. The Royal College of General Practitioners (RCGP) is a professional membership body and registered charity with over 54,000 GPs across the UK and abroad. We are committed to improving patient care, supporting GPs to continually develop their skills and promoting general practice as a discipline. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement.

7. The RCGP sets the educational standards, assessment framework, and curriculum for GP training in the UK. Its responsibilities and remit include:

Curriculum Development

8. The RCGP designs and maintains the GP curriculum. The GP curriculum acts as the educational framework for the three-year specialty training programme for doctors entering general practice in the UK. The curriculum outlines the capabilities required for independent practice. A GP registrar must have been assessed as being 'competent' in all of these capabilities at the end of training in order for the College to recommend them for a Certificate of Completion of Training (CCT) and for them to apply to join the General Medical Council (GMC) GP Register.

Assessment

9. The RCGP oversees the Membership of the Royal College of General Practitioners (MRCGP) examination, which includes:
 - Applied Knowledge Test (AKT). This is a single best answer type exam. The RCGP develops the format and sets the questions, and the exam is taken at Pearson VUE test centres across the UK.
 - Simulated Consultation Assessment (SCA). This is a remote, online examination sat by candidates in GP surgeries. The SCA assesses a GP registrar's ability to integrate and apply skills appropriate for general practice. Candidates are presented with twelve consultations with simulated patients, each lasting twelve minutes. The RCGP designs and delivers the SCA.

- Workplace-Based Assessments (WPBA). WPBA evaluates progress in areas of professional practice and behaviour best tested in the workplace and that are difficult to assess in the Applied Knowledge Test (AKT) and Simulated Consultation Assessment (SCA). While the RCGP designs the WPBA assessments, these are delivered by the Statutory Education Bodies.

10. With the exception of the delivery of the AKT and SCA outlined above, much of the delivery of GP training is done by the Statutory Education Bodies. The GP curriculum requires GP registrars to develop a range of generalist capabilities and a broad base of clinical knowledge. This is delivered primarily through local training programmes. In most UK regions these programmes are managed by a school of postgraduate general practice education or equivalent structure. A director of postgraduate general practice education leads the local network of GP educators and trainers.

11. Within each geographical area, Primary Care Deans, Associate Deans and Training Programme Directors are responsible for training programmes. An individual GP registrar's programme is overseen by their educational supervisor, who is supported by the expertise and resources of a local team, according to local arrangements.

12. To become licensed to practice as a GP within the UK, doctors must pass the RCGP's MRCGP examination, comprising AKT, SCA and WPBA (the latter of which is managed by local NHS Deaneries). In 2024, the SCA succeeded the

Recorded Consultation Assessment (RCA), which was a temporary remote-format assessment promoted by the pandemic to replace the Clinical Skills Assessment, which had required trainees to be assessed face-to-face.

13. In addition to its curriculum and examining roles, the College also produces (in common with many other organisations) CPD resources. The College also accredits a wide variety of educational activities that are identifiable to health professionals as high quality and associated with the high professional standards the RCGP embodies. The RCGP Accreditation Quality Mark is an identifiable symbol of quality assurance that associates educational activities with the professionalism, expertise and commitment to the highest possible standards of general practice.

14. However, RCGP has no leverage over which resources GPs choose to use for their CPD. Similarly, the College has no role in the CPD metrics with which GPs must comply, and which, along with enforcement of professional standards, is the remit of the General Medical Council (GMC).

15. In addition, and by harnessing the voice of our members, RCGP helps shape national policies and guidance in the UK that helps inform delivery of care in general practice, including engaging with politicians and other national decision-makers in the health sector. We also deliver projects to help to identify and spread good practice. It is up to individual GPs to decide whether or not to follow our guidance or CPD output, and RCGP has no role in enforcing standards. GPs are usually expected to take into account the guidelines issued

by the National Institute for Health and Care Excellence (NICE) when making clinical decisions.

PRIMARY CARE ROLE IN MENTAL HEALTH

16. Primary care encompasses a range of services, of which general practice is a core component. This response will therefore focus on our key area of expertise, general practice. In this document, references to primary care will specifically refer to general practice and the role of the GP within that context.
17. Our policy position in relation to the provision of mental health care in primary care titled “Mental Health in Primary Care” [WITN0227002], published in 2017 and valid through the years specified, expressed concerns about the lack of clarity on the role of general practice in the treatment of mental health patients, stating that: “General practice, which is part of wider primary care, is charged with providing care for ‘common mental health problems’ and contributing to health promotion, through the GP Contract, commissioned by NHS England, but there is a lack of clarity around roles and responsibilities for the care of patients with chronic, complex, and disabling non-psychotic mental health problems. Primary care also has a duty to provide physical health care including offering screening, to those people with Serious Mental Illness (SMI) such as schizophrenia. However, there is no clear direction as to who should manage people with stable SMI who no longer require the expertise of specialist secondary care services. Many of these people are being discharged into primary care with no planning or support. Primary care is in a unique position to deliver mental health care, being most people’s first port of call in times of

health care need or the development of symptoms. It is the only part of our health service that offers 'cradle to grave' family orientated, person-centred care, often seeing and supporting patients through significant life events such as pregnancy and bereavement.”

18. The RCGP curriculum acts as the educational framework for the three-year (whole time equivalent) specialty training programme for doctors entering general practice in the UK. It is designed to integrate with GMC's framework set out in “Generic Professional Capabilities Framework” [WITN0067006].

19. The learning outcomes of the RCGP curriculum are organised into five areas of capability. The five areas of capability are themselves composed of 13 specific capabilities that a doctor is expected to acquire during GP specialty training.

20. In the version of the GP curriculum titled “RCGP Curriculum Becoming a General Practitioner” [WITN0227003] in place from 2019 - 2023 these Capabilities were:

1. Fitness to practise
2. Maintaining an ethical approach
3. Communication and consultation
4. Data gathering and interpretation
5. Clinical examination and procedural skills
6. Making decisions
7. Clinical management
8. Managing medical complexity

9. Working with Colleagues and in teams
10. Improving performance, learning and teaching
11. Organisational management and leadership
12. Practising holistically, safeguarding and promoting health
13. Community Orientation

21. The current version of the Curriculum, introduced in 2025, has a slightly different list of capabilities.

22. The GP Curriculum is supported by a series of topic guides, authored by the College, that explore professional and clinical capabilities in more depth and provide examples in practice. Each Topic Guide is intended to illustrate important aspects of everyday general practice, rather than provide a comprehensive overview of that topic, and should not be viewed as a syllabus or a complete and comprehensive list of everything a GP has to know. This is in line with the General Medical Council's standards "Excellence by Design" [WITN0067005] covering curricula design that state "[Curricula must] describe fewer, high-level generic, shared and specialty-specific outcomes". This response includes references to relevant topic guides, where necessary.

23. 'Mental Health' in the GP Curriculum: The first specific curriculum for GPs in the UK was introduced by the RCGP in 2007. Since this date, there have been several new versions of the Curriculum, along with less substantial revisions. A new version of the Curriculum was introduced in August 2019, with an update in 2021 introducing a new topic guide dedicated to planetary health. There has

subsequently been a revised version of the Curriculum launched in August 2025. As the scope of the inquiry covers 2019 - 2023, the 2019 version of the Curriculum is referenced below.

24. The "scope of a GP" as set out in the 2019 version of the GP Curriculum is included in Exhibit [WITN0227003] at page 4.

25. Upon its introduction in 2007, the Curriculum had a Clinical Module titled "Care of People with Mental Health Problems". This subsequently became a "Topic Guide" in the 2019 version, titled "Mental Health".

26. The capability "Clinical Management" concerns the recognition and management of common medical conditions encountered in generalist medical care, safe prescribing and approaches to the management of medicines.

27. Particularly relevant sections of this capability in the GP Curriculum at page 56 of [WITN0227003] include:

- "Develop the knowledge and skills required to provide high-quality, holistic and comprehensive care to groups of patients who may have health and care needs that require you to adapt your clinical approach. Such groups include (but are not limited to)...people with mental health problems"
- "Implement adequate follow-up arrangements (e.g. to facilitate the early diagnosis of evolving problems, assess response to treatment, provide safe monitoring and learn from the outcomes of interventions)"

- “Contribute to an organisational and professional approach that facilitates continuity of care (e.g. through adequate record-keeping and building long-term patient relationships)”
- As a GP, this means that you should refer appropriately to other professionals and services by...”writing referral letters that provide relevant information and explaining the reason for referral [and]...providing ongoing continuity of care for the patient while they wait for their specialist appointment, reviewing progress at suitable intervals.”

THE TREATMENT, CARE, AND MANAGEMENT OF THOSE WITH PSYCHOSIS OR SCHIZOPHRENIA.

28. As referred to above at paragraph 15, GPs follow NICE guidelines which provide evidence-based recommendations for improving the quality and safety of patient care. NICE publishes Clinical Knowledge Summaries (CKS) which relate to current guidelines at the time, and are readily available to all clinicians in primary and secondary care.

29. The management of psychosis and schizophrenia in the UK depends on a collaborative relationship between specialist psychiatry and primary care. Patients may cycle between episodes of acute illness and remission. While specialised psychiatric services provide vital interventions, it is general practice that ensures ongoing, holistic, and monitoring of physical and mental health

throughout the course of the illness. By identifying illness early, supporting recovery, and advocating for patients across different systems, GPs remain central to improving both health outcomes and quality of life for those living with psychosis and schizophrenia.

30. In relation to the the above, the following excerpt has been taken from pages 1 and 4 of the RCGP “Mental Health Topic Guide” [WITN0227004] to clarify our position:

- “Severe behavioural disturbance including psychotic disorders such as schizophrenia, acute paranoia and acute mania” (Page 4).
- “diagnose, investigate and manage mental health conditions... and referral where appropriate” (Page 1)
- “Monitoring of treatments such as anxiolytics and antipsychotic medication” (Page 4).

31. The following is taken from page 56 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Develop the knowledge and skills required to provide high-quality, holistic and comprehensive care to groups of patients who may have health and care needs that require you to adapt your clinical approach. Such groups include ... people with mental health problems."

THE TREATMENT, CARE AND MANAGEMENT OF THOSE WITH A HISTORY, OR POSING A RISK, OF VIOLENCE OR OFFENDING.

32. When patients present in surgery, GPs may be the first professionals to recognise warning signs of potential violence. These include a history of offending, escalating substance misuse, untreated psychiatric symptoms such as paranoia, or personality traits linked to impulsivity. Sensitive questioning, informed by awareness of risk factors, allows for early identification. While detailed risk assessment is often the role of forensic psychiatry, when patients attend surgery GPs can help by monitoring changes over time and alerting relevant agencies.

33. The role of general practice in caring for individuals with a history of violence or offending extends beyond medical treatment. Our responsibilities cover:

- Early detection
- Mental health care (within the remits of general practice)
- Substance misuse treatment
- Physical health care
- Care coordination and multi-agency working
- Safeguarding responsibilities
- Rehabilitation and reintegration
- Crisis management and safety

34. A GP also has broader responsibilities to safeguard public health and safety. These include a duty to balance confidentiality with wider public interest. While patient confidentiality is of paramount importance, GPs should disclose information without consent to an appropriate person or authority if it is justified in the public interest. This is a rare and serious step, but it may be necessary

to prevent significant harm to the patient or others, or to prevent or prosecute a serious crime.

35. By integrating clinical care with advocacy and ongoing support, general practice helps to balance the needs of individual health with public safety.

36. In relation to the above, the following excerpt has been taken from pages 1 and 3 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “acute mental health problems including acute psychoses... the suicidal patient, psychological crises” and “self-harm including putting themselves in dangerous situations” (Page 3).
- “assess risk to make the patient’s safety and the safety of yourself and others a priority” (Page 1).

THE TREATMENT AND CARE OF THOSE FALLING INTO EITHER OF THE ABOVE CATEGORIES WHO ARE NOT CONCORDANT WITH MEDICATION.

37. In cases of non-concordance, the role of general practice is not to enforce medication but to work alongside the specialist clinician, in this case the psychiatrist who takes responsibility for the patient and is providing the care and treatment plan for patients falling into either of the above categories until the patient has been stabilised and no longer represents a risk to themselves or the community. At this stage a joint decision could be made around if the care can be handed over to general practice. The role of general practice is then to

recognise, review the patient and refer onwards to the appropriate agency community mental health team/crisis.

38. Individuals who are under specialist care shall often be prescribed treatment by that individual specialist and it is then their responsibility to follow up patients under their care, including monitoring, adherence, side effects and treatment outcomes. Patients in this situation under a Community Treatment Order (CTO) shall specifically be under the responsibility of a named clinician in secondary care who take the responsibility of prescribing and issues around concordance.

39. In 2021, the GMC published guidance entitled “Good practice in proposing, prescribing, providing and managing medicines and devices” [WITN0067010]. Their guidance states at para 92 that “Whether you propose, prescribe or provide medications using repeat prescribing or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up and review. You should take account of the patients’ needs and any risks arising from the medicines.”

40. In relation to the above, the following excerpt has been taken from page 5 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “The importance of concordance in mental health care.”

41. The following is taken from page 58 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Demonstrate safe and appropriate prescribing, repeat prescribing, medication review and medication management in the community context."

THE ROLE OF PRIMARY CARE IN ASSESSING CAPACITY OF MENTAL HEALTH PATIENTS.

42. The evaluation of mental capacity is vital in contemporary medical practice, ensuring consent, patient autonomy, and safeguarding. In the UK, this is regulated by the Mental Capacity Act 2005 (MCA), which establishes the legal framework.

43. A GP is often the first point of contact for a patient whose mental capacity is in question, especially regarding their health and medical treatment. However, the responsibility for assessing mental capacity also falls to specialists who may make an assessment when they are prescribing treatment also. Ultimately however, the responsibility for a capacity assessment lies with the clinician undertaking the proposed treatment plan.

44. The assessment of capacity is usually made in the moment about the specific health issue e.g. assessing whether or not a patient has capacity to respond to a question such as 'do you want treatment? yes or no'. Capacity issues often arise in general practice, such as when obtaining consent for medication, attending investigations, agreeing to referrals, or engaging with treatments. Patients with mental health conditions like schizophrenia, bipolar disorder,

dementia, or substance misuse may demonstrate impaired decision-making abilities.

45. Capacity assessments can be difficult during short consultation times. Patients with fluctuating capacity (e.g., in psychosis, mania, or delirium) might seem capable at one moment and impaired at another. Cultural or communication barriers can also make assessments more difficult. Another common challenge is distinguishing a capable but "unwise" decision (such as refusing medication) from an actual lack of capacity.

46. When considering areas around lasting power of attorney, this takes into account longer term, more complex decision making which takes away the decision-making process from the individuals and places it elsewhere i.e. with another individual or through the Court of Protection.

47. By applying the principles of the MCA, documenting thoroughly, and liaising with other services, GPs help ensure a balance between respecting autonomy and protecting patients from harm.

48. In relation to the above, the following excerpt has been taken from pages 1 and 4 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- "follow agreed protocols, including those as part of The Mental Health Act and The Mental Capacity Act where appropriate" (Page 1)

- “follow agreed protocols, including those as part of The Mental Health Act and The Mental Capacity Act where appropriate”
- “the role of the GP in sectioning patients; awareness of the Mental Health Act and the Mental Capacity Act” (Page 4)

49. The following is taken from page 57 of the Clinical Management Capability in the GP Curriculum [WITN0227003] :

- "Offering appropriate evidence-based management options, varying these responsively according to the circumstances, priorities and preferences of those involved."

THE ROLE OF PRIMARY CARE IN ASSESSING RISKS POSED BY MENTAL HEALTH PATIENTS, IN PARTICULAR TO THIRD PARTIES.

50. GPs are usually focused on providing care to their individual patient. However, mental illness can increase the likelihood of behaviours that endanger others. These include physical violence linked to psychosis or substance misuse, domestic abuse or neglect of dependents, exposing children to harmful environments, and risks to the public, such as dangerous driving. Vulnerable adults may also be at risk through neglect or financial exploitation. In these cases, the role of general practice would be to refer or report where appropriate. However, as set out in the response to section B, there is a responsibility of sharing of information which includes balancing confidentiality with wider public interest. While patient confidentiality is paramount, GPs need to disclose information without consent if it is justified in the public interest. This is a rare

and serious step, but it may be necessary to prevent serious harm to the patient or others or to prevent or prosecute a serious crime.

51. GPs are well placed to detect early warning signs of risk through continuity of care and long-term relationships with patients and families; however, it is often the case that the families are registered with a different GP to that of the patient. This would occur in situations where young people live away from home whilst at university. GPs are not always necessarily best placed to provide a full forensic assessment of the risk that the patient may pose to others in the future.

52. While GPs are trained to assess risks to safety, this does not mean they can be expected to be experts in assessing risk of violence. Risk assessment is also challenging during short GP consultations, and information is often incomplete. Risk can change quickly, especially in conditions like psychosis or bipolar disorder. GPs must balance maintaining therapeutic trust with acting protectively. The safety of practice staff and other patients must also be prioritised, with zero-tolerance policies against violence. It is important to be clear what is meant by 'risk assessment'.

53. A risk assessment regarding harm to others can only be done really in a multi-agency arena where all the information is available to all professionals. Hence why all safeguarding (child and adult) is done via a multi-agency assessment and why there are specific risk assessment procedures in place for known offenders such as Multi-Agency Public Protection Arrangements (MAPPA) – or when there are concerns about radicalisation e.g. Channel Panel, Prevent etc.

54. Other professionals have very specific risk assessment training e.g. those in forensic psychiatry or in the police. GPs do however need to be alert to indicators that a person's health or behaviour may pose a risk to others and refer to appropriate agencies. However, when patients with mental health issues 'don't engage' with mental health services, they are often discharged and general practice is left holding huge amounts of risk with no support.

55. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- "Assess risk to make the patient's safety and the safety of yourself and others a priority".

THE CIRCUMSTANCES IN WHICH PRIMARY CARE WILL REFER A MENTAL HEALTH PATIENT TO SECONDARY CARE OR FOR A MENTAL HEALTH ASSESSMENT.

56. GPs are expert generalists in the initial identification and management of mental health problems relating to parity of esteem, their expert generalist role, early intervention, integrated care and a patient centred approach.

57. GPs would make a decision to refer a patient to secondary mental health care for serious or complex mental health issues, and where they consider a patient is either at risk to themselves or to others, when illness severity surpasses primary care's capacity, or when there is treatment resistance or diagnostic

uncertainty. Prompt referral ensures access to specialist services, improves outcomes, and protects both patients and the wider community.

58. The College's 2017 "Mental health in primary care" policy statement [WITN0227002] states: "The RCGP recommends that common mental health problems are managed using the stepped care approach recommended by NICE. GPs should manage patients using a combination of medication, psychological therapies, support groups, befriending, rehabilitation programmes, educational and employment support services and referral for further assessment and interventions in secondary care if needed." These referrals can be urgent, routine, or crisis-driven, depending on the clinical situation. The presence of significant risk is the most urgent reason for referral. Patients showing suicidal ideation, intent, or presenting after self-harm need assessment for further harm risk and often require referral to crisis teams or secondary care. Likewise, patients displaying violent behaviour, threats to others, or safeguarding concerns regarding children or vulnerable adults require urgent secondary intervention.

59. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- "ensure early intervention by appropriate referral, follow up and continuity of care where necessary".

60. The following is taken from page 59 of the GP curriculum relating to the Clinical Management Capability [WITN0227003]:

- "Refer appropriately to other professionals and services ... writing referral letters that provide relevant information and explaining the reason for referral"

THE ROLE OF PRIMARY CARE WHERE A MENTAL HEALTH PATIENT IS RECEIVING SECONDARY MENTAL HEALTH CARE IN THE COMMUNITY.

61. Although GPs have an important role in understanding both the physical and mental health needs, a GP's responsibility lies predominantly with those patients who as stated in our 2017 policy statement [WITN0227002] "often do not have active psychosis but may have multiple problems of chronic SMI but discharged from secondary care, personality issues, drug use and mental health problems with additional complex needs". Additionally, our statement says: "The RCGP recommends that the physical health care of people with SMI should be approached and managed in the same way as any other long-term condition." GPs offer continuity, comprehensive care, and access that complement the specialist expertise of secondary care teams.

62. While it would depend on the individual circumstances and agreement, where a mental health patient is receiving secondary mental health care in the community, we would expect the role of general practice to include some or all of the following:

- Shared care prescribing
- Physical healthcare

- Continuity and holistic support, including the consideration of underlying neurodiversity or learning disability
- Risk monitoring and safeguarding
- Care coordination
- Support for family and carers
- Advocacy and social role
- Crisis management

63. By maintaining engagement, monitoring risks, and coordinating care, primary care ensures that patients receive integrated, person-centred healthcare within the community.

64. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- "coordinate care with other organisations and professionals... community mental health teams".

65. The following is taken from page 59 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Providing ongoing continuity of care for the patient while they wait for their specialist appointment, reviewing progress at suitable intervals."

HOW PRIMARY CARE ENGAGES WITH ACUTE AND COMMUNITY SECONDARY MENTAL HEALTH SERVICES IN THE TREATMENT OF MENTAL HEALTH PATIENTS.

66. There will be a range of ways in which primary care engages with acute and community secondary mental health services. However, we will focus on general practice's engagement specifically in line with the remit of the RCGP. The relationship between general practice and secondary mental health care is one of mutual dependence. General practice offers ongoing support, easy access, and holistic assistance, while secondary services deliver specialist expertise and more intensive treatment. Through referrals, shared care, communication, risk management, and crisis intervention, general practice actively collaborates with both acute and community services to ensure safe, coordinated care for mental health patients.

67. Consistent with shared care agreements for many conditions, general practice would expect regular communication from acute and community secondary care mental health services, especially prior to discharge in the form of on-going care planning, communication of treatment plans, follow up arrangements and identified future risks to themselves or others. Effective engagement relies on good communication. Discharge summaries, clinic letters, and shared care plans facilitate continuity across different settings. Under the Care Programme Approach (CPA), run by mental health trusts, GPs can attend multidisciplinary meetings or case conferences. Clear communication guarantees that risk management plans are shared and that the GP remains updated on the patient's mental health condition. GPs would likewise communicate with community secondary mental health services regarding a patient's physical health needs.

68. Shared-care arrangements often formalise the responsibilities for primary and secondary care relating to prescribing. Once patients are stabilised on a medication, many aspects of care revert to primary care under shared-care arrangements. Psychiatrists may initiate medications such as antipsychotics, lithium, or mood stabilisers, but GPs often continue prescribing and organise blood monitoring. Physical health care, including annual health checks for people with severe mental illness, remains primarily the GP's responsibility. In this way, GPs support long-term maintenance while secondary services focus on specialised input.

69. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- "coordinate care with other organisations and professionals... community mental health teams".

70. The following is taken from the page 59 of Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Organise the follow-up of your patients after referral through multiprofessional, team-based and structured approaches, including monitoring, reviewing and regular care planning."

THE ROLE OF PRIMARY CARE IN THE FORMULATION OF TREATMENT PLANS FOR MENTAL HEALTH PATIENTS IN THE COMMUNITY

71. Treatment planning for mental health patients in the community is a dynamic and collaborative process that aims to promote recovery, reduce risk, and improve quality of life. The formulation of treatment plans for mental health patients in the community is predominantly undertaken by secondary care. In the case of individuals with complex or severe mental health conditions, this would be undertaken and coordinated by secondary care. GPs may, however, be involved in the formulation of additional supportive physical treatment plans. For example, patients with diabetes and mental health conditions may have a joint plan around their compliance with medication and monitoring.

72. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “coordinate care with other organisations and professionals... community mental health teams”.

73. The following is taken from page 57 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Develop and implement appropriate management plans for the full range of health conditions that you are likely to encounter in the community."

THE ROLE OF PRIMARY CARE, IF ANY, IN THE RECOMMENDING OR MAKING OF A COMMUNITY TREATMENT ORDER

74. Community Treatment Orders (CTOs) were introduced under the Mental Health Act 1983, as amended in 2007. They enable certain patients with severe mental

illness, usually detained under section 3, to be discharged from hospital subject to conditions that require them to adhere to treatment in the community. CTOs aim to reduce relapse and readmission while supporting patients to live outside hospital.

75. The authority to establish a CTO lies exclusively with secondary mental health professionals. Specifically, the patient's responsible clinician (usually a consultant psychiatrist) must recommend it, and this requires approval from an approved mental health professional (AMHP), typically a social worker trained in mental health law. General practitioners have no statutory role in recommending or authorising a CTO and their involvement at this point would likely be limited to providing information to secondary services.

76. Once a CTO has been implemented, the GP's role becomes more proactive. Many patients on CTOs receive medication through shared-care arrangements, with GPs responsible for prescribing, monitoring, and organising blood tests or physical health checks. GPs continue to deliver holistic care, addressing the physical health inequalities faced by patients with severe mental illness. Additionally, GPs support the patient's broader recovery by tackling social determinants of health such as housing, employment, and benefits, and by supporting families and carers.

77. Importantly, GPs cannot enforce compliance themselves. The authority to recall a patient to hospital for breach of conditions or clinical deterioration rests solely

with the responsible clinician and secondary services. The GP's role is supportive rather than proactive.

78. In relation to the above, the following excerpt has been taken from page 4 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “The role of the GP in sectioning patients; awareness of the Mental Health Act and the Mental Capacity Act (or equivalent legislation)”.

THE ROLE OF PRIMARY CARE, IF ANY, IN MENTAL HEALTH ASSESSMENTS AND DECISIONS AS TO WHETHER A PATIENT SHOULD BE DETAINED

79. GPs are often the first to identify situations where detention may be necessary. They may recognise acute psychosis, suicidal intent, or escalating violence during a consultation or home visit. In such cases, the GP's role is to initiate a referral for a Mental Health Act assessment, usually by contacting the crisis resolution team, community mental health team, or liaising directly with an AMHP.

80. GPs alone do not have the authority to decide whether a patient should be detained under the Mental Health Act. Detention under the Mental Health Act 1983 (as amended) is a legal process that allows individuals with serious mental health issues to be admitted to hospital without their consent if it is necessary for their safety or to protect others. The authority to detain is held by specific statutory professionals, but primary care professionals also play an important supporting role in providing relevant patient information. Instead, the

responsibility for the decision whether a patient should be detained lies with an approved mental health professional, following medical recommendations from two doctors, one of whom will be an 'approved doctor' usually a psychiatrist. Due to competing time constraints and priorities, GPs are not always available at the right time or place, or with sufficient knowledge of the specific patient to contribute effectively to medical recommendations regarding mental health assessments.

81. In relation to the above, the following excerpt has been taken from pages 3 and 4 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “the application of the Mental Health Act as applicable to all the UK Home countries” (Page 3).
- “The role of the GP in sectioning patients; awareness of the Mental Health Act and the Mental Capacity Act (or equivalent legislation)” (Page 4).

THE ROLE OF PRIMARY CARE IN PLANNING FOR THE DISCHARGE OF A MENTAL HEALTH INPATIENT

82. GPs are rarely involved in the planning for the discharge of a mental health inpatient, however, the discharge of a mental health inpatient signifies a key point in the patient's care path. While secondary services lead the process, GPs working with community mental health teams can play a role in ensuring continuity, safety, and comprehensive support as the patient returns to the community. This planning usually takes places between the inpatient, mental

health team and the community mental health team who take on the discharge plan in the community.

83. While secondary services oversee the process, following discharge, responsibility for prescribing often falls to the GP. This may include complex psychotropic medication regimens such as antipsychotics, lithium, or mood stabilisers. The GP ensures continuity of supply and organises necessary monitoring of blood tests and/or physical check-ups. They also support the patient in managing side effects and concerns about medication, physical health care, risk management, and holistic support. Acting as a coordinator, advocate, and long-term carer, general practice helps reduce readmissions and encourages recovery in the community.

84. When a patient has been discharged following detention under section 3, section 37, section 45a, section 47 and section 48 of the Mental Health Act, then they may be entitled to section 117 aftercare which further entitles them to healthcare and free social care and wider support.

85. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “coordinate care with other organisations and professionals... community mental health teams” .

86. The following is taken from page 58 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Contribute to an organisational and professional approach that facilitates continuity of care (e.g. through adequate record-keeping and building long-term patient relationships)."

THE ROLE OF PRIMARY CARE WHERE A MENTAL HEALTH PATIENT DOES NOT ENGAGE WITH COMMUNITY MENTAL HEALTH CARE

87. GPs do not have a formal role in monitoring the engagement of a patient with community mental health services. This responsibility falls with the community health provider. However, community mental health providers may opt to discharge the patient if they do not engage with the community mental health services. Engagement with community mental health services is vital for the care of patients with severe mental illness. However, disengagement is common, often due to lack of insight, stigma, treatment side effects, or chaotic social circumstances

88. This discharge from community mental health services may not take into account the future risks for the patient to themselves or to others. However, there is a role for GPs in recognising and escalating concerns to appropriate agencies e.g. safeguarding, social care etc when alerted by community, carers and family members.

89. The GP may attempt to reengage, deliver physical health care, join other agencies in monitoring risk and link back into secondary care services. In this way, general practice supports more continuous and holistic care.

90. In relation to the above, the following excerpt has been taken from pages 1 and 4 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “The role of the GP in sectioning patients; awareness of the Mental Health Act and the Mental Capacity Act (or equivalent legislation)” (Page 4)
- “coordinate care with other organisations and professionals... community mental health teams” (Page 1)

91. The following is taken from page 59 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Organise the follow-up of your patients ... including monitoring, reviewing and regular care planning."

THE ROLE OF PRIMARY CARE WHERE A MENTAL HEALTH PATIENT HAS BEEN DISCHARGED FROM SECONDARY CARE FOR NON-ENGAGEMENT

92. Discharge from secondary mental health services due to non-engagement is common, especially among patients with severe mental illness such as schizophrenia, bipolar disorder, or personality disorder. For these patients, the GP often becomes the only ongoing professional contact. While GPs cannot force engagement, they play a vital role in providing continued holistic care for that patient. They do so by maintaining contact, providing accurate medical

records, prescribing and monitoring treatment and offering carer and family support.

93. When patients are discharged from secondary care due to non-engagement, primary care, and general practice in particular, is left as the only, often ill-resourced, safety net. The GP cannot force engagement, but by maintaining contact, assessing risk, offering holistic care, supporting families, and escalating concerns when necessary, general practice ensures that these patients are not completely lost to the system. This role balances respect for autonomy with a duty of care and public safety.

94. We recognise that there is a gap for intensive and assertive outreach to a section of the population who may be more at risk to themselves or to others, when they have been discharged from secondary care for non-engagement. GPs may encounter patients who have been discharged who attend for holistic care needs and who may then be referred back to the secondary care mental health team due to their complexity and risk. More assertive outreach teams would be able to manage, with skills based in the community and more integrated approach which provides the link back into general practice.

95. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “coordinate care with other organisations and professionals... community mental health teams”.

96. The following is taken from page 59 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Providing ongoing continuity of care for the patient ... reviewing progress at suitable intervals."

THE APPROPRIATE LEVEL OF INTEGRATION BETWEEN PRIMARY AND SECONDARY CARE DATA AND INFORMATION

97. The ability to connect and exchange information across the healthcare system is a key requirement of digitally-enabled healthcare. The RCGP has long called for improved interoperability between primary and secondary care record systems. GPs report that this is often poor across the NHS. The RCGP's infrastructure report from 2023 titled "Fit for the Future" [WITN0227005], found that 65% of general practice staff said the ability of their IT systems to exchange information with secondary care was not fit for purpose.

98. The appropriate level of integration may depend on the specific organisations sharing data and the protocols in place but at a minimum the ability to access summary data held about a patient by each party would promote better patient care and safety for those with mental health conditions. Where robust governance arrangements are in place, full record sharing could also be appropriate.

99. Information is shared for direct care under GDPR Article 6(1)(e) and Article 9(2)(h), supported by the Health & Social Care (Safety & Quality) Act 2015 and the common law duty of confidentiality through reasonable expectations. For mental health patients particularly in crisis, this sharing need is easily justifiable and well supported by legislation and patients.

100. We recognise that barriers currently remain, for clinicians to share information effectively, including interoperability between legacy systems, varying interpretations of GDPR/confidentiality, and public trust. However, these can be mitigated through Data Sharing Agreements, DPIAs, general GDPR compliance, DSPT compliance, and robust security standards

101. Where sharing is limited, risk assessments are incomplete and multi-agency cross organically working is less effective, particularly for patients with complex mental health needs.

102. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- “coordinate care with other organisations and professionals... community mental health teams”.

103. The following is taken from page 58 of the Clinical Management Capability in the GP Curriculum [WITN0227003]:

- "Contribute to an organisational and professional approach that facilitates continuity of care (e.g. through adequate record-keeping and building long-term patient relationships)."

THE APPROACH TO SHARING RELEVANT INFORMATION WHETHER THERE ARE ANY BARRIERS, LEGAL OR OTHERWISE

104. Poor system interoperability as outlined above is a key barrier to the sharing of information between agencies. This results in a need to rely on emails and letters in some cases which can be time-consuming for clinicians and cause delays where there is a lack of resource available.

105. GPs act as data controllers for patient information collected in general practice, meaning careful consideration must be given to the sharing of data which can only be done where there is a lawful basis and the sharing is necessary and proportionate. Concerns about data privacy and uncertainty about what information should and should not be shared with which parties, can cause barriers to information sharing. Where appropriate governance arrangements are put in place between parties such as via shared care records, this can be managed.

106. In addition, like all doctors, GPs have a professional duty of confidentiality under the GMC's Good Medical Practice so that patient information should not be shared without the patient's consent unless there is a valid legal justification or the disclosure is justified in the public interest. The

GMC's guidance "Confidentiality: good practice in handling patient information" [NUHT0000044] indicates (at paragraph 64 of the Guidance) that public interest disclosures will be in exceptional cases, and (at paragraph 68 of the Guidance) where the risk is so serious that it outweighs the patient's and the public interest in maintaining confidentiality.

107. In relation to the above, the following excerpt has been taken from page 1 of the RCGP Mental Health Topic Guide [WITN0227004] to clarify our position:

- "coordinate care with other organisations and professionals... community mental health teams".

NATIONAL PRACTICE OR GUIDELINES ON MULTI AGENCY WORKING AVAILABLE TO PRIMARY CARE PRACTITIONERS

108. There is guidance available - Multi-agency public protection arrangements (MAPPA [WITN0227006])

AREAS RELATING TO THE ABOVE IN WHICH THE ROYAL COLLEGE OF GENERAL PRACTITIONERS CONSIDERS THAT THERE IS A NEED FOR:

National training and/or guidance

109. The RCGP considers that there is a need for more effective guidance for Multi-Agency Communication and Collaboration, due to: Lack of a single, coherent framework: While there are various guidance documents (e.g., from

the Department of Health and Social Care, NHS England, and NICE), there is no single, overarching national framework that dictates a standardised multi-agency process for managing high-risk patients. This can lead to a patchwork of local arrangements that may not be consistent or effective.

110. Information-sharing challenges: Despite the clear need for agencies (GPs, mental health trusts, police, social services, and probation) to share information to manage risk, there can be significant barriers. These include concerns about data privacy, a lack of interoperable IT systems, and inconsistent understanding of what information can and should be shared. This can lead to critical information not reaching the right people at the right time.

111. Inconsistent "front door" and referral pathways: There is a lack of clear and well-understood referral pathways between services. This is particularly true for people who do not meet the high threshold for specialist mental health services, leaving them "stuck" in a gap where they are not sick enough for secondary care but too unwell for universal services.

Greater training and/or guidance

112. GPs are not sufficiently integrated into multi-agency processes and may lack the time, training, and resources to effectively manage complex and high-risk cases. There is a gap in supporting GP resources i.e. time, training and guidance to be involved in some of these multi-agency risk assessment processes.

113. Violence and harm to others: While a small minority, some mental health patients can pose a risk of harm to others. MAPPA exist for specific high-risk individuals, but there may be gaps in the management of other patients who pose a more general but still significant risk, particularly where there is a lack of clear communication or ability to share data between GPs, mental health services, and the police. General Practice must be given sufficient time to be able to participate and actively engage in Multi agency arrangements which may take significant time out of a clinical day. Training support and development for organisations must be available and a clear process and protected time available to clinicians.

Changes to the current structures, training, or guidance to improve mental health care, particularly in the community

114. Given sufficient resourcing and prioritisation by national and regional NHS bodies, the RCGP would suggest it would be beneficial to see:

- Enhanced integrated services between primary and community care with opportunities to formalise the pathways for those individuals who are at highest risk to themselves or others, linking up acute mental health and primary care services.
- Joint guidelines covering specialist forensic mental health services, community mental health services and primary care services, setting standards for a smoother transition for patients moving between these

services, ensuring consistent support, shared responsibility, and timely referrals for individuals with complex mental health needs.

- The development of guidelines on shared care protocols, defining responsibilities between specialist, community and primary care services.
- Multi -disciplinary training around safeguarding and shared care protocols.

Reducing the risks posed by psychiatric patients to themselves or others.

115. Given sufficient resourcing and prioritisation by national and regional NHS bodies, the RCGP would suggest it would be beneficial to see:

- A national structure for the identification of those who are risk to themselves or others, by community mental health teams. There is need for a structure where assertive outreach teams regularly review that risk and collaborate with multi- agency organisations with a clear plan to mitigate those risks (each organisation needs to understand their accountability to individual patients as well as the public).
- Training for assertive outreach teams that includes safeguarding principles, personalisation of care, multi-agency working and risk management.
- The development of validated, risk assessment tools to enhance the prediction of suicide or homicide.
- Guidance for urgent assessment following carer concerns (similar to Martha's rule in hospitals).

- The use of population health data at both a local and national level to identify and risk stratify patients who require intensive mental health community support.

RECOMMENDATIONS

116. The RCGP has not undertaken any reviews specifically in light of the events of 13th June 2023. However, I consider there to be links with recent government policy in the form of the 10 year health plan which aims implement three shifts in the NHS: from analogue to digital, from hospital to community and from sickness to prevention. The shift from hospital to community has been happening in mental health services over the last 40 years with Care in the Community policy and through the implementation of the NHS and Community Care Act 1990. Through changes in the Mental Health Act 2007 bringing in the supervised community treatment orders (SCT) which allowed some patients to be discharged from hospital on the condition that they adhere to a treatment plan in the community to the last NHS Long term plan (2019) which has started to move care away from a rigid CPA style approach towards more integrated care models. The unintended consequences of these policy drivers has caused significant problems for community mental health services primary care and General Practitioners through underfunding and overstretched workforce and high thresholds for specialist care. This has meant that disjointed teams have been carrying the risks for individuals without the resources (communication, guidance, workforce) to manage the risks effectively.

117. We need any government policy making for the NHS and funding review processes to take this into account and ensure the right investment is prioritised to ensuring the structures are in place to ensure effective collaboration between General Practice community acute and specialist mental health services. We need to invest in effective community assertive outreach teams who are adequately resourced to respond in a timely and effective way and any changes in the Mental Health Act 2007 need to take into account the adequate provision of inpatient mental health care in the future.

IMPROVEMENTS THAT COULD BE MADE LOCALLY AND NATIONALLY TO MULTI AGENCY WORKING TO INCREASE EFFECTIVENESS IN PREVENTING SIMILAR OUTCOMES IN THE FUTURE

118. The RCGP would suggest there is a need for investment in and commissioning support from national and local NHS bodies for the following improvements:

- Protected time to attend MAPPA meetings and to be able to contribute to managing the risks
- Mental health leadership at a local primary care level
- Stronger links with local safeguarding leads
- Clear accountability for follow up with patients and their management, treatment and communication with carers and families.

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: 17 November 2025

INDEX TO FIRST WITNESS STATEMENT OF DR MICHAEL MULHOLLAND

| No. | Inquiry URN | Document Description |
|------------|--------------------|---|
| 1 | WITN0227002 | RCGP Policy area: Mental health in primary care |
| 2 | WITN0067006 | GMC Generic professional capabilities framework |
| 3 | WITN0067005 | GMC Excellence by design: standards for postgraduate curricula |
| 4 | WITN0227003 | GP Curriculum Being a GP |
| 5 | WITN0227004 | RCGP Mental Health Topic Guide |
| 6 | WITN0067010 | GMC Good practice in proposing, prescribing, providing and managing medicines and devices |
| 7 | WITN0227005 | RCGP Fit for the Future Reshaping general practice infrastructure in England report |
| 8 | NUHT0000044 | GMC Confidentiality: good practice in handling patient information |
| 9 | WITN0227006 | Multi-agency public protection arrangements (MAPPA) Guidance 2024 |