IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

THE NOTTINGHAM INQUIRY

CLOSING SUBMISSIONS
ON BEHALF OF
THE ROYAL COLLEGE OF PSYCHIATRISTS

INTRODUCTION

1. The Royal College of Psychiatrists ("**the College**") provides these Written Closing Submissions following the conclusion of the oral hearings in the Nottingham Inquiry ("**the Inquiry**") on 5 June 2026.

2. At the outset, the College would like to acknowledge the families and loved ones of those who died at the hands of Valdo Calocane ("**VC**"), as well as the survivors. In doing so the College echoes the evidence of its witness, the immediate past-President Dr Shubulade Smith CBE, on 1 June 2025 [INQT0000103]:

> *"These tragic attacks should never have happened and nothing I can say can lessen what you've lost or the impact on your lives, but I am truly sorry for your loss. I wanted to thank you again for your determination and perseverance in making sure this that* [sic.] *Inquiry took place. Mental health services need to be good, but they can fail, and when they fail, the consequences are devastating for the patients and for the public, and I'm glad that this Inquiry is taking place, and that it's looking carefully at not just how people in crisis are understood, but how they're cared for, but also how the risks are recognised and where the system falls short. Myself and all my colleagues hope that this Inquiry will lead to practical change, better commissioning decisions, clearer coordination, and more effective and properly resourced care."*[1]

3. The College offers its sincere condolences to all those affected by the actions of VC.

4. These submissions have been discussed and agreed by the college, the past-President Dr Shubulade Smith CBE and the current President Professor Subodh Dave.

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[1] [INQT0000103/1-2/15-6]. References to transcripts in this document, e.g., [INQT0000103/X/X-X] are in the form of the Inquiry document reference/page(s)/line-line].

5. The College's Written Closing Submissions are structured to:

a) briefly remind the Inquiry of the College's role and function;

b) identify the topics the College considers it is most able to assist with within the context of the Inquiry's Terms of Reference by reference to the evidence; and

c) set out the recommendations the College believes the Inquiry should make.

THE ROLE AND FUNCTION OF THE COLLEGE

6. As set out in Dr Smith's First Witness Statement [WITN0320001] at §§12-13 and §§15-16 [WITN0320001_0004-0006], the College is the professional medical body responsible for supporting psychiatrists. It works to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of its members and the profession.

7. The College represents over 22,000 members with approximately 1,600 mental health services[2] signed up to use its quality networks (a range of professional networks that connect its members and support their work in areas such as Child and Adolescent Mental Health Inpatient Services, eating disorders, and psychiatric liaison services to work towards quality improvement in these fields). The College works across all four nations of the UK, as well as supporting members internationally.

8. The College carries out the following functions:

a) developing and maintaining General Medical Council approved curricula for core and higher psychiatric training, including learning outcomes on risk assessment, risk management and multi-agency working;

b) setting and quality-assuring postgraduate examinations and supporting psychiatrists' continuing professional development through accredited events, e-learning and guidance;

[2] Membership of the peer networks provided by the College is not compulsory, as confirmed by Dr Smith during her evidence [INQT0000103/3/22-24].

c) producing clinical, ethical and service-level guidance, including College Reports on assessing and managing risk to others, confidentiality and information-sharing and standards for community mental health services;

d) supporting quality improvement and accreditation of services (for example, through the College Centre for Quality Improvement and programmes such as Accreditation for Community Mental Health Services); and

e) advising government, arms-length bodies and regulators on mental health legislation, policy and service models.

9. Through its functions the College seeks to ensure psychiatrists and multidisciplinary teams across the NHS and independent services are equipped to deliver safe, effective and rights-based care. The College's role is limited to setting and supporting professional and service standards and providing education, guidance and quality improvement infrastructure. It should be noted that the College does not commission, regulate or inspect services; as those responsibilities sit with commissioners, providers and regulators.

10. The College feels it is important to repeat that which is set out at §42 of Dr Smith's First Witness Statement [WITN0320001_0013], namely that whilst it sets standards for NHS Trusts, adherence to such standards is not mandatory; as stated above the College is neither commissioner nor regulator of any services, although it does try and influence best practice in service delivery through the exercise of soft powers.

11. For example, as per §47 of Dr Smith's First Witness Statement [WITN0320001_0014], in respect of standards issued to NHS Trusts the College seeks to influence NHS England ("**NHSE**") (and will, in the future, seek to influence the Department of Health and Social Care ("**DHSC**") following the Government's decision to abolish NHSE) and other equivalent national bodies to be aware of them and to take them into account when commissioning services. Peer accreditation networks are a further example of quality assurance and improvement provided by the College that encourage the uptake of recommendations, but they are voluntary in nature.

12. As summarised by Dr Smith during her evidence:

> *"I wish that the College had a regulatory function. We don't have a regulatory function, we have an advisory function. We provide guidance, we provide standards and we provide training to meet those standards, but*

what we aren't able to provide is implementation unless we are given that function by another regulatory body."[3]

13. The College considers that it is of vital importance that commissioners such as the NHSE[4] take account of and set standards which follow the guidance issued by the College. If there was adherence to and the maintenance of professional standards which follow the guidance issued by the College, then services would improve. The College should be the first port of call for NHSE/DHSC when they are considering revising/reformulating policies. The College would require funding to support implementation of its standards and an appropriate mechanism for them to be enforced, which would in turn result in higher standards of care.

14. Finally, the College would highlight that its work is aimed at ensuring best practice across the profession of psychiatry. In recent years it has sought to drive necessary change and improvement across the board, including through the employment of a director of strategic communications and a supporting policy team.

15. Generally, harm to patients and others is driven not simply by individual error and far more by systemic failures, particularly fragmentation between services, unsafe transitions and inadequate risk management across the system. Practitioners are all too acutely aware of the pressures on them in their work – they are expected to perform to the highest of standards in circumstances where resources and the availability of trained staff is limited. Psychiatrists are constantly challenged to perform their role as gatekeeper to inpatient care within a system with too few beds and too many patients. Of course, there will be occasions when individual practitioners fall short of the high standards expected of them. In those circumstances, the College and the Profession note that it is appropriate that action is taken in accordance with the law. The College understands, however, that the Inquiry is rightly concerned with wider, structural issues and these Written Closing Submissions focus on those matters.

THE EVIDENCE AND TERMS OF REFERENCE

16. The College notes that the purpose of the Inquiry it can most usefully assist with is in helping to learn lessons so that similar attacks might be prevented in the future. The College is well positioned to assist the Inquiry by ensuring its guidance and policies are made available to relevant stakeholders, and by working with regulatory bodies to ensure they are implemented.

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[3] [INQT0000103/4/12-17]
[4] In the future the DHSC when the health service restructure is complete.

17. To that end, the College has focused its Written Closing Submissions on the following broad areas identified by the Inquiry in its Terms of Reference, those being the areas Dr Smith's evidence was concerned with (bold emphasis in the original):

> *"**4. Review the understanding, assessment and management of the risk to VC to others and his risk of offending between 2019 and 13 June 2023**, to identify and address any issues with regard to decisions, actions or omissions of agencies, professional bodies or individuals relevant to the treatment of VC, and the management of his risk to others including whether the relevant guidance was followed appropriately.*
>
> ***(Understanding, assessment and management of risk)**"*
>
> ***"5. Review the effectiveness of national and local multi-agency working and information sharing**, as appropriate, by health and social services, police and the wider criminal justice system, and their adequacy in:*
>
> *(a) providing appropriate care for and monitoring of VC's mental health conditions,*
>
> *(b) the identification assessment and management of his risk to others and risk of offending between 2019 and 13 June 2023, and*
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> *(c) information sharing prior to 13 June 2023 (but only when VC was in the UK).*
>
> ***(Multi Agency working)**"*
>
> ***"8. Provide Recommendations** to ensure lessons are learned and prevent similar attacks in the future. **(Recommendations)**"*

18. The Inquiry will appreciate that, given the College's role and functions as set out above, any evidence given by it in respect of areas 4 and 5 of the Terms of Reference set out above is necessarily one-stage removed from the particular circumstances concerning VC.

19. The College would particularly draw the Inquiry's attention to the evidence from Dr Smith that references the College's report, 'CR201: Rethinking risk to others in mental health services' ("**the Report**") and the accompanying 'Good Practice Guidance on Assessment and Management of Risk to Other People ("**the Guidance**") (as referenced at §24 et seq. of Dr Smith's First Witness Statement [WITN0320001_0008-0015).

20. As per §49 of Dr Smith's First Witness Statement [WITN0320001_0015-16], the College believes the following matters in respect of the Report and the Guidance to be of crucial importance to the Inquiry and its Terms of Reference:

a) at present there is no national commissioning mandatory requirement to integrate the Guidance into psychiatric clinical practice;

b) there may be no local commissioning expectation to integrate the Guidance into clinical practice and no means of formal oversight to assess whether this has occurred;

c) further to points (a) and (b) there are no clear outcome measures/metrics that are standardised across the UK;

d) there is no mandated imperative to integrate the Guidance into clinical practice;

e) there are significant and longstanding resource issues in mental health care in the UK, with a funding shortfall of over 50% of what is needed. Mental illness accounts for 20% of the disease burden but is currently expected to receive only 8.4% of the healthcare budget in 2026/27, with share of spend having already decreased year on year (8.68% in 2025/26, 8.78% in 2024/25 and 9.05% in 2023/24[5]). Chronic underinvestment in mental health services affects both the quantity and type of services that can be delivered but also and most importantly, the quality of services that can be delivered;

f) there are significant workforce shortages in England with 1 in 7 consultant jobs vacant[6] and, on average, 8-9% of mental health nursing posts vacant, more than double the rate in acute trusts[7]), thresholds for intervention are high, and too many services can only offer care and support when a person is in extremis. With continuous cuts to funding[8], and a failure to prioritise new funding for mental services, the quality of care has suffered and will continue to degrade without intervention; and

21. In too many areas in NHS mental health services in England, there simply are not enough inpatient mental health beds (with a surplus in others), which is the result of a 73% reduction in beds since the 1980s[9]. This reduction in inpatient capacity has not been matched by an increase in

[5] [RLIT0000095]
[6] [RLIT0000038]
[7] [RLIT0000096]
[8] [RLIT0000097]
[9] [RLIT0000098]

community care provision (required to keep people well and helps reduce the need for admission). This results in: patients failing to receive longer-term proactive care and support to prevent relapse; patients being in the community without appropriate support even when it is recognised that they would benefit from admission; longer waits in emergency departments; patients being more likely to be sent to inappropriate out of area placements, which are in turn harder to rehabilitate from; and patients being more ill, or having to enter crisis, and be deemed an imminent risk to themselves or others to be considered for admission, increasing the likelihood of their admission being longer in order for them to recover. When patients do access inpatient services, targets including bed capacity and length of stay can influence and override treatment plans and patient need. It is clear from clinical experience, as well as compelling research evidence, that patients who are more unwell pose greater safety risks to themselves and on occasion others.

22. The College emphasises that:

a) the foundations of mental wellbeing are laid early, and so we need to strengthen our focus on early life health and move away from having to intervene later in life. It has long been known that half of mental health problems arise before the age of 14, and three quarters before young people turn 24. After surviving the infectious diseases of childhood, the most likely illness a young person will suffer from is a mental illness.[10]

b) early intervention and continuity of care are key to improving outcomes and reducing risk, particularly in those with severe chronic relapsing remitting mental illnesses yet are not prioritised as viable models of care for a system so under pressure. Many mental health problems can be effectively treated, yet less than half of people with a common mental illness[11] are able to access mental health care. For those with SMI, for example, bipolar illness, it can take up to 9.5 years to get a diagnosis.[12] Effective treatment can be provided in the community if services are commissioned and resourced to provide early intervention of evidence-based care before a person becomes so unwell that they pose a risk to themselves and others and require admission to hospital, possibly under the Mental Health Act 1983 ("**the MHA**"). This is not currently the case;

[10] [RLIT0000099]
[11] [WITN0320043]
[12] [RLIT0000100]

c) recently, a decision was made to not prioritise mental health services for Ambient Voice Technology[13] ("**AVT**") services, with the funding being allocated to acute services. The College sees this decision as a mistake, recognising that psychiatry is a narrative speciality and therefore would greatly benefit from AVT. The College would urge NHSE to reconsider their funding allocation, as this is another example of the underfunding mental health services face;

d) commissioning is primarily based on length of stay and bed occupancy, which does not address quality issues and incentivises services not to admit and to discharge patients early, over and above ensuring effective treatment leading to clinical improvement, regardless of whether that treatment occurs in the community or in hospital. The College has heard from members' about their experiences of providers protecting or 'gate-keeping' services, to tackle high demand or conversely, discharging people early into insecure accommodation as a means of reducing pressure;

e) current commissioning arrangements do not encourage or incentivise the delivery of newer, evidence-based and potentially cost-saving effective treatments that are useful in treating both common mental disorders, severe mental illness and treatment resistant mental disorders, e.g., clozapine for severe mental illness, 3-6 monthly long-acting depot medications, Avatar Therapy for Hearing Voices, transcranial magnetic stimulation, etc. These are well-evidenced, effective treatments that have been known about for years and that can reduce long-term illness and disability but are not readily available in the NHS. Despite being recommended by the National Institute for Health and Care Excellence ("**NICE**"), there currently exists no infrastructure for monitoring the use of effective treatments or the implementation of NICE guidelines;

f) the College still needs to see consistent implementation of the Community Mental Health Framework ("**the Framework**") across England – an evidence-based approach to commissioning and delivery of community care. On average, only 1/3 of people with a mental illness are accessing care in the community, yet areas which have implemented the Framework have seen a 65% reduction in community waiting lists and a 15-20% reduction in secondary care referrals. Data shows that with adequate resourcing and planning the Framework can provide a significant part of the solution; providing an approach which

[13] This uses AI and speech recognition to listen to clinical consultations and automatically converts spoken dialogue into structured medical notes and letters.

enables the right level of care being made available in a tailored fashion to the acuity of the presentation;

g) the safeguard intended to protect mental health spend, the 'Mental Health Investment Standard' has been diluted – it has been changed to protect mental health spending **in line** with inflation, rather than proportional to overall funding growth, as initially intended; and

h) services are often not commissioned based on population-need, clinical expertise or rooted in evidence; in many areas, patients are still unable to access NICE-recommended treatments.[14]

23. As a result of the factors identified above, the College would remind the Inquiry of the evidence given by Dr Smith that those coming into the mental health profession now do not (through no fault of their own) necessarily know what 'good' looks like:

> *"If you are a new consultant coming into* [issues of underfunding and workforce shortages, etc.], *or not just consultants, but any new mental health staff, you would begin to think that well – especially for certain staff who learn a lot on the job, then you would think: well this norm, that actually you don't admit people or you don't start to – you don't bring people into your services unless they are so unwell that they are a risk to themselves or others.*
>
> *And the problem with that is that it means that you don't necessarily know what "good" looks like. So you can still be good at your job but you are working according to what the policies and procedures are of your system…"*[15]

24. The College's surveys have consistently shown that combatting the new norm of what 'good' looks like, and the hard choices that need to be made, is extremely difficult for both established staff as well as for newcomers.

25. The College would also like to highlight the oral evidence given by Dr Smith as to the changing nature of an individual's risk to themselves or others:

> *"…the risk that a person might pose can change over time, and so – particularly in serious violence incidents. Serious violence is a rare event, but it doesn't happen very often. But when it happens, it's devastating. So*

[14] [RLIT0000101]
[15] [INQT0000103/26-27/20-7]

what it means is that a person might not behave in a violent way at all for well over, you know, a year or two, and so during that time, the risk to others is low but at some point it might be much higher.

The problem is, if you make a static judgement – if you make a judgement based on the time that the way they presented at one particular time a year before the violence happens, then you might mistakenly just think this is a person who is low risk. It doesn't take into account all the different factors that might impact and increase the likelihood of them behaving in a violent way.

So when you are thinking about a person's risk, you need to think about it in terms of something that can change, and when you're thinking about it in terms of something that can change, i.e., it's a dynamic thing, then you should be thinking about what are the ways, what are the strategies that we can mitigate that risk? And so then that helps you, and that's why it's important to recognise it can alter over time and that's why it's got to be regularly reviewed, so you can understand, have we been able to mitigate that risk? Have we reduced that risk? Or is it increasing, or is there a new risk that has now come about that we were unaware of?

So for example, I had a patient who has, you know, has a cat, you know, he is someone who had perpetrated very serious violence in the past. We'd managed to treat him, he'd got very, very much better but he was now a very isolated individual. His cat was incredibly important to him. Everything was fine as long as that cat was alive. If anything happened to that cat, then that – we knew that then his risk profile would change and we would have to do something about that."[16]

26. The College considers that the evidence given by Dr Smith about the changing nature of risk presented by a particular person is important context for the Inquiry to consider when assessing how the risk presented by VC was assessed, as well as what recommendations might be appropriate.

27. In this regard, Dr Smith was asked about guidance on risk assessment and indicated that:

"…ideally there would be unified guidance and that everyone would be using a similar approach. One of the difficulties with, certainly in general adult services, has been that there's an expectation that there's a risk assessment done on everybody and, you know, that's a requirement from the commissioners. Unfortunately, there isn't standardisation about what that risk assessment should look like, and so sometimes what's happened is that different hospital trusts have developed their own risk assessment form,

[16] [INQT0000103/13-14/7-20]

and unfortunately that's not necessarily evidence – it's not evidence based, it's not, you know, necessarily reliable. It's often a very static tool, meaning it's just at that point in time.

And people have often been encouraged just to say: is this person low, medium or high risk? And that only tells you about that person when you were seeing them just then, and that's not a good approach to risk assessment and risk management."[17]

28. As to the evidence that Dr Smith gave about the need to provide clear guidance regarding the operational use of the revised detention criteria to address the potential for confusion created by the introduction of the words 'likelihood' and 'may be caused' (set out at §§205-219 of Dr Smith's First Witness Statement [WITN0320001_0066-0069] and covered in her oral evidence[18]). To that end the College notes the evidence of Professor Sir Simon Wessely[19], William Vineall[20] and Baroness Merron[21]. The College agrees with Dr Smith who is supported by Mr Vineall[22] that the statutory wording:

"…needs to be operationalised and what that means is: how are we going to make this work in practice? And right now the Department of Health and Social Care are working with various stakeholders to develop the Code of Practice… Certainly when it comes to detention criteria, making it clear about what is meant by "serious harm"…"

29. The College would also highlight the evidence Dr Smith gave about race and risk; as she set out, it is now recognised that social risk factors drive most mental illness equating to a good 50% plus of the antecedents of mental health problems. In the UK, Black or Black British people are more likely to be vulnerable to these risk factors, when compared to the white population. This means that Black people in the UK are at greater risk of developing both common mental disorders and severe mental disorders, despite there being no increased genetic risk. However, Black people are less likely to present early or access mental health services through primary care, meaning they are far more likely to end up in crisis and more likely to access care through the criminal justice system (40% more likely). Since the 2018 Mental Health Act review, work has been focused on developing methods to improve engagement with Black people so that if they have a mental health

[17] [INQT0000103/21-22/17-10]
[18] [INQT0000103/56-57/2-2]
[19] [INQT0000106/46-49/21-16]
[20] [INQT0000109/63-76/24-14]
[21] [INQT0000110/21-23/21-25]
[22] "…because you need illustrations and understandings and that's why we want to work with all colleagues to ensure that we get a Code of Practice that is understood and gives sets of examples that allow people to be guided on things like "may be caused" and "likelihood" and what we mean by "serious harm"." [INQT0000109/68/7-13]

problem, they will present to services earlier, before they become very unwell and/or go into crisis.[23]

30. Dr Smith further described that the College, by supporting and helping to develop the Patient and Carer Race Equality Framework ("**PCREF**"), recognises this issue and what this means:

> *"…is that this is a group of people we need to make sure get the help they need, and ideally they would get that help earlier rather than waiting until they're in crisis. So we have to change the service so we are more responsive, more accessible, better able to meet the needs of that population."*[24]

31. The 'change' required is adequate resourcing to enable the PCREF to be implemented and be outcome focused. The College has seen positive implementation of the PCREF at a local level but now these improvements need to be quantified; measuring a reduction in disparity in access and experience of care, for example.

32. The College is clear that decisions on detention are not, and should never, be taken on a racial basis. Any clinical decisions based either largely or solely on a racial basis would be clinically negligent and not in line with training or guidance. Best practice dictates that safety assessments must be based on a full assessment, including people's individual biopsychosocial context.

33. Black people (and particularly Black men) face significant barriers in accessing appropriate mental health support which means that a disproportionately large number present late into their illness when they are more likely to be in crisis and therefore have to be detained because the opportunity has been missed for early intervention care which may have avoided detention. The aim must be to reduce relapse and crisis in anyone with SMI, which would in turn reduce any risk they might pose to themselves or others.

34. As regards information sharing, Dr Smith was asked about this, and a lack of confidence in psychiatry as to when information can be shared. She was clear that:

> *"…confidentiality does have limitations; it's not absolute. You can share information when people give their consent. You can share information if it's lawful, if there is thought to be a risk to others, certainly, and you can – and it's also that a person – you can – you should ideally tell the person that you're going to do this, unless you think that in of itself is going to create harm. And certainly when it comes to – there are*

[23] [INQT0000103/66/3-9]
[24] [INQT0000103/66-68/9-5]

inter-agency working panels. So for example, the multi-agency protection arrangement and Multi-agency Protection Panel Arrangement, that's MAPPA, and that will involve a number of different agencies. It can be determined there that actually there is some crucial information that needs to be shared. Good practice is you let the patient know. As I said, if the patient is – it might cause problems, then you may not share that information."[25]

35. Good practice for information sharing is clear; a patient's consent must first be sought however if this is not possible and information has to be shared then clinicians must do so. In such scenarios, patients should be informed that their information has been shared as a courtesy, however if this is likely to cause concern then the clinician should decide what is in the patient's best interests. Safety is paramount – this can and does override confidentiality.

36. Dr Smith went on to clearly explain that transparency in the first admission with a patient is crucial to how that person may engage with a psychiatrist later on.[26] The College suggests that this position is correct, both in terms of expectation setting around data sharing and more generally.

37. Dr Smith also highlighted the difficulties in information sharing caused by different hospital Trusts using different electronic patient records.[27] The College notes the evidence of Baroness Merron that it is her expectation that the Health Bill will address this by the introduction of a single patient record being accessible across separate digital software platforms that can 'talk' to each other.[28] However, notice will need to be taken as to how this is actualised. Currently, even within the same Electronic Patient Record systems, configurations vary across providers; this creates challenges for rotating staff having to seek familiarity with new systems. In short, access to detailed assessments, particularly for patients with long or detailed histories, is not necessarily easy.

38. As to the specific example of sharing information with housing and social care, Dr Smith confirmed that local authorities sharing such information is really important,[29] and agrees with the point made by Counsel to the Inquiry in her questions to Dr Smith:

"…You need to know where patients are living, how they're coping in their community environment."[30]

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[25] [INQT0000103/15-16/22-13]
[26] [INQT0000103/17/16-19]
[27] [INQT0000103/18/1-24]
[28] [INQT0000110/66-68/21-18]
[29] [INQT0000103/41-42/23-14]
[30] [INQT0000103/41-42/25-2]

As regards Community Treatment Orders ("**CTOs**"), this was addressed by Dr Smith in her written evidence (particularly at §§186-197 of Dr Smith's First Witness Statement [WITN0320001_0060-0063]) although she was not asked about it in her oral evidence. The College maintains that CTOs can be an important part of mental health treatment if they are reframed in a way that allows greater communication and mapping of areas of agreement and disagreement between patient and clinician. In this regard the College notes the approval given to the retention of CTOs by Professor Sir Simon Wessely in his evidence.[31] The College invites the Inquiry to adopt the recommendation set out below that suggests retaining but modifying CTOs.

RECOMMENDATIONS

39. The College considers that the Inquiry should consider making the following recommendations:

a) **unified guidance/training being provided by DHSC (following the subsuming of NHSE) on managing clinical risk and risk assessment;**

b) **impose a duty on commissioners to continuously improve the provision of mental health care;**

c) **improve service capacity to meet local population need;**

d) **implementation of the Framework;**

e) **continuity of care for patients across hospital settings and the community;**

f) **retain CTOs within the MHA with modifications;**

g) **implementation of Advance Care Directives ("ACDs") as a statutory requirement;**

h) **amend the detention criteria; and**

i) **implementation of a mental health policy test.**

40. **Unified guidance/training being provided by DHSC (following the subsuming of NHSE) on managing clinical risk and risk assessment.** As per Dr Smith's evidence, the College considers that any such guidance should not be framed defensively but rather:

[31] [INQT0000106/53-54/4-22]

"…a risk, dynamic risk assessments should be about formulation and it really needs to be about understanding what factors might make this person more likely to behave violently towards others, or, in the case of suicide, more likely to harm themselves.

And you develop a risk formulation that helps you to develop a risk management strategy for that person."[32]

41. Dr Smith went on to indicate that the tool developed by Professor Seena Fazel is very useful in identifying those individuals who are likely not to behave in a violent way, which means that resources can be appropriately focussed on those who are likely to do so.[33] Dr Smith also confirmed that such assessment should not be based simply on self-reporting; there should be attempts to get collateral information.[34]

42. Dr Smith further highlighted that the tools used in forensic services, HCR-20 and DUNDRUM, can often take several hours to complete[35] – time which practitioners in general adult services do not have (due to the lack of resources). Mental health services would benefit from an abridged, yet as informed, screening tool. Professor Seena Fazel is developing a practical and useable system which needs further support to bring it into routine practice and the College can assist with its development. But, as ever, funding must be found to support this work or the development of any similar system of assessment. Any such tool should be appropriately validated. The actuarial analysis it provides at a population level should be helpful in strategic commissioning of services, and may help individual clinicians, but should be seen as an aid rather than a replacement of the clinical decision-making process (i.e. high-quality assessment, diagnosis, formulation and a personalised management plan).

43. The College would willingly assist in ensuring the uniformity of any guidance/training the Inquiry felt should be recommended.[36] The College would, however, highlight that risk assessment tools should not be seen as a panacea if issues as to the treatment of patients are not addressed. Risk assessment tools may lead to more consistent decisions being taken as to detention, and the College would support such an outcome, but, as in the case of VC who had been detained on a number of occasions, unless proper treatment follows, a risk assessment tool will not change the danger of that risk eventuating.

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[32] [INQT0000103/23/9-16]
[33] [INQT0000103/28-29/7-5]
[34] [INQT0000103/29/6-13]
[35] [INQT0000103/27-29/17-5]
[36] [INQT0000103/81/9-24]; Second Witness Statement of Dr Shubulade Smith [WITN0320036_0011] at §43

44. To that end, the College considers that it is important that the Inquiry recognises that risk assessment tools are a part of the professional assessment of care required for a patient but they are neither a cure nor a substitute to addressing the systemic issues in respect of proper treatment of patients in mental health crisis.

45. **Impose a duty on commissioners to continuously improve the provision of mental health care,** per the needs of their population. This duty on commissioners would be multifaceted:

a) commissioners should be placed under a requirement to report on their undertaking of an evidence-based, population-needs, clinically led approach to the commissioning of services. In short, they should be required to indicate how the services they have commissioned, directly meet the needs of their local population, understanding severity and acuity of illness and responding needs – particularly for those who currently fall into the 'missing middle'[37]. This approach should apply to both community services and inpatient capacity (number of beds, type of bed, location of bed within an appropriate distance from home, etc.). Only through taking this approach to commissioning, we will see a reduction in health disparities;

b) the need to ensure services meet population need does not remove the need for national oversight and guidance and what 'good' looks like. It is well evidenced that for people to be supported they need preventative care to try and keep them well (tackling the socio-economic determinants, early intervention (community services) to try and avoid relapse, local inpatient care for acute crises and step-down care (supported housing, virtual wards and rehabilitation services) to support their return to the community;

c) the College considers that the commissioning of rehabilitation services should be of particular interest to this Inquiry. A quarter of people treated by early intervention for psychosis services develop long-term, complex problems[38] and a quarter of people with first episode psychosis meet criteria for treatment resistant schizophrenia[39] – cohorts of people who benefit from mental health rehabilitation. The evidence shows that people with complex psychosis do well when they have access to rehabilitation services, progressing from inpatient to community care without readmission. Yet these services are not consistently commissioned across the country – in the coming months the College is

[37] [RLIT0000102]
[38] [RLIT0000103]
[39] [RLIT0000107]

undertaking research to understand the extent of existing provisions and will share the results with the Inquiry, should that be of use;

d) commissioners should be required to report back to relevant bodies (the College, NHSE/DHSC/Care Quality Commission, etc.) as to how they have implemented relevant policies and guidance, to ensure that consistent improvements are taking place. This will require the relevant national bodies to increase their oversight capacity to ensure compliance;

e) in particular, commissioners and service providers should be monitored on their implementation of the Framework and forthcoming Neighbourhood Mental Health Centre guidance. Tracking of the former was a missed opportunity when the Framework was first introduced in 2019 and resulted in inconsistent roll out;

f) for services to provide adequate treatment and support for their population, commissioners must ensure adequate staffing. Not only to deliver a service, but to have time to know and understand a patient, to have capacity to embed the continuity of care model and to engage in research to continuously improve mental health treatments and care;

46. One way to ensure the above is to maintain clinical expertise on Integrated Care Boards ("**ICBs**"). As Dr Smith explained during her evidence,

> *"What you would want to see, because* [the ICBs are] *the commissioners, you would want to see that there is someone in that ICB, or whatever it's going to be called, who is responsible for mental health care delivery and understands – not just responsible for it, because they are, obviously, but understands what's needed.*
>
> *In this new structure, there aren't any – we've only heard of, I think, one what's called OPIC, Office for I don't know – Implementation, Commissioning, sorry – there's only one senior mental health person in these seven – the kind of ICBs together. It's pan-ICBs, and there's only going to be one and I've only heard about that, I think they're starting today, a Medical Director in the Midlands area. But all the others don't have a senior person in charge of mental health who understands about mental health care, which means that, if we're lucky – if we are lucky – there will be somebody in the, you know, commissioning, the new commissioning structure, who understands about mental health care, understands population need, understands the evidence, understands the importance of this being clinically driven and understands that*

the care needs to be delivered in a way that people will actually access the services. Because if they don't, then nothing is going to change."[40]

47. The College would support a recommendation that all new ICBs (or any equivalent body) employ, at a senior level, a person responsible for mental health care with relevant and sufficient training and experience, and ideally psychiatric expertise.

48. Ensuring mental healthcare is represented at this level of decision-making is essential to ensure that services are strategically commissioned. Too often services are commissioned without considering population need, exemplified by the existence of the 'missing middle'[41]; those who are deemed too complex for some services yet not complex enough for others, often people living with serious mental illness. The issue is not that services and structures for this cohort do not exist, rather commissioners either are not implementing these for their population, and/or existing services do not have the capacity to support their local area – issues which would be somewhat solved by having the most appropriately experienced people in the room. Without a shift to strategic commissioning to close this treatment gap, we will continue to see patients fall through the gaps without necessary care – increasing the likelihood of harm to themselves, or others.

49. The College acknowledges the pressures currently placed on ICBs, and the competing priorities at play. While the decision to devolve commissioning is supported by the College, for the above reasoning, there must still be appropriate accountability for commissioning decisions, or lack of. Just as there is accountability for clinical decision making.

50. The College notes that this recommendation was supported by Amber O'Brien, Professional Lead for Mental Health at the Royal College of Nursing,[42] and Amanda Sullivan, Chief Executive Officer and Accountable Officer of NHS Nottingham and Nottinghamshire Integrated Care Board.[43] Ms O'Brien went further in indicating that, in her view, there should be profession specific (i.e., both psychiatrist and mental health nurse, for example) people in leadership positions with mental health expertise. The College would support such a proposition.

51. **Implementation of the Framework.** This Framework underpins the Government's commitment to 'neighbourhood health' and the new Neighbourhood Mental Health Centres ("**NMHC**") as Dr Smith outlines in her evidence:

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[40] [INQT0000103/49-50/17-17]
[41] [RLIT0000103]
[42] [INQT0000105/110/7-23]
[43] [INQT0000108/65/3-25]

"They are an enhanced version of a thing called the Community Mental Health Framework. The Community Mental Health Framework was about trying to make sure that the model of community care was much more -- much more in the prime -- you know, the earlier stage of someone being unwell, much more accessible to people and could provide…"[44]

52. While the College has welcomed the neighbourhood model, there must be greater clarity at a national level that this approach is built on the principles of the Framework. This is necessary for the following reasons:

a) there are areas, as mentioned, who have already implemented the Framework and are reaping the benefits of this approach. Framing the neighbourhood mental health centres as an extension of this work ensures they feel no need to 'reinvent the wheel'; and

b) not every area has the resources, funding or capacity to implement a NMHC at this time yet would benefit from improving their community mental health offer. Situating the model of the NMHC as **a** means of implementing the Framework, rather than the only option of community mental health care, provides areas with the flexibility to improve their service delivery in line with their capacity. The Framework Long Guide[45], originally published in 2019, should be republished alongside the upcoming NMHC guidance. This will allow providers and commissioners to choose an approach best suited to both their capabilities and population need; and

c) the College would also like to take this opportunity to note that there are improvements to be made to the NMHC model to ensure they meet the needs of the population, as there is still a risk that previously unserved people, including the 'missing middle' continue to be forgotten despite a commitment that these centres will support people with serious mental illness. The presence of a NMHC will not immediately rectify the issue of a lack of appropriate community mental health services for people with serious mental illness and so should not be seen as the solution in and of themselves. The relevant services will still need to be commissioned and integrate within this offer of holistic support. The College can provide a fuller briefing on what 'good' community mental health services looks like, should this be of use to the Inquiry.

[44] [INQT0000103/103/17-23]
[45] [RLIT0000110]

53. **Improve service efficiency to meet local population need, through embedding strategic commissioning.** Inpatient bed capacity has drastically reduced creating a gap in service capacity which has not yet been filled by community services. As a result, services are not efficiently able to meet the needs of their population, shown by increased waiting times and inefficient spend. For too long, fixes to the acute pathway have focused on the crux of the crisis; inpatient capacity and crisis support rather than considering the care pathway in its entirety – one of the most effective means of reducing acute pressure is through prevention and step-down care.

54. Community services must be strategically commissioned, implementing evidence-based services such as clozapine for severe mental illness, 3-6 monthly long-acting depot medications, Avatar Therapy for Hearing Voices and transcranial magnetic stimulation. The workforce must also be strategically commissioned based on population need. This is especially important in professional training which requires years to develop professional expertise. These interventions can help to keep people from relapse, reducing acute pressures.

55. Bed numbers need to be reconsidered. A lack of bed capacity in many areas has led to inappropriate Out of Area Placements ("**OAPs**") which, despite NHSE commitments to reduce, still occur. For areas with inappropriate OAPs, a short-term bed increase must occur to bring people back into the community; improving outcomes and reducing ineffective costs. This saving would then be reinvested into community services, including those mentioned above – helping to avoid relapse, reduce acute need and allowing providers to eventually reduce inpatient beds numbers again, but through a much more controlled approach.

56. It is well evidenced that sufficient availability of supported housing has a direct impact on service efficiency; in February 2026, patients waiting for supported housing accounted for 23% of all mental health delayed discharge days.[46] Yet very few NHSE providers are partnered with supported housing providers in their area. The College's report *'Breaking the Cycle; Supported Housing as an Enabler of Mental Health Hospital Discharge and Community Mental Health Delivery Service',* outlines the barriers to greater synergy and how to overcome these.

57. This is a focus of the 'Getting It Right First Time' leads, however there must be assurance that their work will be factored into commissioning. More efficient services equate to better patient care, lower thresholds to access and fewer people having to reach crisis to access support – placing fewer people in danger to themselves and others.

[46] [RLIT0000111]

58. **Continuity of care for patients across hospital settings and the community.** As regards issues around funding and changes to delivery of psychiatry, services would be improved, and risks reduced, if the Inquiry recommends the implementation of continuity of care between hospital and community settings. As Dr Smith explained in her evidence:

> *"…prior to 2005 there was a change in the way in which psychiatry was delivered.*
>
> *So it used to be that we had a situation whereby, as a consultant, you would look after patients in the ward and you would continue to look after them in the communities. There was continuity of care.*
>
> *So when I became a consultant – I was first consultant in 1999, I looked after patients in my ward, followed them through to the community. If they started becoming unwell I could bring them back again into the ward. And so you looked after – you know, this consultant was this continuous person the whole time.*
>
> *2005, as a result of, well, frankly partly to do with the Working Time Directive, also to do with the fact that psychiatrists were very overwhelmed and burned out, but I think primarily to do with the Working Time Directive, new ways of working – a new ways of working model was brought in an approach that, actually, also with the development of new evidence around what are called functional specialist teams.*
>
> *So this functional model was brought in, which was about saying that: look, you will be a doctor that looks – a consultant who looks after patients in the inpatient service, or you'll look after them in the community, or you might look after a specialist team.*
>
> *And so that approach, which we now recognise as being quite a fragmented approach, was a different approach to how psychiatric services were commissioned. So there was much more focus on commissioning specialist teams such as Early Intervention teams, Assertive Outreach teams, you know, specialist eating disorder teams, specialist rehabilitation teams. And there were also the generic Community Mental Health Teams and then there was the obviously generic ward teams as well."*[47]

59. The College would support the implementation of continuity of care and agrees with the evidence Dr Smith gave that, if introduced effectively, it would lead to a reduction in hospital utilisation rates.[48] The College notes with particular approval that Baroness Merron, Minister for Women's Health and Mental Health recognised the fragmentation that has led to a reduction in continuity of care in her evidence.[49] The means of shifting to this model of care will take time and

[47] [INQT0000103/8-9/13-22]
[48] [INQT0000103/89-91/11-8]
[49] [INQT0000110/6/5-17]

consideration – the College would welcome the opportunity to work with the Inquiry to crystalise the practicalities of this recommendation, in time for the Inquiry's final report next year.

60. The College considers the implementation of continuity of care to be of central importance and that it will require a national directive and the active will of the commissioning bodies to achieve it. To that end, the College urges the Inquiry to require those bodies to produce their proposals for how continuity of care will be implemented in as short a timeframe as possible as part of its exercise on recommendations.

61. **Retain CTOs within the MHA with modifications.** The College considers that CTOs can provide an essential therapeutic benefit when used correctly, but their remit should be clarified to ensure they are only used when they will be most beneficial and that joint care planning should be incorporated into their use as much as possible. The College suggests that consideration should be given to amending the criteria to reflect history of non-compliance with treatment, which may lead to subsequent compulsory admission within a defined timeframe.

62. **Advance Choice Documents** ("**ACDs**"), which have been shown to reduce risk of self-harm and harm to others and to reduce involuntary detentions, should be mandatory and used as part of a Personalised Care Framework to achieve those reductions and lessen the requirement for CTOs as well. ACDs should be written and developed by the patient together with everyone involved in their care, so that all involved know what is meant to happen if that patient goes into crisis. They embed trust and understanding in the therapeutic relationship and should, in the College's view, be statutorily required because they have been shown to work and reduce both the likelihood and severity of any recurrence and risk to self and others.[50]

63. The College further invites the Inquiry to note the work it has done to address the disproportionate application of CTOs to racialised communities as set out in Dr Smith's First Witness Statement at §§229-254 [WITN0320001_0072-0078].

64. **Amend the detention criteria.** The College considers that the detention criteria should be amended, as per Dr Smith's evidence, to require the following:

a) that the patient is suffering from a mental disorder of a nature or degree; and

[50] [RLIT0000112]

b) there is a significant risk of serious harm to the health or safety of the patient or of another person or persons; and

c) it is necessary, given the nature or degree of the harm risked, for the patient to receive medical treatment or assessment; and

d) the necessary treatment or assessment cannot be provided unless the patient is detained under the Act; and

e) appropriate treatment or assessment is available for the patient.

The College is of the opinion that the amendments proposed would allow psychiatrists to do a holistic, straightforward clinical assessment of a kind that they are familiar with and which aligns with best practice.

65. **The implementation of a mental health policy test.** As set out in Dr Smith's Second Witness Statement at §§45-57 [WITN0320036_0011-0014] it is well evidenced that mental health is heavily dictated by socio-economic determinants, alongside trauma, genetics, other biological factors and psychological stressors. Those determinants have disproportionate effect on *inter alia* the Black population, given their increased exposure to poorer housing, greater levels of unemployment, lower incomes and greater discrimination than their white peers. The College considers that a mental health policy test, akin to an equality impact assessment, should be rolled out to public bodies to ensure that decisions are made taking those socio-economic determinants into account, which should, over time, positively influence mental health in the whole population.

66. Such a test was publicly committed to in the 21 August 2023 policy paper *'Major conditions strategy: case for change and our strategic framework'* published by DHSC:

> *"To improve treatment and longer term care, we are… bringing forward a 'mental health and wellbeing impact assessment tool', to support policymakers to consider the mental health and wellbeing impacts of all policies…"*

67. Later in the paper that commitment was reiterated:

> *"To support cross-government working, DHSC will also implement a 'mental health and wellbeing impact assessment tool'. This will support policymakers across government to consider the mental health and*

wellbeing impacts of all policies without undue burden. Initially this will be used to develop cross-government policies for the major conditions strategy, before further policy roll-out."[51]

68. A change in Government meant that the major conditions strategy was not developed, and the assessment, or test, was not implemented. The College urges the Inquiry to recommend that the Government reinstates this programme of work as an element of its forthcoming cross-government mental health strategy.

69. In addition to those specific recommendations set out above, the College would invite the Inquiry to note the importance of the following matters as referenced in Dr Smith's written evidence:

a) timely and effective treatment to ensure better long-term outcomes (cf. Dr Smith's First Witness Statement [WITN0320001_0047-0048] at §§148-149);

b) evidence-based treatments (cf. Dr Smith's First Witness Statement [WITN0320001_0048] at §§150-151);

c) strengthen and fully implement community and crisis services (cf. Dr Smith's First Witness Statement [WITN0320001_0048-0049] at §153);

d) improve training on the MHA and the Mental Capacity Act 2005 interface and information sharing (cf. Dr Smith's First Witness Statement [WITN0320001_0049] at §154);

e) promote structured, formulation-based risk assessment and management (cf. Dr Smith's First Witness Statement [WITN0320001_0049] at §155 and the evidence set out above);

f) enhance multi-agency arrangements (cf. Dr Smith's First Witness Statement [WITN0320001_0049] at §156);

g) strengthen national learning systems (cf. Dr Smith's First Witness Statement [WITN0320001_0050] at §157);

h) apply consistent standards across sectors (cf. Dr Smith's First Witness Statement [WITN0320001_0050] at §158);

[51] [RLIT0000115]

i) mandate participation in Quality and Accreditation Networks (cf. Dr Smith's First Witness Statement [WITN0320001_0050] at §159);

j) establish a robust national surveillance function (cf. Dr Smith's First Witness Statement [WITN0320001_0050] at §160);

k) expand use of the College Centre for Quality Improvement established methodologies (cf. Dr Smith's First Witness Statement [WITN0320001_0051] at §161);

l) address services pressures and bed capacity (cf. Dr Smith's First Witness Statement [WITN0320001_0051-0055] at §§163-173);

As stated at the outset, the College is the body responsible for standard setting and training although there is no obligation for our guidance and policies to be adhered to. Despite that the College is well placed to support implementation of recommendations that the evidence shows can improve outcomes in mental health care. Implementing these recommendations is crucial. The College can provide more information on how these recommendations could be actualised, should that be of use to the Inquiry. The College would remind the Inquiry that it has appointed a new Chair to its Ethics Committee[52], which will be overseeing any updates to 'Good Psychiatric Practice: Confidentiality and Information Sharing'. The new Chair will assist the College in implementing any recommendations the Inquiry makes.

CONCLUSION

70. Mental health services cannot continue with a model that relies on crisis services or poorly resourced inpatient care.

71. The College remains ready to assist the Inquiry further, however it can, and looks forward to its findings and final recommendations.

14 August 2026

[52] Second Witness Statement of Dr Shubulade Smith [WITN0320036_0007] at §26.