IN THE MATTER OF THE INQUIRIES ACT 2005

BEFORE HHJ TAYLOR

THE NOTTINGHAM INQUIRY

OPENING WRITTEN SUBMISSIONS ON BEHALF OF

THE DEPARTMENT OF HEALTH AND SOCIAL CARE

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1. The Department of Health and Social Care ("the Department") starts these submissions by an expression of the deepest sympathy to the families of Grace O'Malley Kumar, Barnaby Webber and Ian Coates; and to those surviving victims and their families, Sharon Miller, Wayne Birkett and Marcin Gawronski, of the attacks on 13 June 2023 and their families. Their loss and suffering is incalculable. The Department has met with the families of the bereaved and the survivors on a number of occasions and so has heard first-hand about the incomparable loss and pain of the bereaved, and the suffering and continued life altering injuries of those who survived. The survivors have also expressed that they have at times struggled to have their experiences heard. The Department will work to address this; to ensure that all of those affected by the horrific events on 13 June 2023, the victims, the bereaved and the survivors, are listened and responded to.

2. The Department also recognises the impact that these attacks had on the people of Nottingham and the impact that they continue to have upon the University, the town and its public services. As part of its ongoing work, the Department has met with Celeste and Elias Calocane and listened to the concerns they had around the pressures facing the mental health system; they too have been impacted by the events of 13 June 2023 and Valdo Calocane's historic engagement with services. The Department recognises that there were failures in the provision of healthcare to Valdo Calocane. He was not provided with active and assertive mental health services despite having presented as acutely unwell with psychosis in the past and not taking his medication. The views of his family were not taken seriously. The risk

assessments undertaken in this case failed to make the correct assessment. The Department recognises that the operation of the Trust at the time meant that Valdo Calocane could fall through the gaps and did so.

3. In January 2024 the Department commissioned CQC to undertake a special review of Nottinghamshire Healthcare Foundation Trust. CQC made final recommendations in August 2024, and the Department has been monitoring implementation of these recommendations. We note that the Trust's most recent "well led" CQC report identified that it requires improvement. This is despite there being 39 inspections carried out by the CQC between May 2024 and August 2025 **(DHSC0000507)**. The Secretary of State and Ministers do not consider that this is acceptable progress. To address this, the Department has requested regular updates on implementing recommendations from prior CQC reports and are planning to meet the new leadership team including a newly appointed Chair, Tom Cahill (January 2026). Recruitment is taking place for a new Chief Executive and for other executive posts. The Trust are developing the action plan in response and this was due for submission to the CQC on 12 February 2026.

4. The Department is ultimately accountable for the failings of the NHS system and of NHS organisations. It recognises that whilst there has been significant investment in mental health services over the past ten years, demand has risen and outpaced the services available. There has been significant investment in mental health services over the past ten years – this has led to a 40% increase in the number of people accessing community mental health services for adults and older adults from 476,158 in 2020/21 to 667,218 in 2024/25 **(DHSC0000508); (DHSC0000513)**. However, despite this, a significant and ongoing rise in demand means there remains a substantial treatment gap. This significant rise in demand means that there is a treatment gap. The Department acknowledges that too many people are not getting the support they require or are waiting too long for that support. We also recognise that waiting increases the risks of the need for crisis care and the need for longer standing and more intensive interventions. Early intervention is key to avoid crisis care and the Department knows that this does not always happen. There are also difficulties with the provision of social care to those discharged from mental health services.

5. The Department also recognises that mental health services, like all health services, are overstretched. There are problems with continuity of care and there is not always sufficient capacity in the system for staff to provide the care that they would wish to provide. The Department sets out in this opening the steps that are being taken to improve the system, but there needs to be radical change and redesign of how services are provided. The problems outlined above are long term problems that require intensive and large-scale solutions. The Department is committed to solving these problems, but it will take time to do so.

6. The Department views this Inquiry as a vital part of the ongoing work being carried out and undertakes to carefully consider the evidence already presented and to be heard over the coming months. The Inquiry and other core participants will no doubt be asking the Department probing and challenging questions about its responsibility for failings it identifies: the Department will answer truthfully and straightforwardly.

7. These submissions turn to the role of the Department and the wider public bodies who had responsibility for the oversight and provision of mental health services during the time in question, to various statutory and policy developments relevant to the work of this Inquiry, and to identify what improvements need to be made to the system of provision of mental healthcare for those who have serious mental illness.

8. The Department will use various terms during the course of this opening. One of them is the phrase "severe mental illness". There is no consistent, national or international, definition for this term, but it is consistently used by practitioners, policy makers and academics. The Department uses this terminology in data collection and national guidance to include those who have schizophrenia, bipolar disorder or other psychosis. According to Quality and Outcomes Framework prevalence data, in 2024/2025, 648,282 people (approximately 1% of the total population) were known by their GP to have a diagnosis of severe mental illness (SMI) **(DHSC0000512)**; **(DHSC0000511)**. These figures only account for three of a broader set of conditions which fall under the definition of SMI (bipolar disorder, psychosis, and schizophrenia) and only include those whose condition is recorded on the GP register. NHS England data shows that in 2024/25, 667,218 adults with

an SMI accessed secondary community mental health services (defined as anyone who has two more contacts with secondary community mental health services, which will include people beyond just those with bipolar, schizophrenia and psychosis) **(DHSC0000506)**.

The Role of the Department

9. The Department for Health and Social Care is the Government Department accountable to Parliament, via the Secretary of State for Health & Social Care, for the operation of the NHS, public health and adult social care. The provision of care to Valdo Calocane was not limited solely to the NHS, but also to the Approved Mental Health Professionals who play a key statutory role in making recommendations about whether to detain an individual under the Mental Health Act.

10. The Department's role is to support and advise the Government's health and social care ministers. The Department operates alongside a number of Arm's-Length Bodies that carry out different functions, in respect of the health and care system. This opening tries to explain in very broad terms – more detail of which can be found in the written evidence the Department has filed with this Inquiry – what the Department's role was, and to explain a little about the other significant bodies which it oversaw. During the period in question, this has included:

    I. Being accountable to Parliament for the NHS (through Parliamentary Questions, debates, Select Committees, the work of the National Audit Office). The Department can and does examine and is answerable for significant failures in care to Parliament.

    II. Overseeing and where necessary seeking to amend (with Parliamentary approval) the legislative framework for the NHS. Of particular relevance to this Inquiry will be the work of the Independent Review into the Mental Health Act in 2017, which has resulted in the Mental Health Act 2025 which very recently received Royal Assent.

    III. Seeking the financial resources and support for the NHS within the Government's overall priorities.

IV. Representing the views and interests of the NHS within Government. Developing and supporting strategy and policy for the NHS and adult social care. This includes setting the direction for and holding to account the Department's arm's length bodies, whilst enabling them to exercise day to decision making for the areas they are responsible for in legislation.

V. Dealing with exceptional events when only a Department of State can step in and take the lead. An example of this is the response to the Covid-19 pandemic.

11. Since the 1990s, following the introduction of the National Health Service and Community Care Act 1990, NHS providers of acute and community care have been organised into 'Trusts'. NHS Trusts were able to earn Foundation Trust status allowing for greater freedom from central control. The first wave of Foundation Trusts was introduced in 2004. While Foundation Trusts had a significant degree of autonomy, they have always been subject to oversight from different central arm's length bodies, as is set out in the following paragraphs. Following the implementation of the Health and Social Care Act 2012, day-to-day responsibility for the NHS in England passed to NHS England ("NHSE"). It is this body which supports and oversees the commissioning of health services at present. NHSE allocates the resources to these providers, and, through the Integrated care board (prior to 2023, this organisation was the Clinical Commissioning Group or CCG as established in 2013), commissions services from relevant hospitals, community trusts, General practitioners ("GP"), pharmacists and others for patients living in its geographic area.

12. In 2019, NHS England merged with NHS Improvement. NHS Improvement became responsible for the oversight of NHS Foundation Trusts from 1 April 2016, following the merger with Monitor. Monitor had been responsible for the regulation of Foundation Trusts since 2004. NHS Improvement also had oversight of independent providers of NHS funded care – such as the independent hospital provision which Valdo Calocane was placed in on occasion which was paid for by the NHS, for patient safety policy and programmes – including to try and provide better quality services and greater patient safety, and intervened into Trusts and organisations where it considered that they were not acting safety. It also ran

leadership programmes to build leadership skills at all levels of NHS leadership and had a role in assessing the financial stability of NHS bodies **(DHSC0000516); (DHSC0000515)**.

13. In 2022, the merger of NHSE and NHSI was formalised with the passing of the Health and Care Act 2022. NHS England responsibilities were formalised with Health Education England – which provided education, training and workforce development within the health sector during the period to be scrutinised by the Inquiry.

14. On March 13th 2025, the Prime Minister announced that NHS England was to merge with the Department over the next two years, bringing management of the NHS back into central government. The Secretary of State explained on 13 March 2025 that as a result of the divided structure, "*We have been left with 2 large organisations doing the same roles with an enormous amount of duplication*" **(DHSC0000509)**. This followed the conclusions of the review carried out by Dame Patricia Hewitt which had found that there was substantial duplication of work, including one instance where one local service was required to send 250 reports and forms to NHS England and the Department of Health and Social Care in a single month **(DHSC0000510)**. It is intended that this will provide improved leadership across public health, healthcare and adult social care. It will set strategy and policy, provide clear objectives and enable local health and care systems to deliver.

15. One aim of the merger is to provide better oversight and transparency which the Department believes will help address some of the issues raised in this Inquiry. It is hoped that the new structure will better foster an environment of clear, open leadership. This will require legislation, but the Department is already some way towards the transition to one organisation, with a single joint executive team in place since November 2025, overseeing a single, integrated, structure **(DHSC0000085)**. The joint leadership group will simplify decision-making, foster collaboration, in advance of a formal merger following the passage of the Bill and better support ministers and public services.

NHS Mental Health Services

16. The Department has a mental health team whose role it is to support Ministers to make policy decisions in these areas. It oversees the operation of the Mental Health Act 1983 and took forward the work leading to the successful passage of the Mental Health Act 2025. It has also overseen the establishment and rollout of key interventions including Talking Therapies (formerly Improving Access to Psychological Therapies); Early Intervention in Psychosis services; shifting mental health care from hospital settings to the community; improving crisis care access; mental health support in schools; and suicide prevention. NHS England is responsible for the day-to-day oversight of mental health services. The operational running of both NHS Trusts and NHS Foundation Trusts sits with their Boards. This is overseen by NHSE via NHS Oversight Framework which outlines NHSE's approach to oversight of ICBs and Trusts. The Secretary of State has a statutory requirement to have a 'mandate' to NHSE in place, which sets out objectives NHSE should seek to achieve in the exercise of its functions.

17. There are separate provisions for high security psychiatric services and hospital accommodation for individuals who are liable to be detained under the Mental Health Act 1983 and who, in the Secretary of State's opinion, require treatment under high security conditions due to their dangerous, violent, or criminal propensities. The Secretary of State must approve all providers of high security services, and may give directions to providers about the provision, and to NHSE about the exercise of its functions in relation to these services.

18. The mental health system within the NHS is split into three tiers: primary, secondary, and specialist (sometimes known as "tertiary") care. This Inquiry is concerned with all three of those systems and how they operated – or did not – during the period in question. For many years now there has been an agreed policy of reducing the number of people with serious mental health conditions living in long-term institutional care by providing more community based care, closed to home. That does not mean that there is a place for hospital care, and where necessary, for compulsory detention. This will always include a small number of people who may be a risk to others and so the public requires protection from them,

alongside a much larger group who are a risk to themselves outside of specialist hospital settings.

19. The Department's mental health policy agenda during the relevant period and the preceding years included the establishment and rollout of key interventions that continue today. This included, but was not limited to, the development of a national programme called Talking Therapies (formerly Improving Access to Psychological Therapies) and Early Intervention in Psychosis services. Early intervention in psychosis ('EIP') teams are multidisciplinary community mental health services that provide treatment and support to people experiencing or at high risk of developing psychosis. A national access and waiting time standard were introduced in 2016 for this service.

20. The Secretary of State has a statutory requirement to have a 'mandate' to NHSE in place, which sets out objectives NHSE should seek to achieve in the exercise of its functions (s.13A of the 2006 Act). The changes to the 2006 Act by the Health and Social Care Act 2012 were predominantly to establish a separation between the day-to-day running of the NHS and the strategic role of Ministers. From its introduction in 2012, the mandate was directed to the NHS Commissioning Board, known as NHS England. Then from 2019 to 2022, the mandate was addressed to NHSE (NHS Improvement and Monitor received "remit" letters from the Secretary of State, as they formed constituent parts of NHSE (see para 12), and joint operational guidance was also set out addressed to both CCGs and NHS providers.

21. From 2013 onwards, the mandate has set out an objective to place mental health and its service provision on a part with physical health, and to close the health gap between those with mental health difficulties and the population as a whole. Throughout this period, the Department has recognised that mental health services required improvement. In 2016, NHS England published "Implementing the Five Year Forward View for Mental Health, a five-year programme aimed at expanding and transforming all aspects of NHS mental health services **(DHSC0000015)**.

22. The Health and Care Act 2022 amended the previous requirement to issue the mandate annually, and the mandate has become a more enduring set of priorities.

The Health and Care Act 2022 provided new flexibility for the Secretary of State to decide when the mandate should be updated. The Department has continued to publish mandates to the NHS in 2021-22, 2022-23, 2023-24 and 2025 **(DHSC0000004); (DHSC0000110); (DHSC0000005); (DHSC0000111)**.

23. From 2022 onwards, the NHS mandate focussed upon post Covid 19 recovery – with a commitment to treat mental health with the same urgency as physical health, and in particular to improve access to mental health services, and in particular to create specialist mental health ambulances and specialist psychiatric services available in all urgent care settings.

24. The Department monitors NHSE's performance against mandate objectives and publishes an annual assessment letter from the Secretary of State to NHSE's Chair, which includes an assessment of how effectively NHSE has discharged its statutory duties and, in that year, the extent to which it met any requirements or objectives set out in the mandate.

25. The Government published an NHS long term plan in 2019 **(DHSC0000013)**; this sought to transform care for those with severe mental illness thought integrated community-based models, and aimed to break down barriers between primary, secondary, and tertiary care. A Community Mental Health Framework was also published in 2018 which sought to have evidence based treatment through collaborative person centred care; to improve the quality of life for those with mental ill health; to ensure continuity of care and avoid cliff edges caused by referrals, thresholds for access to services or unsupported discharge; to tackle health inequalities and to build inclusive services for those with complex co-existing needs and those facing marginalisation **(DHSC0000092)**. NHS England committed to investing an additional £2.3 billion per year in mental health services by 2023 – 2024, and funding was given to ICBs to develop these models of care. Adult Social Care Services.

26. Alongside the Department for Housing, Communities and Local Government – which provides the funding for local government in England, DHSC leads on the policy for – adult social care services. Local Authorities have responsibilities under the Care Act 2014 for the provision of services to working age and older adults who

have care and support needs. In respect of those who have been compulsorily detained in hospital, local authority adult social care has joint responsibility with the Integrated care board ("ICB") for the delivery of after care services to patients, which is designed to provide specific support services to enable reintegration back into the community for this cohort and to reduce the risk of deterioration of the patient's mental health condition.

27. Alongside this, the approved mental health professional (AMHP) is a key role under the Mental Health Act providing the gateway in many cases to treatment and care in hospital settings. The AMHP is a specific role that may be occupied by a specially trained social worker/psychiatric nurse/ occupational therapist/ clinical psychologist whos' role is to determine what support is appropriate if there is a concern that someone may a harm to themselves or others. If the AMHP receives a referral, they must decide whether to make an application to detain a patient, or whether there are other better options. The objective of the assessment is to determine whether the criteria for detention are met and, if so, whether an application for detention should be made, for example:

    I. they suspect the person has a mental disorder (for which they arrange for two medical opinions, one of which must be s.12 MHA approved, meaning that they are approved by the Secretary of State under section 12 of the MHA, where they are described as having experience in the diagnosis or treatment of mental disorder and are authorised to make recommendations for the compulsory detention of patients under the Act.);

    II. The person poses a risk to themselves or others;

    III. Consider if there are other options available (e.g. guardianship, or other support not requiring detention).

    It is then the AMHP's final decision as to whether the person should be detained on the basis of the two medical recommendations and their own assessment of the person and their circumstances. The AMHP has various powers under the MHA which includes the power to apply for compulsory admission or to ask for guardianship, and the power to enter and inspect premises where someone is not

receiving proper care and to apply or a warrant to search and remove patients who are living alone and are in need of care.

28. Local authorities are jointly responsible for the provision of after care services alongside NHS Trusts under s117 of the Mental Health Act 1983. These are services to be provided in the community from those who have been compulsorily detained under s3 of the MHA 1983. It is a service which is free at the point of discharge and there is a specific duty to make sure that these services are made available. The services provided are those who arise from or relate to someone's mental disorder and to reduce the risk of deterioration in their condition. These serves are to be provided until the patient no longer requires them.

29. NHS Mental health services are subject to the oversight of the Care Quality Commission – which also has responsibility for inspection, regulation, and monitoring of health and adult social care providers. The CQC is accountable to the Department for the work that it undertakes. It publishes its inspection reports and findings and performance ratings about the care provided. This includes the performance of foundation trusts, and local authorities to deliver adult social care – including how well they integrated care and support within wider health services.

30. The CQC is responsible for the monitoring of how services exercise their powers under the Mental Health Act and discharge their duties relating to the detention of patients. There is an annual report published by the CQC which is designed to identify areas of concern and improvement under the Mental Health Act. It conducts visits and interviews people who are detained under the Mental Health Act.

31. It is also responsible for the provision of a second opinion appointed doctor service which provides independent oversight of compulsory treatment decisions made under the Mental Health Act 1983. Alongside this, the CQC has responsibility to review complaints relating to the use of the Mental Health Act and to make proposals for changes to the Code of Practice.

NICE

32. The DHSC also sponsors the National Institute for Health and Care Excellence – universally known as "NICE" – which provides national guidance and advice to

improve health and social care. There are relevant quality standards in place at the time in question for psychosis and schizophrenia in adults, and about transition between inpatient mental health services and community services which this Inquiry may want to examine. Written evidence from the chair of NICE has been provided to the Inquiry setting out the guidance that they provided during the period.

The Mental Health Act 1983

33. The Mental Health Act 1983 as amended as the Mental Health Act 2007 sets the legal framework, at present, to authorise the detention and compulsory treatment of people who have a mental health disorder and are considered at risk of harm to themselves and/or others. The provisions have been amended by the Mental Health Act 2025. The legislation and decision makers are supported by a statutory 'Code of Practice' which will also be amended and updated. The Mental Health Act Code of Practice provides guidance to registered medical practitioners, approved clinicians, managers, and staff of providers, and AMHPs on how they should carry out functions under the Mental Health Act. It is a legal requirement to have regard to the Code when carrying out functions under the Mental Health Act. This Code will be revised in the light of the MH Act 2025. The Department has committed to extensive engagement in developing the revised Code, including with people with lived experience and their families and carers, staff and professional groups, commissioners, providers and others to do this. In addition, a draft of the revised Code of Practice will go to public consultation to ensure that all relevant stakeholders are given an opportunity to have input into the drafting of the document.

The Mental Health Act 2025

34. The Mental Health Act 2025 reflects recommendations made by an Independent Review, led by Professor Sir Simon Wessely ('the Independent Review') **(WITN0155026); (WITN0155008)**. Full implementation of the Act will take around ten years, due to the time needed to train the workforce and the need to ensure that the right community support is available expand this. However, it does not mean that patients will have to wait ten years to experience the benefits of these

reforms or the wider programme of non-legislative activity that is improving care for people with mental health problems.

35. In the light of the attacks in Nottingham, the Department sought further assurance as to whether the new Act would dilute or prevent detention of those who pose a risk of serious harm to others, as well as themselves. The Department considers that the Act continues to provide robust powers to detain someone who poses a risk of serious harm:

    I. The Department is aware that some aspects of the Act which have clarified the rationale and necessity for detention have been criticised by some as weakening the ability of clinicians to detain patients. The Department does not agree that this is the case, and the Act is not designed to drive down the numbers of those detained or the reasons why they are detained. The Department considers the powers under the new Act set out more clearly the test and rationale for detention.

    II. The Department does not believe, the MHA 2025 will change the fundamental powers and purpose of the Act, which is to detain and treat people when they are so unwell they become a risk to themselves or others. As set out in Sir Simon Wessely's Independent Review; when such infringements on liberty and autonomy are deemed necessary, we must ensure that people are treated with dignity. The reforms are designed to drive better, more personalised care of those with the most severe mental health conditions, and to give them greater choice and control over their treatment, whist maintaining the ability to compel treatment where necessary for patient and public safety. Patient and public safety remains a paramount consideration, if we seek to improve outcomes for people subject to detention, to drive better care, we have a greater chance to keep people safe.

36. The Inquiry has asked questions of the Department as to the rationale for the Act and why it has been introduced. The previous Act was introduced nearly 40 years ago, and approaches, treatment and clinical standards have altered during that time. Furthermore, the need to ensure that the patient is at the centre of decision

making was a significant factor in requiring legislative change. The aims of the Act are:

I. **First, Improving Patient Safeguarding**

i. To have four guiding principles which reflect the requirements of treatment provided under the Act: they are Choice and Autonomy, Least Restriction, Therapeutic Benefit and the Person as an Individual; please note that least restriction does not mean no restriction, nor does autonomy override all other considerations.

ii. To introduce statutory care and treatment plans for patients detained under the Mental Health Act – including those who are subject to Community Treatment Orders. Counsel to the Inquiry has comprehensively explained in their opening the role of Community Treatment Orders and whether or not Valdo Calocane should have been subject to one after his discharge form hospital. Again, the aim of these plans is to ensure that treatment and care is comprehensively described, alongside a discharge and importantly a safety management plan. These plans are meant to be reviewed by hospital managers for their quality and provide a set of basic standards to support individuals.

iii. The Independent Review of mental health found that the criteria for detention under the Mental Health Act 1983 were too vague. New criteria have been introduced as follows. Someone will – once the Act is implemented, meet the criteria if:

- The patient is suffering from **psychiatric disorder** of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

- **Serious harm** may be caused to the **health or safety** of the patient or of another person unless the patient receives medical treatment. The clinician therefore needs to give specific consideration to the harm which may be caused; and

- It is necessary, given the **nature, degree and likelihood** of the harm, for the patient to receive medical treatment. This is not designed to be some kind of formulaic risk matrix or for someone only to be detained because of the likelihood of a harm occurring. The idea behind these criteria is to create a holistic assessment of risk – something may be unlikely but serious and thus justify detention. There is no minimum threshold or percentage, nor could there every be given the varied and wide presentation of those with serious mental illness; and

- The necessary treatment cannot be provided unless the patient is detained **under this Act**, and appropriate medical treatment is available for the patient. *Appropriate medical treatment is defined as - treatment that "has a **reasonable prospect** of alleviating, or preventing the worsening of, the disorder or one or more of its symptoms or manifestations".* It is not, and this must be stressed, based upon concepts of whether something is or is not a specific condition.

iv. When deciding to discharge a patient, the responsible clinician will need to consult with another professional who has been involved in the patient's care and treatment, whether that be in the community or hospital, to strengthen informed decision making around discharge and to formalise best practice.

v. The Act also introduces a reform of Community Treatment Orders to reflect the revised criteria in respect of detention. This will, it is hoped, ensure increased oversight and scrutiny of such orders. These reforms are designed to address longstanding issues, notably people being on a CTO for far too long, when it is no longer appropriate, and especially, black people being disproportionately made subject to CTOs. However, CTOs are an important safeguard, and it is important that the small number of people who benefit from them can still be discharged from hospital subject to the possibility of being

recalled to hospital for further medical treatment, if necessary. Under the Mental Health Act 2025, a person cannot be discharged from a CTO without agreement from a community clinician who has oversight of the person's engagement with treatment in the community and whether their symptoms are deteriorating – this additional professional oversight should mean that they cannot be discharged until they are ready.

vi. Increasing the oversight of the mental health tribunal to those in detention and who wish to be discharged, by permitting more frequent rights of appeal for the tribunal to examine whether the detention criteria continue to be met and automatically referring patients to the tribunal in more circumstances. We want to increase oversight by the tribunal as the independent review of the MHA found that sometimes patients are left to languish in hospital, while they could have been discharged and cared for in the community i.e. in a less restrictive environment. There are two ways a person can be seen by a MHT, they can appeal or they are automatically referred. If a patient has not used their right of appeal, they will be automatically referred. This is to ensure that patients who, for whatever reason (e.g. they lack capacity, or feel disempowered from appealing), are still reviewed by the MHT. The frequency with which a person can use their appeal right, and the frequency of automatic referrals are both increasing under the MHA reforms. The Mental Health Act will shorten the period that a patient may be detained for treatment before detention must be renewed. This change will mean that a patient's detention will need to be reviewed more frequently. Shortening the duration of authority to detain someone for treatment is intended to increase the frequency with which clinicians will have to justify the case for ongoing detention.

II. **Second, Improving Patient Choice and Autonomy**. The Department recognises that this focus has been the subject of worries and concerns as to whether or not this means less of a focus on safety. It is the Department's

view that improving patients' rights should not be seen in conflict with patient and public safety. Better care and treatment, focused on the individual's needs, facilitates their effective engagement with services and treatment, and their recovery and continued health. The Department recognises that compulsory medication is sometimes the only option to getting a person well again, which is why the MHA 2025 maintains the power. It says this because it considers that where people have sufficient support and help from their family members and others and are listened to, they are much more likely to comply with their treatment and so avoid the spiral of serious risk seen in this case and in others. Second, because the focus on choice is alongside a requirement for more considered and reflective decision making and a system of 21st century support for those who are unwell who can see the signs of deterioration and be listened to and act upon them. The main changes set out in the Act are:

i. Introducing a new clinical checklist requiring clinicians to, among other things, support the patient to be involved in decision making about their treatment, and to consider their wishes and feelings when doing so.

ii. Introducing duties on health commissioners that, in particular, aim to facilitate people at risk of detention to make an Advance Choice Document, while they are well and in the community. This is to provide them with support to be able to say what help they want if unwell or lack capacity. That will enable clinicians to be able to more easily and quickly recognise and be able to implement detention where required or to secure treatment.

iii. Strengthening treatment safeguards that, together, aim to see that the patient's wishes, feelings, beliefs and values play a more central role in clinical decision making and that there is greater independent oversight of compulsory treatment decisions. This is because the Independent Review found that sometimes clinicians fail to take the time to understand a person's wishes and feelings, undermining their dignity and the clinician-patient relationship, or that they make no

effort to account for the person's wishes or preferences when it would be entirely justified to accommodate them.

iv. Allowing patients to choose someone to be their 'Nominated Person' instead of the current system of "Nearest relative" which is not fit for the way that people now live their lives. The nearest relative is assigned according to a hierarchical list of relatives. This doesn't represent modern family frameworks, for example, stepparents are not included, and assignment of relatives is by the eldest first. Sometimes this gives the role to an individual that doesn't know the patient well or may even be a risk to them. The nominated person should be listened to by health services and provide the early warning alert to clinicians, including having powers to contact services to ask for admission for the person who is unwell. The Nominated Person will have specific statutory functions under the MHA, as with the Nearest Relative now. Such functions do not undermine the need to work with and engage with the patients' family members including parents of patients under eighteen.

v. Expanding access to Independent Mental Health Advocates ('IMHAs') to voluntary patients in England, who are not detained under the Act. We consider that this will provide an additional level of safeguard to both those who are unwell, and to statutory services and families.

vi. Ensuring decisions around care and treatment, and how the wishes of patients and views of carers have been considered, are clearly articulated and recorded through care and treatment plans. This does not mean prizing choice above other considerations, but in creating a system of acting in a patient's best interests – that does not always mean doing what they wish. The Department recognises a need to improve and to record decision making to ensure continuity of care. More continuity of care and more information will improve and nor reduce patient safety.

III. Limiting the Detention of People with a learning disability and autistic people (without a qualifying co-occurring mental health condition). These changes, whilst of essential importance to many, are not matters which are directly related to the issues raised by this Inquiry.

IV. Improving access to those in the Criminal Justice System. Much of this is not of direct relevance to the terms of reference. Once implemented, clause 48 of the Mental Health Act will remove police cells and prisons from the definition of places of safety under Part 3, section 55 of the 1983 Act, and removes police stations as places of safety for "civil patients" under sections 135/136. Before implementing changes to sections 135 and 136 of the Mental Health Act 1983, DHSC will work closely with the Home Office, police and the NHS to better understand the implementation requirements. For the purposes of removing prisons as a place of safety under section 55 of the Mental Health Act 1983, the Ministry of Justice are developing a cross-agency workplan to safely enact the proposed reforms.

V. Strengthening the Powers of Clinicians where there are concerns around public protection and patient safety:

   i. The revised detention criteria will not hinder a clinician's ability to detain someone where it is necessary to protect either themselves or others. Introducing the threshold of 'risk of serious harm' to the detention criteria will require clinicians (and subsequently the Mental Health Tribunal) to consider risk as part of the assessment or tribunal process.

   ii. Details of the reasons for detention will be recorded in the relevant statutory forms and in the patient's care and treatment plan.

   iii. The Act increases the rigour of the protocol around discharging someone from detention, introducing mandatory consultation requirements before discharge to strengthen the decision-making process. The Act reforms seek to change this – helping make sure that the decision to discharge is carefully considered and receives greater professional oversight from a multi-disciplinary team.

iv. Families and carers will be more involved in decision making. The Act allows individuals to set out who should be involved in their care if they experience mental health crisis using the processes for nominating a Nominated Person and for creating an Advance Choice Document. A person's family, friends or peers can play a valuable role in a person's care and that they may be able to provide critical insights and support in a situation where the individual is unwell and poses a risk to self or others. These policies also seek to avoid family, friends and carers from being excluded from the picture when a person becomes unwell and may disengage from those relationships or from mental health services. More widely, the Act places greater emphasis on clinicians engaging with family and carers, including when making treatment and care planning decisions, to ensure that they are appropriately recognised as important part of the patient's support network.

37. In conclusion, the Department has set out above various initiatives in place and being developed which it considers will lead to long term improvements in care for patients and the public. It has specifically considered and focussed upon the need to create a system where patients are listened to, valued and put at the centre of their care, so that they will respond more effectively to services aimed at them. That will, in turn, lead to less disengagement and more effective treatments and outcomes. The Department does not suggest that this will be easy or that progress will be linear; but that such is both necessary and essential to reduce the risks to the public and to the patient.

DHSC knowledge of Valdo Calocane

38. The Department has checked all departmental inboxes and its correspondence database for correspondence sent or received before 13 June 2023 containing the name "Valdo Calocane". These searches produced no results. There is therefore no record of the Department being aware of Valdo Calocane at any time before 13 June 2023. The Department first became aware of VC shortly after the attacks.

39. When Valdo Calocane's criminal proceedings concluded, the Department was aware of a number of issues relating to Nottinghamshire Healthcare NHS Foundation Trust. This included the Trust's role in previously providing mental health care to Valdo Calocane, reports that over 30 staff working at Highbury Hospital had been suspended over reports of falsification of observation records, and that Rampton Hospital (one of the three high secure hospitals across the country) had recently had its CQC inspection rating downgraded from "requires improvement" to "inadequate".

40. The Department accepts that Valdo Calocane did not receive the community health care he should have upon discharge from hospital in 2022 and was allowed to not be adequately monitored or supervised. The Department also agrees that he should have been subject or could have been subject to a Community Treatment Order to compel his compliance with medication. Community mental health care services are and have been the primary mechanism by which the government has sought to provide care to individuals who have complex needs. They are designed to meet that persons mental, physical and wider social needs, and are run on a multi-disciplinary basis incorporating clinicians, social workers, and those employed by the NHS, local authorities, charities and other voluntary bodies. They include services with specific conditions – such as psychosis – but also home treatment and crisis team that provide time limited intensive support to those suffering from a mental health crisis. They are commissioned by integrated care boards alongside local authorities.

41. The CQC report into Nottinghamshire Healthcare NHS Foundation Trust found that in addition to action required by this specific trust, there was also a "*need to look more closely at community mental health services nationally to fully understand the gaps in quality of care, patient safety, public safety, and staff experience in community mental health services*." **(WITN0155030)**. The Department is committed to working with NHSE and the wider sector to address these very substantial challenges. The Department will respond shortly to the Health and Social Care Select Committee, following their recent report on community mental health services.

42. The CQC's review of Nottinghamshire NHS Foundation Trust published on 26 March 2024 and 13 August 2024 highlighted that such services required particular attention across England **(WITN0155030); (WITN0155033)**. The CQC concluded there is a need to look more closely at community mental health services nationally to understand the gaps in quality of care, patient safety, public safety and staff experience in community mental health services. The CQC report further found that inconsistent care planning, poor communication between services and a lack of care co-ordinators was putting patients and the public at risk – and this was a widespread issue nationally.

43. Valdo Calocane was discharged from services and at times it appeared that he may have been non-compliant with medication and was reluctant to engage with mental health services, such as in September 2022 **(WITN0084001)**. The Department recognises that non-engagement is a recurring problem. Those with severe mental illness often live with these illnesses for their whole lives, and the support of the health services needs to reflect this in the services provided and in being able to go back into the system efficiently and quickly should deterioration occur. As a result of the lack of information sharing and the absence of access to information, professionals did not monitor Valdo Calocane's mental health deterioration over time. This led to, for example, a failure to actively manage Valdo Calocane in transfer between the community mental health team and his GP **(WITN0084001)**. There should have been resources to carry out this exercise. Failing to engage with services, not turning up to appointments, not answering messages, are not often in this group of patients a sign of health or a conscious decision, but a sign of mental ill health and a lack of insight into how unwell they are. Help is needed for this group even if it is difficult to deliver and requires persistence, patience, and perseverance.

44. The Department and wider Government has recognised that services require improvement in terms of quantity and quality and has sought to take steps to address this over a number of years, both through funding and changes to care models.

    I. Implementing the Five Year Forward View for Mental Health 2016 **(DHSC0000015)**;

II. The NHS Long Term Plan – Published January 2019 **(DHSC0000013)**;

III. NHS Long Term Workforce Plan – Published June 2023 **(NHFT0017698)**;

IV. 10 Year Health Plan for England – Published 3 July 2025 **(DHSC0000096)**;

V. Modern Service Framework (MSF).

45. In 2019, for example, the NHS Long Term plan identified the need for parity for mental health services and set out plans for new, funded, NHS action to strengthen its contribution to prevention and health inequalities. This included every local area across England being required to set out specific measurable goals and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years and provide an improved therapeutic offer in inpatient mental health services by increased investment in interventions and activities. Priorities for inpatient mental health settings included eliminating inappropriate out of area placements, reducing the average length of stay, capital investment to upgrade the physical environment, and reducing suicides. The 2019 NHS Long Term Plan sought to bring the typical length of stay back to the national average of 32 days, which was expected to contribute to ending out of area placements. This is still current policy. The Long Term Plan, also set out the aim for mental health psychiatric liaison services to be available in all acute hospital A&E departments and inpatient wards in 2023/24, which has now been achieved.

46. The NHS Long Term Workforce Plan published in the Department has also sought to address staffing shortages in mental health services. The Department is alive to the fact that this does not solve the workforce shortages, and the problems with workforce retention. There is high turnover in mental health services, and this does compromise the quality of care. This Government has committed to recruiting an additional 8,500 mental health workers by the end of this Parliament. Almost 8,000 of these workers have been recruited since July 2024. The Government intends to publish a new Workforce Plan. The 10 Year Workforce Plan will seek to ensure the NHS has the right people in the right places, with the right skills to care for patients, when they need it, This workforce plan will also set out how we deliver change by making sure that staff are better treated, have better training and more fulfilling roles.

47. Continuity of care often enables better quality of care for those with severe mental illness: conversely lack of continuity – a hallmark of Valdo Calocane's care but also more broadly can be inimical to improvements in mental ill health. There needs to be meaningful time for meaningful engagement, from both named psychiatrists and care-coordinators.

48. Alongside the increase of staff, Modern Service Frameworks are being introduced by the Government. One of the first concerns severe mental illness. Severe mental illness is associated with severe and persistent health inequalities. These frameworks are to define a long-term outcome goal: to identify the evidenced interventions; to support towards it; to identify how such will be implemented and supported; to produce an ability for some areas to innovate, and to support the creation of novel ideas. A clear focus from the pandemic is the need for the health system to be able to innovate and create – drawing on the insights and creativity of those working within it. The development of Modern Service Frameworks is clinically-led and overseen by the National Quality Board – a body which, since 2009, has brought together senior clinical leaders from the NHS alongside regulatory bodies, patients and patient representatives. The Modern Service Framework for severe mental illness is due to be published 2026.

49. As set out in the 10 Year Plan, through moving to neighbourhood care models for mental health, the Department will seek to remove excessive referrals and handovers to ensure care is delivered by one integrated team - comprising NHS professionals and others with a relevant remit for supporting people with serious mental illness. In mental health services, the vision for a Neighbourhood Health Service is supported by the 24/7 neighbourhood mental health model, which is currently being piloted in six areas. There will be integrated crisis services and community support and open access beds, which will not require a referral, to facilitate support to those who need it. These services will involve:

    I. Open 24/7 with no referral needed.

    II. A holistic approach to mental health encompassing housing, employment, and social support in the round.

    III. Person centred: designed to improve continuity of care.

IV. Community based: located in the middle of the community to reduce stigma and improves access.

V. Multi-disciplinary teams: including NHS staff, those from the voluntary sector such as Voluntary, Community, Faith, and Social Enterprise organisations (VCFSE) and peer support workers.

50. Each centre is led by a partnership between the NHS, those with lived experience, and Voluntary, Community, Faith, and Social Enterprise organisations. The model for these hubs was in part inspired by the model of community healthcare found in Trieste, Italy, which has been recognised by the World Health Organisation as a model of good practice. These six pilots are taking place across England, and the NHS is working with fifteen associated sites to proceed using their own resources and commitments. The Department is working with NHS England to understand what barriers exist to implementation across the country, recognising that there is a need for good digital platforms which enable central record keeping, good governance, clear leadership outcomes.

51. The Department very much hopes that these will develop a strong community of practice which can then be rolled out.

52. The 10 Year Plan will also see the Department invest up to £120 million to bring the number of mental health emergency departments to around 85, meaning there will be one co-located (or very close to) 50% of existing Type 1 A&E units.

53. There is a commitment in the 10 Year Health Plan to improve Assertive Outreach (AO) care and treatment to ensure 100% national coverage in the next decade. To support this roll-out, further work may be required to understand the evidence and provide guidance to support effective AO models.

54. In 2025, the government increased investment in mental health care by an extra £688 million, with all systems forecast to deliver the Mental Health Investment Standard (MHIS) in 2025/26. Over the next three years, ICBs will be required to meet the MHIS by protecting mental health spending in real terms: in other words, rising in line with inflation from 2026/27. £473m capital funding will also be available

over 4 years to invest in new models such as 24/7 Neighbourhood Mental Health Centres, Mental Health Emergency Departments, and other capital projects.

CQC Report and its implementation

55. The CQC Section 48 Review highlights the need for services to engage more effectively with patients suffering from severe mental illnesses, so patients do not 'fall through the gaps', especially those patients who most struggle to engage in their treatment. It is clear that this is a concern raised by a number of parties and which runs through the written evidence presented to this Inquiry by the families, stakeholder groups and health bodies **(DHSC0000165)**.

56. The Department and the Secretary of State have sought assurances from NHSE on progress against the recommendations from all three strands of the CQC review commissioned by the Secretary of State under s48 of the Health and Social Care Act 2008. This has included a meeting with CQC and NHSE on 31 July 2024 to discuss how they and the Nottinghamshire Healthcare NHS Foundation Trust are progressing the recommendations, and how they will work together to make swift, sustained improvements to mental health services **(WITN0155035)**. The Secretary of State also requested regular progress reports, with NHSE providing updates on 23 October 2024, 4 December 2024, 7 August 2025 and 12 December 2025 **(DHSC0000463); (DHSC0000477)**.

57. The recent CQC Inspection Report, following a well-led inspection into the leadership, culture and governance of the NHFT in September 2025, was published 14 January 2026 and gave a rating of 'requires improvement' for Well Led **(DHSC0000507)** (A well-led inspection is an inspection under the CQC's single assessment framework, providing NHS Trusts with a single trust-level rating which focuses on leadership and culture.) The CQC highlighted that the board lacked a unified vision and cohesive working approach, with tensions between quality, finance and governance, and inconsistent challenge from non-executive directors; and ongoing problems with poor culture and staff experience. It also raised the Trust's lack of strategic focus on improving its estate and removing dormitory accommodation, breaching the Health and Social Care Act 2008. The CQC has required the Trust to submit an immediate and wide-ranging action plan,

addressing the following: embedding a shared vision and strategy, strengthening culture and workforce equality, and implementing the Patient and Carer Race Equality Framework (PCREF).

Implementing the 10 Year Health Plan

58. There have been a significant number of reports and investigations which have taken place prior to the commencement of this Inquiry. This has allowed the Department and NHS England to reflect upon what improvements are required in advance of the start of this Inquiry, which in part influenced the recommendations in the 10 Year Plan.

59. One of the key shifts as part of the 10 Year Health Plan is the progression from analogue to digitalisation. The 10 Year Health Plan sets out a vision for a single patient record - this provides patients a single, secure and authoritative account of their data, enabling more coordinated, personalised, and predictive care. This will ensure continuity and increased knowledge of the history of a patient. The new single patient record will also help to support continuity of care by bringing together a patient's medical data into one place and making it visible across different care settings. This is one of the approaches that the Government is exploring to reduce fragmentation and improve the ways that mental health services work with each other and with other public agencies.

60. Continuity of care should be the norm: it is not the standard. The absence of continuity, both between services and within services, means individuals are passed around, and often involves patients having to repeat their history or services not being aware of what may have been tried before.

61. Within the context of the Neighbourhood Health Service at the core of the 10 Year Health Plan, there is an opportunity for better join-up locally across different services and settings. Without effective planning and collaboration between inpatient and community-based teams, discharge from inpatient settings can be a cliff edge for patients if they do not have the right care in place in the community.

62. The Department recognises that the most recent national guidance on risk management in mental health services was published by the Department of Health

in 2009 **(DHSC0000038)**. The Personalised Care Framework ("PCF"), due to be published shortly by NHS England, will provide updated national guidance on the minimum standards expected of mental health services, including in the management of risk.

63. The PCF sets out minimum standards of care to address variation in quality of services that patients receive following implementation of Community Mental Health Framework and implements an approach so that everyone receiving treatment and support for their mental health gets the basics of good care.

64. The framework sets out the core aspects of care for people who require help from secondary or integrated primary, voluntary, community and social enterprise, and secondary care mental health services. These core principles dictate that people using NHS commissioned community mental health, crisis and inpatient services should:

    I. have a care and support plan that is current and that is reflective of the needs of the person at that point;

    II. have a person within the service responsible for their care and support plan and for developing a trusted therapeutic relationship;

    III. be able to have their care and support plan reviewed when things change, as well as be able to quickly re-access help when they need to (such as when their mental health deteriorates following a period of stability); and

    IV. have their experience and outcomes of care and treatment measured and responded to.

Conclusion

65. We end these submissions as we began, focusing on the bereaved, and survivors of the attacks on 13 June 2025. We thank again the families of Grace O'Malley Kumar, Barnaby Webber, and Ian Coates; as well as those surviving victims, Sharon Miller, and Wayne Birkett for speaking to DHSC, urging DHSC to do more, and for being so clear sighted and committed to the provision of better care and services.