Front sheet: Public Board of Directors
Item number: 16
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Private/ public paper:	Public
Report Title:	Plan to respond to **Independent Mental Health Homicide Review** and consolidate with internal learning
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Presented by:	Caroline Johnson, Executive director of nursing and professions
Vision and values:	This supports the Trust's vision regarding ***continuous improvement of services*** and ***ensuring excellent services***. This report addresses ***working together for our service users*** and a ***commitment to quality*** in understanding patient safety issues and learning from these. The report emphasises that ***everyone counts***.
Purpose and key actions:	This report aims to assure the Board of Directors regarding the Trust's response to the findings from the high-profile reviews of Nottinghamshire NHS Foundation Trust, conducted by NHS England and the Care Quality Commission (CQC). These reviews were initiated following the tragic deaths of Barnaby Webber, Grace O'Malley-Kumar, and Ian Coates in June 2023, as a result of attacks carried out by Mr. Valdo Calocane, a patient experiencing serious mental illness. The programme will address recommendations relevant to SHSC and match these recommendations to already known and in action internal learning following serious incident investigations and external homicide reviews of SHSC patients. The programme will ensure the voices of staff and patients are reflected in the ongoing learning and actions that need to be taken forward.
Executive summary:	NHS England has published an Independent Mental Health Homicide Investigation following the tragic death of Barnaby Webber, Grace O'Malley-Kumar and Ian Coates in June 2023. The report highlights instances where Mr Valdo Calocane, a patient experiencing serious mental illness, was failed by mental health services, which had devastating consequences. On the 5 February 2025, Claire Murdoch, National Director for Mental Health, and Dr Adrian James, Medical Director for Mental Health, asked Mental Health Providers to review local action plans, ensuring they address the issues identified in the Independent Mental Health Homicide Review into the tragedies in Nottingham. The request from NHS England is for NHS Trusts to review the action plans initially produced for the Integrated Care Board (ICB) in December 2024, but to expand these plans to capture learning from internal sources. Action plans should pay particular attention to: • Personalised assessment of risk across community and inpatient teams • Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved

	agencies) • Multi-agency working and information sharing • Working closely with families • Eliminating Out of Area Placements in line with ICB 3-year plans ICB plans should be updated to reflect the outcomes of Provider led reviews and any actions identified to make improvements locally. Updated action plans should be discussed in both trust and ICB Public Board meetings **no later than 30 June 2025**. The report provides assurance in relation to work that was already underway to ensure SHSC learns and improves through the findings of the Independent Homicide review and the CQC Review. The home first programme scope is already addressing a considerable amount of the work required. A detailed timetable of activity is outlined to ensure that the Board is provided with the assurance required to meet the requirements outlined in the NHSE letter by the 30 June 2025.

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*	**x**	*No*		
Deliver Outstanding Care	*Yes*	**x**	*No*		
Great Place to Work	*Yes*	**x**	*No*		
Ensuring our services are inclusive	*Yes*	**x**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.
There is a requirement under CQC to learn from patient safety incidents, and this programme of work centralised what learning is being taken and the impact this is having to improve services.

BAF and corporate risk/s:	**BAF 0024** Risk of failing to meet fundamental standards of care caused by lack of appropriate systems and auditing of compliance with standards, resulting in avoidable harm and negative impact on service user outcomes and experience, staff wellbeing, development of closed cultures, reputation, future sustainability of particular services which could result in potential for regulatory action. This item will support reduction of this risk by ensuring systems and governance of identified areas where the Trust is not meeting standards of care.
Any background papers/ items previously considered:	The Board of Directors received a report in relation to the Trust response to the Nottingham attacks in September 2024.
Recommendation:	The Board of Directors are asked to: • **receive assurance** of the approach that is being taken to learn from the NHS England review of Nottinghamshire NHS Foundation services and ensure robust improvement plans are developed and discussed in both trust and ICB Public Board meetings no later than 30 June 2025.

Board of Directors
Plan to respond to Independent Mental Health Homicide Review and consolidate with internal learning
26 March 2026

1. Introduction

This report aims to assure the Board of Directors regarding the Trust's response to the findings from the high-profile reviews of Nottinghamshire NHS Foundation Trust, conducted by NHS England and the Care Quality Commission (CQC). These reviews were initiated following the tragic deaths of Barnaby Webber, Grace O'Malley-Kumar, and Ian Coates in June 2023, as a result of attacks carried out by Mr. Valdo Calocane, a patient experiencing serious mental illness.

The Trust acknowledges the profound impact these events have had on the victims' families and the community. It is essential that we learn from these tragic events and thoroughly review our services and processes to reduce the likelihood of similar attacks occurring in Sheffield.

2. Summary of the CQC and NHSE review learning

NHS England published an Independent Mental Health Homicide Investigation and the CQC published a 'Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust.' The Main learning points from both reports are summarised below:

Risk Assessments
• Maintaining contemporary assessment and management plan • Quality of assessment and management plan • Collaboration with others especially the service user and family, but also professionals involved or previously involved in care • Clear formulation / risk management plans / safety plans • Inconsistent approach to risk assessment • Clinical response and escalation in response to the risk assessment and management plan • Training around risk management

Care planning
• Collaboration with service users and ensuring their voice is heard • Concise/good quality (holistic and based upon need rather than diagnosis) • Monitorable

- Involvement of family and any other professionals involved
- Inconsistent approaches

Record keeping

- Quality of daily records – concerns they were not complete or accurate, understandable, concise, showing analysis of risk and presentation
- Feeding into ongoing plans for care and recovery
- Person centred
- Discharge record keeping

Discharges

- Robustly engaging service users who are not engaging with community teams
- Discharges from community teams taking place in the absence of face to face meetings with service users to assess risk
- Large caseloads impacting resources to manage service users when they do not engage
- When a person is an in-patient, the decision making around discharge at Nottingham NHS Foundation Trust sat with the inpatient responsible consultant, and this could be a shared responsibility between the inpatient and community responsible consultants.

Family and Carer Involvement

- Family were at times not listened to when trying to provide professionals updated information on Mr Calocane's risks and their concerns about his wellbeing
- Family not part of risk assessment or formulation

Out of Area Placements

- Suitability, as part of an acknowledgement that care should be delivered locally where possible, and in this case Mr Calocane's admission to an out of area PICU came at an important point in his treatment
- Joint working to support discharge particularly where patients are showing a pattern of not engaging in the community following discharge

3. Trust Response to the Learning

Following the publication of the CQC report, the following actions were taken:

1) We undertook an audit to gain immediate assurance that our policies did not permit discharge from services based on non-attendance unless supported by robust multi-disciplinary discussion. The scope of the audit was to assess the reasons for discharge for all patients discharged from community mental health teams between 1st September and 31st October 2024. Auditors identified patients discharged following not engaging and then reviewed the care and treatment around attempts to engage patients, and around decision making following unsuccessful attempts. From this audit, it was found that

- there was assurance that no patients were discharged following disengagement by any one individual member of staff.
- Nine patients had been discharged after not engaging, in all cases attempts were made to contact patients, although there was not a consistent approach to this.
- All patients had MDT discussions prior to discharge.
- There were inconsistent approaches to addressing risk as part of this MDT discussion.
- There is improvement needed for discharge documentation and updates to risk assessments prior to discharge.
- The Trust has documented principles related to disengagement, and more work is needed to utilise these principles to create clear guidance and a plan to implement. This will be re-audited.

2) We undertook a self-assessment against the NHSE maturity index for intensive and assertive treatment in September 2024, which was approved by our Executive Management Team and was shared with the ICB.

3) We created an action plan against the NHSE maturity index for intensive and assertive treatment in December 2024, which was approved by our Executive Management Team and shared with the ICB.

4) We have established weekly audits of care plans, risk assessments and record keeping across our community mental health service. From these audits it has been identified that:

- There is good clinical record keeping.
- There are concerns about the personalisation of care planning and work such as PROMs should support with this. There are also actions underway to review the care planning template and utilise the re-launch of Rio to improve the template.
- The audit is exploring risk assessments tools, but the audit tools used need an update to support the teams to explore this fully, and this update is being undertaken with the Clinical Effectiveness Team.

5) Training has been implemented to improve the quality of risk assessment within both CMHTS

6) A thematic review into family and carer involvement in care is underway as this was identified as a theme in the review of patient safety incidents in Q2 and Q3 2024/25.

6) A steering group that has been established to develop and implement a programme of work to implement the learning from the Nottingham reviews, oversee delivery of the gap analysis action plan and address initial audit findings.

4. The Programme of Work

4.1 NHSE Requirements

On the 5 February 2025, Claire Murdoch, National Director for Mental Health, and Dr Adrian James, Medical Director for Mental Health, asked Mental Health Providers to review local action plans, ensuring they address the issues identified in the Independent Mental Health Homicide Review into the tragedies in Nottingham.

The request from NHS England is for NHS Trusts to review the action plans initially produced for the ICB in December 2024, but to expand these plans to capture learning from internal sources.

Action plans should pay particular attention to:

- Personalised assessment of risk across community and inpatient teams
- Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
- Multi-agency working and information sharing
- Working closely with families
- Eliminating Out of Area Placements in line with ICB 3-year plans

ICB plans should be updated to reflect the outcomes of Provider led reviews and any actions identified to make improvements locally.

Updated action plans should be discussed in both trust and ICB Public Board meetings **no later than 30 June 2025**.

4.2 The Scope

Guidance from South Yorkshire ICB to all providers is that plans should be inclusive of:

1) The Action Plan Generated from self-assessment against the NHSE Maturity Index for Intensive and Assertive Community Care

2) Learning from Nottinghamshire Healthcare NHS Foundation Trust

3) Internal Learning identified

3.3 The aim

While immediate action was taken to audit and understand the Trust's position in relation to the learning identified from the NHS Review, particularly where this linked to internal learning, it was identified that a larger programme of work is needed to be to address areas that require further improvement and provide assurance to the board. The aim of the project is to ensure that the Trust puts in place the most effective responses to recommendations, does not duplicate effort or risk contradictory responses across services:

- To consolidate all the already ongoing internal actions relating to the themes highlighted in the Nottingham Review report.
- To brief staff on the contents to the Nottingham Review report and gather their input into the solutions
- To understand from staff through exploration, and using service user feedback, the barriers the system presents to the production and maintenance of high-quality risk assessments, care plans and patient records.
- To map out new processes and develop products to address the systemic causes of the issues
- To consolidate, validate and streamline the actions to be undertaken to address the issues.
- To deliver the actions and enable oversight through a single streamlined governance and assurance route.
- To provide assurance that SHSC acknowledges the areas identified by the CQC and NHS England in relation to Nottingham services and is responding to those.

Alongside the scope set by the ICB, SHSC has identified this as a unique opportunity to create a holistic, collaborative and overall meaningful action plan addressing the identified areas that have been noted in internal learning such as serious incident investigations, regulation 28s and feedback from coroners court, with input from staff and with oversight and involvement of patients and carers. It is important to note that there are interdependencies between this programme of work and the Home First Programme and Culture of Care, which will be mapped as the programme progresses.
The MHLDA Collaborative Akeso review will also inform the improvements to CMHT processes and productivity. The review suggests that there is an opportunity to better manage both demand and subsequent caseload levels through alternative ways of working.

The Approach

Table 1 below outlines the timeline of activity that is underway that will ensure the Trust responds robustly to the NHSE ask by the 30 June 2025.

Table 1 – Timeline of activity to provide a response to NHSE by 30 June 2025

Activity	Detail	Lead	Timescale
ToR and kick start meetings established	ToR prepared Two engagement meeting held with relevant leaders	• Greg Hackney • Ciara Perera	January 2025 **Complete**

Activity	Detail	Lead	Timescale
Collate the learning and recommendations from Nottinghamshire Healthcare and internal learning	Collate all the recommendations from the Nottingham report, our internal review of homicides report and 2 NHSE Homicides reports	• Ciara Perera	14 March 2025 **Complete**
Formulate a central plan which includes the actions being progressed in response to learning and recommendations	Develop an overarching improvement plan that incorporates the recommendations from the Nottingham report, our internal review of homicides report and 2 NHSE Homicides reports	• Emma Highfield • Ciara Perera	28 March 2025
Consult with our service users and families on the actions that have been generated	Detailed consultation will be included in the action plan. This will not be undertaken prior to governance of the plan	• Emma Highfield	June 2025
Establish a series of trust-wide learning events to engage clinical services to develop the central plan	St Mary's Conference Centre booked	• Emma Holland • Chris Wood • QI • Workplace wellbeing • EBE's	Mid-March – Mid-May (account for RIO)
Establish governance to deliver against improvement actions	PMO engaged	• Caroline Johnson	April 2025

5. The Outcomes

Through the proposed approach which will be managed through the already established steering group the following will be achieved:

Table 2: Product and Timescales

Requirement	Group	Timescale
Summary of the approach and plan	Executive Management Team	March 2025
Detailed plan in response to Independent Mental Health Homicide Review into the tragedies in Nottingham	Executive Management Team	May 2025
Detailed plan in response to Independent Mental Health Homicide Review into the tragedies in Nottingham	Quality Assurance Committee	May 2025
Detailed plan in response to Independent Mental Health Homicide Review into the tragedies in Nottingham	Trust Board	June 2025
Programme Governance to deliver the action plan	Reporting into Executive Management Team and the Quality Assurance Committee	Monthly reports July 2025 onwards

6. Recommendations

The Board of Directors are asked to:

- **receive assurance** of the approach that is being taken to learn from the NHS England review of Nottinghamshire NHS Foundation services, and ensure robust improvement plans are developed and discussed in both trust and ICB Public Board meetings no later than 30 June 2025.