Public Board of Directors
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Confidential/public paper:	Public
Report Title:	**Plan to respond to the Independent Mental Health Homicide Review into the tragedies in Nottingham**
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Presented by:	Greg Hackney, Deputy Director of Operations Emma Highfield, Interim Deputy Director of Nursing
Vision and values:	This plan aims to meet the holistic vision of the Trust, improve the mental, physical and social wellbeing of the people in our communities. It meets the following values: • Working with and advocating for the local population • Refocusing our services towards prevention and early intervention • Continuous improvement of our services • Locating services as close to peoples' homes as we can • Developing a confident and skilled workforce • Ensuring excellent and sustainable services Values include • We **work together** • We are **inclusive** • We keep **improving**
Purpose:	This plan to respond to the Independent Mental Health Homicide Review (named the "Learning into Action Plan") is presented for assurance to the Board of Directors. The plan is one of the outputs of a programme of work to 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 next steps of 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. NHS England, the CQC and mental health trusts are in agreement that there is shared learning from the gaps and barriers in Nottingham NHS Foundation Trust services which should be analysed by all Trusts, to understand if action should be taken in relation to similar barriers. Initial analysis has already taken place within the Trust to seek immediate assurance about the areas identified by NHS England. In addition, a more in-depth programme has been developed which aims to match the recommendations from NHS England to similar recommendations which have arisen from internal reviews of patient deaths, and external reviews which have occurred about Trust patients who have committed

	homicide. There are several similar recommendations and underway actions. The Board of Directors is asked to review the centralised learning into action plan, along with an acknowledgement that there is more to be done to capture staff and service user engagement within the plan as part of the continuous development. **Next steps for the learning into action plan** It is important that this action plan is meaningful and engages staff to enable real change. As such, staff feedback will be incorporated into the plan through forums led by heads of nursing. It is also important this plan addresses patient concerns. A patient safety partner is supporting with oversight of the project. In addition, patient and carer input is being sought to inform the central action plan through a service user engagement session. This feedback will inform the final action plan. This plan will need to be strongly governed both by individual teams but also centrally. The programme of work is being overseen by the executive management team (EMT), and the plan itself will feed into the clinical quality and safety group and/or the learning and improvement forum (which aims to be in place from May).

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*		*No*	**x**	
Reduce inequalities	*Yes*	**x**	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.	
We have developed our plan based upon learning from the Independent Mental Health Homicide Review of the NHS care and treatment provided to Valdo Calocane by Nottinghamshire Healthcare NHS Foundation. Our plan encompasses a self-assessment against the NHSE Maturity Index for Intensive and Assertive Community Mental Health Care, as well as learning from SHSC incidents. Our plan intends to meet fundamental standards of care, our legal obligations as a mental health provider, and to meet clinical standards of partnership working. Ultimately, our plan strives to improve the quality and safety of Sheffield Health and Social Care clinical services.	
Board assurance framework (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:	This is the first time this paper has been received.
Recommendation:	The Board of Directors are asked to: • **note** the approach that we have taken to develop our plan to respond to the Independent Mental Health Homicide Review • to receive **assurance** that the actions we intend to progress are appropriate and proportionate to the learning identified and will lead to improvements to the quality and safety of our services. • **Note** that this plan will iterate as we continue to engage with staff and service users to tailor our approach.

Public Board of Directors

Plan to respond to The Independent Mental Health Homicide Review into the tragedies in Nottingham

May 2025

1. Introduction

This report aims to assure the Board of Directors regarding the Trust's response to the findings from the high-profile review 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.

Nottinghamshire NHS Foundation 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 incidents 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
- Informing ongoing plans for care and recovery
- Person centred Care was not always evident
- The absence of a robust record template for inpatient and community discharges

Discharge Planning

- 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. Mr Calocane's pattern of disengagement with community teams, following inpatient admission, was not recognised and this may in part have been due to the use of an out of area placement.

- 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 in relation to 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, without an MDT discussion.
- 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 using a variety of methods as outlined in the Supporting Attendance at appointments Guidance. The guidance recommends using a variety of methods (phone, letter and texts).
- All patients had MDT discussions prior to discharge.
- There were inconsistent approaches to addressing risk as part of this MDT discussion. MDT records do not specifically state in all cases that risk was discussed as part of discharge considerations.
- 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 then 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. Within this, it was identified that to achieve full maturity, there would need to be investment across several teams to provide additional roles for substance misuse recovery and PSI, at a cost of £618,365. This has been submitted to the ICB following approval by the Executive Management Team in April 2024. The ICB submitted the costs to NHS England to inform future funding decisions.

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. We intend to monitor delivery of the action plan through a programme group which will report to our senior leadership team and our Executive Management Team.

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 a good standard of clinical record keeping.

- Care plans are not sufficiently personalised. Learning will be shared from the Culture of Care project on the in-patient wards which has a focus on care plans and the implementation of Patient Reported Outcome Measures (PROMS) will also support the required improvements. There are also actions underway to review the care planning template and utilise the re-launch of the electronic patient record (Rio) to improve the template.
- The audit reviews risk assessment tools, but the audit tools used need an update to support the teams to explore this fully to ensure they are aligned with recent external guidance on risk assessing, and this update is being undertaken with the Clinical Effectiveness Team. It is expected to be ready July 2025.

5) Training has been implemented to improve the quality of risk assessment within both CMHTS. This training has taken place as part of the roll out of the personalised assessment of risk document and has been delivered to 80 clinical staff.

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. This will be a two-phase review, with the second phase expected to conclude in September 2025, and this will be inclusive of family and carer engagement in the findings and recommendations.

6) A steering group that has been established to develop and deliver 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. This is chaired by the Deputy Director of Operations and reports to the Executive Management Team.

4. The Work Product

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**.

In terms of ongoing governance, it is expected that Trusts will continue to have oversight of implementation of their workplans and discuss this in their respective committees and boards. For SHSC, it has been identified that the plan will be monitored through the Senior Leadership Team on a monthly basis, with quarterly updates to the Executive Management Team, Quality Assurance Committee and the Board.
The Trust also provide updates to the ICB via the Quality, Performance, Public Involvement and Experience (QPPIE) committee and the Mental, Health, Learning Disabilities, Dementia and Autism Strategic Delivery Group (MHLDDA SDG).

4.2 Progress to Date

A centralised learning into action plan has been drafted. This is the front facing name for the Plan to respond to the Independent Mental Health Homicide Review. At this stage, the plan incorporates all actions in the targeted areas, that are ongoing across the Trust. The plan will iterate based on audit findings, incident analysis and the national evidence base.

The action plan meets the requirements outlined by NHS England. The Trust was already aware of gaps in areas identified by NHS England's learning recommendations from their review of Nottinghamshire Healthcare Foundation Trust and is taking robust action to address known gaps.

The actions already in place align with internal reviews of SHSC patients following homicides, which identified learning regarding:

- Personalisation of risk assessments
- Assessing risk longitudinally
- Ensuring pathways of care that promote joint working
- Proactive and dynamic care planning for complex cases
- Ensuring a more proactive approach to family involvement
- Ensuring practitioners are confident and skilled to work with those experiencing substance misuse and mental health problems.

SHSC have aimed to go further than to simply address the NHSE ask. The Trust aims to create a centralised learning into action plan that is holistic, and reflects the voices of patients, families and carers. Due to timescales, this is not currently in the iteration of the plan being presented to the QAC, but work is ongoing to ensure that the final plan sent to the ICB will reflect recommendations from staff and patients. Please refer to the next steps below for more information on how this will be done.

Early recommendations from the staff engagement events which have gone ahead indicates a need for:

- More robust risk assessment processes with clear guidance for staff and reducing an over-reliance on checklists. The personalised assessment to risk project aims to deliver on this.

- Acknowledging and adjusting to system limitations around patient care, particularly in reference to risk management.
- Promotion of collaborative MDT approaches and implementing training to staff around this.
- Ensuring assessments on discharge from inpatient settings examine how patients are likely to present in the community, and risks around this.
- Clear systems for supporting family input and sharing risk management with families proactively.
- Developing a culture of long-term care planning that links to risk management.

Positively, this early feedback is similar to learning identified from internal reviews of care and treatment and there are some workstreams already addressing many of the key recommendations staff have identified. Heads of nursing will be identifying actions to support, where actions are not already in place to address barriers identified by staff.

4.3 The Remaining Steps

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
Terms of Reference (ToR) and kick start meetings established	ToR prepared Two engagement meeting held with relevant leaders	• Greg Hackney • Ciara Perera	January 2025 **Complete**
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**

Activity	Detail	Lead	Timescale
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 **Complete**
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	May 2025 **In progress**
Establish a series of trust-wide learning events to engage clinical services to develop the central plan	St Mary's Conference Centre booked. First 2 sessions held. 2 more sessions to be held.	• Emma Holland • Chris Wood • QI • Workplace wellbeing • EBE's	Mid-March – Mid-May (account for RIO) **In Progress**
Establish governance to deliver against improvement actions	PMO engaged	• Caroline Johnson	April 2025 **Completed**

5. Recommendations

The Board of Directors are asked to:

- note the approach that we have taken to develop our plan to respond to the Independent Mental Health Homicide Review
- receive assurance that the actions we intend to progress are appropriate and proportionate to the learning identified and will lead to improvements to the quality and safety of our services.

- Note that this plan will iterate as we continue to engage with staff and service users to tailor our approach.