Humber and North Yorkshire Health and Care Partnership

NHS Humber and North Yorkshire Integrated Care Board (ICB)

| Agenda Item No: | 8 |
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| **Report to:** | Humber and North Yorkshire Integrated Care Board |
| **Date of Meeting:** | 19 June 2025 |
| **Subject:** | **Intensive & Assertive Community Mental Health Treatment Review**<br>**Review of the Independent Homicide Investigation report into the care and treatment provided to the service user by Nottingham Trust** |
| **Director Sponsor:** | Michele Moran – Chief Executive Officer, Humber Teaching NHS Foundation Trust and ICB Mental Health Provider Representative, Mental Health, Learning Disabilities and Autism Collaborative |
| **Author:** | Lynnette Robinson – Adult Mental Health Programme Lead, MHLDA Collaborative |

**STATUS OF THE REPORT:**

Approve ☐ Discuss ☐ Assurance ☒ Information ☒ A Regulatory Requirement ☒


**SUMMARY OF REPORT:**

This paper provides a briefing in relation to the outcome of the Intensive & assertive Community Mental Health Treatment Review & Independent Investigation report into the care and treatment provided to the service user involved with the tragedies that occurred in Nottingham.

The review has been requested by NHSE following the publication of the independent investigation homicide report.

**Summary**

- Following the publication of the independent homicide investigation findings, all mental health providers have undertaken an immediate review of the recommendations and have identified areas where:
  - assurances are already in place
  - actions for improvement are in place
  - new actions are required to be taken aligned to the additional learning from the Independent review.
- Mental health providers have reviewed the level of care and treatment available locally for patients who require intensive and assertive community treatment, alongside policies for engagement and disengagement. All providers are assured that disengagement is not used as a reason for discharge.
- Significant positive engagement from all providers to close the gaps.
- Intensive and assertive community care requires dedicated resource and, in some areas, a new clinical model.
- At the time of finalising the action plan no additional resource has been identified.
- All providers have asked that the action “interoperability of clinical systems” be escalated to NHSE as a national objective, requiring coordinated action on a broader scale.


**RECOMMENDATIONS:**

Members are asked to note the content of this paper.

## ICB STRATEGIC OBJECTIVE

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| Leading for Excellence | ☒ |
| Leading for Prevention | ☒ |
| Leading for Sustainability | ☐ |
| Voice at the Heart | ☒ |

## IMPLICATIONS

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| Finance | N/A |
| Quality | The MHLDA Collaborative is responsible and accountable to the ICB and will report directly to NHSE. The Mental Health Programme Lead is offering clinical support and coordinating partnerships across the 3 providers. In terms of governance, it is expected and agreed that Provider Trusts have oversight of implementation of their workplans and will provide updates to the ICB via the MHLDA Collaborative. |
| HR | N/A |
| Legal / Regulatory | NHSE have requested that updated action plans should be discussed in both trust and ICB public board meetings no later than 30 June 2025 and progress against plans should be regularly reported to ICB boards. |
| Data Protection / IG | N/A |
| Health inequality / equality | N/A |
| Conflict of Interest Aspects | No conflicts of interest have been identified prior to the meeting. |
| Sustainability | N/A |

**ASSESSED RISK:**

The purpose of the independent investigation was to identify learning for NHS delivered care to understand if there are lessons that could be learned that could prevent something similar occurring in the future.

The gaps in provision for this patient group have been added to ICB risk register and providers risk registers.

**MONITORING AND ASSURANCE:**

The Provider organisations have oversight of implementation of their workplans and provide updates to the ICB via the MHLDA Collaborative.

**ENGAGEMENT:**

An in-depth review has been undertaken involving wider stakeholders including people with experience of using services and carers to ensure we have a clear understanding of our position, and any further work required from a range of perspectives.

**REPORT EXEMPT FROM PUBLIC DISCLOSURE** No ☒ Yes ☐

If yes, please detail the specific grounds for exemption.

**Intensive & Assertive Community Mental Health Treatment Review**

**Review of the Independent Homicide Investigation report into the care and treatment provided to the service user by Nottingham Trust**

## 1. Introduction

The following paper presents the recommendations from the independent investigation into the care and treatment provided to the service user involved with the tragic incidents that occurred in Nottingham published in February 2025.

***This follows on from the first briefing to the ICB public board December 2024.***

This paper builds on the outcome of the previous CQC review of mental health services at Nottinghamshire Healthcare which made several recommendations for improvement against which all Mental health providers within Humber and North Yorkshire have existing improvement plans.

NHSE have requested that updated action plans should be discussed in both trust and ICB public board meetings no later than 30 June 2025 and progress against plans should be regularly reported to ICB boards.

| **List of providers which the review covers** |
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| - Humber Teaching NHS Foundation Trust – Hull & East Riding<br>- NAVIGO – North East Lincolnshire<br>- Tees, Esk & Wear Valleys NHS Foundation Trust – North Yorkshire & York<br>- Rotherham, Doncaster and South Humber - North Lincolnshire information has been submitted via South Yorkshire ICB and assurance has been received for oversight) |

## 2. Issue

Some people who experience psychosis, particularly where paranoia is present, struggle to access “routine” evidenced-based care and treatment. This can be due to core services not being able to meet people’s needs.

Separate/specialist services for this client group dissolved over a decade ago and in most areas moved to generic teams. For this group of people, it is critical that mental health services can meet the person’s needs by adapting the approach to engagement, providing continuity of care, and offering a range of treatment options for people experiencing a varying intensity of symptoms. People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others.

## 3. Background

### 1st phase – Review of local service provision (completed)

As a first step in improving care, NHS England included a requirement in the 2024/25 NHS Priorities and Operational Planning Guidance that all ICBs “review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge”.

Mental health providers have reviewed the level of care and treatment available locally for patients who require intensive and assertive community treatment, alongside policies for engagement and disengagement. All providers are assured that disengagement is not used as a reason for discharge.

***Following your review are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?***
Whilst overall services are generally working well, there are some areas that require action to achieve full maturity against the new guidance. Humber and North Yorkshire is not fully assured.

We can confirm there are no blanket Did not attend (DNA) policies for this patient group and discharge decisions are held within Multi-disciplinary teams.

**2nd phase – Identify gaps and resource requirements (completed)**
As part of these reviews, ICBs were asked to report any gaps and barriers to delivering good care that they have identified (e.g. resourcing and workforce implications of delivering this care). These high-level resource requirements plans have been developed by the provider trusts and submitted to NHSE.

**3rd phase – Publication of Independent Mental Health Homicide Investigation**
On the 5th February 2025 NHS England published the independent investigation into the care and treatment provided to the service user involved with the tragedies that occurred in Nottingham where 3 people tragically lost their life.

The purpose of the independent investigation was to identify learning for NHS delivered care to understand if there are lessons that could be learned that could prevent something similar occurring in the future. The Independent review made 12 recommendations for NHS England, ICB and Nottinghamshire health care NHS Trust.

Following the publication of the review, NHS England have requested that all ICB's and NHS mental health providers review their existing local action plans in place following the CQC review of mental health services at Nottinghamshire Health Care NHS Trust in line with the 12 recommendations.

NHS Trust's providing mental health services have been asked to pay particular attention to the following:

- 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

## 4. Recommendations from the Independent Investigation

There are twelve areas of improvement identified.

**The first two are national recommendations led by NHSE.**

1. There are unmet needs/insufficient support for people with serious mental illness from mental health services, particularly for those who struggle to maintain engagement with services.
2. The risks to patients and others are not always fully understood, managed, or documented.

**NHS Provider recommendations**

Following the publication of the independent investigation findings the mental health providers have undertaken an immediate review of the recommendations and have identified areas where assurances are already in place, where action plans for improvement are in place as part of the work undertaken to address the learning from the CQC review into Nottinghamshire health care, and where new actions are required to be taken aligned to the additional learning from the Independent Review.

Table 1 below summarises the current position.

| Recommendation | Summary from the Independent Report | Current Summary Position of HNY Providers (detailed action plans by provider are available) |
|---|---|---|
| **3.** Review any previous action plans to implement recommendations. | Trusts should undertake an audit of their implementation of recommendations from previous reviews including from Serious Incidents and the CQC to evaluate the outcomes following implementation. Also, they should seek to understand if the changes made have had a positive impact on the quality and safety of care delivered, including the views of those with Lived Experience. | Good assurance from audits undertaken following learning from patient safety incidents in terms of implementation but requires further review to capture positive impact on the quality and safety of care delivered. |
| **4.** Ensure the trust has an overarching Serious incident policy | The trust wide Patient Safety Incident Response is in line with NHS England's new patient safety framework (PSIRF) which captures procedures to be taken to examine all patient safety incidents (PSIs). | All providers have fully implemented PSIRF utilising a range of validated methodologies to examine PSIs. Internal Audit of the process to be undertaken in 2025 |
| **5.** Family engagement develop/enhance. | The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience.<br>The Trust should then develop processes, in line with national guidance to support effective family engagement. | Family engagement structures is embedded however differs across providers & local implementation is variable. Learning is being shared between providers to support a system wide offer. |

| Recommendation | Summary from the Independent Report | Current Summary Position of HNY Providers (detailed action plans by provider are available) |
|---|---|---|
| **6.** Clinical information sharing | Develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. | Clinical information sharing via interoperable clinical systems is challenging at a local level, achieving seamless and fully integrated across organisational working remains a challenge. Yorkshire shared care record project offers partial assurance. To effectively address this issue, HNY wish to escalate this as a national objective, requiring coordinated action at a broader scale to establish the necessary infrastructure and standards for seamless information exchange across healthcare systems. |
| **7.** Across organisational working | Review and evidence effectiveness & reliability of communication processes across all system partners. | Partial assurance but requires further review to ensure effectiveness. Due to ongoing issues with existing clinical information sharing systems, achieving seamless and fully integrated across organisational working remains a challenge and requires continued attention and improvement. |
| **8.** Governance arrangements | Develop the ability to triangulate safety critical information to inform existing and emerging issues. | Triangulation processes in place ie closed cultures dashboard, Performance Reports, Accountability Review Process, Thematic reviews of incidents triangulated with complaints, claims and workforce data from |

| Recommendation | Summary from the Independent Report | Current Summary Position of HNY Providers (detailed action plans by provider are available) |
|---|---|---|
| | | which priority areas for action are identified. |
| **9.** Policy development and review | All Trust policies are current, updated and written in a manner that enables staff to practice in line with the policy. | Policies are either in date or under review. Assurance via the Head of Corporate Affairs |
| **10.** Peer support | Ensure that there is a robust peer support offer within community mental health services. With appropriate recruitment, support supervision and leadership. | Peer support offer in place across the 3 providers. Local implementation is variable. Review of the service is underway to include support and supervision which will be added to the existing action plan. |
| **11.** Care planning | Ensure care planning arrangements are co-produced with the voice of service users, families and or support networks | All providers have arrangements in place to ensure care plans are co-produced. Further quality assurance of care planning is necessary to ensure that the voices of service users, carers, families, and support networks are included as a priority. This is essential to guarantee that care plans comprehensively capture all needs and actions. |
| **12.** Joint clinical decision making | Ensure the voice of all those involved in care and treatment of an individual is heard and considered within the context of planning for care and treatment | Further improvement work required to strengthen approaches regarding ensuring the voice of all those involved in care and treatment of an individual is heard and considered. This is already within each provider action plan. |

(*no6 - Clinical information sharing – All providers have requested this action is escalated)

## 5. Governance

In terms of a governance framework, the MHLDA Collaborative is responsible and accountable to the ICB and will report directly to NHSE. The Mental health programme lead is offering clinical support and coordinating partnerships across the 3 providers. In terms of governance, it is expected and agreed that Provider Trusts have oversight of implementation of their workplans and will provide updates to the ICB via the MHLDA Collaborative.

Progress against the existing plans is underway with progress reports scheduled with providers Executive Management Teams, clinical governance and place quality groups.

The gaps in provision for this patient group have been added to ICB risk register and providers risk registers.

NHSE have requested that updated action plans should be discussed in both trust and ICB public board meetings no later than 30 June 2025 and progress against plans should be regularly reported to ICB boards

Progress updates and associated reports have been shared at the following meetings.

- HNY ICB Quality Committee - 24th April 2025
- HNY MH/LDA Executive Group - 2nd June 2025

## 6. Next steps

Following the initial immediate review of recommendations an in-depth review has been undertaken involving wider stakeholders including people with experience of using services and carers to ensure we have a clear understanding of our position, and any further work required from a range of perspectives.

The existing action plan developed following the CQC review into Nottinghamshire Health Care has been embedded and updated to incorporate the recommendations from this independent review and any further actions identified from engagement with stakeholders.

- At the time of finalising the action plans, all providers are considering the challenge of statutory responsibilities for delivering a balanced budget and ensuring availability of resources for transformation.

- Estimated costs required to close gaps, rationale, and how this will build from the services currently in place has been submitted to NHS England. At this stage, there is no clarification that there will be any new funding available. Decisions regarding funding will be made via the national treasury NHS spending review.

- The Essential standards of care for people with SMI where engagement is a challenge with links to the Care Programme Approach/person centred planning changes are underway, led by NHSE.

- The gaps in provision for this patient group have been added to ICB risk register and providers risk registers.

## 7. Conclusion

Following the initial immediate review of recommendations from the independent investigation report and CQC review, assurance has been identified in several areas with further work to strengthen our approaches identified in others. Estimated costs required to close the gaps, rationale, and how this will build the services currently in place has been submitted and at this stage, there is no clarification that there will be any funding available.

The Board are asked to note the content of this paper, and the next steps outlined above.