REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Extraordinary Part A**	**ENCLOSURE:** **B**
DATE OF MEETING:	**19 June 2025**	
REPORT TITLE:	**Independent Mental Health Homicide Review into the Tragedies in Nottingham:** **Update on Somerset's Action Plan to Improve Intensive and Assertive Community Treatment for People with Serious Mental Illnesses**	
REPORT AUTHOR:	**William Barnwell, Associate Director, Mental Health, Autism and Learning Disability and Neil Jackson, Deputy Service Group Director, Mental Health & Learning Disabilities**	
EXECUTIVE SPONSOR:	**Shelagh Meldrum, Chief Nursing Officer and Director of Operations**	
PRESENTED BY:	**William Barnwell, Associate Director, Mental Health, Autism and Learning Disability** **Neil Jackson, Deputy Service Group Director, Mental Health & Learning Disabilities** **Dr Andreas Papadopoulos, Medical Director of Mental Health & Learning Disability**	

PURPOSE	DESCRIPTION	SELECT (Place an 'X' in relevant box(es) below)
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	
Discuss	To discuss, in depth, a report noting its implications	X
Note	To note, without the need for discussion	
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	X

SELECT (Place an 'X' in relevant box(es) below)	LINKS TO STRATEGIC OBJECTIVES (Please select any which are impacted on / relevant to this paper)
x	Objective 1: Improve the health and wellbeing of the population
x	Objective 2: Reduce inequalities
x	Objective 3: Provide the best care and support to children and adults
x	Objective 4: Strengthen care and support in local communities
x	Objective 5: Respond well to complex needs
	Objective 6: Enable broader social and economic development
	Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT
Multi-agency review of intensive and assertive outreach services, led by Somerset Foundation Trust. Submitted to NHS England for review. Update provided to ICB Board in November 2024. Discussion in December Quality Committee. The action plan has since been considered at the Mental Health Autism and Learning Disability Programme Board. Delivery is monitored at the Serious Mental Illness steering group.

REPORT TO COMMITTEE / BOARD
These slides provide: • Information regarding the Nottinghamshire homicides, subsequent reviews, and request for system action plans • Actions taken in Somerset in response to the homicide reviews • An update on action plan progress • An update on next steps and areas for further attention

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	An EIA has not been completed as no commissioning activity has yet been undertaken. However, in a general sense, people with serious mental illness are some of the most vulnerable groups in society, with a clear intersection with protected characteristics. The Trust has involved Experts by Experience (EbyE) in their work to date, and EbyE are also be represented in the Serious Mental Illness (SMI) Steering Group.
Quality	Implementing the recommendations would increase the safety and quality of services.
Safeguarding	Implementing the recommendations will improve the quality and safety of services, ensuring they safeguard the welfare of vulnerable service users and other individuals who may encounter them. A failure to implement the recommendations, resulting in gaps and delays in the provision of timely Assertive Outreach and wider Community Mental Health Services provision to individuals with Serious Mental Illness, will increase safeguarding risk for both services users and the wider public and negatively impact the ability of services and organisations to meet their statutory safeguarding duties.
Financial/Resource/ Value for Money	NHS England has asked all systems to provide provisional costings for the full suite of recommendations, to indicate the scale of the challenge and support planning/next steps. In Somerset, to implement 100% of the recommendations would cost circa £3m. There is no indication yet that national funding will be made available to support this. Systems have been asked to prioritise actions with little/no financial implication.
Sustainability	N/A.
Governance/Legal/ Privacy	N/A
Confidentiality	N/A
Risk Description	There is a risk that there is insufficient dedicated Intensive and Assertive Outreach support for people with Serious Mental Illness. This could lead to harm to patients, workforce and public.

Nottinghamshire Homicides Independent Inquiry:

Intensive Assertive Outreach (IAO) Services for People with Serious Mental Illness (SMI) -

Action Plan Update

19 June 2025

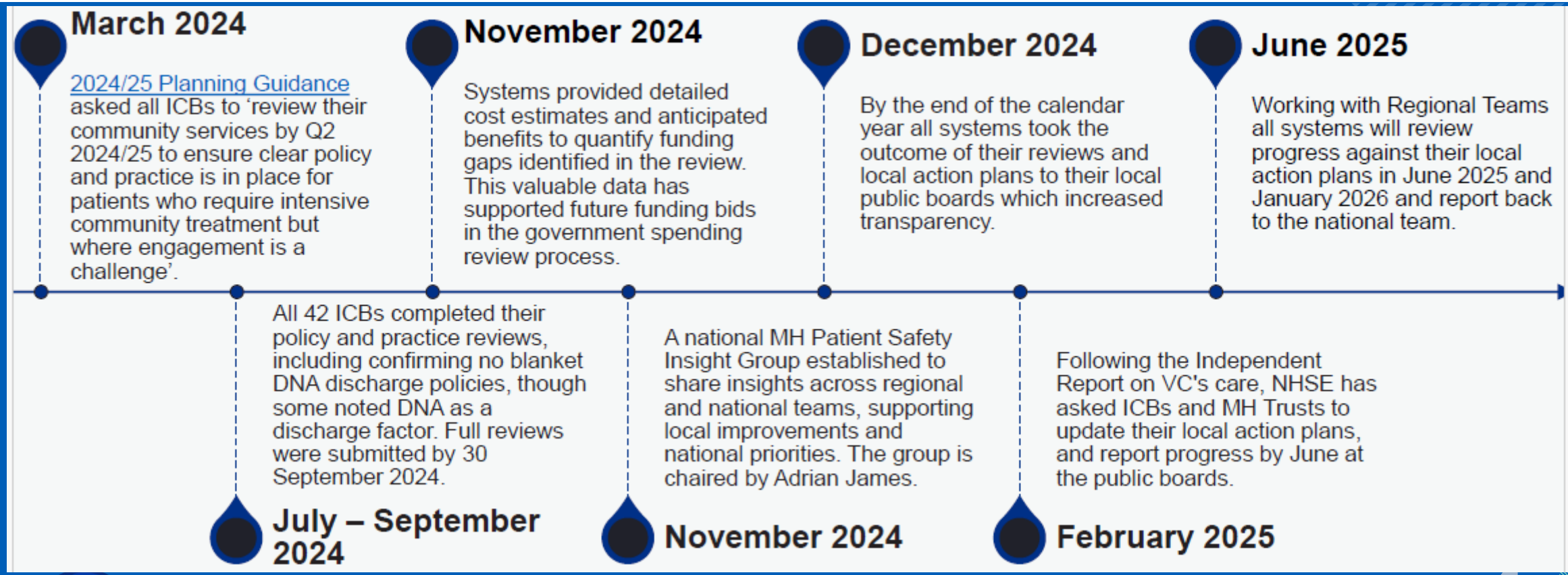
NHS Somerset

Background

- In 2023 three members of the public (Ian Coates, Grace O'Malley-Kumar and Barnaby Webber) were tragically killed by Valdo Calocane. Valdo Calocane had been a patient of Nottinghamshire HealthCare Foundation Trust (NHFT).
- The Care Quality Commission (CQC) completed a final review of Nottinghamshire HealthCare Foundation Trust mental health services and asked all other systems to undertake a review of local services considering the CQC recommendations.
- Subsequently, NHS England asked all systems to review their Intensive and Assertive Community Treatment for people with severe mental illness who require treatment but where engagement is a challenge.

NHS Somerset

Timeline



Action Plan

- Somerset's action plan was presented to the ICB and Trust Boards in November 2024.
- The action plan was refined with Experts by Experience.
- A multi-agency and multi-professional Serious Mental Illness group was established to oversee delivery and further development of the action plan.

NHS Somerset

Guiding Principles

Key workers

Every service user should have a skilled key worker within an MDT to provide personalised care, monitor early relapse signs, and implement appropriate interventions.

Assessments

Assessments should prioritise psychological and physical safety, incorporating risk formulation.

Care plans

Care plans must be reviewed at least every six months, with effective collaboration across agencies. Care plans should detail clear pathways for escalating care when needed.

Carer and family engagement

Services must actively involve both the individual and their support network, where appropriate, in care planning, treatment, risk management , and transitions in care even where direct information sharing is restricted.

Supporting people during times of hospitalisation

Key workers must maintain contact during inpatient stays, offering continuity of care.

Staff need to have the right level of skill and competency

Training should ensure that staff possess the necessary competencies in engagement techniques, risk assessment, trauma-informed care, and managing co-occurring conditions such as substance misuse.

Care delivery

Dedicated Assertive Outreach Teams do not need be in place; however, community teams need to ensure they can provide dedicated provision for this patient group.

Governance

Governance structures, from ICBs to service-level procedures, must proactively identify, communicate, and mitigate risks

Multi-agency working

A multi-agency approach to information gathering is required, ensuring that decisions about patient care are informed by data held across the health, social care, and criminal justice systems.

Independent Mental Health Homicide Investigation - Feb 2025

Systems were asked to review and update plans, paying particular attention to:

- **Personalised assessment of risk across community and inpatient teams. Work includes:**
  - Dialog + as a care plan that reflects personalised care in a dynamic manner; used across MH services
  - Establishment of risk formulation recording in line with NICE guidance with expectation for every patient to have a personalised safety plan
  - Forensic Link workers embedded in the community and inpatient teams
  - Creation of high risk of harm to others patient list with oversight from senior leadership team
  - Embedded Risk to Others training

Independent Mental Health Homicide Investigation - Feb 2025

Systems were asked to review and update plans, paying particular attention to:

- **Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies). Work includes:**

- Developing transitions pathways that ensure continuity of care between inpatient and community with appropriate follow ups
- S117 policy update includes management of transitions
- Reviewing and enhancing discharge checklists and guidance
- DNA SoP in place and DNA and Disengagement meetings already in place

Independent Mental Health Homicide Investigation - Feb 2025

NHS Somerset

Systems were asked to review and update plans, paying particular attention to:

- **Multi-agency working and information sharing. Work includes:**

- Use of SIDER for information sharing between GPs, MH and some acute services
- VCFSE access to RiO
- Develop and recruit Public protection lead role
- Fund and recruit Organisational MAPPA lead
- Multi-Agency Risk Management Meetings (MARM); Safeguarding driven
- Creative Solutions Panel; multi-agency attendance including social care, housing, etc

Independent Mental Health Homicide Investigation - Feb 2025

Systems were asked to review and update plans, paying particular attention to:

- **Working closely with families. Work includes:**

- Trust wide initiative ‘People who Matter’
- Family Liaison Workers embedded in wards
- EbE involved and actively contributing to SMI action group
- Personalised safety plans involve families and carers
- More work is needed

Independent Mental Health Homicide Investigation - Feb 2025

NHS Somerset

Systems were asked to review and update plans, paying particular attention to:

Eliminating Out of Area Placements in line with ICB 3-year plans. Work includes:

- Low user of out of area placements (OAP) already
- Transformation work
- Escalation process embedded for when OAP is required

Wider Work: Homicide prevention

A homicide prevention project has been underway for 3 years.

Work includes:

- Review of all patients with significant risk to others - either by the Forensic team or Forensic Liaison workers
- Development of new policies and procedures
- Risk to others training by forensic service colleagues
- Working more closely with families
- Improved multiagency working.
- A risk of harm to others oversight group

NHS Somerset

ICB Risk 682

Description:

If the ICB is unable to identify funding for assertive outreach, then the Somerset system may be unable to comprehensively respond to the learning identified in the nationally mandated (…) review, resulting in capacity issues in mental health, leading to serious incidents, significant regulatory scrutiny, or poorer outcomes for people with serious mental illness.

(Logged in October 2024)

NHS Somerset

Risk Controls

1) Multi-agency development and review of the Assertive and Intensive Treatment document.

2) Review of the document by NHS England, with feedback.

3) Action plan in place.

4) Discussion at the ICB Board and associated sub-committees.

5) Somerset NHS Foundation Trust led steering group in place, with multi-agency representation as appropriate.

6) Risk recorded on Trust's risk register.

7) Reference and steering groups in place to review plans and gain assurance on delivery - chaired by Associate Medical Director.

8) Progress reviewed at Mental Health Service Group governance meetings on a two monthly basis, and quarterly at the system Mental Health, Autism and Learning Disability Programme Board.

Gaps in controls

- 1) Financial challenge - no current finance streams identified to respond to the issues raised.

- 2) NHSE advise systems to focus on short-term actions with minimal resource implications.

NHS Somerset

Next steps

- SMI Clinical Lead appointed but will require time and support to familiarise with progress already made and gaps identified.

- Action plan must be strengthened to better address the following:
  - Improved data quality
  - Multi-agency working and information sharing
  - Working closely with families
  - Eliminating Out of Area Placements in line with ICB 3-year plans

- Progress will be reviewed with NHSE in June 2025 and again in January 2026