

BOARD MEETING

Title	Independent Mental Health Homicide Review		
Paper Date:	02 July 2025	Board Meeting Date:	08 July 2025
Purpose:	Discussion	Agenda Item:	10
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Executive Summary

Following the conviction of Valdo Calocane and the subsequent Care Quality Commission (CQC) review into mental health services in Nottingham, a series of significant recommendations were made to NHS England (NHSE). These events underscored critical system-wide failings in the identification, engagement, and treatment of individuals with severe mental illness—particularly those experiencing psychosis and disengaged from conventional mental healthcare pathways.

In response, NHS England published new guidance for Integrated Care Boards (ICBs) in July 2024 – later updated in February 2025 – focused on enhancing intensive and assertive outreach for people experiencing psychosis who are not fully engaged with mental health services. The guidance recognises that traditional service models often struggle to meet the complex needs of individuals where symptoms such as paranoia create barriers to accessing evidence-based care and treatment. NHSE called for a proactive, flexible, and person-centred approach that includes continuity of care, a broader range of treatment options, and adaptive methods of engagement.

Between July and September 2024, a comprehensive evaluation using NHSE's maturity matrix was undertaken to assess current Assertive Outreach service provision. This assessment identified service delivery gaps and informed the development of clear priority areas and actionable plans. The overarching aim is to maximise engagement with individuals who are difficult to reach, thereby reducing reliance on acute care pathways, preventing hospital admissions, shortening lengths of stay, and decreasing involvement with the criminal justice system.

The approach is centred on delivering goal-directed interventions that improve clinical and social outcomes, while enhancing the involvement of families and carers throughout the care process. This marks a renewed commitment across systems to deliver integrated, responsive, and recovery-focused mental health support for some of the most vulnerable individuals in society.

The purpose of this paper is to provide assurance on the current areas identified for development and the action plans developed to address them.

Action Required

The board are asked to:

- Note the information regarding the Independent Mental Health Homicide Review into the tragedies in Nottingham.

<ul style="list-style-type: none"> Take assurance in relation to the actions undertaken by NHS BOB, Berkshire Health Care Foundation Trust and Oxfordshire Healthcare Foundation Trust to respond to the new national guidance on intensive and assertive community mental health treatment
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Conflicts of Interest:	No conflict identified
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Date/Name of Committee/ Meeting, Where Last Reviewed:	The paper will be discussed at System Quality Group on 16 July 2025. It has been reviewed by the relevant Trust Boards.
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Independent Mental Health Homicide Review

Context

1. On 5 February 2025 NHS England published an Independent Mental Health Homicide Investigation into the tragedies in Nottingham in June 2023 when Barnaby Webber, Grace O'Malley-Kumar and Ian Coates lost their lives. The report highlights instances where Valdo Calocane, an individual experiencing serious mental illness, was failed by mental health services, which had devastating consequences.
2. The publication of the Independent Investigation follows a Care Quality Commission (CQC) special report, published in two parts on 26 March and 13 August 2024, which highlighted findings from a rapid review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT). The reports specifically emphasized the need for policies and practices that support proactive engagement of people with severe and relapsing mental illness, ensuring they receive the care they need, and that DNAs (did not attend) are never used as a reason for discharge from care.
3. Since the publication of the CQC special report in August 2024, work has been undertaken in BOB and all Integrated Care Systems (ICSs) to review and improve intensive and assertive community treatment for people with serious mental illness, in light of learnings from the tragedies in Nottingham. BOB ICB, Oxford Health NHS Trust (OHFT) and Berkshire Healthcare NHS Trust (BHFT) completed an audit of compliance against national guidance in September 2024.
4. In October 2024, NHS England asked systems to develop proposals and identify the resource gap to achieve full compliance with national guidance. In response, a proposal was developed by the two Trusts and signed off by the ICB. Subsequently, there has been no additional funding received to support this work.
5. Following the publication of the Independent Mental Health Homicide Investigation in February 2025, all ICBs and all Trusts were to present an update to their public Boards by June 2025 to provide assurance on the improvement work in local systems.
6. The purpose of this paper is to provide assurance on the current status, plan, and resource implications of Assertive Outreach (AO) and Intensive Community Mental Health Care for individuals with serious mental illness – particularly those at high risk who are not effectively engaging with standard services across BOB ICS.

National recommendations

7. The CQC Special Report Part 1 (March 2024) assessed the patient safety and quality of care provided by Nottinghamshire Healthcare Foundation Trust (NHFT), including community mental health services and inpatient services at Rampton Hospital. The report highlighted areas of concern, including staffing levels, leadership, demand for services, and access to care. It made a series of recommendations to the Trust to ensure that its services do more to provide safe care and treatment within reasonable waiting times, and protect patients, families, and the public from the risk of harm. The report notes that other community mental health services may be facing many of the same challenges as NHFT.
8. The CQC Special Report Part 2 (August 2024) reviewed the available evidence related to the care of Valdo Calocane during the period he was under the care of NHFT. Rather than a single point of failure, the report identifies a series of omissions and errors of judgment that contributed to a situation where a patient with serious mental health issues did not receive the support and follow-up he needed. Key themes identified were assessing and managing risk in the community, the

quality of care planning and engagement, medicines management and reviews, discharge planning, and managing people who find it difficult to engage with services.

9. NHS England published Guidance on intensive and assertive community mental health treatment (July 2024), linked to the findings from the CQC special report in Nottingham, to support all local systems in reviewing the policies and practices in place for people with severe and relapsing mental illness. The guidance emphasizes the specific actions that services need to take to ensure that people are receiving and engaging in the care they need, and that people who DNA (did not attend) are never used as a reason for discharge from care for this vulnerable patient group.
10. Within the guidance, NHS England defined the cohort of individuals that may require intensive and assertive community treatment as follows:
'People presenting with psychotic symptoms (irrespective of diagnosis) who are known to mental health services presenting with repeated mental health inpatient admissions. There is involvement with multiple partner agencies/services and the person has multiple social needs (housing, finance, self-neglect, isolation). The person often presents with co-occurring drug and alcohol problems, and may not respond to, want to, or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms. The person is vulnerable to relapse and/or deterioration with serious related harms associated not limited to violence and aggression. The person requires responsive and intensive pro-active support. Concerns may have been raised by family / carers.' (NHS England, 2024)
11. The Independent Mental Health Homicide Investigation (February 2025) reiterates the findings regarding assertive community treatment and active engagement, and makes the following additional recommendations to be addressed within local action plans:
 - 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.
12. NHS England has accepted the national recommendations in the report in full and has taken steps to implement the two national recommendations from the independent review:
 - Care delivery: That there is sufficient resource, for community models that provide safe and effective delivery of care, and that services for people with serious mental illness are in line with evidenced based practice, and co-produced by people with lived experience;
 - Risk: That there are mechanisms in place to understand clinical risk, share information, and that there is a dynamic approach to risk management, based on individual need.

BOB review of intensive and assertive community mental health treatment

13. During August and September 2024, a review process was undertaken to assess the compliance of the BOB system with the new guidance on intensive and assertive community mental health treatment (July 2024).

Berkshire Health Care Foundation Trust's response

14. BHFT identified the following areas of development for the Assertive Outreach (AO) and Intensive Case Management (ICM) models in Oxfordshire and Buckinghamshire and how the Trust plans to address them as set out in Tables 1 and 2 below.

Table 1	
Developmental Areas	BHFT's Response
Analysis and Implementation	BHFT has thoroughly reviewed the guidance on intensive and assertive outreach and has implemented key actions, with further actions planned
Model Enhancement	The Trust is scoping enhancements to its service model, with an update expected in Q1 2025/26.
Operational Challenges	Key challenges include: <ul style="list-style-type: none"> • Inconsistent availability of Shared Care depot medication agreements with Primary Care. • Limited collaboration with Local Authority-commissioned substance misuse providers due to resource constraints preventing joint assessments and outreach work.
Standalone AOT Model Limitation	BHFT cannot provide a standalone AOT model despite evidence of its effectiveness. A costed proposal was submitted, but no funding has been allocated by NHSE or ICB. Current plans focus on enhancing existing services, though this carries risks regarding the capacity of CMHTs, CRHTTs, and specialist teams.
Workforce Strain	The current approach, while maximizing safety within available resources, lacks the dedicated staffing and capped caseloads of a standalone AOT model. The operational burden may impact consistent delivery of intensive outreach.
Named Workers and Caseloads	BHFT is embedding 'named workers' for individuals with serious mental illness. NHSE suggests a capped caseload of 15 per worker, but current plans do not confirm this. Feasibility must be assessed, and a standardised safer staffing tool is recommended to support this assessment.

Table 2	
Area of Focus	BHFT's Response
Proactive Safety Work	Much of BHFT's activity predates the Nottingham review, informed by internal safety intelligence, PSIRF work, NICE guidance, and responses to serious incidents (e.g. Forbury Gardens homicides).
Alignment with Review	The Trust has taken early initiative on these matters and has strong assurance in progress that aligns with key Nottingham review recommendations.
Continuity of Care	The Named Worker function is crucial for reducing duplicate assessments. Emphasis is needed on collaborative care planning between community and inpatient teams during hospital stays to support safe discharge and long-term treatment.
Peer Support	Current plans lack explicit focus on peer support, despite its mention in the Nottingham review. Integration of supervised peer workers should be considered.
Staff Training Assurance	Assurance is recommended that staff training includes co-morbidities, substance misuse, social factors, and legal frameworks (e.g., CTOs, MHA, s.117).
Governance and Oversight	Strong focus and governance, with oversight through the Quality and Performance Executive Group and the Trust Board.

Oxfordshire Health Care Foundation Trust's response

15. OHFT identified the following areas of development for the Assertive Outreach (AO) and Intensive Case Management (ICM) models in Oxfordshire and Buckinghamshire and how the Trust plans to address them as set out in Tables 3 and 4 below.

16. OHFT has advised of a two phased approach with phase 1; focusing on assurance and model development including policy review, maturity index assessment and cost modelling and phase 2: focusing on establishing a structured programme to implement AO/ICM across Buckinghamshire and Oxfordshire including governance and oversight within 6 core workstreams in Table below.

Table 3	
Developmental Areas	OHFT's Response
Identification of Patients (Data & Analytics)	<ul style="list-style-type: none"> • Use of a data-driven algorithm incorporating indicators such as repeated hospital admissions, DNA rates, disengagement, and known risk factors. • Develop a shared, visual population dashboard to inform clinical decisions and track unmet needs.
Interventions and Workforce Development	<p>Planned approach to:</p> <ul style="list-style-type: none"> • Review caseload sizes and Multi-Disciplinary Team (MDT) working structures. • Align workforce training and capabilities to national specifications (e.g. trauma-informed care, motivational interviewing). • Clarify what interventions are most effective and feasible.
Service User and Community Involvement	<p>Approach to be taken includes</p> <ul style="list-style-type: none"> • Co-production with Experts by Experience (EbEs), including those from underrepresented groups. • Build on Oxfordshire's early engagement work to incorporate feedback from those who are seldom heard. • Engage carers and community groups in shaping service design and evaluation.
Partnerships and Cross-Agency Governance	<p>Better integration is needed across the Place system with the approach to be taken through</p> <ul style="list-style-type: none"> • Strengthening governance via Complex Case Forums with health, social care, housing, police and VCSE partners. • Clarify responsibilities, joint working expectations, and escalation processes.
Alignment on policy and procedures	<p>To ensure consistent and complaint care processes, there is a plan to:</p> <ul style="list-style-type: none"> • Review and standardise Standard Operating Procedures (SOPs) across teams. • Align care planning, safeguarding, and discharge processes with best practice and CQC expectations.
Clinical Assurance Processes	<p>To improve consistency and visibility of risk management, OHFT are planning to:</p> <ul style="list-style-type: none"> • Introduce clear clinical assurance systems, including thresholds for medication reviews, safeguarding concerns, and caseload supervision. • Use digital tools to track and audit these processes.

Table 4	
Area of Focus	OHFT Response
Data	Creation of an algorithm to identify patients with AO/ICM needs based on hospital admissions, risk factors, DNAs.
Interventions & Workforce Training:	Review of psychosocial interventions, caseloads, MDT working, and training alignment to national specs.
Experts by Experience Involvement	Engagement of Experts by Experience (EbEs), ethnic minorities and community groups in shaping services.
System Partnerships	Strengthening governance through complex case forums with system partners.
Governance and Policy Oversight	Review and alignment of standard operating procedures and care policies. Oversight at the Trust Board
Assurance Processes	Focus on risk, discharge, safeguarding, and medication management standards

Implications

17. Financial implications: The action plans have identified where funding would be required to fulfil the AOT model. It should be noted that most of the work is focused upon quality improvement of existing resources/policies and improved system collaboration.
18. Legal implications: Completing this work and ensuring that patients with a similar risk and engagement profile to Valdo Calocane are intensively and assertively followed up by community mental health services ensures equality of access to services, as per the requirements of the Equality Act 2010. Ensuring this response to these patients will also avoid a future incident of a similar nature to that which occurred in Nottingham, avoiding the regulatory and legal implications as have been seen there.
19. Other compliance: The review concluded that there is a reasonable level of compliance with the new national guidance on intensive and assertive community mental health treatment (NHS England, 26 July 2024), but actions have been identified to ensure that all teams are compliant.
20. Risks: The CQC special report and Independent Mental Health Homicide Investigation highlight the potential risks to patient and public safety and the need to ensure intensive and assertive community mental health treatment to mitigate this risk. The review of current policies and practice within BOB highlighted areas for improvement around clinical assurance processes and identification of patients most at risk.
21. Quality and Safety implications: The action plans arising from the review within BOB are focussed on improving the quality and safety of care for individuals with severe mental illness, in line with the national recommendations.
22. Equality, diversity, and health inequalities:
This work focuses upon a group of patients who may find advocating for themselves and their needs difficult due to the nature of the illness that they have. This work therefore addresses the potential health inequality experienced by this group of patients in accessing mental health care.
23. Patient and public engagement: The reviews have identified the necessity of production with Experts by Experience (EbEs), including those from underrepresented groups, incorporate feedback from those who are seldom heard and engage carers and community groups in shaping service design and evaluation.
24. Health and wellbeing implications: The work described above could potentially reduce the impact of this group of patients upon the wider health system in BOB. If, as is aimed, this group

of patients are engaged with services in an intensive and assertive way, this should result in a reduction in Emergency Department attendances at times of mental health crisis, as more assertive engagement should negate the need for this.

Conclusion

25. The CQC special review (August 2024) and the Independent Mental Health Homicide Investigation (February 2025) have highlighted significant issues with community mental health care which, without immediate action in local systems, will continue to pose a risk to patient and public safety. The corresponding review of policies and practice within the BOB system identified some areas for improvement to ensure full compliance with the new national guidance. The plans will continue to be monitored to ensure that BOB is compliant with the through the regular bilateral meetings with the Trusts and through the Mental Health Provider Collaborative governance architecture. Both Trusts have robust oversight and systems to monitor the delivery of their action plans. It is proposed to further strengthen the ICB's oversight of the action plans through discussion with the Mental Health Provider Collaborative which will be completed by August 2025.
26. NHS England is expected to confirm in June 2025 whether additional resource will be invested to support local systems to achieve full compliance with the guidance. Following this, compliance with the guidance will be reassessed in Q3 2025/26.

Asks of the Board or of members present

27. To note the information regarding the Independent Mental Health Homicide Review into the tragedies in Nottingham.
28. To take assurance in relation to the actions undertaken by NHS BOB, Berkshire Health Care Foundation Trust and Oxfordshire Healthcare Foundation Trust to respond to the new national guidance on intensive and assertive community mental health treatment Input questions for resolution if required.