

Independent investigation into the care and treatment provided to VC

Nottinghamshire Healthcare NHS Trust and Nottingham & Nottinghamshire Integrated Care Board Action Plan.

	Area for improvement	Recommendation	Actions being taken by the Trust	Lead	Completion date
3.	<p>Recommendation implementation</p> <p>We are aware that there have been a number of reviews into Trust services, particularly over the last twelve months and there is considerable pressure on the Trust to improve services whilst delivering care for their population. We have not sought to duplicate recommendations but want to emphasise the importance of the Trust ensuring that implementing recommendations results in positive change to quality and safety.</p>	<p>The Trust should ensure that they have implemented the recommendations made by other reviews to date, including from the Serious Incident report and the Care Quality Commission. After a period of no longer than nine months from implementation, the Trust should seek to understand whether the changes made have had a positive impact on the quality and safety of care delivery. Views of those with lived experience must be integral to assure the robustness of the Trust's internal assurance process.</p>	<ol style="list-style-type: none"> 1. The actions from the reviews will be fully implemented. 2. The Trust has an Integrated Improvement Plan overseen by the Trust Board which has a dedicated programme on Patient Safety and Quality Improvement. We will ensure the themes from all the reviews will be addressed in that plan. 3. An Executive Oversight Board is to be established with membership including senior clinicians, patients and carers and the ICB will oversee the learning and improvement from all of the reviews. Internal assurance processes will be fully aligned with external and system groups. 4. Embedding sustainable improvement will include: <ul style="list-style-type: none"> • Learning and evaluation events with staff, patients and carers • Conference in early summer • Launch and implementation of the Patient Safety Strategy • Developing a suite of opportunities for learning from patient safety, such as preceptorship, staff induction. 5. Measuring the impact and effectiveness of the change by: <ul style="list-style-type: none"> • Completion of quality and safety reviews • Gaining patient and carer feedback on the impact of the changes • Completion of audits to measure improvement • Utilising the metrics reported in Safenow and patient experience to inform progress • Impact of the actions will be monitored, overseen and reported to the Quality Committee. 	<p>Deputy Chief Nurse Trust Board</p> <p>Chief Nurses from the Trust and ICB</p> <p>Deputy Chief Nurse, Directors of Nursing and Patient Safety</p>	<p>April 2025</p> <p>In place</p> <p>March 2025</p> <p>September 2025</p>
4	<p>Serious Incident Policy</p> <p>We found that the Trust's serious incident policy is</p>	<p>The Trust needs to ensure that its Patient Safety Incident Response is in line</p>	<ol style="list-style-type: none"> 1. The Trust published their Patient Safety Incident Response Policy and Plan in April 2024, this policy outlines how we they have improved capacity to 	<p>Associate Directors of Patient Safety</p>	<p>March 2025</p>

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	not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.	with NHS England's new Patient Safety Framework (PSIRF). Processes should be developed to ensure that subsequent lessons have been embedded in clinical practice and corroborated and supported by people who use the services, their families, carers or support network.	<p>improve; by identifying trends, evidencing actions taken, embedding improvements.</p> <ol style="list-style-type: none"> 2. The Reporting, Management and Learning from Incidents Policy, which replaces the Serious Incident Policy has been written and is in the process of consultation with all key partners. Its focus is on engagement and improvement. The policy describes a patient safety governance process where learning is shared from 'ward to board', which will ensure we are able to embed learning into practice. 3. The increased use of available data in a user-friendly format to enhance people's ability to understand, resolve and improve care and to ensure that the changes made can be monitored to ensure that they are impactful and embedded, 4. Themes and lessons from reviews, and incidents will be shared as part of the implementation of a continuous cycle of differing communication avenues to provide learning opportunities through briefings and learning events for staff, patients and families 5. Introduction of the Patient Safety Specialist and PSIRF training programme which is supported by the PSIRF training syllabus 6. Introduction of the Patient Safety Partner to begin to develop a framework for involving patients in patient safety and ensuring that learning is corroborated and supported by people who use services (also see actions in relation to recommendation 8) 7. An internal audit completed by an external company is currently being completed which is evaluating the Trust implementation of PSIRF. 		
5	Family engagement We found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not	The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services,	<p>The Trust recognises that engagement is central to all improvements. In recognition, it has appointed an Associate Director of Participation, Co-Production, and Patient and Carer Experience.</p> <p>This person will:</p> <ol style="list-style-type: none"> 1. As part of the strategy, appoint a Lead for Carer Involvement and will lead on a range of innovations 	Associate Director of Participation, Co-Production, and Patient and Carer Experience.	September 2025

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	<p>discussed with them. We also found that there were opportunities to co-produce aspects of care planning with VC and his family, particularly around safety and scenario planning.</p>	<p>their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (i.e. the Triangle of Care¹ and the Patient and Carer Race Equality Framework²), to support effective family engagement. The new processes should inform decisions on care, treatment and the management of both safety and risks.</p>	<p>such as, appointment of a Trustwide carer lead, develop carer drop-ins, carer corners (inpatients)</p> <ol style="list-style-type: none"> 2. Lead the development of an innovative, creative participation strategy. This will be co-developed with patients, carers, the community and staff 3. Increase the number of carer support workers 4. Aim to triple the number of volunteers working in our services 5. Include in the Carers Strategy the development of introduction/ information booklets 6. Ensure this work will be underpinned by the Patient and Carer Race Quality Framework (PCREF) 7. Arrange engagement event for carers scheduled for mid-February 8. Create brief videos developed for staff about the importance of involving carers 9. Co-produce sessions to be included on the Trust induction about the importance of working with carers. 10. Implementation of the Personalised Care Policy and associated training (detailed in recommendation 11) ensure that people are involved in all aspects of care planning. <p>The impact will be measured by:</p> <ul style="list-style-type: none"> • Production and implementation of the Involvement Strategy • Increase in the number of peer support workers and their involvement in key aspects of the day-to-day work such as embedded in clinical teams, involvement in Quality and Safety Reviews • Feedback forums for peer support workers and volunteers • Included in Complaints response letters, asking if people would like to be involved in the Trusts improvement journey. 		

¹ [The Triangle of Care \(carers.org\)](http://carers.org)

² [NHS England » Patient and carer race equality framework](#)

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			<ul style="list-style-type: none"> The reduction of complaints where lack of engagement is raised. Increased volume of personalised care plans demonstrating people's involvement in their care. 		
6	<p>Clinical information sharing We found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.</p>	<p>The Trust should develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share.</p>	<ol style="list-style-type: none"> The trust will ensure that its internal systems are interoperable and allows sharing of related patient data across all care groups and settings. The Trust has already ensured that continuity of care principles is embedded with private inpatient providers of sub-contracted beds, (which includes access to RiO) and this is now stipulated within contracts, enabling robust oversight. The Trust will review and strengthen the electronic information sharing processes with Primary Care and other providers, such as discharge summaries. The ICB and the Trust will establish a multi-agency working group with key partners to develop and strengthen current processes. The multi-agency group will: <ul style="list-style-type: none"> Review information shared across discharges and or shared pathways Identify how information and communication can be developed leading to improved shared clinical decision making Review of Memorandums of Understandings, Information Sharing Agreements, and mechanisms for sharing information with partners Develop a multi-agency plan for improving interoperability of information sharing systems. 	<p>Deputy Chief Nurse and Chief Digital Information Officer</p> <p>Deputy Medical Director</p> <p>Chief Nurses from the ICB and Trust</p>	<p>September 2025</p> <p>June 2025</p> <p>September 2025</p>
7.	<p>Across organisational working We found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full</p>	<p>The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes</p>	<ol style="list-style-type: none"> The Trust, the ICB, the police and system adult safeguarding partners will work together to undertake a review of existing communication policies, and assess <ul style="list-style-type: none"> Reliability of process Effectiveness and impact of information shared Opportunities for key information sharing points to be maximised 	<p>Chief Nurses for the ICB and Trust and ACC Nottinghamshire Police</p>	<p>June 2025</p>

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	understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.	across all system partners relevant to mental health care, treatment and risk management.	<p>A review of Memorandums of Understandings, Information Sharing Agreements and mechanisms for communication</p> <p>2. A review of Trust policies and processes to ensure there is a focus on engagement with external providers and mechanisms for families to remain engaged.</p>	Deputy Chief Nurse	September 2025
8	<p>Governance arrangements</p> <p>In this case, we identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.</p>	<p>Recommendation</p> <p>The Trust and the Integrated Care Board should seek existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.</p>	<p>The Trust have implemented a range of strategies to improve reporting, increase transparency of risk management processes and governance. To achieve a shared understanding, these changes have been completed in conjunction with our partner organisations. The changes the Trust have implemented are summarised as follows:</p> <ol style="list-style-type: none"> 1. Change in the focus of the Trustwide Significant Incident Review Group to enable improved oversight by including safeguarding and legal incidents, sharing learning and agreeing actions with clinical and service leads 2. Rapid Improvement Groups have been established which provide oversight and assurance of improvement plans. Progress is reported to the Quality Committee and the Integrated Improvement Board 3. Improvement, Oversight and Assurance Group with our system partners 4. Implementation of the Safe Now Dashboard which provides clinical services with information on a range of care, quality and safety measures. This provides early triangulation of areas of potential risk requiring a response. <p>To improve Ward to Board reporting the Trust has implemented a range of new Patient Safety Governance processes, including:</p>	<p>Deputy Chief Nurse, Deputy Medical Director, and Chief Digital Information Officer.</p> <p>Chief Nurse and Patient Safety Associate</p>	<p>June 2025</p> <p>June 2025</p>

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			<p>1. Patient Safety and Learning from Deaths Group to triangulate data and identify emerging issues</p> <p>2. Care Group Safety and Experience meetings which are localised service specific governance meetings reporting to the Patient Safety Group</p> <p>3. Complex Incidents Oversight Group which is attended by senior clinical leaders</p> <p>4. Full implementation of PSIRF which includes revised PSIRF panel whose role is to scrutinise and sign off completed investigations and reviews</p> <p>5. Quality assure Patient Safety papers presented to the Quality Committee.</p> <p>Next steps</p> <p>1. Deliver updated Quality Governance and accountability framework, aligning to all Care Groups.</p> <p>To improve ICB oversight and the ability to identify and communicate potential and existing issues and risks the ICB have:</p> <ul style="list-style-type: none"> • Used the safe now dashboard to identify, triangulate risks and issues and undertaken appropriate enquiries • Established a system risk register to ensure that strategic risks are collectively understood and owned • Established a patient safety specialist forum to support PSIRF implementation and learning. <p>Next steps</p> <ul style="list-style-type: none"> • Continued iteration of safe now as a data driven assurance tool • Embed a new oversight approach within the ICB to ensure that operational, performance and quality metrics are triangulated in regular internal meetings • Implementation of regular reporting of trust metrics into the system quality group to enable dynamic system risk assessments 	<p>Director of Patient Safety</p> <p>Deputy Chief Nurse</p> <p>Chief Nurse ICB</p>	<p>June 2025</p> <p>April 2025</p>

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			<ul style="list-style-type: none"> • Formalisation of system clinical safety huddles • A commitment to review the approaches utilised by Multi Agency Public Protection Arrangements (MAPPA) and Dynamic Support Registers (DSRs) to see what we can learn from their shared escalation processes. 		
9	<p>Policy development and review We found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day to day practice. In a number of instances, there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.</p>	<p>The Trust should ensure that all Trust policies are current, updated and written in a manner that enables staff to practice in line with the policy. Where appropriate, policies should be co-produced with people with relevant lived experience. Policies should include clear guidance for escalation when key deliverables within the policy are not able to be achieved. The Trust should have processes in place to trigger requirements for renewal or review.</p>	<p>The Trust will undertake a comprehensive review of all policies and procedures which will include:</p> <ol style="list-style-type: none"> 1. Reviewing the governance structures for the development ratification and implementation of policies and procedures, which will include ensuring that triggers are embedded for timely review of existing and agreed policies. 2. The review or development of each policy will include a person with lived experience as a co-author. 3. Clear, concise and accessible guidance for patients, families and staff through the development of 'policies on a page'. 4. Staff will be informed of changes to policies through briefing ward/team meetings supported by policy on a page. 	<p>Deputy Chief Nurse, Deputy Medical Director and Corporate Lead for Policies.</p>	<p>September 2025</p>
10	<p>Peer support In VC's case we found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural</p>	<p>As part of the implementation of the community mental health framework, the Trust should ensure that there is a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. To facilitate a meaningful effective peer</p>	<ol style="list-style-type: none"> 1. The Participation Strategy will build on the current work and expertise of Peer Support workers, expanding the breadth and diversity of these to ensure that people are able to access culturally appropriate groups. 2. The Associate Director will lead the work to ensure robust and supportive systems are in place for the recruitment, enhanced supervision and support plans, training for Peer Support workers and the important role they have in working with our patients. 3. The Peer Support Workers along with our volunteers will participate in our Quality and Safety Reviews, thereby ensuring the voice of the patient and carer is central. 	<p>Associate Director of Participation, Co-Production, and Patient and Carer Experience.</p>	<p>September 2025 and January 2026</p>

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	background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.	support offer, the Trust must consider and have robust mechanisms for recruitment, training, support and supervision and role structure including peer leadership.	The effectiveness of the Participation Strategy will be reviewed in 12 months' time by evaluating the progress against the key aims of the strategy.		
11	Care planning We found limited evidence that care planning arrangements were co-produced with VC and his family. Building on are of improvement 5, once the Trust has developed the family engagement offer, arrangements need to be put in place to ensure co-production of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family.	The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.	<ol style="list-style-type: none"> 1. Implementation of the Personalised Care Policy and associated training. This includes safety planning, risk assessments, safe discharge, and care planning. 2. Implementation of the new Clinical Risk Training which incorporates risk to self, risk to others, vulnerability and neglect. 3. Implementation of Dialog+ care plan which is patient centered with a focus on change. 4. Develop policy on a page guidance for co-production of care and safety plans. 5. Review the care plan template on RiO to ensure they meet the standards for co-produced care plans and written in a language accessible for patients and their families. 6. Deliver co-produced training, delivered by people with lived experience which includes Talking Heads, on co-production of care and safety planning. 7. This work will be supported by the implementation of recommendations 5 and 10. 8. After 6 months, complete a deep dive audit of random selection of care plans. 9. Quality of care plans will be incorporated into clinical supervision policy and guidance. 	Care Group Nurse Directors for Mental Health Community and Nurse Consultant for Suicide, Self-Harm and Clinical Risk.	September 2025
12	Joint clinical decision making We observed that inpatient services did not appear to always pay sufficient regard to some potentially	The Trust needs to ensure that the voice of all of those involved in the care and treatment of an individual is heard and considered within the context of the long-term	<ol style="list-style-type: none"> 1. The Trust is committed to implementing the Culture of Care standards for inpatient wards. To further this work, this will also incorporate quality standards for ward reviews and discharge, with the emphasis being on equal partnership. 	Care Group Nurse Director for Mental Health Inpatient and Community	September 2025

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	<p>important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.</p>	<p>planning for an individual's care and treatment. Where consensus is not reached about the best plan of action, there needs to be a clear process to escalate views for further consideration. All professionals need to feel empowered to challenge decisions and have the appropriate mechanisms to do so.</p>	<p>2. The Service Guide for Acute Mental Health wards and Community Services will be reviewed to describe expectation of each professional role in the MDT, and how these interface particularly, through discharge meeting and methods to ensure a seamless pathway. This will include a clear escalation process when views differ.</p>		