NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

Our Ref: PW/KJJ/FOI/0226/1607

16th March 2026

Smithfield One
Leonard Coates Way
Hanley
Stoke-on-Trent
ST1 4FA
Telephone: 0300 123 146

Sent by email

Dear

FOI/0226/1607
Your request for information under the Freedom of Information Act 2000

Thank you for your request for information under the Freedom of Information Act 2000, received on the 5 February 2026.We can now confirm that the Staffordshire and Stoke-on-Trent Integrated Care Board can provide the following information.

An anonymised copy of this response will be made publicly available on the ICB website. Please note the ICBs responses in blue text.

I understand from publicly available reports that concerns were raised by North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership NHS Foundation Trust (MPFT) regarding adherence to the Right Care, Right Person (RCRP) process. The Integrated Care Board (ICB) subsequently:

- **Undertook an initial review which identified four cases where the RCRP process may not have been followed, and**
- **Commissioned a joint thematic review in collaboration with the Police, the Police Fire and Crime Commissioner, NSCHT, and MPFT, focusing on the application of RCRP processes.**

Under the Freedom of Information Act, please could you provide the following:

1. **A copy of the initial review into the four cases referenced above, including any findings or summary notes.**
   The ICB are not the data owners for this information, in order to obtain this information you will need to submit your request directly to the following providers:
   - West Midlands Ambulance Service (WMAS) – foi@wmas.nhs.uk
   - University Hospitals of North Midlands (UHNM) – foi@uhnm.nhs.uk
   - Midlands Partnership Found Trust (MPFT) – foi@mpft.nhs.uk
   - North Staffordshire Combined Healthcare Trust (NSHCT) – foirequests@combined.nhs.uk

2. **A copy of the joint thematic review report (or the latest available version) conducted by the ICB in collaboration with North Staffordshire Combined Healthcare NHS Trust (NSCHT), Midlands Partnership Foundation NHS University Trust (MPFT), the Police, and the Office of the Police, Fire and Crime Commissioner.**
   Please find attached a copy of the report which was presented to the ICB meeting in January.

Please note that after reviewing the attached document we have to come a conclusion that certain information had to be redacted according to Section 40(2) (Personal Information) and Section 41 (Information Provided in Confidence) of the Freedom of Information Act 2000, which are both absolute exemptions and therefore no PIT is required. Therefore, certain information has been withheld under S41 as it was provided in confidence and disclosure would constitute an actionable breach of confidence. Certain information has been redacted under S40(2) as it constitutes personal data relating to identifiable individuals.

3. **The independent specialist review report commissioned by the ICB to provide assurance regarding the learning and mitigations identified in that thematic review. If the independent specialist's review has not yet been completed, please provide the expected date for its completion.**
   The ICB does not hold this information as a specialists review has not been commissioned.

If full disclosure of any report is not possible, please provide:

- A redacted version, or
- A summary or executive overview that outlines key findings, lessons learned, and actions taken.

Should you require any further information or clarification regarding this response please do not hesitate to contact us. If you are dissatisfied with the response, you are entitled to request an internal review which should be formally requested in writing and must be within 40 working days months from the date this response was issued.

To request an internal review

You can request an internal review by contacting the Staffordshire and Stoke-on-Trent ICB FOI team by emailing; staffsstokeFOI@staffsstoke.icb.nhs.uk or by post to the address at the top of this letter within 40 working days of the initial response.

If you are not content with the outcome of your internal review, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the Staffordshire and Stoke-on-Trent Integrated Care Board's FOI complaints procedure.

The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
www.ico.gov.uk

Yours sincerely

Vasileia Pitarokoili
Head of Governance

Enc.

Staffordshire and Stoke on Trent
Multi- Agency
Patient Safety
Thematic Review/Deep Dive

Distribution list

Incident ID number:	Multiple across systems
Date incident occurred:	7-10-24 to 3-3-25
Report approved date:	12/11/25
Approved by:	UHNM MPFT NSCHT WMAS SSOT ICB Staffordshire Police

Name	Position and Organisation	
SSOT ICB		Chief Nursing and Therapies Officer
NSCHT		Chief Nurse
UHNM		Chief Nurse
MPFT		Chief Nurse
WMAS		Chief of Staff and Head of Enhanced Care Patient Safety Specialist
Staffordshire Police		Assistant Chief Constable

About Multi- Agency Patient Safety Thematic Review/Deep Dives

A multidisciplinary team (MDT) or Multi Agency review supports health and social care teams to:

1. Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents)

2. Agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.

3. To explore a safety theme, pathway, or process.

4. To gain insight into 'work as done' in a health and social care system.

By 'work as done' we mean how care is delivered in the real world, not how it is envisaged in policies and procedures (work as prescribed) or recounted in a walk through or a talk through (work as described).

We have used the SEIPS (Systems engineering initiative for patient safety) 1 framework (see https://www.england.nhs.uk/wp-content/uploads/202SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf) to structure the MDT Review.

Healthcare is complex because it is highly variable, uncertain, and dynamic. It is a socio-technical system which is characterised by multiple interactions between various components, both human and technological. SEIPS is a framework for understanding outcomes within complex socio-technical systems.

MDT reviews are most useful when a wide range of stakeholders share their perspective on 'work as done' in the health or social care system being analysed.

A note of acknowledgement

These distressing incidents have had a significant impact on patients, family carers and friends as well as on the staff involved. The investigation team want to thank everyone who has contributed in any way to either the provider investigations or this deep dive.

Thank you also to all members of the muti disciplinary, multi organisation investigation team who have demonstrated how effective a collaborative systems approach can be.

Executive summary

Incident overview

Escalations from North Staffordshire Combined Healthcare Trust (NSCHT) and Midlands Partnership Foundation Trust (MPFT) regarding what was felt to be a non-adherence of Right Care Right Person process were made both to the Mental Health Portfolio Team and the Quality Team at the ICB. This was followed by several staff employed at NSCHT raising similar concerns with the ICB Chairperson on a visit to the services. On initial review there were four instances where it was felt the Right Care Right Person process had not been adhered to and that in all four cases the patients had been found deceased. Each provider has followed their Patient Safety Incident Response Framework plan in reviewing each incident as related to them.

It was agreed following discussion with between the Police and the Fire and Police Commissioner, the ICB and MPFT and NSCHT that the ICB would facilitate a joint deep dive/thematic review into all four incidents specifically around RCRP processes.

Summary of key findings

1. System challenges and blockers contributed to delays in gaining access to properties to check on service users where there was concern for safety.
2. Whilst a full launch of phase one and two of RCRP had been undertaken by all of the three NHS Hospital providers and information shared within these organisations, there were apparent gaps in fully/robustly cascading the information to everyone relevant.
3. Whilst the Right Care Right Person process had been fully launched across the system the stepping down of the governance meetings for the process meant that there was no opportunity or ongoing joint governance to identify deficiencies in understanding in a timely manner.

It is, however, important to note that once providers reviewed these individual incidents multiple actions have commenced and there have been, to date, no similar incidents recorded (Since March 2025).

Summary of areas for improvement and safety actions

Area for improvement: Clear System Governance and Oversight for RCRP process and action plan.

Area for improvement: System approach to be designed and agreed so confusion and misunderstandings limited.

Area for Improvement: Relaunch of RCRP across system to ensure well socialised and understood.

Table of Contents

References

System Engineering Initiative for Patient Safety	https://www.england.nhs.uk/wp-content/uploads/202SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf
National Partnership Agreement Right Care Right Person	https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp
NHS Guidance on Implementing Right Care Right Person	https://www.england.nhs.uk/long-read/guidance-on-implementing-the-national-partnership-agreement-right-care-right-person/
Patient Safety Incident Framework	https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

Glossary of Terms

Term	Description
Patient safety incident response framework	This framework determines the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.
After Action Review	An After-Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links, or identify issues
Learning Response meeting	MPFT fortnightly meetings between the Patient Safety Team and individual Care Groups to enable collaborative discussion and decision-making regarding any incidents which may require a PSIRF learning response
Joint Learning Review	Learning responses in which system partners are invited to ensure that insight is gained across the patient's journey, and learning shared across applicable organisations
Comprehensive safety review	This is a proportionate review that allows the exploration of care utilising a chronology of care delivered, understanding the contributory factors using safety engineering initiatives in patient safety (SEIPS) to see how the deviation of care occurred and what are the learning opportunities that we can use to improve care delivery or celebrate the notable practice from our teams
Ambulance response times	All calls received within the Integrated Urgent and Emergency Care Operations Centres at WMAS are assessed in accordance with the Department of Health National Guidelines using a process called NHS Pathways (NHSP). NHSP is a patient assessment triage tool, used by Call Assessors, to determine the most suitable level of care, appropriate to the presenting symptoms of the telephone call. It is a national requirement to use an assessment system to triage all 999 calls, to assist Ambulance Services in prioritising the high number of calls received. WMAS are expected to adhere to national ambulance response times when responding to emergency calls
Category 1 Ambulance Response	**Category 1** is for calls about people with life-threatening injuries and illnesses responded to in an average of 7 mins. Respond in an average of 7 minutes, with 90% of Category 1 calls reached within 15 minutes.
Category 2 Ambulance Response	**Category 2** is for emergency calls responded to in an average time of 18 minutes. Mean average arrival time of 18 minutes, of a resource with a suitably qualified clinician within. 90th percentile target of 40 minutes.
Category 3 Ambulance Response	**Category 3** is for Emergency calls responded to at least 9 out of 10 times before 120 minutes.
Category 4 Ambulance Response	**Category 4** is for less urgent calls responded to at least 9 out of 10 times before 180 minutes.
Mental Health Act	The Mental Health Act 1983 (MHA) is the main legislation in England and Wales that governs the compulsory admission and treatment of people with a mental health disorder, allowing for detention and treatment without consent if there is a risk of harm to the person or others. It sets out the rights and safeguards for individuals subject to such detention, known as being "sectioned".
Mental Health Scrutiny Committee	Panel which unpicks 4 cases of multi-agency working, each agency involved discuss relevant material, share, and discuss. Other non- involved members also get to understand challenges, best practice, and learning.
Control room	**Police** Force Contact Centre - Command and Control of call takers and dispatchers for police resources **WMAS** The Integrated Urgent and Emergency Care (IEUC) Operations Centre, often referred to as ambulance control room, are responsible for receiving and managing emergency calls. When a 999 call is made, trained call handlers gather essential information and assess the urgency of the situation using the NHS Pathways triage system. Dispatchers then coordinate the most appropriate response, whether that is an ambulance, a specialist team, or support for hospital transfers. These centres also provide real-time updates to ambulance crews and manage requests from healthcare professionals. By directing resources efficiently, IEUC aim to ensure patients receive timely and appropriate care.
SMART Action	SMART stands for Specific, Measurable, Achievable, Realistic (or Attainable), and Time-Bound (or Timely). It is a goal-setting framework that provides a structured approach to making actions and objectives clear, focused, and practical for individuals and organizations.

Background, Context, and description of the patient safety incident

Incidents

On the xxxx [redacted]

There have also been a cluster of incidents related to similar issues over the previous few months.

[redacted]

[redacted]

In light of these incidents and concerns being raised by staff within both MPFT and NSCHT regarding the Right Care Right Person Process a *Thematic Review* was commissioned by Staffordshire and Stoke on Trent (SSOT) relevant Executive Directors from the Integrated Care Board (ICB), University Hospitals of North Midlands NHS Trust (UHNM), Midlands Partnership University Foundation Trust (MPFT), North Staffs Combined Healthcare NHS Trust (NSCHT), Staffordshire Police and West Midlands Ambulance Service (WMAS).

Context

The National Partnership Agreement: Right Care, Right Person (RCRP) https://www.gov.uk/government/publications/national-partnership-agreement-right-care-right-person/national-partnership-agreement-right-care-right-person-rcrp sets out the collective national commitment from the Home Office, Department of Health and Social Care, the National Police Chiefs Council, Association of Police and Crime Commissioners and NHS England to "*work together to end inappropriate and avoidable involvement of police to incidents involving people with mental health needs."*

The Right Care Right Person Framework is there to assist police with decision making about when they should become involved in responses to incidents which involve those people with mental health needs.

The threshold for police assistance is:

- to investigate a crime that has occurred or is occurring; or
- to protect people, when there is a real and immediate risk to the life of a person, or of a person being subject to or at risk of serious harm.

NHS England Guidance on implementing the National Partnership Agreement Right Care Right Person https://www.england.nhs.uk/long-read/guidance-on-implementing-the-national-partnership-agreement-right-care-right-person/ reinforces the importance of the RCRP in ensuring that people are receiving timely access to a mental health specialist and that police are involved only when appropriate. They are clear that "implementation of the NPA RCRP needs to put people's wellbeing and safety first, ensuring they do not fall through the gaps between services."

Guidance on implementation from NHSE focusses on 5 principles:

- Working in partnership – effective multi-partnership working
- Personalisation – people with mental health needs should be treated with empathy, compassion, respect and understanding: a positive experience.
- Least restriction – always consider least restrictive alternatives.
- Addressing health inequalities - designed to meet the needs of the population.
- Using local intelligence to monitor and adapt implementation – be informed by the local data.

System partners Implementation of RCRP

In the months leading to the live launch of RCRP the following actions and processes were undertaken:

SSOT ICB

Right Care, Right Person was introduced in February 2024 and implemented using a phased approach:

- July 2023 – Autumn 2023: Internal and external engagement; policy and procedure development; training package design.
- Autumn 2023 – Christmas 2023: Training rollout.
- February 2024: Concern for Welfare (Phase One).
- May 2024: AWOL from a Health Facility (Phase Two).
- August 2024: Transportation (Phase Three).
- November 2024: Section 136 & Voluntary Mental Health (Phase Four).

In Staffordshire and Stoke-on-Trent, partnership structures to support the implementation of RCRP have evolved over time.

Staffordshire Police initially chaired an RCRP Partner Task to Finish Meeting, which has since been stood down following the completion of the project implementation phase, with oversight now managed by national policing teams.

Alongside this, the ICB chaired a weekly Health Tactical Group to discuss the phase implementation and as a drop-in forum for staff to raise concerns, queries, or escalations, which highlighted the need for a broader system-wide conversation due to the identification of concerns of harm as per this report.

To address this, the ICB convened a RCRP Partnership Meeting with all partners to ensure clear delegation of roles, responsibilities, and expectations, with meetings held at three and six months to monitor progress.

Building on this foundation, a further all-partner meeting is now being established to maintain momentum and strengthen relationships, review emerging themes and trends, share learning, consider legislative and Mental Health Reform updates, and provide strategic oversight of the entire RCRP programme.

Engagement and promotion of the Right Care, Right Person (RCRP) programme was undertaken through the MHLDA Delivery Group and the UEC and Crisis Board, working closely with system partners and with a particular focus on the Crisis Care Centres and pathways across Staffordshire and Stoke-on-Trent.

Further engagement was also completed with the ICB Clinical Reference Group, chaired by the MH LDA Clinical Lead, and attended by representatives from NSCHT, MPFT, and the Local Medical Committee (LMC), ensuring that clinical perspectives and system-wide input were incorporated into the development and implementation process.
Supporting documents developed during the rollout include One Minute Guides for Phases One and Two, a Tripartite Agreement, and a Section 136 Standard Operating Procedure.

<u>UNHM</u>

UHNM provided information and communications via Trust wide communication messages (utilising email) and also via specific forums and meetings prior to the February 2024 launch.

There continues to be Right Care Right Person section on the Trust's intranet site for staff to access information and guides on what RCRP is and how to guides for staff to use.

Presentations on RCRP were provided to the Trust's Working Group in March 2024 and there were also 2 walk arounds completed at both County Hospital and RSUH Emergency Departments so that staff knew what the UHNM AWOL Checklist was and how to access and use it.

The checklist and guide were laminated and publicised in both Emergency Departments.

RCRP update is included on the Trust's Vulnerable Patient Working Group Agenda and included on all Emergency Department Mental Health Forums. A quarterly Vulnerable Patient Newsletter also includes RCRP updates.

NSCHT

NSCHT was initially invited to an engagement with Staffordshire Police in August 2023 to start the early data sharing and become aware of this new project that was being implemented across the system. The trust received a draft guidance document form NHS England which would support the work required to be undertaken to support the implementation.

In January 2024, NSCHT stood up a RCRP steering group which was aimed and tasked with taking them through the 4 stages of implementation to the RCRP, which evolved into a project group supported by our Transformational Management Office (TMO). A communications strategy was also formulated at this time to engage all staff on this new process and how they were implementing this change within the Trust and was championed by the Chief Operating Officer and Chief Nurse.

Regular updates were provided on key elements of this project with the key highlighted changes as below:

- Incident reporting categories re-defined for RCRP
- Review of current Missing Persons Policy which was updated and approved to support the new approach required for RCRP inclusive of key escalation points as well as quick reference guides for staff to follow
- Regular briefings communicated to staff at key milestones
- Specific element of the Trust intranet for RCRP for ease of access to information.

WMAS

The rollout of RCRP across WMAS was cascaded in a tailored and targeted way, focusing on the areas and teams where it was most relevant. This included updates for the Mental Health Response Vehicle, revisions to relevant policies, communication with ambulance control room staff, and weekly briefing articles to keep staff informed of any changes. WMAS also has a Head of Clinical Practice for Mental Health who monitors ongoing developments, works closely with external providers, and ensures that any necessary changes are implemented across the service. Despite these efforts, the overall impact of RCRP on the ambulance service was limited. Given case law, the ambulance service owes a duty of care where there is a patient at a known location with a known medical need – in these circumstances, they may discharge that duty in a number of ways, including remote assessment or in person. Practically this means that it is very rare that WMAS refuse a call for service and that little variation in existing practices were necessary to meet RCRP

MPFT

In preparation for the launch of RCRP MPFT identified key representatives from across the Trust to be part of the implementation group alongside Staffordshire Police, including across mental health and physical health services and corporate representation including the Trust's Security Manager and Head of Mental Health Act and Mental Capacity Act. Communications were disseminated across the Trust via the weekly staff update, with a dedicated "*sharepoint"* page for RCRP providing further information. Further, to support with oversight from any emerging issues a new incident category was established to allow for information feed into regular meetings between MPFT and the Police.

A 'due diligence' checklist was also introduced to support staff to understanding expected steps to be completed prior to Police contact to ensure that all appropriate steps had been completed by healthcare staff prior to requesting police intervention.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation Facilitator:	xx	Associate Director of Quality, Patient Safety and Maternity	SSOT ICB
Investigation leads:	xx	Head of Quality, Safety & Compliance Department	UHNM
	xx	Head of Patient and Organisational Safety	NSCHT
	xx	Patient Safety Investigations Manager	MPFT
	xx	Associate Director of Safety, Risk and Compliance	MPFT
	xx	Patient Safety Learning Response Lead	WMAS
	xx	Head of Clinical Practice – Mental Health	WMAS
	xx	Mental Health Operations Manager	Staffordshire Police
	xx	Lead Nurse for Quality and Patient Safety	SSOT ICB
	xx	Lead Nurse for Quality and Patient Safety	SSOT ICB
	xx	Senior Portfolio Manager - Mental Health	SSOT ICB
Investigation facilitators	xx	Head of Quality & Governance	MPFT
	xx	Head of Nursing	UHNM

Summary of investigation process

In March 2025 it became apparent that there were escalations coming to the ICB from health providers regarding the Right Care Right Person process. Concerns were being raised that when the police were asked for support it was not forthcoming and that harm was potentially being caused because of this. These issues were incident reported within organisations and shared with the ICB Mental Health portfolio and Quality Team.

A request for more information went from the ICB to WMAS, Staffordshire Police and both NHS Providers and after review of the information it was possible to identify four service users where a call under RCRP had been made, and the determination made by the police was now being challenged.

Staff at both Mental Health providers (MPFT and NSCHT) had also raised concerns internally and staff at NSCHT had raised concerns with the ICB Chair

Escalation of these concerns was made formally to the ICB System Quality Group in April 2025 and the Quality and Safety Committee in April 2025. Initially a meeting was held with the Staffordshire Police and Fire Commissioner and ICB Chair which was followed by a meeting with Staffordshire Police senior team.

It was agreed that the ICB would facilitate a thematic review of all the four cases specifically around the RCRP process. All health organisations would review each case individually under their Patient Safety Incident Response Framework (PSIRF) https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/.

Terms of Reference

The aim of the review is to understand the systems and processes that led to the outcome's as described in a way which demonstrates compassionate engagement with those involved, application of a range of system-based approaches to learning from patient safety incidents and ensure a considered and proportionate response to the incident and associated concerns.

At its conclusion, the review aims to develop a proportionate stakeholder agreed safety improvement plan for monitoring at the SSOT ICB System Quality Group.

The process, facilitated by Staffordshire and Stoke on Trent ICB Quality team, included:

- Learning identified through the partner agencies' investigations.
- Collaborative use of tools such as SEIPS to ensure effective, robust, and proportionate system wide learning recognising where improvements can be made to generate and support continuous system wide improvements.

To ensure there is no misinterpretation of the purpose of the review the review will:

- Promote a positive culture of multi-agency learning and review, learning together by professionals from different organisations.
- Implement a philosophy of openness, integrity and learning to improve care for others who face similar tricky situations to produce lasting improvements to services: and
- Apply Being Fair principles in relation to the review of staff actions during the incident. This will ensure that no individual is named or blamed and that learning is systemic unless a serious breach of conduct is identified through separate HR processes.

See Appendix 2 Terms of Reference

Information gathering

A. Information from Provider Reviews

All providers who participated in the index events undertook internal (or joint) reviews.

Patient A

I. An After-Action Review was undertaken by WMAS for this incident:
This included a full review of what was expected to happen and what actually happened, review of decisions taken and analysis of why there was a difference between what was expected and what actually happened.
The findings related specifically to the RCRP processes have been fed into this deep dive and include:

- Impact of pressures in system leading to decisions being taken regarding re tasking of ambulances
- System issues in what the mental health nurse at WMAS was able to see in regard to waiting status of patient/ambulance status.
- Communication challenges between Police and WMAS

A full programme of safety actions is in place at WMAS following this investigation and includes:

- Updated and re-distribution of required notices
- Plan for collaboration with Staffordshire police services regarding communication processes and tools
- Development of improved guidance for call assessors
- Review of appropriateness of request management for welfare checks leading to development of robust agreed guidance
- Review of “arrival time resource”

II. A Joint *Learning Review* was also undertaken by MPFT with UHNM, WMAS and Police.
This included a full review of what was expected to happen and what actually happened.
The findings related specifically to the RCRP processes have been fed into this deep dive and include:

- Communication challenge/blocks between all stakeholders as the event progressed.
- Lack of clarity regarding who was responsible for the patient on a number of occasions.

A full programme of safety actions is in place following this investigation and includes:

- All organisations have ensured attendance at the Mental Health Scrutiny Panel to ensure joint communication and working.
- UHNM and MPFT to jointly review checklists for staff to use in these instances and ensure system wide approach.
- Further promotions and training of RCRP processes for UHNM and MPFT

II. Review undertaken by Staffordshire Police as part of normal working highlighted the following:

- Lack of understanding of RCRP process by clinicians
- Lack of clarity regarding escalation reasons and risk to patients from callers
- Calls from professionals needs to ensure that immediate threat is present, and the patients’ whereabouts is known, should checks be made and still not found then the individual could potentially be considered a missing person.

Patient B:

I. A Comprehensive Safety Review was undertaken by NSCHT for this incident:
This included a full review of patient care which is not within the remit of this review. It has noted that the patient had not voiced any historical or recent thoughts to harm self or end her life.
The findings related specifically to the RCRP processes have been fed into this deep dive and include:
    - No instigation of RCRP process or contact with police when contact was not able to be made with the patient.

Safety recommendations made in regard of this include:
    - Review opportunity for staff members to also escalate concerns to police if the Right Care Right Person checklist was considered once family had further shared their concerns.
    - Review RCRP checklist.

II. Review undertaken by Staffordshire Police as part of normal working highlighted the following:
    - RCRP decision tree was completed.
    - Family contact with police at station not logged however call to contact centre was. This potential risk is to be further mitigated by the further roll out of training re escalation to control room for decision making.

Patient: C

I. A Comprehensive Safety Review was undertaken by NSCHT for this incident:
This included a full review of patient care which is not within the remit of this review.
The findings related specifically to the RCRP processes have been fed into this deep dive and include:

- Apparent lack of RCRP escalation when health staff advised incident did not meet threshold – however health staff called an ambulance.

Safety recommendations made in regard of this include:

- written guidance to be produced to provide support staff when contacting the Police about concerns for a person's welfare and safety. For this to include:
  - Key words / statements to be quoted.
  - An overview of the escalation process.
- Trust's RCRP Checklists to be reviewed in line with this.
- Discussion at Muti Agency Health Scrutiny Panel

II. Review undertaken by Staffordshire Police as part of normal working highlighted the following:

- The circumstances reported to the police did not suggest there was an immediate threat or risk to life, and therefore, in accordance with force policy, it did not meet the criteria for police attendance and no appeal was made regarding this decision at the time.
- Family contact with police at station not logged however call to contact centre was. This potential risk is to be further mitigated by the further roll out of training re escalation to control room for decision making.
- The person with the most awareness of the individual did not call the Police. Lack of understanding and risk was not conveyed in call.
- Calls from professionals needs to ensure that immediate threat is present, and the patients' whereabouts is known, should checks be made and still not found then the individual could potentially be considered a missing person.

II. Review undertaken by WMAS highlighted the following:

- Category 3 response time was not met this was found to be due to regional delays for all ambulance responses.
- There was a missed opportunity to triage the call using the "risk of suicide" option this would have meant an automatic upgrade to a category two ambulance response if no clinical intervention were provided by phone within 30 minutes, or an ambulance response within 40 minutes. It is highly likely an ambulance resource would have arrived on scene sooner if the case had received the automatic upgrade however, it is not possible to determine an exact time.

Patient D

I. MPFT discussed this incident in their fortnightly care group learning response meeting and felt that the care from MPFT was appropriate, and the issue was in terms of accessing the property and response under RCRP. This was following responses from WMAS and Staffordshire Police to their review and in light of the ICB Review (this document).

II. WMAS have undertaken a review of the incident with findings showing no issues with care.

III. Review undertaken by Staffordshire Police as part of normal working highlighted the following:
- Calls from professionals needs to ensure that immediate threat is present, and the patients' whereabouts is known, should checks be made and still not found the missing person.
- It was felt that the person making the call did not have or did not share all the history and risk related to this patient and so level risk was not conveyed in call.

B. Deep Dive/Review Information processing

A working group was commenced following agreement of Terms of Reference to look at the findings for all provider reviews to ensure a robust understanding of the challenges and system issues found.

A System Engineering Initiative for Patient Safety (SEIPS) Framework was used to understand a how a work system can influence processes and hence shape outcomes. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf

Figure 1 Overview of SEIPS Framework

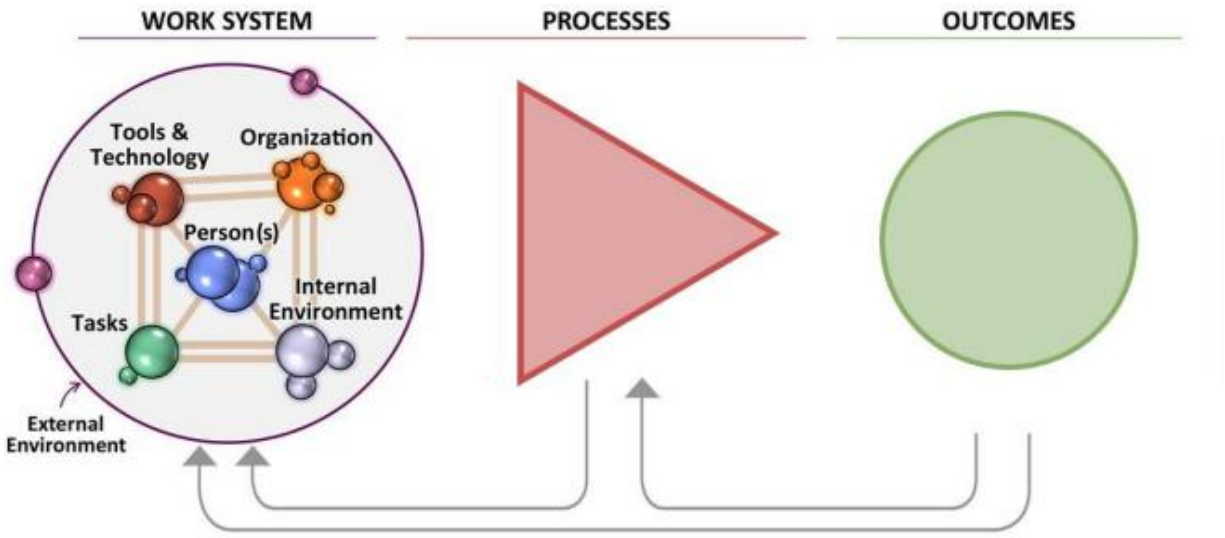
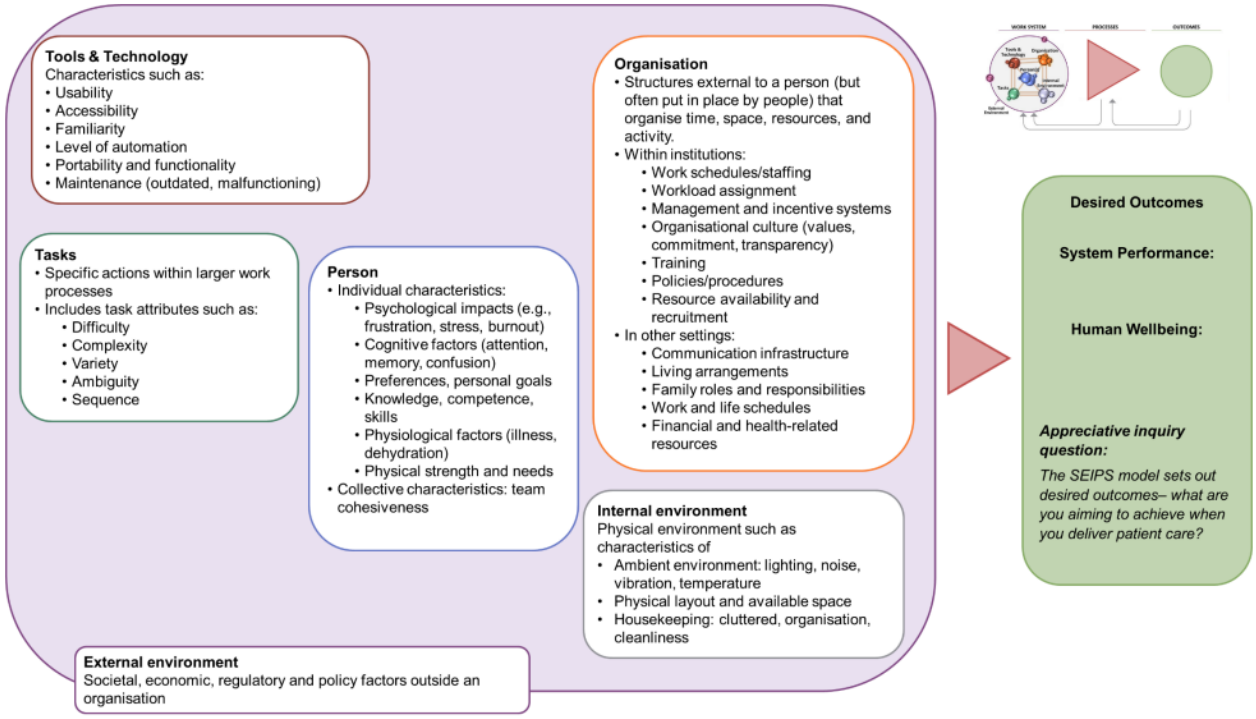
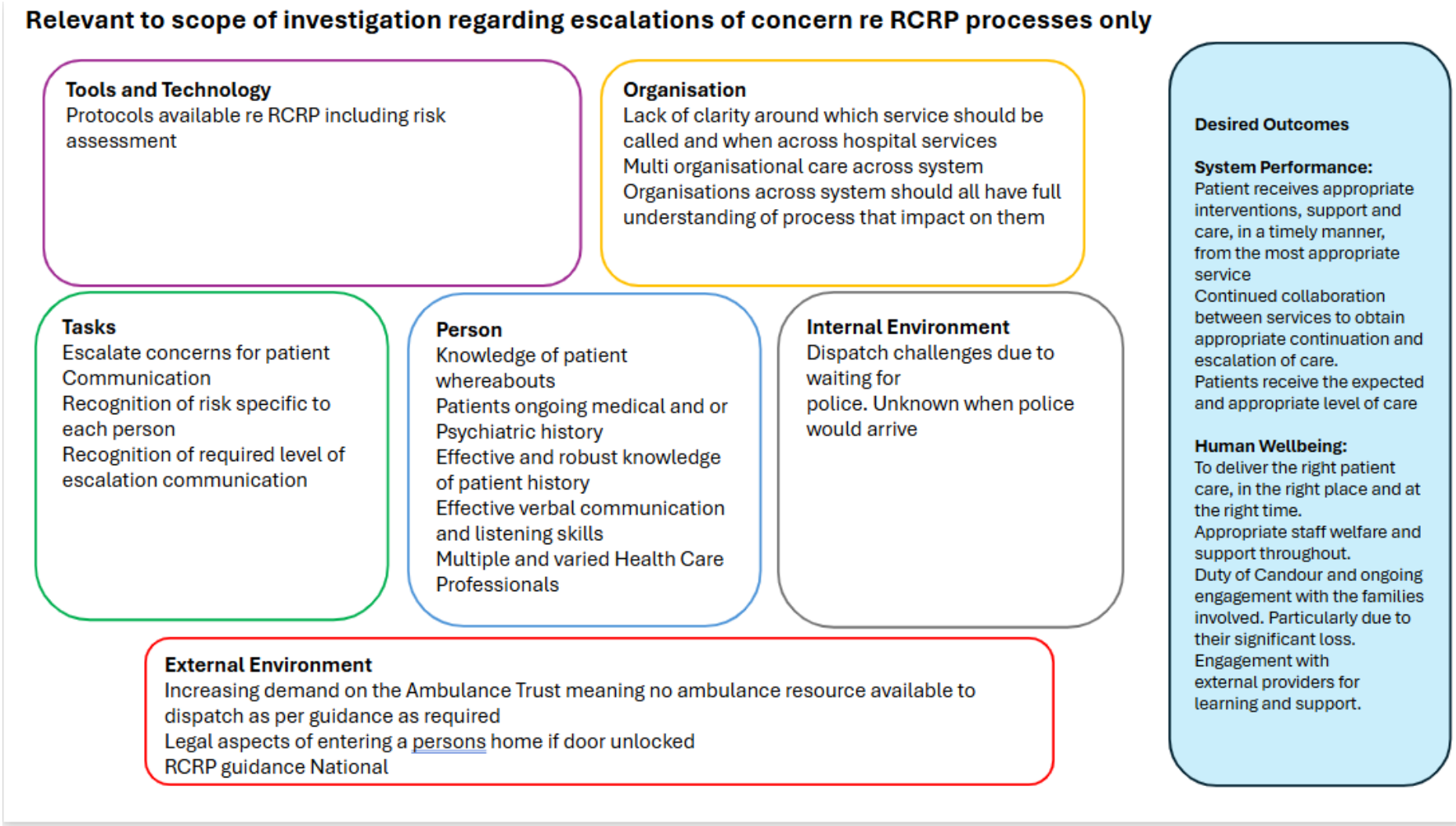


Figure 2 Overview of SEIPS Work system.



Using the tool specifically focused on the Right Care Right Person Process we were able to collate the interconnecting variables leading to the actual outcomes and desired outcomes.

Figure 3 SEIPS review of work systems around RCRP.



This was followed by a review of work as imagined versus work as done focused on the work systems as above. (Tools and Technology, Organisation, Tasks, Person, Internal environment, and External environment)

Work System	Work as Imagined	Work as Done	Outcome
Tools and Technology	RCRP Protocol ensures correct application of process and includes risk assessment	Protocol not always adhered to and risk assessment not always clear	Risk and concern not fully understood based on information given
	RCRP includes escalation process	Escalation process not always followed after police say not attending as does not meet threshold	Lack of ability to rectify the misunderstanding
Organisation	RCRP Protocol available for all within system to use	ED at UHNM Not aware of process or protocol	Risk and concern not understood based on information given
	Clear process for all to follow	Multiple versions of check list	Risk and concern not understood based on information given
	Organisations across system all have full understanding of process that impact on them	Not every Trust within system was fully aware of process. Not everyone in all trusts was aware of escalation process	Lack of use of escalation process as required, when decision is this is not an RCRP case
Tasks	Clear process to follow to raise a significant concern for safety	Protocol and requirements not followed, information not adequate to demonstrate risk from health practitioners to police	Risk and concern not understood based on information given
	Staff are able to escalate following the protocol	Staff unaware they can escalate	Lack of ability to rectify the misunderstanding
	Calls to police are clear and informed and clearly articulate the risk	On occasion the risk is not articulated clearly	Risk and concern not understood based on information given
Person	Most senior person with clear knowledge of patient will raise concern with police	Varied staff levels with varied knowledge of patient made calls to police	Risk and concern not understood based on information given
Internal environment	Communication should be effective across all stakeholders	Communication was not always effective	Leading to misunderstandings
External environment	Ambulances are sent within mandated KPIs	Impact of high volume of calls and holds at ED departments means this is not always possible	Categories cannot always be adhered to, and it is essential risk is highlighted to ensure correct category

Findings – What has been learnt.

Using the SEIPS Framework during the review means that the analysis and findings can also be structured in the same way.

Focussing on the framework's six work system elements (People, Tasks, Tools/Technology, Physical Environment, External Environment, Organisation) and their interactions, rather than focusing on a single cause allows the development of a more comprehensive and effective improvement plan and ensures the whole system is looked at rather than single individual/provider failures.

People	Task	Tools and Technology	Organisational	Internal environment	External Environment
Varied levels of knowledge of process across staff in all organisations	Information needed regarding process is not clear to all	No clear templated checklist across system	Not all provider staff were fully aware of process after launch	Communication not always effective – risk not always articulated	Ambulance response times cannot always be adhered to. The risk must be clear to allow this
	Information needed regarding escalation is not clear to all	RCRP was not fully cascaded across all of system	Not all provider staff were aware of escalation process after launch		
	Lack of clarity on type and level of information needed to meet criteria for attendance	Complexities of different pathways	Lack of clarity on ownership/ Governance of process once launched		

Summary of findings, areas for improvement and safety actions

On review of the findings, it is apparent that system challenges and blockers contributed to delays in gaining access to properties to check on service users where there was concern for safety. Whilst a full launch of phase one and two of RCRP had been undertaken by all of the three providers and information shared within these organisations. There were gaps in fully/robustly cascading the information to everyone relevant. This meant that there were a number of healthcare staff in the community and in hospitals who were not fully aware or had a full understanding of the process and its needs and requirements.

That, whilst the Right Care Right Person process had been fully launched across the system the stepping down of the governance meetings for the process meant that deficiencies in understanding were not reviewed and discussed in a timely manner. (note there was an informal health tactical group)

A full improvement plan is needed to resolve these blockers to effective system ownership of Right Care Right Person.

It is, however, important to note that once providers reviewed these individual incidents multiple actions have commenced and there have been, to date, no similar incidents recorded (Since March 2025).

Safety action summary table

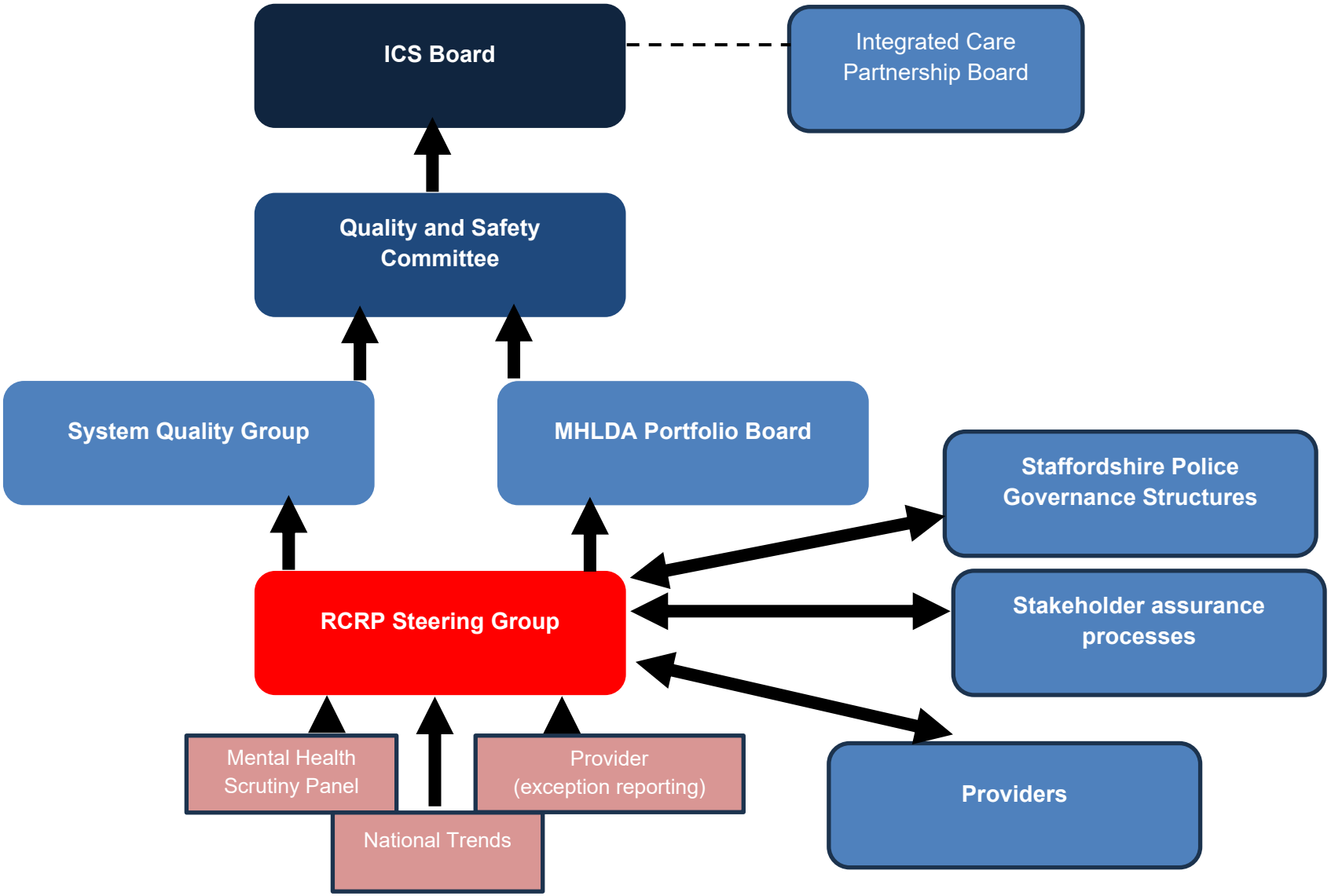
Area for improvement: Clear System Governance and Oversight for RCRP process and action plan								
	Safety action description *(SMART)*	**Safety action owner** *(role, team directorate)*	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** *(e.g. daily, monthly)*	**Responsibility for monitoring/ oversight** *(e.g. specific group/ individual,)*	**Planned review date.** *(e.g. annually)*
1.	Robust Governance process for RCRP Process	ICB SRO	31st October 2025		Recommenced Steering Group	Monthly	ICB Quality & Safety Committee MHLDA Portfolio Board (tbc)	Annual
2.	Terms of Reference For Steering Group	ICB SRO	31st October 2025		Terms of Reference written	Annual	MHLDA Portfolio Board (tbc)	Annual
3	Commitment from all stakeholders to contribute to learning in steering group	All members	31 October 2025		Audit of attendance	Quarterly	MHLDA Portfolio Board (tbc)	Annual
4	Agreed reporting for escalation and assurance to ICB Board	ICB SRO	31st October 2026		Quarterly reports	Quarterly	Quality and safety committee as above MHLDA Portfolio Board (tbc)	

Area for improvement: System approach to be designed and agreed so confusion and misunderstandings limited								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight** ***(e.g. specific group/ individual,)***	**Planned review date.** ***(e.g. annually)***
5.	Agreed templates across all stakeholders for accessing RCRP support	ICB SRO and Steering Group	31st December 2025		Consistent templates for use across partners with consistent language and triggers	Quarterly Audit of usage	RCRP Steering Group	Quarterly
6.	Agreed templates for escalation process across all stakeholders for escalation	ICB SRO and Steering Group	31st December 2025		Consistent templates for use across partners with consistent language and triggers	Quarterly Audit of usage	RCRP Steering Group	Quarterly

Area for Improvement: Relaunch of RCRP across system to ensure well socialised and understood								
	Safety action description ***(SMART)***	**Safety action owner** ***(role, team directorate)***	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency** ***(e.g. daily, monthly)***	**Responsibility for monitoring/ oversight** ***(e.g. specific group/ individual,)***	**Planned review date.** ***(e.g. annually)***
7.	Relaunch of RCRP across all system	ICB SRO	31st January 2026		Full relaunch of process and templates	Monthly review of instances RCRP enacted at Steering group	RCRP Steering Group	
8.	Audit of adherence to process to be commenced 6/12 after launch	ICB SRO	30TH April 2026		Audit of all RCRP calls made to Staffordshire police with review of process/tools and outcomes	6 months	RCRP Steering Group	April 2026
9	All system partners to undertake reviews for assurance that all staff understand legal processes relevant to their speciality							

Appendices

Appendix 1 Suggested Governance Process



Appendix 2 Investigation Terms of reference

Confidential

Staffordshire and Stoke on Trent

Multi- Agency

Patient Safety

Thematic Review/Deep Dive

oi

Terms of Reference

30 May 2025

Background

[redacted]

There have also been a cluster of incidents related to similar issues over the previous few months, it must be noted these are not yet investigated so factually may not be accurate.

- [redacted]
- [redacted]
- [redacted]

[redacted]

Purpose

This Thematic Review has been commissioned by Staffordshire and Stoke on Trent (SSOT) relevant Executive Directors from the Integrated Care Board (ICB), University of North Midlands NHS Trust (UHNM), Midlands Partnership University Foundation Trust (MPFT), North Staffs Combined Healthcare Trust (NSCHT), Staffordshire Police and West Midlands Ambulance Service (WMAS).

The aim of the review will be to understand the systems and processes that led to the outcomes as described above in a way which demonstrates compassionate engagement with those involved, application of a range of system-based approaches to learning from patient safety incidents and ensure a considered and proportionate response to the incident and associated concerns.

At its conclusion, the review will have developed a proportionate stakeholder agreed safety improvement plan for monitoring at the SSOT ICB System Quality Group.

Staffordshire and Stoke on Trent ICB Quality team will facilitate the process, and it will include:

- Learning identified through the partner agencies' investigations.
- Collaborative use of tools such as SEIPS to ensure effective, robust, and proportionate system wide learning. Recognising where improvements can be made to generate and support continuous system wide improvements.

It should be noted that an appropriately redacted version of the review and individual organisational reports could be published in public domain under Freedom of Information Requirements however it is essential that before any release of the findings all appropriate legal review processes take place and all partners agree.

To ensure there is no misinterpretation of the purpose of the review:
The review will:

- Promote a positive culture of multi-agency learning and review, learning together by professionals from different organisations.
- Implement a philosophy of openness, integrity and learning to improve care for others who face similar tricky situations to produce lasting improvements to services.
- Apply Being Fair principles in relation to the review of staff actions during the incident. This will ensure that no individual is named or blamed and that learning is systemic unless a serious breach of conduct is identified through separate HR processes.

Scope

The review will analyse the After-Action Reviews undertaken by each provider for each of the incidents above from realisation of concern to outcome for each patient and will ensure the voice of all parties are heard either by interview or statement.

Whilst there is a significant amount of anecdotal noise in the system regarding the “Right Care Right Person” process the review will focus on the factual evidence of the four cases to ensure robust evidence collection and focus. It is felt that this will then lead TO an improvement plan which will address the anecdotal concerns as well and this will be monitored. The purpose of the review is to explore multi-agency interpretation and implementation of RCRP and not to pre-determine that misapplication occurred. The National Partnership Agreement :Right Care Right Person RCRP and NHS England guidance on implementing the National Partnership Agreement will be used to ensure all partners work from the same understanding – the same “work as imagined/described”.

It must be understood by all partners that police participation is without prejudice to ongoing or future investigations and that findings of this review are not determinative in any legal forum.

Methodology

The review will be facilitated by SSOT ICB Patient Safety Specialist and Associate Director of Quality and Patient Safety.

Facilitation **will** include:

- Chairing and arranging a fortnightly incident review working group.

- Ensuring collation of all evidence available
- Facilitating a system-based approach using national recommended tools as appropriate, including:
    - System Engineering Initiative for Patient Safety (SEIPS) framework (appendix 1)
    - Stakeholder Mapping (accimap – appendix 2)
    - Interviews based upon guidance from NHS England *guidance on interviews*
    - Link Analysis (HTA appendix 3)
    - Timeline development

- Drafting the final agreed REVIEW and amending as per members discussions

Facilitation **does not** include the collection of evidence of review of evidence e.g. notes and logs this remains within the remit of the relevant provider both health and police who will collate the information and complete timelines and After-Action Reviews for each of the above cases.

All stakeholders will agree to work collaboratively to ensure a robust and system wide approach to investigation and learning.

The final report will be agreed by all partners and then shared by each relevant stakeholder with their own Executive Team and by the SSOT ICB with the System Quality Group. The final report will be completed using the template report from NHSE: Review Tool

H. M. Coroner may also request a copy of this final review, and all partners must be made aware of the request and response by the relevant stakeholder.

System wide learning and recommendations for improvement will be monitored at System Quality and Performance Improvement meetings.

Data Sharing

All Health data shared should remain fully anonymised throughout the review process. It will also be essential to ensure that any sharing of police logs or data complies with GDPR, DPA 2018, and MOPI guidance. There should be an agreement on secure information-sharing protocols and data minimisation. This is to be in place and agreed before any data sharing outside of normal health processes commences.

Multi-agency Members

- Staffordshire and Stoke on Trent ICB – Chair
- West Midlands Ambulance Service.
- University Hospital North Midlands.

- Midlands Partnership University Foundation Trust
- North Staffordshire Combined Healthcare Trust
- Staffordshire Police.

Proposed members list at Appendix 4

All members will endeavour to attend the fortnightly meeting which will be held via Teams and to contribute to the review. A copy of the ICS Leadership Compact is at Appendix 5 and all members will be reminded of it at each meeting to ensure a supportive learning environment.

Governance and Reporting

Final report will be shared with the Quality and Safety Committee with actions then being monitored via the ICB System Quality Group.

Any escalations agreed during any of the review meetings will be sent to the nominated Executive members as at Appendix 6 by the Chair

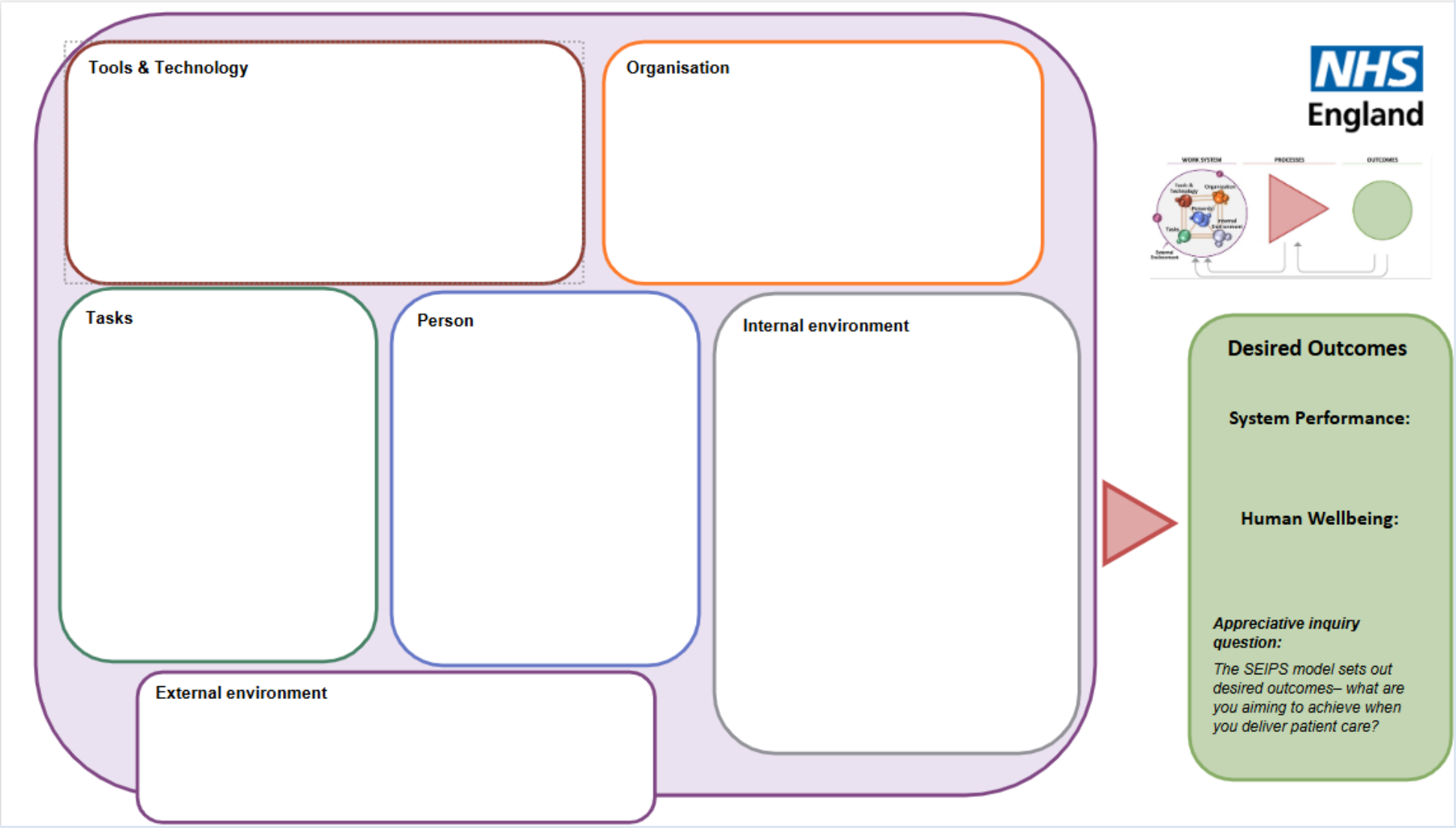
Anticipated high level timelines.

- Panel to meet fortnightly.
- Individual organisations complete after action reviews evidence submitted by 30 June 2025
- Initial review of themes and findings by 31 August 2025.
- Final Report available 14th September 2025

Family Engagement

Both Legislative and Professional Duty of Candour responsibilities will sit within the relevant Stakeholder and NHS Stakeholders will be required to follow national requirements of the Duty of Candour process. It is important however that all stakeholders recognise that sharing of all patient details in the report will not be possible and each family/next of kin will require an amended report.

TOR Appendix 1 SEIPS



TOR Appendix 2 Accimap

AcciMap Template

External level

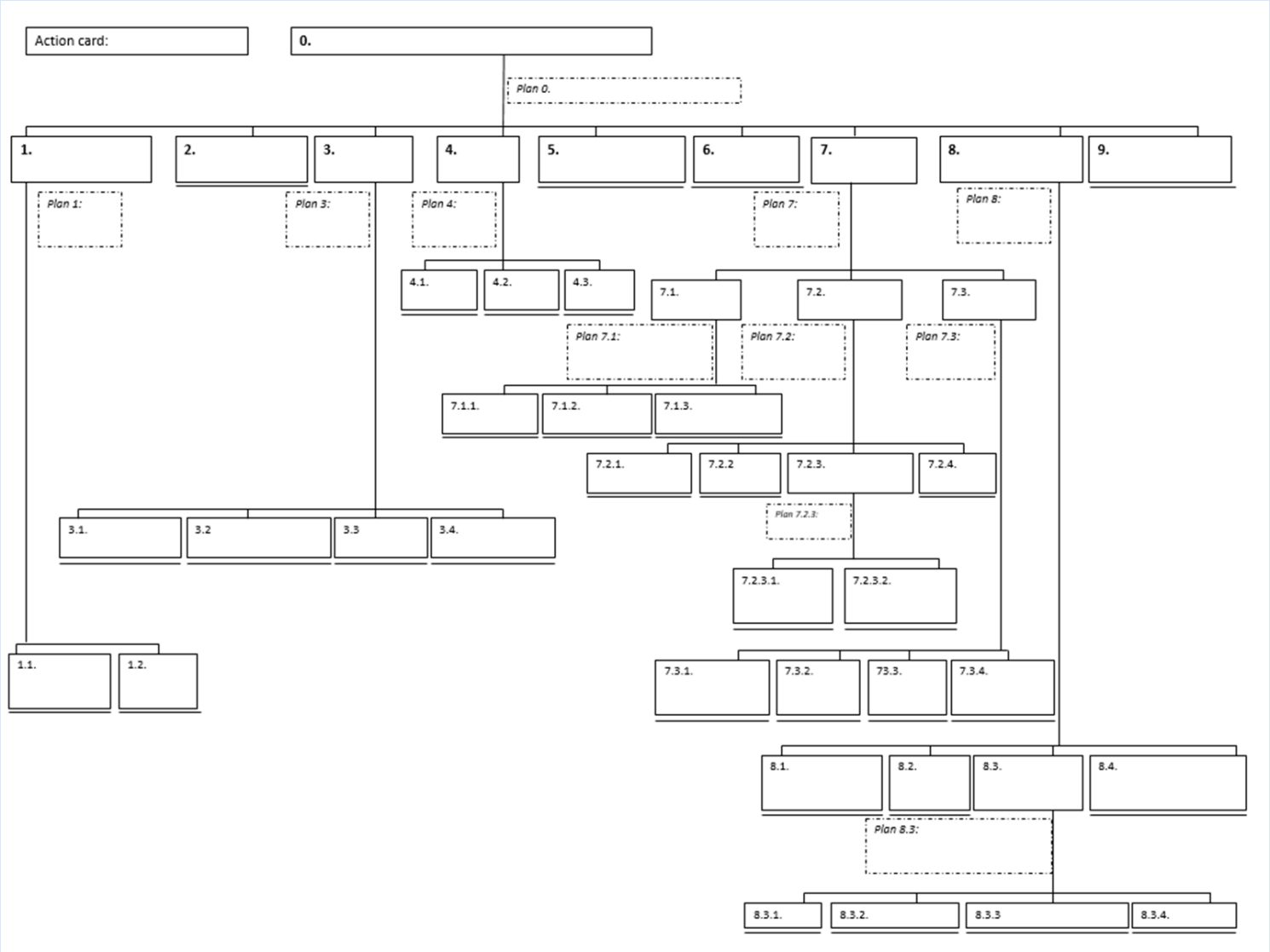
Organisational level

Operation level

Immediate event and condition level - actor activities, equipment and surroundings

Outcomes

TOR Appendix 3 HTA Analysis



TOR Appendix 4

Name	Organisation	email	Job Title
	SSOT ICB		ICB AD Quality and Patient Safety and ICB Patient Safety Specialist (Co-Chair)
	SSOT ICB		Lead Nurse for Quality & Patient Safety
	SSOT ICB		Lead Nurse for Quality and Patient Safety
	SSOT ICB		Senior Portfolio Manager - Mental Health
	UHNM		Head of Quality, Safety & Compliance Department/Patient Safety Specialist
	NSCHT		Head of Patient and Organisational Safety / Patient Safety Specialist
	WMAS		
	WMAS		Patient Safety Learning Response Lead
	MPFT		Head of Safety & Risk Management/Patient Safety Specialist
	MPFT		Patient Safety Investigations Manager
	Staffordshire Police		Early Intervention and Prevention Unit (EIPU) Head of Vulnerability and Problem-Solving Lead for Mental Health
	UHNM		Lead for Vulnerable People
	UHNM		Lead for Mental Health &Learning Disability

TOR Appendix 5

Name	Organisation	email	Job Title
	SSOT ICB		CNTO Caldicott Guardian
	SSOT ICB		Acting CEO
	SSOT ICB		Acting CMO
	SSOT ICB		Chair
	Staffordshire Police		Investigation Exec Lead
	Staffordshire Police		Investigation Strategic Lead
	Staffordshire Police		*Will receive and share with Police leads
	WMAS		Head of Patient Safety
	WMAS		Patient Safety Director
	UHNM		CNO
	UHNM		Deputy CMO
	MPFT		CN
	MPFT		CMO
	NSCHT		CN
	NSCHT		CMO
	NSCHT		COO

TOR Appendix 6

Staffordshire & Stoke-on-Trent System Leadership Compact

Trust

- We will be **dependable** we will do what we say we will do and when we can't, we will explain to others why not
- We will act with **integrity** and **consistency** working in the interests of the population that we serve
- We will be willing to take a **leap of faith** because we trust that partners will support us when we are in a more exposed position.

Courage

- We will be **ambitious** and willing to **do something different** to improve health and care for the local population
- We will be willing to make **difficult decisions** and take proportionate risks for the benefit of the population
- We will be open to **changing course** if required
- We will **speak out** about inappropriate behaviour that goes against our compact.

Openness & Honesty

- We will be **open** and **honest** about what we can and cannot do
- We will create a **psychologically safe environment** where people feel that they can raise thoughts and concerns without fear of negative consequences
- Where there is disagreement, we will be prepared to **concede** a little to reach a consensus.

Leading by Example

- We will **lead with conviction** and be ambassadors of our shared ICS vision
- We will be committed to **playing our part** in delivering the ICS vision
- We will live our **shared values** and agreed leadership behaviours
- We will positively promote **collaborative working** across our organisations.

Respects

- We will be **inclusive** and encourage all partners to contribute and express their opinions
- We will **listen actively** to others, without jumping to conclusions based on assumptions
- We will take the time to **understand** others' points of view and **empathise** with their position
- We will respect and uphold **collective decisions** made.

Kindness & Compassions

- We will show **kindness, empathy** and **understanding** towards others
- We will **speak kindly** of each other
- We will support each other and seek to solve problems **collectively**
- We will challenge each other **constructively** and with **compassion.**

System First

- We will put **organisational loyalty and imperatives** to one side for the benefit of the population we serve
- We will spend the Staffordshire & Stoke-on-Trent pound **together** and **once**
- We will develop, agree and uphold a **collective** and **consistent** narrative
- We will present a **united front** to regulators.

Looking Forward

- We will focus on **what is possible** going forwards, and not allow the past to dictate the future
- We will be **open-minded** and willing to consider new ideas and suggestions
- We will show a willingness to **change the status quo** and demonstrate a positive 'can do' attitude
- We will be open to **conflict resolution.**