Kent and Medway
NHS and Social Care Partnership Trust
Information Governance & Records Management Department
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Sent via email

Dear James,

Request for Information

I write further to your request FOI ID 47297 under the Freedom of Information Act 2000 regarding: -

PSIRF

Your request is set out below:

1. Frameworks: What specific guidance and frameworks are currently being used by NHS England, the Integrated Care Board (ICB), safeguarding boards, and local authorities for investigating and learning from mental health-related homicides, inpatient MH deaths, Deaths in custody, and community MH deaths by suicide? Please provide details on how these frameworks align with or differ from the superseded NHS Serious Incident Framework and the new Patient Safety Incident Response Framework (PSIRF).

   Please contact the Kent and Medway ICB for their direct response - kmicb.foi@nhs.net

   The Kent and Medway Adult Safeguarding Board (SAB)does not over-see specific mental health related deaths or incidents outside of the Care Act duties; however, should a mental health homicide or incident be identified that is relevant to share with the board to enable shared learning and assurance local mechanisms are in place to do this. Any challenges in the system that may place people at risk such for example a delay in the local authority authorisation of deprivations of Liberty Safeguards which effects the system is placed as an agenda item for the boards oversite. This ensures there is not a duplication of roles and the right organisation has the ownership of strategic learning such as the ICB and NHSE. Internal provider learning is commenced, with the actions monitored by the ICB.

   The Community Safety Partnership do not manage any mental health related deaths outside of the Domestic Abuse Related Death Review. Mental Health Homicide Reviews are commissioned by NHSE with the ICB providing assurance that the learning and actions have been implemented.
   Should a Mental Health Homicide Review commissioned by NHSE identify learning and information that is relevant to share with the Safeguarding Adult Board a notification is made for awareness and consideration of any system learning as relevant.

The SAB does not have any involvement with PSIF or incidents outside of the Safeguarding Adult Review Criteria or Care Act duties, however can busy themselves with the functioning to ensure safeguarding activity is applied. Assurance is usually though the Safeguarding SAF audit, produced and overseen by the safeguarding board to ensure safeguarding activity is delivered which includes providing evidence of learning from safeguarding reviews is in place.

2. Multi-agency collaboration arrangements: How does the ICB, in collaboration with NHS England and the Care Quality Commission (CQC), track and address recurring themes identified in mental health-related deaths, homicides, and serious incidents across the CCGs/ ICB region/Trusts from 2013 to 2024? Please provide any thematic analyses, trend reports, or systemic vulnerability assessments conducted during this period.

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3. Formal arrangements or Partnership agreements: What formal mechanisms exist for collaboration between NHS England, the Health Services Safety Investigation Board (HSSIB), CQC, ICBs, Community Safety Partnerships, and safeguarding boards in implementing recommendations from various investigations from multiple statutory bodies and inclusive of internal trusts reviews? Please provide details of any joint action plans or shared learning frameworks to analyse the multiple recommendations regarding recurring themes and confirmation that the recurring themes are reflected in the PSIRF organisational profile and annual quality account workstreams reported on to health watch, Trust board and ICB as part of the annual quality account submissions.

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   Safeguarding:

   There are several different mechanisms depending on the type of safeguarding incident and learning review. Therefore, I have separated the different responsibilities.

   Domestic Abuse Related Deaths: The community safety Partnership (CSP) oversee domestic abuse related death reviews (DARDR) previously known as Domestic Homicide Reviews for Kent and Medway. This is a multi-agency forum lead by the CSP with partners such as the police, ICB, health & the local authority as core standing members. The case reviews, recommendations, system and agencies learning are collated and shared, including evidence capture of activity undertaken within this forum, the CSP are the lead agencies. This enables shared learning, monitoring of actions and system oversight.
   Requests for information can be made to the CSP via domhomrev01@kent.gov.uk
   Kent Community Safety Partnership - Kent County Council

   Kent and Medway Domestic Homicide Review Steering Group

   Care Act Duties: Safeguarding Adults at risk. The system learning sits within the Kent and Medway Safeguarding Adults Board. The board standing members are executive leads/directors from the ICB, NHS health providers, Local Authority, Police, Probations, Prisons, Fire and Rescue, Health Watch and Volunteer services. Learning from reviews and recommendations for the system are shared in this forum, with agency and system actions overseen by specific subgroup ie policy, reviews, quality. The SAB legally must provide an annual report which stipulates the activity undertaken to address learning as a system. All agencies are expected to contribute and are audited by the board via a SAF to ensure they are delivering and supporting the board to deliver safeguarding functions which is predominantly learning and improvement in the system.
   Request for information can be made to KMSAB@kent.gov.uk

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4. Quality and safety Governance strategies alignment: How does the ICB's and Trust's quality and clinical governance strategies specifically address the embedding of learning from multiple mental health-related incidents reviews, especially recurring themes and recommendations? Please provide the strategy document and any associated policies or procedures that outline this process.

   Please contact the Kent and Medway ICB for their direct response - kmicb.foi@nhs.net

   Please use the following link to access the Kent and Medway NHS and Social Care Partnership Trust – Patient Safety Incident Response Framework Policy – psirfpolicykmptcorg17601.pdf

   Please use the following link to access the Kent and Medway NHS and Social Care Partnership Trust – Patient Safety Incident Response Plan - kmpt-psirf-plan-v10-final.pdf

5. Effectiveness of the NHS System Oversight Framework. SOF oversight framework and contract management: What measures have been implemented by NHS England to maintain the model fidelity of Early Intervention in Psychosis (EIP) and Assertive Outreach (AO) teams from 2013 to 2024? Please provide insight reports submitted for assurance via the contract's management meetings and the annual EIP improvement plans submitted to NHS England for the past 2 years. Insight reports on staffing levels, caseloads, and any changes to these service models and copies of assurance reports provided to NHS England after the Nottingham incident related to community mental health challenges and best practice concerns Risks associated with the National Community Mental Health Transformation programme are these risks reflected on the NHS England, ICB and Trusts Board Assurance (BAF) for public Transparency reporting or reflected on the respective risk appetite statements for the period 2022 to 2024?

   The Kent and Medway NHS and Social Care Partnership Trust do not currently have Assertive Outreach Teams this function is currently integrated into the community teams and is being reviewed in light of the Nottingham tradegy. The Trust have completed a gap analysis and are currently working with the Kent and Medway ICB to develop a model that will enhance support offered to those who would traditionally fall into the AOT cohort.

   Please find attached copies of the Trusts EIP SDIP for the past two years.

   The Trust does not have a current risk appetite statement at the moment. The Trust Board will be formulating one this year.

   In relation to the CMHF sitting within the BAF please use the following link to access the BAF which is currently published on the Trusts website as part of the Board meeting pack - https://www.kmpt.nhs.uk/about-us/trust-board/board-meetings/ In relation to the CMHF sitting within the BAF please see the November Board Meeting Pack, page 41 Risk ID 08157

6. Safeguarding monitoring insight reports: How are the ICBs, ICPs, and local authorities monitoring and addressing concerns raised about increased caseloads and service pressures within Community Mental Health Teams (CMHTs) following recent CMHT transformations across England? Please provide any risk assessments or mitigation plans related to these changes that have been submitted by Trusts as system assurances to ICB/NHS England. Especially about the EIP and AOT services.

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Now that all partner agencies are fully recruited, we are moving into the next phase of the implementation. Voluntary, community and social enterprise partners will be working with clinical services to provide a holistic triage at the front door to ensure all social and clinical interventions are offered as appropriate. The ICB are providing systems support to ensure robust demand and capacity with an action plan in place. All is monitored is line within the agreed governance framework.

7. Recurring themes: What specific actions have been taken in response to the recommendations from the NICHE 2022 thematic analysis on recurring themes in homicide incidents related to mental health service delivery challenges and best practices, the McCallion review (2019), and the NCEPOD "A Picture of Health" report (2022)? Please provide information evidence of how these recommendations have been incorporated into local strategies and practices.

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8. Organisational NCISH self-assessments: How do the Trust, Integrated Care Board (ICB), and Integrated Care Partnership (ICP) ensure that all mental health service providers conduct annual self-assessments as recommended by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)?

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   The Kent and Medway NHS and Social Care Partnership Trust benchmark workstreams against the NCiSH toolkit to improve safety when developing the Trust's suicide prevention approach (2023-2026). The Trust's approach was finalised on the 13th December 2023. KMPT have plans to undertake this next annual audit with suicide prevention colleagues in this quarter.

9. Responsiveness to Organisational Suicide Trends analysis: Given the concerning trends in suicide rates among mental health patients in the community, in inpatient wards, and in custody, it is crucial that these self-assessments are rigorously implemented and monitored. Please provide details on the mechanisms in place to ensure accountability and adherence to these self-assessments 10. Organisational Suicide Prevention Policy and strategy: Additionally, how do you support and oversee the implementation of these assessments and effective policy and strategy implementation to safeguard patients as part of the Organisational Preventative Duties? Evidence of any multi-agency e.g NHS England, ICB, CQC, safeguarding Boards, Health and wellbeing boards advocacy, and service user groups review processes or action plans developed in response to these assessments and strategies in alignment with the joint strategic needs assessments of the populations served would be highly appreciated.

   The Kent and Medway NHS and Social Care Partnership Trust has allocated and dedicated colleagues whose role includes suicide prevention, to ensure this work is adhered to. This includes a Senior Responsible Officer (SOR) for suicide prevention, a Clinical Risk and Suicide Prevention Trainer and Mortality Review Manager. Suspected suicide numbers are regularly reviewed by the Trust's Mortality Review Manager and shared with key stakeholders and the Trust Board via thematic reports and the mortality report. These feed into the workstreams of the toolkit and action taken accordingly.

   Any suicide that may be related to domestic abuse is referred to the Community Safety Partnership for review and consideration; if the DARDR (previously DHR) criteria is met a review is commissioned by the CPS following the Home Office Guidance. All reviews and recommendation are shared with the Home Office for agreement prior to publication. The actions, themes and recommendations are monitored and shared within the domestic homicide steering group which the ICB, Local Authority, Police, Health Agencies, Etc are standing members to ensure multi-agency oversite for shared

improvements, learning and collaboration. The ICB are responsible to ensure the activity is completed as the health system statutory partner.

10. Organisational freedom to speak-up self-assessments: I am writing to request copies of your organisation's Freedom to Speak Up self-assessments for the period 2022 to 2024, along with the corresponding Trust Board action plans for that period. Additionally, please provide aggregated data on compliance with the Freedom to Speak Up guidelines and details of any improvement actions taken as a result of these assessments for the year 2024 copies of your organisation's Freedom to Speak Up self-assessments for the period 2022 to 2024, along with the corresponding Trust Board action plans for that period. Additionally, please provide aggregated data on compliance with the Freedom to Speak Up guidelines and details of any improvement actions taken as a result of these assessments for the year 2024.

    Please find attached a copy of the Freedom to Speak Up action plan and reflection and planning tool that the trust has completed within this time period.

11. Section 75 agreements and partnership lead commissioner collaborative arrangement: Could you please provide details on the formal agreements or memoranda of understanding that exist between the Integrated Care Board (ICB), local authorities, and mental health service providers? Specifically, I am interested in understanding how these agreements stipulate joint risk ownership and liability, as referenced in alliance contracting models, for delivering preventative duties under the Care Act 2014, Mental Health Act 1983 Section 117 aftercare, and the Health and Care Act 2022.

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    The Trust is formally commissioned to provide mental health services to three main commissioners, NHS Kent and Medway ICB (provision of Inpatient and community Mental health and learning Disability Services within Kent and Medway), NHS England – a small number of specialist commissioned services, The Kent Surrey and Sussex provider Collaborative – lead provider for low and medium secure Forensic services and learning Disability Services. All are formally commissioned using the NHS Standard Contract.

12. Safeguarding Best practice: Implementing the SAAF and other Safeguarding and safety frameworks and best practices: How do the Trust, Integrated Care Board (ICB), and Integrated Care Partnership (ICP), in conjunction with the Care Quality Commission (CQC) and local safeguarding boards, monitor and support the implementation of robust safeguarding and 'Freedom to Speak Up' processes within mental health services? Please provide the most recent evidence and reports available, including safeguarding boards' effectiveness in addressing trends and recurring themes such as sexual safety, neglect, and all forms of abuse. Additionally, could you share any annual reports available for the past four years?

    The ICB develop their contract provider enquiries around the Safeguarding Assurance Framework, we provide the evidence to the ICB that the duties required are met. This is done via quarterly return to the ICB.

    The Safeguarding Adults Board, overseas safeguarding adults' activity and captures evidence of delivery via audit and multiagency policy and joint delivery with the local partners via quarterly meetings, and sub-group settings.

    For information regarding how the safeguarding adults board delivers on this please direct this enquire to the safeguarding board KMSAB@kent.gov.uk

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13. Investments: Could you please provide details on the investments made by the Trust, local authorities, safeguarding boards, Integrated Care Board (ICB), and NHS England in developing patient safety centres, quality management systems (QMS), and safety management systems (SMS) from 2022 to 2024? Specifically, I am interested in information regarding the funding allocated, projects implemented, and outcomes achieved during this period.

    The main Trust investment has been the move to the NHSE Patient Safety Response Framework, please find attached a copy of the Trust's PSIRF plan.

    In order to extract the requested investment information and collate the results would require a manual exercise to identify and review specific time spent on the implementation of PSIRF across the Trust's directorates and would exceed the appropriate time limits, as per the Freedom of Information Act 2000 section 12(1) which does not oblige a public authority to comply with a request for information if the authority estimates that the cost of complying with the request would exceed the appropriate limit.

    Please contact the Kent and Medway ICB for their direct response - kmicb.foi@nhs.net

14. Strategic Transformative learning: How does the Trust, ICB, and ICP board ensure that learning from Domestic Homicide Reviews (DHRs), NHS England commissioned care and treatment reviews, NCISH reviews, and HSSIB and NCEPOD reviews involving mental health service users are effectively shared and implemented? Please provide evidence of any multi-agency review processes or action plans developed in response to the integrated implementation of recommendations from multiple bodies (e.g., HSSIB, NHS England, NCEPOD, NICHE) regarding mental health best practices to address recurring themes and public safety from 2022 to 2024.

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I confirm that the information above completes your request under the Freedom of Information Act 2000. I am also pleased to confirm that no charge will be made for this request.

If you have any questions or concerns or are unhappy with the response provided or the service you have received you can write to the Head of Information Governance at the address on top of this letter. If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision.

Yours Sincerely

On Behalf of
The Information Governance Department