Kent and Medway
NHS and Social Care Partnership Trust

Quality Accounts

2024-2025

We are caring | inclusive | curious | confident.

Contents

CEO's statement

This report looks back at how we've performed against the second year of our organisational strategy, and my first full year as CEO. It looks closely at our efforts on patient safety, providing effective care, and responding to patient feedback. It also outlines core work to deliver our strategic priorities, and builds upon our 2024/25 annual report and accounts.

Included in this report are:

1. Our approach to improvement and our new Doing Well Together programme
2. Outlining how we have performed against our priorities for 2024-2025
3. Key accomplishments from the past year

Once again, I want to share my sincere thanks with our staff for their dedication and hard-work; with our partners for their continued support, especially with the transformation of our community services (Mental Health Together); and with our patients and their loved ones for their willingness to share their feedback. Their input is invaluable in enhancing the care we deliver.

From a patient safety standpoint, we're seeing calmer and safer wards thanks to the success of new ways of working designed to reduce violence and aggression. This is something we want to build on and expand into our community teams. We have also seen encouraging progress on making our trust a more welcoming and inclusive place for everyone.

We've been working closely with our partners to strengthen our community services, through Mental Health Together, which has been created with the full range of patients' needs in mind and established to help people access all the support they need more easily, in one place, without having to deal with lots of different services.

While we're absolutely committed to making these improvements for patients now and in the future, as our Chief Nurse Andy Cruickshank says in his statement, this was a big change for our staff. We're focused on learning from this, to help change feel smoother and more empowering for them in the future.

We've been careful to make sure that all information and data presented in this report is accurate, and provides a fair and balanced reflection of our performance this year. Under the guidance of our board, and the efforts of my executive management team, we have taken all reasonable steps to verify the accuracy of the data used.

To the best of my knowledge, the contents of this document are accurate. The director's statement confirms that we have adhered to the standards required for this account.

S. Stenson.

Sheila Stenson
KMPT CEO

Director's statement

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on arrangements Trust Boards should put in place to support data quality for the preparation of the quality report.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

1. The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - papers relating to quality reported to the board over the period April 2024 to March 2025 › the 2024 national patient survey
    - the 2024 national staff survey
    - the Head of Internal Audit's opinion of the Trust's control environment dated 10 June 2025
2. The Quality Account presents a balanced picture of the trust's performance over the period covered.
3. The performance information reported in the Quality Account is reliable and accurate.
4. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
5. The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

Dr Jackie Craissati
Trust Chair

Statement from the Chief Nurse

I am delighted to introduce the quality account for 2024-25 for KMPT. The work represented here characterises the range of commitment and ambition to deliver care in KMPT.

This year brought significant change to our community services, with challenges in handling referrals and ensuring we have the right people in the right roles. We're reviewing the model with staff, service users, and partners to refine it and achieve the vision behind the transformation. While progress has been made, there's more to do. It's exciting but challenging work, and we know not all experiences have been positive. Collaboration remains key to delivering meaningful change for our communities.

Across the organisation, teams have collaborated to tackle complex issues like violence and aggression, achieving impressive results in reducing ward conflict and creating more therapeutic environments. Their efforts this year are something to be proud of.

The Quality Account Priorities for this year are particularly important from a clinical perspective. These are:

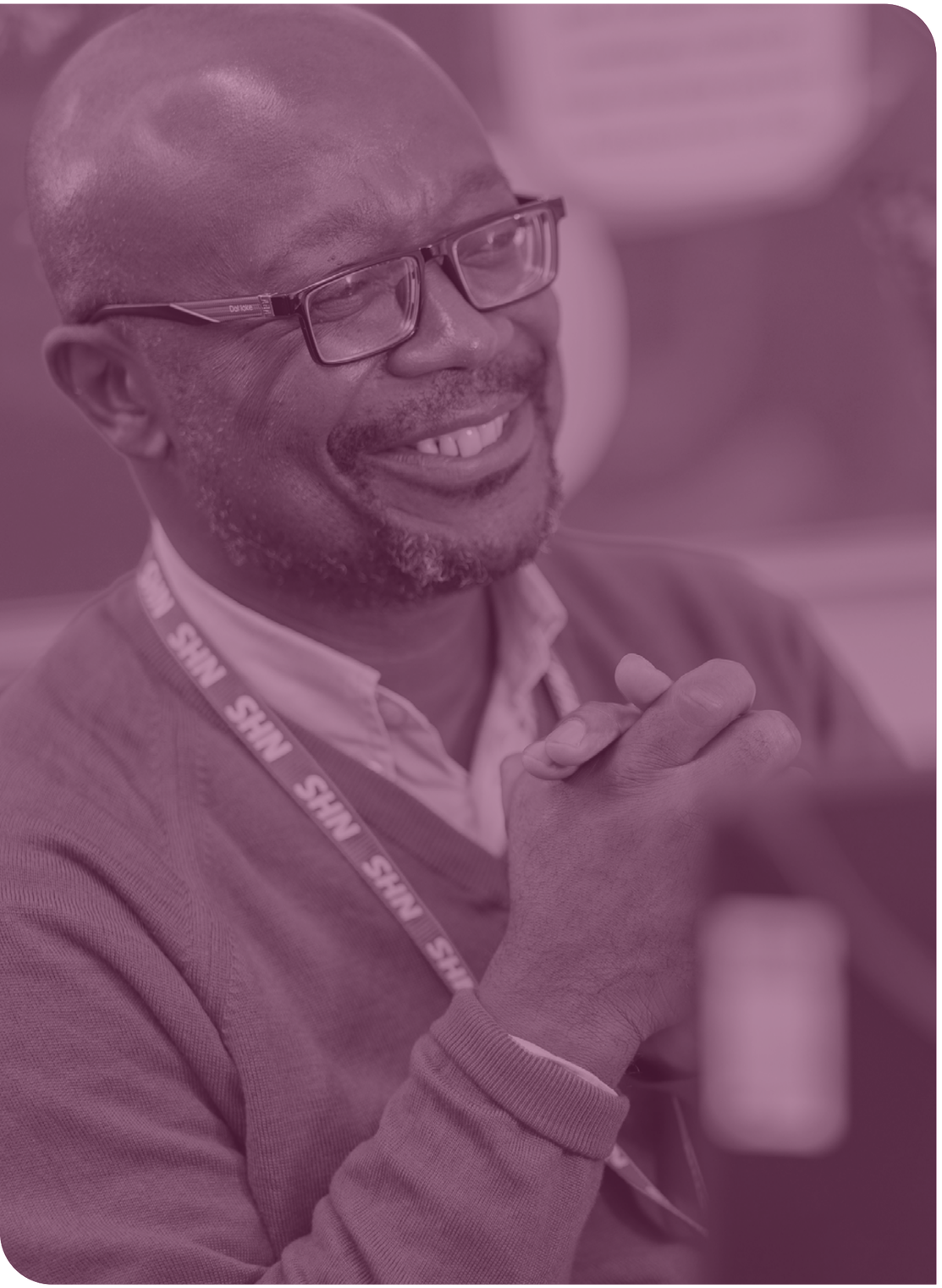
1. Working with families – ensuring that the care we provide relies on the partnership and participation of families and loved ones whenever we can.
2. Reducing self-harm – this has become the biggest incident category on our women's wards and we need to develop effective ways of understanding and collaborating with our patients to help reduce this.
3. Women's health – this area of care in mental health has been frequently overlooked. Understanding peri-menopause, menopause, sexual and reproductive health, amongst a range of other issues, and the interaction of these events with women's mental health, has not been a central clinical approach. We need to change this and deepen our understanding and practice.

The work in this report, is focussed on improving outcomes for those we serve and improving the experience of working in KMPT, as well as becoming a more integrated part of the fabric of our communities. It is a really exciting time of growth and development and although change can be daunting, we are setting course to make KMPT a truly fantastic organisation to be part of, and to care for you.

This account represents some of the great quality work of the staff in this organisation. There is much more that goes on every day that is largely hidden or taken for granted. To all those staff, I thank you and look forward to bringing some of that work into light over the year ahead.

Andy Cruickshank
Chief Nurse

Part one



Our Approach to Improvement - Doing Well Together Improvement Programme

In December 2024, KMPT agreed a new approach to Improvement; our Doing Well Together Improvement Programme.

Doing Well Together (DWT), will bring an organisational, systemic approach to improvement, creating a ward to board connection, ensuring that daily continuous improvement is part of everything we do.

Our previous QI approach has been incredibly effective at driving individual improvement projects and creating enthusiasm and encouraging a collaborative approach to change. However, many of these improvements were found to be 'standalone' and were not connected to organisational priorities.

Doing Well Together seeks to build on the foundations created by the QI approach but consists of 5 key pillars:

Strategy Deployment

Strategy Deployment is a process by which we can ensure that all improvement projects are aligned to our organisational strategy. We do this through a process called 'catchball' that engages each directorate in their contribution to our wider organisational goals. In turn, we will use a similar approach, supported by data to identify how each department can contribute to directorate goals through a series of small improvement projects. This creates alignment and ensures that everyone, from ward to board, are pulling in the same direction.

1. **Capability Building**

   Our Improvement team provide a range of training programmes from basic improvement awareness training which is included in the induction of all new staff to in-depth problem-solving training using A3 Thinking as well a number of other improvement tools to identify a problem, understand the current state and determine root causes before identify sustainable improvements. We seek to provide our staff with the knowledge, skills and empowerment to solve problems aligned to our strategy. We have already accredited 30 people in A3 Thinking which each successful delegate completing an improvement project in their area.

2. **Improvement Management System (IMS)**

   The Improvement Management System (IMS) provides frontline teams with a number of improvement tools and techniques which engages staff in small, daily improvements enabling them to making meaningful changes for staff and patients in their workplace. Our Improvement Management System rollout starts in June 2025.

3. Improvement Projects

Improvement projects are still a vital part of any improvement programme. We will be introducing in depth improvement methodologies such as A3 Thinking and DMAIC (Define, Measure, Analyse, Implement, Control) to help solve our most complex and challenges problems. These projects are supported by our experienced Improvement Practitioners to ensure lasting improvements for our staff and patients.

4. Leadership Behaviours

Delivering a culture of improvement and driving true, data driven improvement that gets to the root of the problem requires our leaders to live the values of improvement by developing a coaching approach to change/ improvement, empowering teams and individuals to driver their own improvements and championing improvement methodologies. We are incorporating these behaviours as part of the trust's new leadership development programme, Leading Well Together.

In 2024/25 there have been key focus areas to ensure readiness for this new approach:

1. Build a new Improvement Team – bringing together the Quality Improvement and Transformation teams to create a single Improvement team and developing the team's knowledge and skills in new improvement methodologies.
2. Supporting the development of a delivery plan for year 3 of our trust strategy – ensuring a focused approach to improvement so that we are able to get to the root of some of our most complex challenges such as Dementia diagnosis, patient flow and the community mental health framework (CMHF)
3. Continue to support on-going improvement efforts across the organisation including a number of QI projects a well as large scale transformation programmes.

Examples of some of the Improvement projects completed this year

HTT Reasonably Adjusting for Service Users with autism (ASD)

- Implemented Ask, Listen, Do (ALD) Framework into the 'first visit protocol' for people referred to the HTT who have an established diagnosis of ASD.
- Implemented a more personalised care plan to aid rehabilitation for ASD patients.
- Utilisation of purple magnets on the patient board to easily identify persons with autism that came onto the caseload. This allowed staff to remember to utilise the ALD framework with those patients.
- Demonstrated that staff perception of the HTT's effectiveness at treating people with ASD increased from 2.8 to an average of 3.8.
- Staff found the new care plan and protocol extremely useful, with an average score of 4.1 out of 5.
- Feedback from staff showed they felt the new care plans allowed for more person-centred care as well as supporting the needs of people with ASD.

South Kent & Costal RED Meetings

- Improvement made to the process of conducted RED board meeting which had become up to 90 mins long.
- Majority of RED board meetings are now 15-45 mins in duration and staff engagement in the meetings is much improved, with attendance having nearly doubled.
- Saved time has resulted in 1-2 hours of extra clinical time per staff member, per day. It is estimated that this equates to 500 hours of clinical time saved per week or up to £400,000 per annum.
- There has been a reduction in SI's reported incidents that mention the RED meeting as being a factor from 3 to 0. This was measured over a 1-year period, spanning equal time duration from both before and after the trial of the new template.
- Improved process now being shared across the trust to maximise the benefits of this project.

Getting the Basics Right – SMS appointment reminders

- Utilisation of text, messaging reminders to patients to reduce the number of 'did not attends' DNA's at the DGS Mental Health Together Team.
- The number of unattended appointments fell by 79 over 10 weeks during the pilot.
- Estimated value of increased clinic utilisation £21,052.
- The use of SMS is now being rolled out across the organisation.

Other Improvement Projects completed include:

- Creation of an art therapy mural on Jasmine ward.
- Pilot use of portable ECGs.
- Reduction in agency spend in Urgent & emergency Care (UEC) Crisis Line.
- Development of serious incident training and coroner's inquests to resident doctors.
- Improved sexual safety on Tarentfort ward.
- Improved physical health compliance in DGS depot/ clozapine clinics.

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Quality Priorities 2025-2026

Self-Harm

Self-harm remains the most frequently reported incident type across the organisation. While it occurs across all service areas, the highest rates are reported on the women's inpatient acute wards. Evidence indicates that self-harming behaviours have a significant impact not only on the individuals involved, but also on the wider population of the ward. When self-harm is prevalent it can affect other patients' sense of safety, potentially increase the trauma that they experience, and can lead to more frequent use of restrictive practices as a means of reducing risk.

Managing and witnessing self-harm can also have a profound emotional and psychological effect on staff. This can include experiencing feelings of self-blame, trauma, stress, compassion fatigue, frustration, and helplessness. These experiences are linked to increased work-related sickness, which can contribute to staff shortages, a reliance on temporary or unfamiliar staff, as well as the rates of staff retention. This, in turn, affects consistency, team cohesion, and both staff and patient perceptions of safety on the ward.

Whilst most frequently reported in inpatient settings, self-harm incidents occur across the full range of services provided by the organisation, and any improvement efforts therefore have to consider the needs of staff, patients and their family, friends and carers across the range of clinical services and settings. Through the work of the newly established Trust Wide Self-Harm Steering group, which has representation from all clinical disciplines and from all directorates, the following pieces of work have been commenced:

- Updates to the InPhase reporting system have been made and now allow for better data collection, including more detailed information about the number of incidents and methods of self-harm.
- A baseline survey has been developed to gather staff perspectives, experiences, and beliefs regarding self-harm. The survey also provides staff with an opportunity to highlight what is working well and where they feel that they need further support.
- We are working with the Communications Team to create a centralised intranet resource hub for staff, focused on self-harm awareness, strategies for management, and support.
- A review is underway with the Training Department to assess the uptake of the existing self-harm-related training offer. Additionally, a scoping exercise is being conducted to benchmark training provision against other mental health trusts.
- Information is currently being developed to help families, friends, and carers understand the approaches and limitations around the management of self-harm within inpatient settings.
- In collaboration with the Engagement and Involvement Team, we are initiating work to establish focus groups of individuals with lived experience of self-harm. These groups will inform future service development by

sharing what those with lived experience feel would have been most helpful in supporting their needs when they were accessing services.

- A pilot initiative has been launched focusing on the use of alternatives to self-harm.
- A pilot initiative has been launched around the use of Minimal Risk Activity Packs for those who self-harm.
- Work is underway to look at how sensory ladders might be used as a means of supporting self-regulation for those who self-harm.

Women's Health

NHS England has published a 10 years Women's health strategy which highlights disparities in care for women in the workplace and in care settings.

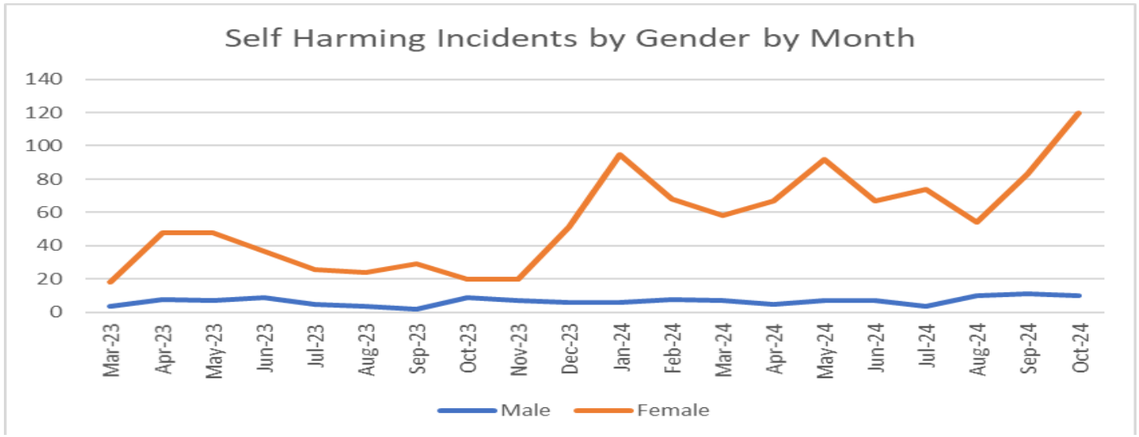
Local context

KMPT inpatient services moved to single sex wards in March 2023 in line with government policy to improve sexual safety.

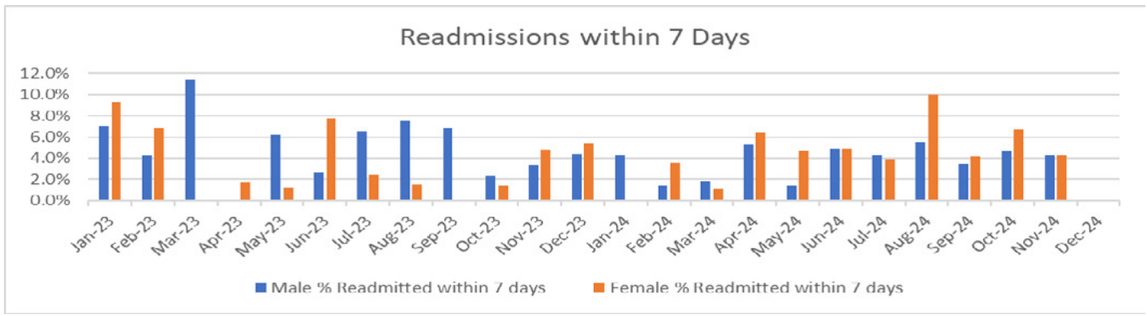
There are notable differences in the needs of Women on our wards.

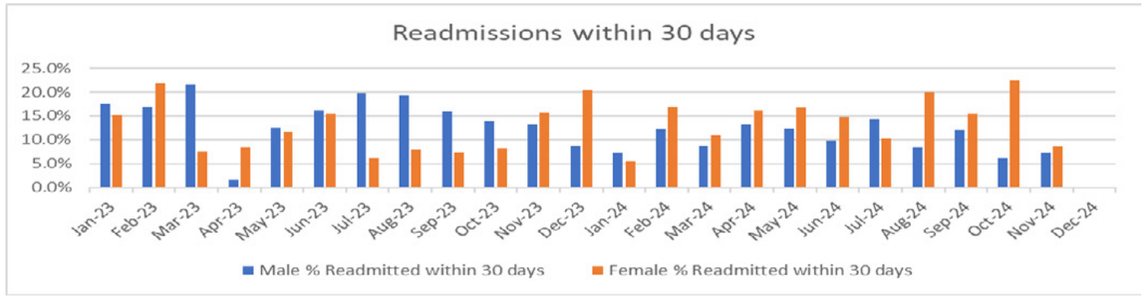
Notable data:

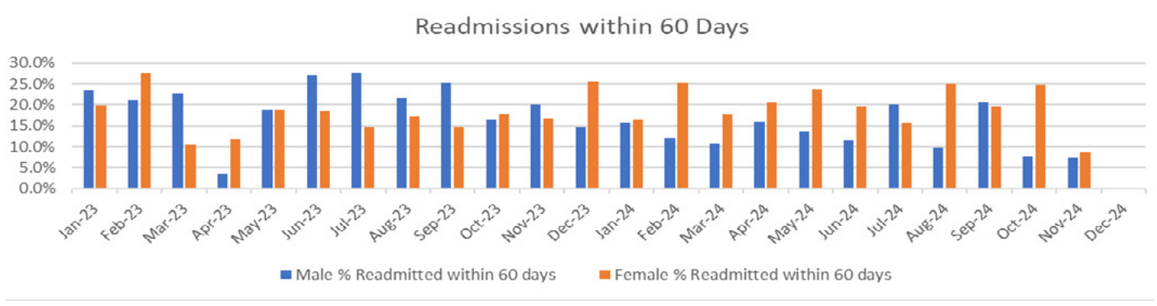
Self-harm incidents



Readmissions







Primary Diagnosis ICD 10 2023-204 - Female

ICD10 Code	ICD10 Code Description	Count of Primary Diagnosis
F603	Emotionally unstable personality disorder	220
F259	Schizoaffective disorder, unspecified	86
F200	Paranoid schizophrenia	68
F319	Bipolar affective disorder, unspecified	64
F102	Mental and behavioural disorders due to use of alcohol| Dependence syndrome	51
F323	Severe depressive episode with psychotic symptoms	41
F239	Acute and transient psychotic disorder, unspecified	40
F412	Mixed anxiety and depressive disorder	36
F311	Bipolar affective disorder, current episode manic without psychotic symptoms	32
F431	Post-traumatic stress disorder	28

Primary Diagnosis ICD 10 2023-204 - Male

ICD10 Code	ICD10 Code Description	Count of Primary Diagnosis
F200	Paranoid schizophrenia	185
F102	Mental and behavioural disorders due to use of alcohol| Dependence syndrome	91
F259	Schizoaffective disorder, unspecified	77
F603	Emotionally unstable personality disorder	64
F29X	Unspecified nonorganic psychosis	47
F319	Bipolar affective disorder, unspecified	34
F323	Severe depressive episode with psychotic symptoms	33
F329	Depressive episode, unspecified	28
F195	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances| Psychotic disorder	28
F191	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances| Harmful use	27

Work will be delivered across 3 main topic areas over 3 project workstreams:

- Clinical- Diagnosis prevalence and overshadowing
- Health Promotion- Menopause and reproductive health (staff and patient well-being)
- Interventions-Education, training, resources and skills

Clinical areas to include:

- Acute inpatient women's wards
- Forensic women's wards

Working groups to meet week beginning 26 May 2025 to scope topic areas.

Working with Families

KMPT has heard for many years, the struggles that some families and loved ones have in being involved and heard in relation to the care of a member of their family. The barriers to making this a universal approach to the work have eluded the sorts of systemic design solutions that could reshape this into core practice and value within clinical services.

There are examples of great practice across the organisation, and there are clinical leaders who can help shape and deliver this.

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The main areas for development and their corresponding actions are:

1. Embed Family and Carer Involvement into Organisational Culture

- Make family inclusion a core value: Explicitly state it in mission statements, staff inductions, job descriptions, and performance metrics.
- Use frameworks like the Triangle of Care (Carers Trust) to audit and guide services, especially around information sharing, carer engagement, and joint working.
- Review internal policies to ensure they do not inadvertently create barriers to involvement.

2. Improve Workforce Capability, Confidence, and Supervision

- Deliver mandatory training on carer engagement, communication about consent, and systemic thinking (e.g. Behavioural Family Therapy, Open Dialogue).
- Provide regular reflective supervision to help staff explore their feelings and judgments when working with families.
- Introduce family peer workers into teams to act as bridges and mentors.

3. Co-Produce Services with Families, Friends, and Carers

- Involve families in service planning, delivery, and evaluation – invite them to co-design induction processes, care pathways, and communication tools.
- Set up family/carer advisory groups to provide feedback and challenge tokenistic practice.
- Use family narratives in training and service redesign to increase empathy and understanding.

4. Create Flexible and Accessible Pathways for Family Involvement

- Develop family inclusion protocols that provide clarity around what can be shared without breaching confidentiality (e.g. general advice, risk discussions).
- Use technology to offer flexible meeting options and information sharing (evening Zoom calls, e-consent forms).
- Offer family-focused support at the point of discharge, including psychoeducation, signposting, and check-ins.

5. Build Infrastructure to Sustain Change

- Develop a Family Liaison role or team, housed within Patient Experience, Safety, or Community Services, to champion the work.
- Include family engagement metrics in quality dashboards, audits, and service reviews.
- Establish a community of practice across teams to share innovation, learning, and challenges.

6. Normalize Positive Risk-Taking Around Information Sharing

- Provide scenario-based training on consent and capacity, encouraging clinicians to think relationally (e.g., "What can I share?" instead of "What can't I?").
- Clarify boundaries in communication and reduce fear through support from IG specialists or legal teams in team discussions.

Next steps:

The actions outlined above will be scoped to establish what is already working in KMPT and then where the gaps are and how to manage them.

There will be 3 workshops over the next 6 months that will be themed based on the evidence above.

The training and resourcing implications will be worked through and the system changes required will need careful alignment given the scale of other change programmes that are underway. The principle is to create a timely introduction that fits with the developing models of practice.

The evaluation of this will be considered and rolled out in due course.

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Statements Relating to the Quality of Services - Our Services

KMPT provides a range of secondary care mental health services to a population of approximately 1.9 million people across Kent and Medway. KMPT has approximately 4,000 employees.

The key highlights on our income for 2024-25 are:

- Our total income for 2024-25 was £300m.
- £278m related to patient care activities.
- £22m was other operating income.
- All income was generated through our operations as an NHS Trust.

KMPT provides:

- Acute inpatient mental health services
- Acute inpatient psychiatric intensive care services
- Liaison Psychiatry
- Crisis services
- Community Mental Health services - including Secondary Care Psychological Services and Mental Health Learning Disabilities Services
- Perinatal Mental Health Community Service
- Acute Inpatient Mother and Baby Unit
- Early Intervention in Psychosis;
- Inpatient rehabilitation
- Community rehabilitation
- Older adults' inpatient services
- Older adult community services
- Medium and low secure forensic services
- Women's Forensic Outreach Service
- Offender Personality Disorder Service
- Learning Disability Forensic Outreach Service
- Forensic Mental Health Outreach Service
- Forensic Learning Disability Services
- Substance Misuse In-patient Detox Unit
- Neuropsychiatry
- Neuropsychology
- Liaison, Diversion & Reconnect Service
- Community Brain Injury Service

Registration and regulation

The trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008 and is registered without conditions for its 17 registered locations. The trust continues to have an overall rating of good.

In March 2024, the CQC conducted an unannounced focussed inspection on Amberwood and Cherrywood Wards at Littlebrook Hospital in response to safety concerns relating to deaths that had occurred whilst patients from these wards had been on section 17 leave. This inspection reflected the new single assessment framework that the CQC had rolled out nationally whereby quality statements were used to assess and make judgements on the quality of a service provided (these have replaced the previous key lines of enquiry (KLOEs).

This inspection focused on the safe and well-led key questions and included an assessment of the following quality statements:

Safe	Well-led
Learning culture	Governance, management and sustainability
Safe systems, pathways and transitions	Learning, improvement and innovation
Safe and effective staffing	

The final report was published in January 2025 and the rating for the safe key question, moved from inadequate to requires improvement overall. The well-led key question rating remained the same as when last inspected in 2023, as requires improvement overall.

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The CQC had stated that during this assessment, they saw that there were systems and processes that had been implemented by the trust to support the staff to manage the concerns relating to section 17 leave arrangements and that these were in the process of being embedded into the day to day running of the wards. Staff had access to safety bulletins sent out by the acute directorate governance team and these were being discussed and disseminated in staff team meetings and via the clinical governance structure.

Patients were positive about the wards at Littlebrook Hospital, stating that they were confident in the ward managers and the staff team's ability to keep them safe and that they were receiving the care and treatment they needed. Patients described feeling safe on the wards even when people are distressed, they had confidence in the staff to keep them safe. Patients felt that the staff were doing their best to help them to improve their mental health and support them to leave hospital.

Patients stated however that they were not always aware of their care and treatment plans and didn't always know who to go to when they wanted to discuss their care or to raise a complaint. Patients said they had not received any written information when they had first come into the hospital and that this would have been helpful. The acute directorate were in the process of reviewing their patient information leaflets at the time of inspection and had subsequently removed them while they were being updated.

Following the conviction of Valdo Calocane in January 2024 for the killings of 3 members of the public in June 2022, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008.

As part of CQC's review, they were asked to look at 3 specific areas:

1. A rapid review of the available evidence related to the care of Valdo Calocane.
2. An assessment of patient safety and quality of care provided by NHFT.
3. An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity.

In March 2024, CQC published the first part of their review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since the last inspection in July 2023. In August 2024, CQC published the second part of their review. The issues identified in NHFT were noted as not unique to this trust as CQC found systemic issues with community mental health care and therefore made recommendations relevant to all providers; one of which being that all mental health trusts were required to conduct a gap analysis against the recommendations made.

11 gaps/areas for further development were identified by the trust and these focussed on:

- Reviewing policies following transformation of services.
- Strengthening engagement and involvement with families and carers.
- Improving the assurance around discharge processes.
- Having a robust system for monitoring waiting times using new national metrics.
- Strengthening the patient flow pathway so that there is an increase in bed availability
- Having access to shared records that cross all healthcare services so that full risk history and family dynamics can be understood in greater depth.
- To consider how to support patients that disengage with services via an assertive outreach approach.
- To consider how regular reviews of treatment plans for treatment prescribed in line with key NICE guidelines can be reviewed on a regular basis in order to identify further learning.
- To consult with GP practices to ensure that suitable structures are in place for support, advice and escalation.

CQC had also stated that there would be a national review that is conducted over a 2-year period focusing on the crisis and community mental health pathways and that this will assess the impact of the rollout of the community mental health framework in different regions of the country highlighting areas where it is working well and those where further improvements can be made. All mental health providers will be part of this review and services visited accordingly.

In March 2025, the CQC conducted an announced onsite inspection of the trust's crisis services and health-based places of safety and community based mental health services for adults of working age. This was followed up by a review of data and offsite interviews with members of staff. KMPT was the first trust identified as a pilot for the aforementioned national review.

On 8 April 2025, the trust was issued with a Section 29A warning notice due to the following:

1. Routinely detaining patients in section 136 suites (health-based places of safety), beyond the expiry of their section 136 detention under the Mental Health Act 1983, without any legal framework.
2. Risk assessment and management of patients in the community mental health services being variable, with the trust not always mitigating against avoidable harm.

The trust has been asked to make significant improvements by 30 July 2025. In order to meet this deadline, a quality improvement plan has been developed for both points and daily calls have been put in place in order to monitor the delivery of these actions.

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Quality Networks and Accreditation Schemes

The Royal Collage of Psychiatrists provides a programme of quality networks and accreditation schemes. Below are details of the Kent and Medway NHS and Social Care Partnership Trust participation for 2025 - 2026:

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | **PLAN** PSYCHIATRIC LIAISON ACCREDITATION NETWORK	**The liaison teams** - in the process of benchmarking their current practice against the PLAN standards and formulating action plans to close any gaps.
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | **MSNAP** MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME	• **Ashford Memory Service -** accredited until September 2026 • **Canterbury Memory Service -** accredited until November 2025 • **Dartford, Gravesham and Swanley Memory Service -** accredited until October 2027 • **Dover/Deal Memory Service -** member • **Medway Memory Service -** accredited until September 2027 • **Shepway Memory Service -** member • **Thanet Memory Service -** member
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | **ECTAS** ELECTROCONVULSIVE THERAPY ACCREDITATION SERVICE	ECT Suite Maidstone is accredited until June 2026.
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | **C of C** THE COMMUNITY OF COMMUNITIES	• **Brenchley Unit -** accredited extended to 2025 • **Ash Eton -** are peer reviewed and not yet accredited
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | **FORENSIC** QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES	• **Trevor Gibbens Unit -** medium secure service is member • **Allington Centre -** low secure service is a member
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | **PQN** PERINATAL QUALITY NETWORK	**Kent and Medway Perinatal Mental Health Community Service -** accredited until December 2027

Other Accreditation Schemes:

National Autistic Society	**Dartford low secure LD services** are in the process of working towards National Autistic Society Accreditation (NASA).
Restorative Justice Council	**The Brookfield Centre** is looking to become a registered service.
CARERS TRUST	**KMPT** has been awarded 2 stars by the Carers Trust.

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Research & Innovation: Delivering Our Strategy in 2024 / 2025

Our ambition is to increase opportunities for our patients, their carers, our staff and the wider public in locally-led research projects.

Recent investment into Research and Innovation (R&I) is starting to be realised, as we move forward on our intention to be a truly research active organisation.

Work of the department is split between several teams to develop, set up, provide governance for, manage and deliver Clinical Research for the Trust. From July 2024, we had completed recruitment to KMPT funded posts, that ensure we are able to increase the number and variety of those involved in our research.

We are starting to increase the ways we add value to real life problems in the Trust. A current example being where we have received recognition from members of Executive Management Team by bringing a research lens to, and applied for research funding to help address, the clinical flow challenges in the KMPT Metal Health Together programme.

To deliver our strategy, we have focussed on the following areas.

Increase the number of studies we develop ourselves

The Research and Innovation Team have made significant strides in developing its research capabilities and working to foster a culture of innovation in mental health research. The team has worked to focus on creating a robust research infrastructure to support the growth of locally led research activities, developing research initiatives and providing guidance in study design and funding applications.

As table 1 shows, the increased of activity from the business case post resulted in us being awarded £918,7666 in additional income in 24/25. Of this, £78,6818.26 was Capital income, to be used to start to develop our Clinical Research Facility and a second Hyperfine low field Scanner. Both of which will enable us to generate more of our own research and attract commercial studies.

Impact of original BCRG investment: Significant increase in activity can be seen since the Business Case investment in R&I took place.

	2023-2024		2024-2025	
	Number	£	Number	£
Total Bid Submissions	12	£2,298,878	33	£14,649,764
Grant Income success	7	£557,584	12	£918,766

The team has been working to strengthen its academic relationships with various institutions including the University of Kent, Canterbury Christ Church University, University College London and Kings College London. These relationships have led to an increase in the number of collaborative funding applications we have been developing and provided increased opportunities for clinicians to act as co-applicants on research bids.

A great example of this is the 'CHIP-D' study. Funded by a £1.7million Wellcome trust grant, secured by Prof Shergill in his Kent and Medway Medical School (KMMS) role, is now open. This study explores the dynamic relationship between circadian biomarkers, sleep, cognition, and mental health. Our shift workers as well as patients with psychosis will have the opportunity to receive an in-depth sleep report, which will help us understand the impact of sleep on their mental health and daily functioning using brain scans and cognitive assessments.

Dr Jo Rodda has collaborated with other organisations to ensure we are part of a successful £3.8million pound grant focussed on dementia diagnosis. Additionally, we are part of another embargoed award totalling £2million that will help dementia support services in Kent and Medway as part of the clinical study. The impact of these studies will be seen imminently.

We have seen an increase in the number of new Principal Investigators (PI) / Co-Investigators 's coming from KMPT and the Research Community is continuing to grow, and several new project leads are coming from here. In addition, the work with the Communities of Practice are beginning to show encouraging signs of engagement with planned research workshops already in the pipeline with the hope to run more in the future.

Developing Our Clinicians

We now have 15 KMPT staff members who have a split role across research, clinical care and/or academic work at the University of Kent.

KMPT has its first NIHR Academic Clinical Fellow – a trainee doctor receiving joint research and clinical training– fully funded by the NIHR – so in effect a completely free resource for KMPT.

KMPT Quality accounts 2024-2025

We were also awarded £20,000 to comprehensively upskill and give new opportunities to 5 KMPT pharmacists, thus expanding our capabilities in clinical trials. In addition, we also invested in equipment for the storage of trial medication in our Clinical Research Pharmacy Office in Priority House.

KMPT Publications

In 2024-2025, 49 KMPT clinicians contributed to 38 publications which included book chapters, journal articles and editorials. These activities develop their skills, research reputation as well as KMPT's profile.

Staff Research Champions

Across 2024/2025 the team has taken significant steps to foster positive working relationships within staff spanning all the trust directorates. This year the team reinstated the role of Staff Research Champion (SRC), enabling the embedding of research across the trust. The revamping of the previously known Staff Research Ambassador role has enabled expectations for staff involvement to be clear, with line managers providing support and approval of protected time for research related commitments.

November 2024 marked the successful completion of the team's first ever Staff Research Champion Induction Event. We provided staff with extensive training to support them in their role. We currently have a total of 14 new SRCs, with the long term aim to have one SRC within every team across all 5 directorates.

Increasing access to Research opportunities for our patients

This year we included 396 KMPT service users, their family members, carers and our staff across 21 open studies.

This year, the team celebrated a significant achievement, enabling 10,000 participants to be involved in research. This milestone represents over 12 years of growth, innovation and expanding research capabilities across various clinical areas.

We are delighted to have offered this many people the opportunity to participate in national multi-site Portfolio research.

COBALT	Open in KMPT since January 2024 and recruitment remains open
Title	ComBining memantine and cholinesterase inhibitors in Lewy body dementia Treatment trial
KMPT Target	10
KMPT recruits	10 (5 people with dementia and 5 carers)
Study Sponsor	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust
KMPT PI and Job Role	Jo Rodda - Consultant in Older Adult Psychiatry

COBALT continues to offer clinical trial opportunities for our service users living with dementia. This year the team achieved a record by randomising two participants within one week. The team have also been commended for their rate of recruitment for patients with a Parkinson's Disease Dementia diagnosis, something which the study is struggling with nationally.

Furthermore, the study it has enabled a total of 6 junior doctors an opportunity to undertake study related training, gain experience supporting a clinical research trial and develop research skills in the undertaking of participant informed consent.

FReSHSTART	Open in KMPT between April 2022 and March 2025
Title	Function REplacement in repeated Self-Harm: Standardising Therapeutic. Assessment and the Related Therapy (WP4 – Randomised Controlled Trial)
KMPT Target	41
KMPT recruits	53
Study Sponsor	University of Leeds
KMPT PI and Job Role	Fareedoon Ahmed - Consultant Psychiatrist

The R&I Delivery Team have facilitated the study since 2022, training 16 KMPT liaison psychiatry clinicians to deliver two different types of psychological therapy, the first time an intervention has been modified and adapted for those who self-harm (Cognitive Behavioural Therapy or Acceptance Commitment Therapy). 53 of our KMPT patients have taken part in the trial to date (26 receiving therapy, 27 standard care), with results expected soon.

This year the initiation of a second KMPT Liaison recruitment site in Medway has provided increased opportunity for staff development and CPD, through novel research training and development of skills to delivery therapy with their patients. The continued collaboration between KMPT R&I staff and KMPT Liaison teams has enabled KMPT to importantly reach an already under-researched population of patients. Our Clinical Research Practitioners (CRPs) continue to forge positive working relationships within Liaison services.

KMPT Quality accounts 2024-2025

A recent internal audit undertaken within the Dartford Liaison Service highlighted the positive impact FRESHSTART therapy has had on its patients and their outcomes. As a result, the team is now having further discussions on how to continue the great work being done following recruitment close and utilise the skills that their team have developed to continue supporting their patients. This highlights the positive impact of the intervention and successful embedding of research into practice.

Developing our ability to deliver Clinical Research

Since the incredible success from the NIHR Capital Infrastructure Award for a Portable MRI scanner (£260,000) and following the delivery and placement of the scanner at Verona Holmes, CCCU and KMMS campus, in Canterbury in April 2024, we are now working closely with colleagues at Kent Medical School (KMMS), University of Kent and Canterbury Christ Church (CCCU) to develop research together using this state-of-the-art equipment,

KMPT is the first and only UK NHS Trust to own a low field MRI scanner, which places KMPT on the research map for leading the way in this area of clinical research. The scanner is smaller, less expensive and more portable than traditional MRI scanners and could replace standard brain scanning in dementia assessments. To support this amazing opportunity, we have appointed a Magnetic Resonance Responsible Person (MRRP) to hold the responsibility of ensuring safety of patients, staff and equipment in the MR room and a Magnetic Resonance Safety Expert (MRSE) to provide expertise and guidance on the MR safety matters. KMPT and our academic partner's staff have now been trained in the use of the Hyperfine scanner ahead of the machines imminent use, which will be for a variety of research including looking at how we can improve our dementia assessments and diagnosis pathway, with potential to supporting early access to treatment and directly improving patient care. In due course the machine will be available for clinical care.

Following a second success in the NIHR Capital Infrastructure Award this year, KMPT are to receive further funding to purchase a second Portable MRI scanner and capital building costs to refurbish KMPT estate to house the second scanner (£786,818). This award will enable KMPT to develop a second MRI research suite and house it on KMPT estate, this will allow regional access for patients to imaging research opportunities, in both the East and West. R & I have been working with Estates and Procurement to deliver the timely spending of this award.

Increase Research Awareness and Engagement

Our Community Research Partners

It is imperative that we continue to ensure we are able to develop research that is relevant to the diverse communities which we serve. To this end we have developed a model of engagement that seeks to identify key voluntary and charity sector organisations with whom we can develop long standing, trusting relationships with, to upskill them in research development and to share research opportunities with their communities. With the development of the trust wide Involvement and Engagement team, these partnerships will be managed centrally to benefit the wider organisation as we as Research.

To date we have Community Partnership pledges with over 30 organisations ranging from domestic abuse charities, male mental health organisations, homeless charities and sports organisations who have a particular interest in mental health.

Our Community Research Partners support us to spread the word of research to those who many not have been opportunities to take part previously. We have worked to ensure that the relationship we build with our partners are meaningful and mutually supportive. From these partnership new research projects have begun to emerge. We currently have a new study in development in partnership with Keep Talking Services that focuses specifically on tackling loneliness.

Community Research Champions

This is a fresh take on engaging the Kent and Medway public and patients in local mental health research and services. This concept promotes diverse participant recruitment within KMPT research because the Partnerships and Engagement Team recognised that to help communities and organisations feel empowered within mental health research and services, we should celebrate and support the lived experiences of the people involved with our Community Research Partnerships.

In May 2024, we successfully held our first Community Research Champion induction event. This was attended by 18 new champions, some of whom represented some of our Community Partners and other who are individuals who just have a keen interest in mental health research.

The day started with various member of the Research and Innovation team talking about the department and the research that we undertake. Champions had the opportunity to discuss how they can support KMPT research in their communities and received training on the department's approach to community engagement. Feedback from the event was overwhelmingly positive.

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"The presentations were clear and concise, with a few laughs which was nice to take the edge off when in a new place with new people".

"They make you feel very welcome and I enjoyed it so much".

"All the team were very engaging, made me feel comfortable"

Our Research Activity in Numbers

Research Funding Applications 2024 to 2025

Application lead	Application title	Funder	Application value	Status
Jo Rodda	Reading for Older people Connecting with Kids and Enjoying time Together: The ROCKET project.	Research for Patient Benefit | NIHR	£150,000	Unsuccessful
Amy Hammond	NIHR Capital Funding Application	NIHR Equipment Application	£786,818	Successful
Holly Till	Community partner event	Kent County Council	£1,475	Successful
Jo Rodda	CRN Underserved Communities	Clinical Research Network: KSS	£21,677	Unsuccessful
Holly Till	CRN Contingency funding	Clinical Research Network: KSS	£20,677	Successful
Sarah Dickens	NIHR Research Capacity Funding (RCF)	Research capability funding | NIHR	£25,000	Successful
Sukhi Shergill	Human-Centric AI for Early Detection: Investigating Virtual Human Clinical Interview for Predictive Analytics	Engineering and Physical Sciences Research Council	£2,500,000	Unsuccessful
Sukhi Shergill	Sensitivity to light as a marker of sleep and circadian health: enabling early diagnosis through the use of virtual zeitgebers	Engineering and Physical Sciences Research Council	£2,500,000	Unsuccessful

Sukhi Shergill	Management of psychosis	Engineering and Physical Sciences Research Council	£2,350,000	Unsuccessful
Sukhi Shergill	Dementia focus	Engineering and Physical Sciences Research Council	£2,350,000	Unsuccessful
Jo Rodda	REEF Funding	University of Kent	£2,934	Successful
Eromona Whiskey	Addressing health inequalities in psychosis management: Why lower rates of clozapine prescribing in black patients?	Wellcome	£154,000	Unsuccessful
Jocelyne Kenny	Helping develop psychological resources for children whose parents have acquired brain injury	Research for Patient Benefit | NIHR	£253,064	Unsuccessful
Bosky Nair	Using eye-tracking to explore links between perinatal mental health and autism in the first two years of life	Research for Patient Benefit | NIHR	£261,460	Unsuccessful
Amy Hammond	CRN Contingency funding	Clinical Research Network: KSS	£12,850	Successful
Sukhi Shergill	Modelling Excitation/ Inhibition for Cognitive Symptoms and Treatment Response in First Episode Psychosis	Wellcome Trust	£2,500,000	Submitted
Douglas McInnes	Developing an intervention to reduce the levels of loneliness for people with serious mh problems: The Listen study	Research for Patient Benefit | NIHR	£182,365	Unsuccessful
Natalie Farley	ARC KSS Springboard	NIHR ARC	£5,000	Successful
India Butler	ARC KSS Springboard	NIHR ARC	£5,000	Unsuccessful
Madeline Bridges	ARC KSS Springboard	NIHR ARC	£5,000	Unsuccessful
Kasia Wawrzyniak	ARC KSS Springboard	NIHR ARC	£5,000	Successful

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Deidre Bond	ARC KSS Springboard	NIHR ARC	£5,000.00	Unsuccessful
Alison Welfare-Wilson	Trauma Informed Research	NIHR	£110,291	Unsuccessful
Imogen Sargent	ODESSI	NIHR	£25,554	Unsuccessful
Sukhi Shergill	Mental healthcare applications of virtual humans	Engineering and Physical Sciences Research Council	£0	Successful
Jo Rodda	GRACE (Goal-directed Accessible, Equitable, evidence-based Care)	Alzheimer's Society	£47,555.00	Submitted
Eromona Whisky	Clozapine and prescription profiles (RfPB)	NIHR	£95,965.00	Submitted
Sukhi Shergill	Digital Mental Health Applications	Wellcome Trust	£211,022.00	Submitted
Sukhi Shergill	NIHR Professorship	NIHR	£0.00	Submitted
Amy Hammond	Contingency Fund	NIHR	£7,388.00	Successful
Holly Till	Contingency Fund	NIHR	£4,925.00	Successful
Amy Hammond	Contingency Fund	NIHR	£10,044.00	Successful
Amy Hammond	Contingency Fund	NIHR	£3,555.00	Successful

Non NIHR Portfolio studies Running in 2024-2025

Principal investigator	Project short title	Project site date open to recruitment	Project site status
Simon Russon	Family experiences of systemic family therapy (SFT) in older adults.	09/11/2023	Closed
Madelaine Lambie	The SAFARI study	09/11/2023	Closed
Kasia Wawrzyniak	Effects of online Metacognitive Training group on distressing beliefs	05/02/2024	Open

Eric Barratt	STRESS-COPE Study v1 (this project is sponsored by KMPT)	11/07/2024	Closed
Athena Duffy	Experience of EMDR for previous birth trauma in pregnant people	12/09/2024	Closed
Elizabeth Davison	Birth experiences, Sense of Self and Postpartum Psychosis (V1)	26/04/2024	Closed
Hayley Freeman	Experiences of socket comfort and communication V1.0	05/08/2024	Open
Leah Adams	A DBT IE intervention in forensic MH: a narrative analysis	07/10/2024	Open

All NIHR Portfolio Studies supported by KMPT 1st April 2024 to 31st March 2025

KMPT PI Name	Project short title	Lifetime Target	Lifetime recruits	Recruits in year 24/25	Project site status at 31st March 2025
Mudasir Firdosi	PPiP2	247	143	16	Open
James Osborne	ODDESSI RCT and Process Evaluation	184	212	0	Closed - follow up complete
Nigel Ashurst	Genetic LinksAnxiety and Depression	40	71	10	Open
Sarah Holmes	Minder Healthcare Management Study	1	601	218	Open
Alice Cenerelli	EDGI UK	5	9	1	Open
Agostina Secchi	Pharmacogenetics	20	85	16	Open
Andy Inett	Trauma-AID	52	68	13	Closed to recruitment - in follow up
Joanne Rodda	APPLE-Tree: pilot and RCT	6	62	0	Closed
Fareedoon Ahmed	FReSH START RCT	41	53	24	Closed to recruitment - in follow up

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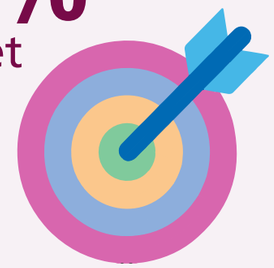
Ahmed Ismail	STOP	23	5	2	Closed
Joanne Rodda	COBALT	10	10	4	Open
Rachel Daly	CLEAR	2	0	0	Open
Amanda Fuller	Radar follow-up study	3	6	0	Closed to recruitment - in follow up
Albert Jones	SPACES feasibility study	12	14	14	Closed
Emma Bowler	DIAMONDS Randomised Control Trial	6	6	6	Closed to recruitment - in follow up
Brett Cole	Understanding anger and aggression	20	24	1	Closed
PI Not Applicable	NCISH	1	722	43	Open
Wendy Cooper	VISION-QUEST	5	3	3	Open
Abigail Afrey	Service configurations for psychosis	20	22	21	Open
Victoria Clark	A Shared decision making ExpeRience in mENtal HEalth (SERENE) measure		0		Closed
Margaret Nolan	SPACES full scale RCT	36	16	15	Open

Data Quality

88%
dataset score



During 2024-25, KMPT submitted records within prescribed deadlines to the Mental Health Services Data Set (MHSDS). Results are published monthly via NHS Digital.

Trusts' data quality is measured using the Data Quality Maturity Index (DQMI) – MHSDS Dataset Score, this was expanded to 36 items in April 2024. The latest nationally published figures (December 2024) show KMPT at 88% against a target of 95%, exceeding the national average of 67.4%.

Improving Data Quality

The KMPT Informatics Strategy sets out the ambition for informatics over that period to maximise the value and benefits from the data we generate and have access to. The strategy supports in the delivery of the Trust's objectives primarily:

- Consistently deliver an outstanding quality of care.
- Make continuous improvement the heart of what we do .
- Maximise the use of digital technology.

The trust's Data Quality Group terms of reference we last reviewed in December 2024 ensuring the priorities are directed to issues that will result in the greatest benefit in line with the trust's latest strategy and national priorities.

In addition, within the 2023-2026 Strategy, there are key objectives defined for technology, data and knowledge to transform patient care and our productivity. These are:

- Have consistent, accurate and available data to inform decision making and manage issues.
- Enhance our use of IT and digital systems to free up staff time.
- Effective digital tools are in place to support joined-up, personalised care.

Part two

Performance Against Mandatory Quality Indicators

The Trust is monitored against a set of core indicators which are published by NHS England. Robust procedures are embedded within the trust to address variances in compliance against these indicators, including a review of any instances of non-compliance to ensure lessons are learnt to further improve our performance in the future.

The Single Oversight Framework (SOF) sets out how NHS England (NHSE) oversees Integrated Care Boards (ICB) and NHS trusts, using one consistent approach. On occasion published data differs from KMPT held data due to processing variances carried out by NHSE against national data sets. In such circumstances KMPT work with NHS England to resolve disparities to ensure a single version of the truth wherever possible. There is a quarterly meeting with ICB colleagues where indicators are discussed and further detail provided against both areas of concern and those where KMPT demonstrates good performance.

NHSE monitor providers' performance under each of these themes and consider whether they require support to meet the standards required in each area. Individual trusts are segmented into four categories according to the level of support each trust needs.

KMPT Quality accounts 2024-2025

KMPT's current segmentation is 2. A breakdown of measures reported against the Single Oversight Framework as at May 2025 is shown below:

Indicator	Period	Value	National Display	Target or Standard	Rank
S000a: NHSOF Segmentation	2025 01	2:Flexible			
S035a: Overall CQC rating	2025 01	3 - Good			13/62
S059a: CQC well -led rating	2025 01	3 - Good			13/62
S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a)	2023	8.88%	9.94%		49/66
S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	2023	15.20%	17.70%		49/66
S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, their relatives or other members of the public	2023	28.10%	25.10%		60/66
S067a: Leaver rate	2024 12	7.67%	6.94%		49/67
S068a: Sickness absence rate	2024 09	4.77%	5.01%		16/67
S069a: Staff survey engagement theme score	2023	6.89/10	6.89/10		56/66
S071a: Proportion of staff in senior leadership roles who are from a BME background	2023	11.30%		12%	25/64
S071b: Proportion of staff in senior leadership roles who are women	2024 12	60.70%		62%	37/43
S071c: Proportion of staff in senior leadership roles who are disabled	2023	7.22%		3.20%	11/64
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	2023	57.50%	56.40%		48/67
S086a: Inappropriate adult acute mental health placement out -of-area placement bed days	2024 03	0		0	1/52
S121a: NHS Staff Survey compassionate culture people promise element sub-score	2023	6.88/10	7.09/10		61/66
S121b: NHS Staff Survey raising concerns people promise element sub-score	2023	6.5/10	6.46/10		53/66
S125a: Adult Acute LoS Over 60 Days % of total discharges	2024 03	13%			5/50
S125b: Older Adult Acute LoS Over 90 Days % of total discharges	2024 03	38%			19/50
S133a: Staff survey - compassionate and inclusive theme score.	2023	7.42/10	7.3/10		54/66
S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	2023	1.9		1	45/64
S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	2023	1.2		1	51/64

The SoF is due to be replaced by the newly proposed NHS Performance Assessment Framework which is currently undergoing consultation. This will likely result in some variation in the metrics against which the trust in monitored against.

Culture of Care Programme

Cohort 1: Quality improvement for wards - Bluebell

Wards Involved: Bluebell and Fern

Programme: NHSE Collaborative 2-Year Programme (currently underway at KMPT)

Patient-Centered Initiatives Being Implemented:

- sensory checklist completed on admission
- soft-touch keyboards installed in offices to reduce noise during patient meetings
- individual washbags provided to help prevent loss of patient clothing
- sensory equipment purchased

Additional Updates: KMPT staff continue to actively participate in national forums and sharing networks.

Cohort 2: Staff care & development

Wards Involved: Orchards, Jasmine, Fern, and Boughton

Programme: 6-Month Initiative (commenced March 2025)

Focus Areas:

- cultivating reflective spaces
- implementing practical changes to enhance staff culture

Key Objectives:

- delivering high-quality relational care
- promoting positive informal interactions on the ward
- creating psychologically safe environments
- let me know if you'd like this formatted for a report or presentation

KMPT Quality accounts 2024-2025

Information Security and Governance Update

The Trust has continued to develop and adopt a number of increasingly secure digital platforms to enable communication, remote working and increased efficiency, enabling all services to continue to interact with, and support our patients, partners and the public through the constantly evolving ways of working.

The Trust has worked alongside its partners to implement shared care records, ensuing that the correct information is in the correct place at the correct time, and will be introducing a patient portal system early in 2025/26 to increase collaboration with our patients.

In line with NHS Digital guidance on Data Security and Protection Incidents, it is necessary for all NHS Trusts to report any incidents of Data Security and Data Protection breaches on the Data Security Protection Toolkit (DSPT) and also in their respective annual reports.

The Trust had 2 Data Security and Protection incidents as defined by the NHS Digital guidance. These incidents were reported to NHS Digital on the DSPT and automatically reported via the DSPT to the Information Commissioners' Office (ICO). Of these incidents, one related to information disclosed in error and one related to inappropriate access to information. All incidents were thoroughly investigated internally, and all required actions taken and lessons learnt by the Trust have been completed.

These incidents have informed improvements to the organisation's information risk management process and enabled process changes surrounding storage of, and access to personal data.

The Chief Finance and Resources Officer is the Senior Information Risk Owner (SIRO) of the organisation, providing information risk management expertise at Board level. The SIRO oversees the consistent implementation of the information risk assessment process by Information Asset Owners, as described in the relevant organisation policies and procedures. Additionally, the SIRO acts as chair to the Trust-Wide Information Governance Group which is attended by the Caldicott Guardian (Chief Medical Officer (CMO)) and Data Protection Officer, as well as clinical and operational representatives.

The Data Security and Protection Toolkit and Information Risk Register are key enablers to embedding good practice, as well as identifying and managing key information risks. As a result, the Information Governance and Records Management Department have put into place a range of appropriate policies, procedures and management arrangements to provide a robust framework for Information Governance in accordance with the NHS Digital requirements.

The Trust continuously reviews its systems and procedures for the confidentiality, integrity and security of personal and confidential data, and always works

towards reducing data security incidents. As a result of investigations into incidents and reviews of IG, Data Security & Records Management by the Information Governance Group, measures are taken to ensure the procedures and policies on Information Governance and Data Security are updated to enable compliance.

Additionally, the Trust has systems and processes in place to govern access to confidential data and to ensure guidance and standards are followed when staff are using or accessing confidential data. The Trust monitors its Information Governance and Data Security risks through the Information Governance Group.

The Trust commissions internal auditors TIAA to undertake annual audits of the evidence collated for its yearly on-line submission of evidence for the DSPT.

KMPT Quality accounts 2024-2025

Improving the safety for the people we care for (Patient Safety Quality Improvements)

We have successfully transitioned into PSIRF which has served as the framework for learning and improvement after patient safety incidents, with QI being the methodology for systematically improving processes to enhance outcomes. The overall aim was to deliver high quality and safe care.

In 2024 we developed a plan which set out how we wanted to maximise learning and improvement using the four aims of PSIRF:

1. **Compassionate engagement & involvement of those affected by patient safety events**

   Learning responses have been designed to treat everyone equally, fairly and respectfully. We have continued to maintain contact with patients, families and carers who have been affected a patient safety incident and given them opportunity to be involved when we have undertaken safety reviews and investigations. We have trained staff to facilitate learning responses (Rapid Reviews) and developed resources and guidance packs for teams and staff that are required to participate. We will continue to promote a safe and restorative just culture for reporting incidents within the trust and through feedback have seen a positive change in staff experiences. Our Patient Safety Partner attends incident decision panels and ensures the voices of those affected are heard in all discussions. Further improvement work that promotes working with families will be aligned with existing trust plans.

2. **Application of system-based approaches to learning from patient safety events**

   We have adopted a human factors framework called SEIPS (System Engineering Initiative in Patient Safety) to understand how different levels of the work systems affect health related outcomes. This supports meaningful conversation and prevents apportioning blame as it looks at

the whole system rather than solely on individual actions. We have carried out training to enable our workforce to use SEIPS as a problem-solving tool when a patient safety incident has occurred and have the Patient Safety Syllabus level 2 available for staff to complete on iLearn. We have also used it within InPhase, our incident reporting system to capture themes from problems in care. At no additional cost, we have made arrangements with the Health Services Safety Investigations Body for in person SEIPS training to be delivered to 30 members of our staff which will increase confidence when leading on learning responses and playing an active part in investigations.

3. Considered & proportionate responses to patient safety events

We have introduced a range of proportionate learning responses which has ensured resources allocated to learning are balanced with those needed to deliver improvement. By prioritising what we investigate, we have minimised multiple reviews and Patient Safety Incident Investigations (PSII's) of the same incident where problems are known and instead increased the use of other more agile and inclusive approaches specifically, Rapid Reviews After Action Reviews (AAR's) and Thematic Reviews. We will continue to focus our efforts on learning and improving. The intention is to create a collaborative approach to learning and a safe, no blame environment. From the implementation of PSIRF on 30 September 2024 to 31 April 2024, the following learning responses and investigations have been undertaken:

- 82 Rapid Reviews
- 12 AARs
- 11 PSIIs
- 3 Thematic Reviews

4. Supportive oversight focused on strengthening response system functioning & improvement

PSIRF aims to build and maintain effective systems for responding to patient safety incidents, ensuring they are efficient and effective in learning from and improving patient care. To achieve this, we are using QI methodology for systematically improving processes to enhance outcomes. Our vision is to reduce the number of safety actions that are generated following incidents and instead map recommendations and outcomes to existing KMPT, quality improvement work, priorities and strategies and use our learning response findings and other patient safety insights, such as mortality reviews, patient and staff experience and complaints to inform our local priorities. We have used a range of platforms and forums to share learning through newsletters, communities of practice, a learning review group, learning events, directorate investigation review panels and other service specific groups and meetings. To further develop this, we are asking frontline staff and team leaders how immediate learning and examples of good practice can be shared within their working environment. Their responses will guide us in seeking the most effective way to share learning from incidents promptly. We will align examples of good practice to the new trust values and continue to examine patient safety incidents 'in the spirit of reflection and learning', rather than as part of a 'framework of accountability'.

KMPT Quality accounts 2024-2025

Our PSIRF plan has remained a live document that we review and change as practice evolves and becomes embedded. We have taken a flexible approach and considered the specific circumstances in which patient safety issues and events occurred, the needs of those affected and have used proportionate response that are fair and promote a just, learning culture to maximise our understanding.

Improving the experience of the people we care for (Patient Experience)

Trust Wide Patient and Carer Experience Meeting

Governance for patient and carer experience across the organisation is provided by the bi-monthly Trust Wide Patient and Carer Experience meeting. This forum brings together staff from KMPT, partners from external organisations such as Health Watch, individuals with lived experience and colleagues from patient safety, PALs and complaints. The meeting provides strategic oversight for the patient and carer experience agendas, encompasses a monitoring and assurance function around experience data and provides a clear line of accountability and communication from the clinical directorates to the executive levels of the organisation.

Patient Experience Feedback

Patient experience feedback across the organisation is collected through a variety of means across the organisation.

Patient experience questionnaires are completed and collated for individual services as part of accreditations such as the Quality Network or Memory Service National Accreditation Programme (MSNAP).

Inpatient acute services hold regular community meetings which allow patient experience information to be raised and acted on in real time. Longer stay inpatient services, such as forensics, hold regular patient experience meetings or patient council meetings which also enable those receiving treatment from the service to raise their views and have them responded to. A number of the specialist services also run bespoke patient satisfaction surveys focusing on particular elements of their service. Inpatient rehabilitation services also hold regular meetings to provide patients with the opportunity to give their thoughts and feedback on the service that they receive.

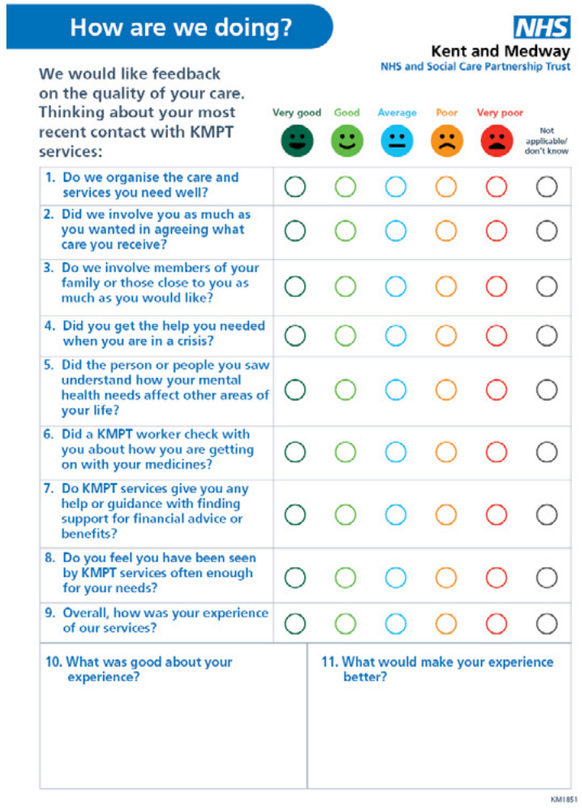
Patient Reported Experience Measure (PREM)

The organisation has its own Patient Reported Experience Measure (PREM) which offers respondents the opportunity to provide both quantitative and qualitative feedback about their experience of KMPT services.

The quantitative questions asked are based on previous Community Mental Health survey results and allow the respondent the opportunity to rate how well

they feel that individual services are addressing each of these areas. The scores and trends of these scores are able to be tracked over time to provide a picture of how people are experiencing services at a local, directorate and organisational level.

Patient Report Experience Measure



How are we doing?

NHS
Kent and Medway
NHS and Social Care Partnership Trust

We would like feedback on the quality of your care. Thinking about your most recent contact with KMPT services:

	Very good	Good	Average	Poor	Very poor	Not applicable/ don't know
1. Do we organise the care and services you need well?	○	○	○	○	○	○
2. Did we involve you as much as you wanted in agreeing what care you receive?	○	○	○	○	○	○
3. Do we involve members of your family or those close to you as much as you would like?	○	○	○	○	○	○
4. Did you get the help you needed when you are in a crisis?	○	○	○	○	○	○
5. Did the person or people you saw understand how your mental health needs affect other areas of your life?	○	○	○	○	○	○
6. Did a KMPT worker check with you about how you are getting on with your medicines?	○	○	○	○	○	○
7. Do KMPT services give you any help or guidance with finding support for financial advice or benefits?	○	○	○	○	○	○
8. Do you feel you have been seen by KMPT services often enough for your needs?	○	○	○	○	○	○
9. Overall, how was your experience of our services?	○	○	○	○	○	○

10. What was good about your experience?	11. What would make your experience better?

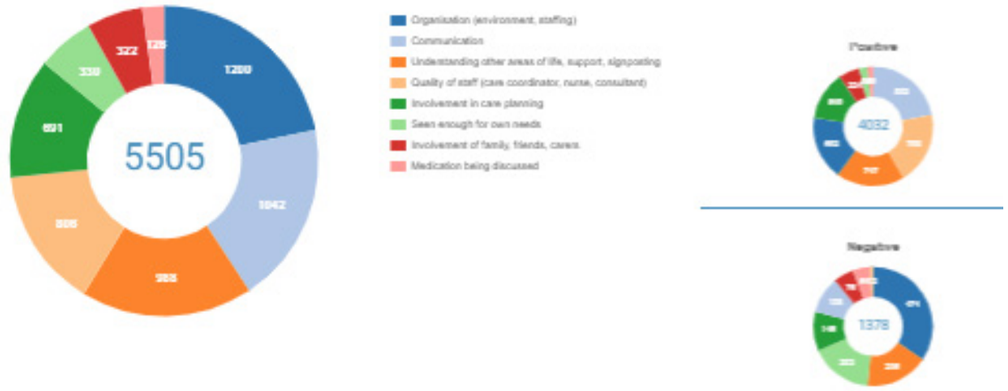
KM1851

In terms of the quantitative data provided, the patient experience mean indicator has consistently remained above 8 out of 10 which is in the range where patients 'strongly agree' that their experience of KMPT services has been positive.

Themes from the qualitative data, both in terms of what was positive about the respondent's experience and what they felt could be improved, are identified and then used to drive service improvement.

The top themes linked to positive experience over the last 12 months were communication, quality of staff, understanding other areas of life, support and signposting and organisation (which includes both the environment and staffing). Top themes identified as areas for potential improvement during this period were organisation (including both environment and staffing), understanding other areas of life, support and signposting, being seen enough for own needs and involvement in care planning.

Qualitative themes from PREM feedback



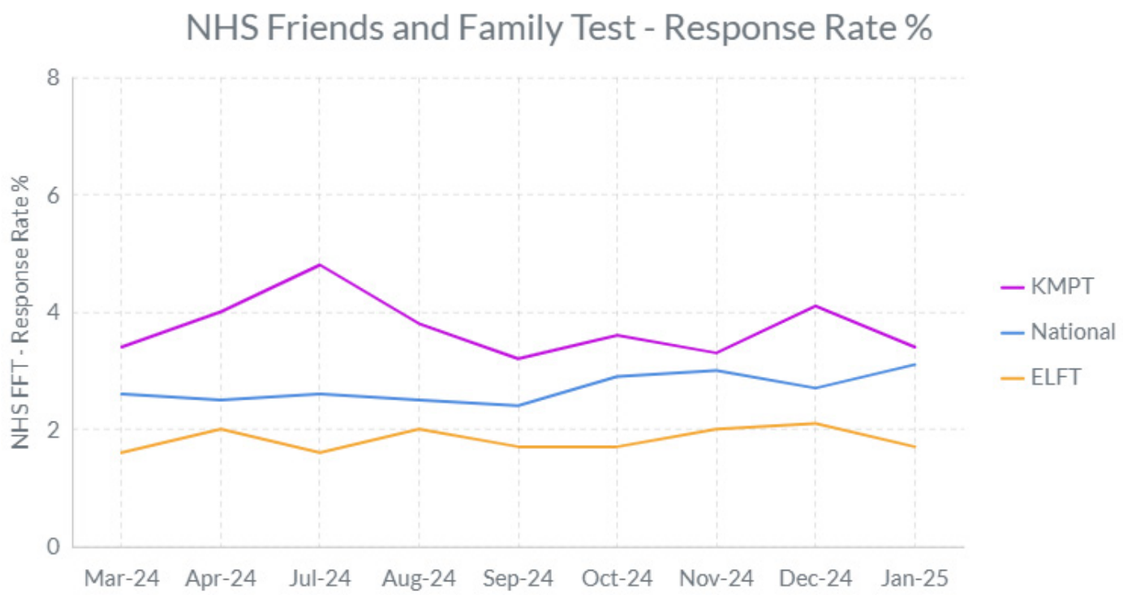
NHS Friends and Family Test

The national NHS Friends and Family Test (FFT) question is "overall, how was your experience of our service?". It is a mandatory question that NHS services must ask to provide the opportunity for those who use NHS services to provide feedback on their experience.

When benchmarked against the national FFT percentage positive scores for mental health trusts, we are on par with the national indicator for England (excluding Independent Sector Providers) which is currently at 88%. KMPT percentage positive scores for the FFT are regularly within the national indicator for England (including Independent Sector Providers) which is at 89%.

The national indicator for percentage negative responses to the FFT is 5%. KMPT's percentage negative score is 4%, indicating that the organisation has received fewer responses from respondents that have indicated that their experience of services was poor or very poor than is found nationally.

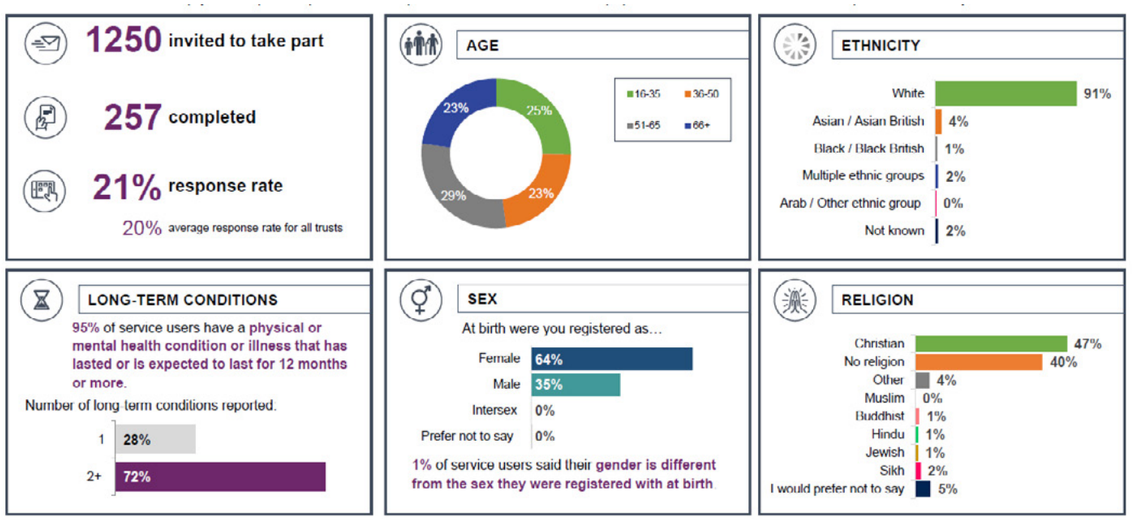
Based on the most recent data available, KMPT is also within the top 20 mental health organisations across the country in relation to the response rates for the FFT.



Community Mental Health Survey

KMPT participates annually in the CQC Community Mental Health Survey, which is facilitated by an external company. The survey is sent to a random sample of 1250 individuals who have engaged with the community services provided by KMPT and the responses provided by this sample are then compared against those of other mental health trusts across the country.

Who took part in the survey?



257 responses to the survey were received and based on this information, the following were identified as the areas that those accessing KMPT services felt experience was best and where it could further improve.

Areas of best experience and areas of improvement

It is of note that the Community Mental Health Survey was conducted prior to the full implementation of the Community Mental Health Framework which it was anticipated would have a positive impact on some of the areas highlighted for improvement.

Triangle of Care

The Triangle of Care is a partnership between professionals, the person being cared for and their family, friends and carers to support recovery. The Triangle of Care has six essential standards for practice which are as follows:

- Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- Staff are 'carer aware' and trained in carer engagement strategies.
- Policy and practice protocols regarding confidentiality and sharing information, are in place.
- Defined post(s) responsible for carers are in place.
- A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
- A range of carer support services is available.

The Triangle of Care accreditation scheme recognises providers who have committed to change through self-assessment of their existing services, and by implementation of the programme according to the six standards. KMPT has been awarded and has retained its two-star Triangle of Care rating, indicating that all inpatient, crisis and community services have been assessed and that the provider organisation remains commitment to driving forward the carer experience agenda.

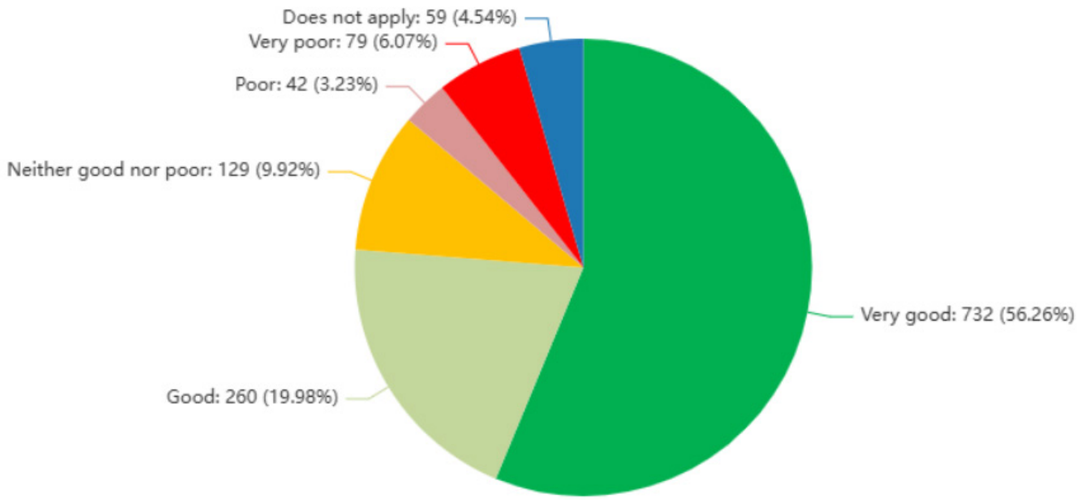
Triangle of Care Steering Group

The Triangle of Care Steering Group also takes places on a quarterly basis and is attended by KMPT staff, external partner organisations and individuals with lived experience of caring. This group is responsible for driving forward the Triangle of Care agenda through the development of guidance and training, troubleshooting obstacles encountered during practice, planning and raising the profile of events linked to carers and furthering the role of families, friends and carers in co-production work across the organisation.

Family, Friends and Carer Survey

KMPT continues to offer a survey to anyone whose loved ones are under the care of its services. This forms a key part of the organisation's ongoing commitment to hearing the voices of family, friends and carers and to using their views on quality, safety and experience to shape and develop services.

Overall how was your experience as a family member, friend or carer within KMPT?



Over the past 12 months 1194 responses have been received for this survey (74.6% of which were provided in hard copy and 25.4% of which were provided digitally). The feedback provided via the Family, Friends and Carer survey indicates that the majority of respondents felt that their views were sought throughout their contact with KMPT, they were approached by staff in a respectful and kind way, that they were given information about the care, support and treatment that the patient received and that their overall experience with the service was positive.

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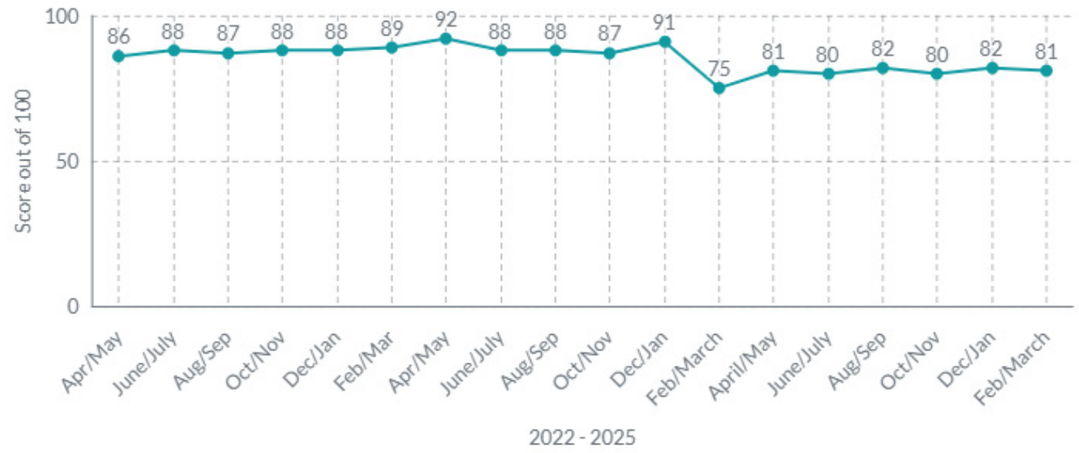
Overall how was your experience as a family member, friend or carer within KMPT?



Feedback from families, friends and carers is also collected via the individual services as part of national accreditation programmes.

Planned Areas of Work

- Review the PREM and Family, Friends and Carer Experience Measure questions.
- Review the outcomes of the next CQC Community Mental Health Survey.
- Improve the recording of information related to carers on the electronic patient record system.
- Continue with accreditation process to retain 2-star Triangle of Care rating.
- Develop the focus on triangulating patient experience data.
- Work with digital and business intelligence colleagues to streamline. processes involved in collecting experience data and to improve accessibility of the data.

Improving Clinical Effectiveness and Clinical Audit

Clinical audit and quality improvement activities

Clinical audit is used to evaluate whether standards of care are of a high quality. Where improvement is required, actions are identified, implemented and monitored. The next section describes this in greater detail.

National clinical audit activity

The NHS England Quality Accounts List published by Healthcare Quality Improvement Partnership (HQIP), for financial year 1st April 2024 and 31st March 2025 contained 8 projects relevant to services provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT) that planned to collect data during the year.

Between 1st April 2024 and 31st March 2025 KMPT was actively involved in data collection for 7/8 (88%) of the relevant projects from the Quality Accounts List. The Trust did not take part in the Prescribing Observatory for Mental Health (POMH) topic 21b use of melatonin due to staff pressures in mental health of learning disabilities team (MHLD). The MHLD team were undergoing a challenging reorganisation, with a number of key staff leaving the service. This decision was approved by members of the trust executive management team.

A summary of all the projects from the Quality Accounts List that KMPT participated in during the reporting peelectronic patient record systems is given below, along with the current stage that the project is at.

Project no	Title	Type of project	Project stage
N/A	Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Learning disability and autism Programme	Continuous
593/22	POMH-UK Audit 7g: Monitoring of patients prescribed lithium	Clinical Audit	Complete
632/22	POMH-UK Audit 22a; Use of anticholinergic (antimuscarinic) medicines in old age mental health services	Clinical Audit	Complete
649/23	NCEPOD End of Life Care	Clinical Audit	Complete
4243-23	POMH-UK Audit 23a; Sharing Best Practice Initiatives	Clinical Audit	Complete
4569-23	POMH-UK Audit 16c; Rapid Tranquilisation	Clinical Audit	Action Planning
4772-23	POMH-UK Topic 24a; Opioid medications in inpatient mental health services	Clinical Audit	Planning
4976-23	National Clinical Audit of Psychosis NCAP Early Intervention in Psychosis Service EIP 2024 audit	Clinical Audit	Complete
6563/25	POMH-UK Audit 18c; Use of Clozapine	Clinical Audit	Planning
6605-25	NACEL Mental Health Spotlight Audit (national audit of care at the end of life)	Clinical Audit	Data collection
6832-25	POMH Topic 20c; Improving the quality of Valproate prescribing in adult mental health services	Clinical Audit	Planning
171/18	National Audit of inpatient falls	Clinical Audit	Data collection

The reports of 6 national clinical audits were reviewed by KMPT between 1st April 2024 and 31st March 2025 and KMPT intends to take the following actions to improve the quality of healthcare provided. The actions from national clinical audit and quality improvement projects from the HQIP Quality Account List are monitored by the Clinical Audit and Effectiveness Team. Please email kmpt.clinicalaudit@nhs.net for further details.

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

The LeDeR team link in with the patient safety team to share any completed LeDeR reviews. There were 3 for KMPT that were shared with us in 2024/25. 2 had learning for KMPT. We collected the learning and shared with governance teams in January 2025. No actions as such have come out of the reviews from KMPT but the learning has been shared.

POMH-UK Audit 7g: Monitoring of patients prescribed lithium

- Design Lithium Pro-forma covering pre-prescribing requirements ready to be put onto Electronic patient record system.
- Introduce Lithium cards to Lithium patients (added to pro-forma to be entered on Electronic patient record system, keeping record of Pts. with cards).

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POMH-UK Audit 22a; Use of anticholinergic (antimuscarinic) medicines in old age mental health services

- **Shared results widely:** East and West continuing professional development meetings, Older Adults Community of Practice, Non-Medical Prescribers Forum, Drugs and Therapeutics Committee, Medication Matters Newsletter.
- Pharmacy produced an anticholinergic effect on cognition (AEC) guideline.
- Pharmacy produced a list of anti-cholinergic medication with burden details to share with clinical colleagues.
- AEC covered in Junior Doctors Training.
- Pharmacy produced a list of low AEC's.
- Pharmacy produced guidance for older adult patients prescribing antidepressants with anticholinergic effects.
- All staff using one recognised rating AEC scale (provided in this POMH project) when prescribing & ward pharmacists providing training to clinical staff on how to use.

POMH-UK Audit 23a; Sharing Best Practice Initiatives

This national report included several examples of best practice initiatives taking place at KMPT, which was excellent news for the trust. A poster was created and shared widely to celebrate KMPT successes.

POMH-UK Audit 16c; Rapid Tranquilisation

- **Results shared widely:** Drugs and Therapeutics Committee, Medication Matters Newsletter, circular to medical staffing, presentation at trustwide CPD, Acute Directorate and Forensic Directorate governance meeting.
- Business intelligence (BI) reports on rapid tranquilisation incidents on the wards have been created, with ward level data available to all wards covering standards for rapid tranquilisation.
- CQC improvement plan in place.

National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis Service (EIP) 2024 audit

- Findings shared and discussed with teams and directorate.
- Business Intelligence Team contacted NHSE and the NCAP providers to outline concerns with the data from mental health minimum data set (MHSDS) and to request the use of different data.
- Care Co-ordinators to be responsible for ensuring that physical health checks are completed and Physical Health Team to support when required.
- Further training for staff inputting SNOMED Codes for all physical health requirements.
- Review how many people across the North Kent Directorate are trained in Phlebotomy and to enable them to take up the training.

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Local Clinical Audit and Quality Improvement Activities

The reports of 55 completed local clinical audits were reviewed by KMPT between 1st April 2024 and 31st March 2025 and KMPT intends to take the following actions to improve the quality of healthcare provided. Not all projects required actions and some of the actions are from a single cycle of clinical audit.

These actions are monitored by the project supervisors and leads. Further information may be available by emailing kmpt.clinicalaudit@nhs.net

Mattress audit	All condemned mattresses were replaced.
Medical devices clinical audit	• Results disseminated and matrons are responsible for local action plans. • Medical devices training has been updated into two e-learning packages.
Resuscitation Service Community Review	• All areas advised to use automated external defibrillator (AED) checklist, which includes regular servicing. • Clinical training given to staff expected to utilise NEWS2 escalation plans. • Training time allocated into rostered working hours.
Evaluation of prescription processes and security	• Staff reminders issued. • Labels for recording date of opening on creams and liquids moved for easier access for staff.
A clinical audit of antipsychotics side effect monitoring using Glasgow Antipsychotic Side-effect Scale (GASS) at trust wide Community mental health teams	• Hard copies of the GASS form and the simplified version should be easily accessible in the depot clinic and be handed to the patient for completion while they are waiting at the reception. • Generate a list of names of service users who are due GASS each week. To be included in the Community mental health team monitoring spreadsheet. • A proforma to include GASS next due to be attached to depot and clozapine prescriptions. • Patients clinic invitation letter to include a reminder that GASS is due. • Clinic electronic patient record system entry to include specific date that GASS is due and should be actioned. if the client refuses it should be documented and another date should be assigned for completion.
Myocarditis monitoring during Clozapine initiation	Arrange teaching sessions for the doctors on the new protocol.
Trust wide Annual Infection Prevention and Control Audit	• Local/ward improvement plans developed. • More regular visits form infection prevention and control team. • Identification of an infection control link practitioner per ward/community team.

Clinical audit of compliance with physical health monitoring of Community mental health team patients on depot medications as recommended by NICE	Good compliance with recommendations was demonstrated. Collaborative working would be the key to continuing this good practice and make improvements in areas that needed improvement (such as Prolactin monitoring).
Clinical Audit of the CAPA assessment service at Dartford, Swanley and Gravesend Community mental health team	Active Review team(no longer in operation) now check completion of care plan, risk assessment and cluster patients.
A clinical audit looking at retrospective referrals from GPs and whether they meet policy guidelines in Canterbury and Coastal Community mental health team	GP letter format to include the specific required items in the physical health monitoring, esp. Prolactin.
A clinical audit of Olanzapine use and monitoring among clients with the Early Intervention Service	Physical health clinic to assist with monitoring
Clinical audit of risk assessment documentation, as recorded on Electronic patient record system progress notes for Ashford and Canterbury Community mental health team	• Training for staff, the Open Dialogue approach and caseloads becoming more streamlined has had a positive impact on the quality of risk assessments and management. • Providing patients with check list flyers to be ticked by their GPs.
Audit of Post-Diagnostic Support and Psychosocial Interventions offered following a diagnosis of dementia in Medway community mental health team	• Tighter record keeping of patients who have been diagnosed with Dementia and whether or not they have been offered, referred to, and have accepted/ declined post diagnostic support and/or psychological interventions. • If a patient has not been offered post diagnostic support, reasons for this should be clearly documented and recorded within the patient's notes. • In cases where patients had no recorded reasons as to why post diagnostic support and/or psychological interventions were not offered; reasons as to how this has happened should be explored to identify future learning objectives. • Clinicians external to the service should be informed of the community mental health team post-diagnostic pathway to ensure that all patients have access to post diagnostic support. • If it is determined that for whatever reason post diagnostic support is not appropriate for the patient, the option of post diagnostic support should be offered to their family.

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Audit on blood tests performed by Crisis Resolution and Home Treatment Team: clinical indications, current practice and recommendations	GP correspondence to facilitate the checks. The implementation of change has resulted in improvement in adherence to the Trust Policy and the documentation of rationale for requesting investigations. This will hopefully assure accuracy in the management of the results, as well as avoid confusion of incidental findings.
Clinical audit on the use of antipsychotics in the behavioural and psychological symptoms in Dementia (BPSD)	Review of monitoring requirements and side-effects to be considered at each review and we may want to use a template to ensure this happens.
WK Directorate - Sharing of Learning from electronic patient record systems Incidents in Business Meetings	Governance lead to share the findings of this audit at suitable forums including: • Senior Leadership Team forum • Team managers forums e.g. monthly directorate Quality & Patient safety Meeting
A clinical audit of Care Programme Approach care plans & community mental health teams / Early Interventions in Psychosis in West Kent Directorate	• Themes to be shared initially with senior leadership team and then at team level quality report. Electronic patient record system refresher / training needs identified as result of audit. Matrons providing training, either 1:1 or in a group. • Power BI training to support identification of key performance indicators . • Team Level quality highlight report adjusted for team members to take ownership and provide solutions to their low performing measures. • Senior Leadership Team reviewing Care Plan compliance at the weekly huddles . • General managers monitoring improvement weekly with teams. • As part of their development and understanding of performance, encouraging invitation of care-coordinator (with low compliance) to join the monthly local performance review meetings. • Clinical Audit to be shared in Quality and patient safety meeting . • Quality checks support monitoring for quality of care plans, aligning with triangulation of risk.
Improving Medical Handover at Littlebrook Hospital	• Forum frequency and scheduling were amended, advertisement improved, and the forum was expanded to include on-call doctors across the whole trust. • Establishing an on-call forum was a valuable intervention for both consultants and trainees working on an on-call rota and has led to a further quality improvement project. • Increasing trainee and consultant engagement with the forum is the next phase of this project.

Clinical audit of NG225 self-harm	The implementation of updated risk training for the trust, alongside the changes to the electronic patient records system risk assessment.
A Clinical Audit on "as required" Psychotropic medication in acute inpatient wards	Topic to be added to junior doctor e-prescribing training.
Provision of venepuncture equipment on acute adult inpatient psychiatric wards	Extra (missing) equipment purchased for wards.
Audit of adherence to admission Blood Tests list in Ruby Ward	• Update admission baseline checklist to include the vacutainers for each blood test. • Create a poster and put in Ruby Ward Drs and Nurses office. • Put the poster and instructions in Ruby Ward induction pack for doctors.
Sensory Environment Audit for Learning Disability Inpatient Services	• Recommendations/actions have been identified & sent to relevant team members for views & actioning. • Consideration to dimmer switches on the wards or if desk lamps can be made available. • Review of notice boards, de-clutter, make clearer, less jargon. • De-clutter communal spaces. • Work with patients to produce signs for staff to not slam doors. • Work with patients to produce a poster on tips for coping with overwhelming noise on the ward. • Option for patients to use ear defenders to see if they are suitable/comfortable. • Patients informed in good time of noisy work being carried out on the ward. • To deliver more basic sensory awareness training to ward/other multidisciplinary team staff. • To redo the environmental audit in July 2025.
HS12 risk compliance	• Governance Team to review all HS12 risks are in date and have review date. • Governance Team to review all updated HS12 have up to date HS12 uploaded.
HS00 Compliance	• Teams without a HS00 Workplace checklist risk to review and add the risk (Learning disabilities forensic outreach service, East Kent Neuropsychiatry & Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Service). • Governance Team have planned support for teams whose risks are out of date or are due for review before 30/06/2024. • Governance Team to check teams have up to date HS00 Workplace Checklist uploaded to Inphase.

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Risk Quality Audit for Forensic and Specialist Directorate	Share the results within The Local Business Unit Meetings. 2 General Managers to ensure regular senior staff attendance at the monthly risk forums where: • Overdue risks are reviewed • Risks coming out of date in the next 3 months are reviewed • Risks are reviewed to ensure they meet the trust standard of IF, THEN, RESULTING IN • The Governance Team will continue to check the directorate's compliance, however, no further re-audit is required.
Restrictive Practice Log Compliance	SLT Actions: • General Managers to share the results with their team and remind them of the need to review their logs every three months. • General Managers to ensure future requests for the logs in order to audit are actioned. Future requests will include one email request and a follow up escalation request after two weeks. Reminders will also be given in the daily huddles.
Audit of Current Vitamin D Testing on Bridge House Detoxification Unit	A simple intervention of a prepopulated blood form was able to increase our compliance from 0% to 86.67%, and maintained this at 90%. Moving forward, we would also recommend the review of Bridge House Operational Policy to include guidance on Vitamin D testing, particularly on admission.
Forensic & Specialist Directorate Purple Folder Audit	• During annual check, person responding to call knows how to answer the questions when asked "do you have the purple folder. • Staff answering Phone calls to be able to respond appropriately to Purple folder call. • Staff to be able to answer the questions in the purple folder audit. • Repeat mock call for the 10 Teams who were partially or not compliant with the Purple Folder Procedure. • Re-audit of Non-compliant Purple Folder Procedure Teams. • All Teams to know the Purple Folder Procedure (Annual Check). • During annual check (mock call), person responding to call knows how to answer the questions when asked "do you have the purple folder". • Staff to be able ask the appropriate the questions in the purple folder audit.

Evaluating Rosewood Mother and Baby Unit's compliance with Vitamin D monitoring and prescribing for Mother's admitted to the unit	High levels of compliance demonstrated.
A clinical audit of self-harm Electronic patient record systemdocumentation on Walmer ward (including Walmer-Bedgebury)	• To share the results with the Walmer team MDT and confirm actions to be taken. • To ensure a capacity assessment is completed for all patients whom seelectronic patient record systemusly self-harm. • To ensure capacity assessments are recorded in the ELECTRONIC PATIENT RECORD SYSTEM capacity section. • For the patient's care plan to clearly state where the patient's management plan is and for this to be consistent for all patients (e.g. Uploaded or in the ELECTRONIC PATIENT RECORD SYSTEM progress notes). • To carry out a re-audit in three months, focussing on the standards that were not met.
The effectiveness of the Forensic and Specialist Services(FSD) Senior Leadership Team (SLT) meetings – cascading of information	• To improve process of items discussed in SLT being cascaded to Business Unit meetings. • To ensure items are shared promptly. • To ensure local meetings are occurring and include the sharing of relevant information from the SLT. • Recommendation for feedback (sharing key points) to be re-introduced from the SLT meetings.
A clinical audit of care plan letters (discharge letters) (NICE) - PMHCS	• Team was 100 % compliant the first 3 standards. • Standard 4 to be audited in next round as this was recently introduced.
A clinical audit of care plan letters (discharge letters) (NICE) - THRIVE (Psychological Support for Birth Trauma and Loss)	High compliance with standards demonstrated.
A clinical audit of patients physical health assessment records on Emmetts ward (including Emmetts-Bedgebury)	Monitor if the following measures are being recorded during Physical Health Assessments: • Blood Pressure Smoking habits • Substance Use • HBA1C (Blood Sugar) • Lipids • Nutrition
A clinical audit of patients on Emmetts ward to ensure medic Electronic patient record systementries are completed at the time of the patients' review	100% of patients Electronic patient record system entries were updated within 24 hours by the Medic.

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A clinical audit of the completion of Moving and Handling assessments and Venous, Thromboembolism (VTE) risk assessments on Emmetts ward (including Emmetts-Bedgebury)	• In Round 2 there was an improvement in the recording of Moving & handling Assessments and VTE Risk Assessments both on admission and when there were mobility changes/issues.
Nice Quality Standard (QS 159) - Audit of the Process of Discharges across low secure & forensic learning disability services	• Care plans should be sent within 24 hours to everyone identified to be involved in a client's care. This should then be clearly documented within the distribution section of the care plan. • If a care plan is not shared with the client, the reason for this should be clearly documented. • The findings of this audit are to be shared with the local team.
An audit of the Quality of Neuropsychological assessments within the Neuropsychology service at the Kent and Medway NHS and Social Care Partnership Trust	• Share the project with the team in order to agree to actions, based on the project recommendations. • Develop a check-list of important information to complete which could be uploaded to Electronic patient record system when conducting a neuropsychological assessment and present this to the wider neuropsychology and neuropsychiatry teams for review.
A clinical audit of the wards therapeutic programmes within the 4 low secure/ learning disability wards	• The results of this audit to be shared with the local team • The programmes for all wards should be simplified and made easier to read, suggestions include removing items such as medication and meal times which are not therapeutic work, including pictures and increasing font size. • Ensure all programmes include a smoking cessation slot (at least monthly). • To consider the possibility of listing offence related groups or 'closed psychology group' or 'invite only' to show they are happening without sharing offence-related information as shown on Marle Ward.
To audit the implementation of the multidisciplinary team therapeutic programme Forensic - Low Secure Wards	• Significant improvements in offering and recording activities. • Ensure that Electronic patient record system progress notes are updated when a therapeutic activity is offered to a patient regardless of whether they partake or not.
A clinical audit of care plan letters (discharge letters) (NICE) – Mental health learning disabilities	Compliance with standards 1, 2 and 3 improved to 100%.
A clinical audit of care plan letters (discharge letters) (NICE) – Learning disabilities forensic outreach liaison service	• Further discussion with the Team regarding when a discharge letter would not be sent. • Improvements with both Standard 3 & 4 will make the team fully compliant.

A clinical audit of care plan letters (discharge letters) (NICE) - Neuropsychiatry	Team was compliant across all four standards & achieved 90%+ compliance across 3 standards.
A clinical audit of care plan letters (discharge letters) (NICE) - Neuropsychology	• Need to increase % letters written to the person. • High compliance with other standards.
A clinical audit of care plan letters (discharge letters) (NICE) - Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Service	• The team was mostly compliant with the first 2 standards but some improvement to all 3 standards will make the team fully compliant. • Re-audit to be confirmed.
A clinical audit of care plan letters (discharge letters) (NICE) – Community brain injury team	Full compliance will all standards.
A clinical audit of care plan letters (discharge letters) (NICE) - Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Service	• The team was mostly compliant with the first 2 standards but some improvement to all 3 standards will make the team fully compliant. • Re-audit to be confirmed.
Audit on Clozapine prescription across the medium secure forensic wards	• All wards were fully compliant with FBC monitoring & discussion diet & fluid standards with patients. All wards achieved over 90% compliance with the following standards; Discussions regarding exercise. Blood tests performed within required timescale. Clozapine plasma levels are checked annually. Wards achieved over 80% for review of clozapine following starting, reducing or stopping smoking and for patient being provided with Clozapine leaflet.
Audit on Clozapine prescription across the low secure forensic wards	There are no patients who are non-compliant with Trust Policy.
Mental health learning disabilities service compliance with sodium valproate protocol	• Increase awareness of the importance of completing risk assessment forms for all patients starting Sodium Valproate, and in particular those of child bearing potential. This can be done via presentation in a teaching session or poster presentations. • Set a specific alert/reminder on the patient's page on Electronic patient record system flagging if they have been started on Sodium Valproate for a psychiatric indication and do not have a valid risk assessment. • A field to be in place for the Outpatient summaries written by clinicians or HCPs of patients who are on sodium valproate, which would include a date for when the patient last had their risk assessment completed. • Consider creating an online version of the ARAF and integrate it into Electronic patient record system.

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Clinical Audit of Mental health learning disabilities Patients Prescribed Melatonin by Psychiatrists, including Medication Annual Review in line with POMH Standards	• Disseminate action plan with Mental health learning disabilities service & Specialist Service managers. • Discuss at Hub meetings include transition information to cover melatonin. • Send email to all Mental health learning disabilities Consultants, SAS & Trainee Doctors & Non-medical prescribers in Mental health learning disabilities with a reminder. • Reminders in Medicine Matters Newsletter. • Pharmacy to consider providing a training session & ensure melatonin prescribing is included. (The anxiety & insomnia psychopharmacology training on iLearn are available).
THRIVE (Psychological Support for Birth Trauma and Loss): Emailing letters to patients (NICE)	Implement and create an Admin Email correspondence check list.
Audit on inquiring about driving history from clients with alcohol dependence on admission at Bridge House Detoxification unit	"Are you currently driving or not?" to be added to the initial admission history format.

Medical Workforce - Recruitment and retention

Following on from Last years progress and success KMPT medical education department and the Medical staffing departments has continued to make big strides with:

- Increased recruitment to Consultant Psychiatrists positions within KMPT and reduction in the yearly medical agency spend by £860,103.
- Training Medical students, Foundation trainees, GP trainees and Resident doctors in psychiatry at both Core training and speciality grade levels.
- Further expansion of the Resident doctors' numbers in KMPT.
- Strengthen the Continuous professional development opportunities for all medical staff.
- Participation, success and recognitions of our students, trainees and doctors at various regional and national conferences.
- Reviewing and establishing the Medical management structure in KMPT to ensure improved supervision of doctors at all levels and the establishment of the Peer supervision groups for senior doctors.
- Noticeable results by trainees in annual GMC trainee survey and by KMPT doctors in the annual NHS staff survey.

Medical Schools

KMPT supports medical students from two UK medical schools - Kent and Medway Medical School (KMMS) and King's College London - Guys Kings and St Thomas' (GKT).

KMMS

This year is KMPT's third year of hosting KMMS year 3 students for their psychiatry rotations. Placements have been facilitated for 128 students for the 24/25 academic year. The delivery model was altered for the 24/25 academic year seeing the medical students on placement over 3 rotations across the year with the average length of rotation being 10/11 weeks. The students are on placement two days a week with teaching on a Thursday and one specific case-based discussion day (per rotation) combined with other activities hosted by KMMS.

In addition, KMPT provides Clinical Academic Tutors to 18 students at the moment by 10 Consultant Psychiatrists.

During Sept 24 in addition to year 3 students, we also facilitated 64 students in year 5 for their psychiatry module, the students rotated every 3 weeks across 6 rotations with placements and teaching across all 3 weeks.

On the 11th April 2025, KMMS confirmed that they had been granted full accreditation by the General Medical Council. As of the 9th April 2025

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KMMS joins the list of institutions authorised to award UK primary medical qualifications - this marks a major milestone ahead of their first students graduating during the summer.

GKT

This year KMPT hosted GKT Year 4 students for their psychiatry placements across 4 blocks of 8 weeks of the 24/25 academic year. Placements were facilitated for 112 students.

KMPT provides 27 Education Supervisors for Block 1 students only and also facilitates 8 QIP groups with 8 QIP supervisors from Block 1 to the end of Block 3.

GKT students are in placement two days a week with regular teaching on a Thursday, this academic year has seen the introduction of additional teaching on some Wednesdays and a Skills Revision Day on the last Monday of the block.

Our total number of medical students on placement for 24/25 from KMMS and GKT Medical School were = 304 students per year, which was based on the actual placement data (Note - Maximum capacity is 326 placements.

Postgraduate Training

KMPT is working with NHS England KSS to support increased number of resident doctors at various levels training in different specialities in Psychiatry.

We continue to focus on increasing our specialist trainee numbers with a long-term plan to develop Consultant psychiatrists in the region which will meet the demands of the local service.

Current Number of Resident Doctors (as of April 2025)

We have a total of 41 Core trainee Resident doctors in Psychiatry and 34 Specialist resident doctors in KMPT. The Core trainee numbers is predicted to expand by 6 more doctors and the higher trainee numbers by 2.

We are also supporting our GP workforce development in the region by supporting the training of 23 GP trainees and 14 GPITP trainee in Psychiatry. We will be supporting an extra 2 GPITP trainees linked to EKHUFT from August 2025.

We are also working with our local acute hospital trusts and supporting psychiatry training for a total of 41 trainees in their foundation years (Foundation Year 1 x 23, Foundation Year 2 x 18) We will be supporting an extra Foundation year 2 trainee linked to MTW starting from August 2025.

In the last year KMPT continued to offer developmental opportunities to Resident Doctors - Aug 2024 - July 2025

- 1 x Chief Registrar Post (Linked to Royal College of Physicians)
- 2 x Medical Education Leadership Fellow Posts (Linked to Brighton and

Sussex Medical School)

- 2 x Undergraduate Medical Education Fellow Posts
- 2 x PHD Fellows (Linked to the Kent and Medway Medical School)
- 1 x Academic Clinical Fellowship in General Psychiatry (linked to Brighton and Sussex Medical School and Kent and Medway Medical School Aug 24-July 27)

Medical Recruitment

Continuing from last year's success with our medical recruitment we have had another very successful year. KMPT recruited 14 consultants and 14 speciality doctors. We have also created the new specialist grade doctor and have been successful in recruiting to 2 of the newly created posts. One KMPT specialty-doctor successfully completed her Certificate of Eligibility for Specialist Registration (CESR) and obtained the Certificate of Completion of Training (CCT) on the General Medical Council specialist register in 2023 and took up a Consultant Psychiatrist position within KMPT. This has also resulted in a significant drop of £ 860,103 in the yearly agency spend.

Clinical and Managerial Supervision Structure

In the last year we have agreed a clinical and managerial supervision process for doctors of all grades in KMPT. We have a weekly supervision for the trainee doctors with their clinical supervisors which is monitored by the medical education department. We have created 20 peer supervision groups for consultant and specialty doctor grade doctors. A CPD peer group is a group of psychiatrists who come together in order to discuss their development needs and consider how best these needs can be met. This also provides opportunity for mutual support. The managerial supervision for all the consultants is managed by the respective Lead psychiatrists who line manage the consultants.

Main Highlights of the Various Surveys

GMC Survey 2024 for trainees

- KMPT Ranked 44th out of 204 NHS Trusts in the UK and Scotland.
- KMPT Ranked 4th out of 16 NHS Trusts in Kent Surrey and Sussex.
- KMPT had a total of 19 Green flags (positive outlier nationally) on the survey.

GMC Trainer Survey 2024

KMPT have all green flags (positive outlier nationally) for Educational Governance, Supportive Environment, Handover, Support for Training, Rota Issues, Resources to Train and Training & Professional development and Time to Train.

NETS Survey 2024

The NETS survey has been the only national survey open to all healthcare

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students, trainees and apprentices, including resident doctors and dentists in postgraduate training. The non-mandatory annual survey covers key themes like induction, clinical supervision, facilities, learning opportunities and teamwork.

- KMPT ranked 6th out of 15 NHS Trusts in the KSS region for Overall Experience.
- KMPT had a total of eight blue flags (positive outlier nationally) on the survey.
- KMPT received one red flag against the sexual safety indicator against Priority House from the Medicine Postgraduate responses.

The responses by the medical directorate to all the categories covered by the National annual staff survey were all above the national bench mark scores.

Various Recognitions of our Medical Staff at Regional and National Level in 2024/25

KMPT doctors from across all the grades and specialities received many awards in various categories at regional and national level.

HSJ Awards 2024

Dr Afifa Qazi Chief Medical Officer	Shortlisted for Clinical Leader of the Year
Jagdip Bahia and Pharmacy Team Chief Pharmacist	Shortlisted in the Medicines, Pharmacy and Prescribing Initiative of the Year
KMPT Tarentfort Unit	Shortlisted for the HSJ Patient Safety 2024 Awards

RCPsych SE Division Conference Awards 19th March 2024

Dr Bosky Nair Dr Tasneem Sautally Dr Serena Merchant	Winner Trainer and Trainee Project of the Year 2024
Dr Mo Eyeoyibo	Psychiatric Trainer of the Year
Dr Richard Brown Consultant Dr Joel Lawson Medical Education Fellow	Shortlisted for Trainee and Trainer Awards for the integrated Trainer and Trainee Project Award of the Year
Dr Elizabeth Junaid HST Trainee	Shortlisted for Trainee and Trainer Awards for Innovator of the Year
Dr Swarupa Sribaskanda HST Trainee	Shortlisted for Trainee and Trainers Awards for Trainee Peer of the Year

Royal college of Psychiatrists SE Division Conference 08/05/2024

KMMS Medical Student Project supervised by Dr Jo Rodda and Professor Sukhi Shergill	Received an Award at RCPsych SE Division Conference 2024
KCL Medical Student QIP co-supervised by Dr Verity Williams and Alan Dunlop	Received an Award "Implementation of Multi-Modal Psych education Resources to Enable Early Engagement in Guided Self-Help Stepped Care Model for People with Functional Neurological Disorders (FND)"

Kent Sussex Surrey (KSS) Psychiatry Trainees Conference - 4th July 2024

Dr Abdul Basit (employed by Dartford and Gravesham) nominated by Dr Rachel Daly	GP Trainee of the Year
Dr Adanegbe Omoruyi (employed by Dartford and Gravesham) nominated by Dr Rachel Daly	Foundation Trainee of the Year
Dr Sajitha Nair	Core Trainee of the Year
Dr Sharna Bennett	Higher Trainee of the Year
Dr Jo Rodda	Trainer of the Year

Royal college of Psychiatrists Annual Awards 2024

Dr Rachel Daly	Psychiatric Educator of the Year
Dr Asif Bachlani	Psychiatrist of the Year Award
Mental Health of Learning Disabilities (MHLD) North Kent Team	Team of the Year: Intellectual Disabilities

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National Medical Education Leaders Awards 2025

Dr Jo Rodda	Highly Commended Outstanding Contribution to Teaching by an Individual
Angela Pendleton	Postgraduate Medical Education Manager of the Year
Medical Education Department	Highly Commended Outstanding Contribution to Teaching by a Team or Department

Posters/Presentations at Regional and National Conferences by KMPT medical staff

Event Date	Event Name	Trainee Name	Grade	Type of Presentation	Poster/Presentation Title
26th March 2024	KSS Annual Conference for Doctors in Training	Dr Walter Chuang	F1	Poster	Promoting Patient Safety: An Audit of Dartford Gravesham and Swanley Home Treatment Team's (DGS HTT) communication with Primary Care
		Dr Elizabeth Junaid	Higher Trainee	Poster	A Service Evaluation of Clinicians Writing Clinic Letters to Patients
		Dr Ifeoma Neye-Akogo	Higher Trainee	Poster	Enhancing the Outflow of Clinical Ready for Discharge Inpatients within Kent and Medway NHS and Social Care Partnership Trust (KMPT)
		Dr Adeola Adeyemi & Dr Suresh Thapaliya	Higher Trainees	Poster	Well-Aware QI Project: Well-being Support Awareness for Specialty Trainee Doctors in KMPT
16th April 2024	Medical Psychotherapy Faculty Newsletter	Dr Mukund Vandekar	Core Trainee	Abstract in RCPsych	Reflections from a Core Psychiatry Trainee: Navigating the Psychotherapeutic Space
8th May 2024	RCPsych SE Division Conference	Anushka Saxena, Tahani Dahir, Stephanie Lapitan, Adna Mohamud	Year 4 Medical Student – GKT	Oral Poster Presentation	Implementation of Multi-Modal Psychoeducation Resources to Enable Early Engagement in Guided Self-Help Stepped Care Model for People with Functional Neurological Disorders (FND)

		Amelia Townsend	KMMS Year 4 Medical Student	Poster and BMJPsych Supplement	A systematic review of studies of attitudes and beliefs of healthcare professionals toward non-epileptic attack disorder (NEAD)
		James Dobrzanski	KMMS Year 4 Medical Student	Poster and BMJPsych Supplement	A systematic review of the use of portable ultra-low field magnetic resonance imaging in non-acute brain imaging and its potential use in dementia assessment
		Lois Clark, Simona Hossain and Sua Youn	GKT Year 4 Medical Students	Poster – QI Project	Improving carers' engagement for patients admitted to Psychiatric Intensive Care Unit (PICU): A quality improvement project
17th – 20th June 2024	RCPsych International Congress	Gonjan Kaur, Edelyne Tandanu, Prem Ojha	GKT Year 4 Medical Students	Poster	Impact of raising staff awareness on recording patient consent to receive text message reminders of appointments and increasing the frequency of reminders on did not attend (DNA) rates in community mental health (CMH): a quality improvement project
		Dr Suresh Thapaliya	Higher Trainee	Poster	Challenges and Delay in Treatment with Clozapine Due to Thrombocytopenia: A Case Study
		Dr Rachel Rice	Higher Trainee	Poster	A Clinical Audit of the Assessment and Management for those Diagnosed with Young Onset Dementia within the Shepway CMHSOP
		Dr Sylvia Fatunla	Core Trainee	Poster	Clinical Audit of Dementia Diagnosis and Management according to disease severity

		Dr Aderopo Adelola Additional Contributors: Professor Sukhi Shergill, Dr Eromona Whiskey, Dr Agostina Secchi, Dr Pat Morgan, Dr Arun Vincent, Hayley Stenzel and Donna East	MTI	Poster	Developing the new Kent Complex Psychosis Service (KCPS): Reducing the limitations imposed by treatment-resistant psychosis
		Dr Segun Ayanda	Core Trainee	Poster	Audit of Current Vitamin D testing on Bridge House Detoxification Unit
		Dr Sharna Bennett Dr Verity Williams Dr James Anslow	Core Trainee Higher Trainee Core Trainee (now SAS)	Poster	Improving On Call support for Doctors: A Quality Improvement Project
		Dr Tasneem Saumtally Dr Serena Merchant	F1 F2	Poster	Improving Equity of access for women admitted to a psychiatric mother and baby unit in Kent
		Dr Ahmed Elshafei	CT3	Poster/Oral	Carer Engagement and support in North and West Kent Rehabilitation Service
		Dr Swarupa Sribalaskanda	ST6	Poster	Introducing the dementia crisis service in East Kent, can we reduce rates of hospital admission?
26th July 2024	National Association of PICUs Annual Conference 2024	Dr Shantala Satisha Nathan Vasudevan Cheryl Lee	Consultant	Poster/Oral	Use of Zonal Observations to reduce restrictive practices on a male PICU **Won Best Oral Presentation Award**

12th Sept. 2024	Faculty of Neuropsychiatry Annual Conference 2024	Amelia Townsend	KMMS Year 5 Medical Student	Poster	A systematic review of studies of attitudes and beliefs of healthcare professionals towards non-epileptic attack disorder (NEAD) in adults
3rd & 4th Oct. 2024	Faculty of Psychiatry ID Conference	Dr Sharna Bennett	ST5	Poster	Organising a regional ID Conference – our experiences and lessons learned
5th Nov. 2024	RCPsych Annual Medical Education Conference	Dr Sharna Bennett Maham Zahid	ST5 CT3	Poster/Oral	Creating a mentoring programme: Kent and Medway Psychiatry Undergraduate Scheme (KAMPUS)
		Dr Joel Lawson	ST6	Oral Presentation	Charting New Horizons: Understanding the Impact of Medical Licensing Assessment (MLA)
		Dr Joel Lawson Dr Sharna Bennett Dr Hanna Mansi Dr Maham Zahid Dr Rachel Rice	ST6 ST5 Med Ed Fellow ST4 CT3 Med Ed Fellow ST5	Workshop	Escape Room Taster Session

Publications

Dr Suresh Thapaliya, ST5 Psychiatry, published in the BMJ Case reports for a project completed during his ST4 placement.

Dr Maria Moisan, published in BJPsych Open - Addressing an Identified Need: Training in Serious Incidents Investigations and Coroner's Inquests for Psychiatric Trainees in Kent and Medway NHS Social Care Partnership Trust (KMPT) - Abstract.

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Sustain improvements in the timely completion of Duty of Candour

The Duty of Candour is a general duty to be open and transparent with people receiving care from us. It applies to every health and social care provider that CQC regulates.

The regulation defines 'notifiable safety incidents' and specifies how registered persons must apply the Duty of Candour if these incidents occur. The ultimate responsibility for ensuring the Duty of Candour is carried out rests with the registered person. Duty of Candour is not just good practice in respect of involving families in learning reviews, it is a legal requirement this is reflected in both the Trusts PSIRF and Duty of Candour Policy.

There is a guided timeframe for completion of Duty of Candour. The 'Due date' records a 10-working day indicator which is stated in the trust's local policy to provide a measure for "As soon as reasonably practicable". This should not be seen as a target.

Between April 2024 and March 2025 there were 145 cases of Duty of Candour. The number of cases that have met the Duty of Candour criteria has reduced in 2024/25 following the introduction of more meaningful and timely investigations to identify if the case is a notifiable patient safety incident prior to commencing Duty of Candour. This new way of working aligns to the PSIRF.

Compliance in 2024/25 has been measured by is as follows:

- All 145 cases had verbal Duty of Candour completed, or there were appropriate mitigating circumstances.
- 142 had an initial Duty of Candour letter sent to the patient or family or there were appropriate mitigating circumstances.
- In regards to verbal Duty of Candour, 125 were completed within 10 days or had appropriate mitigating circumstances.
- In regards to written Duty of Candour, 114 were completed within 10 days or had appropriate mitigating circumstances.

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We have delivered regular Duty of Candour training to all Band 5 and above staff working in clinical Directorates. We provide resources and guides to support the training and evaluate feedback to ensure staff feel confident when applying the regulation.

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Equality Diversity and Inclusion

In accordance with the legal obligation of the Public Sector Equality Duty to annually publish information demonstrating compliance, this report continues to offer a progress update on our primary strategic goals: enhancing health outcomes, improving patient access and experience, fostering a representative workforce, and promoting inclusive leadership.

Additionally, it presents information pertaining to each of the nine protected characteristics (where data is available), detailing our accomplishments, alignment with the Care Quality Commission's guidance, and adherence to NHS England Standards.

Our Equality, Diversity, and Inclusion Team (EDI) has been actively engaged in ensuring compliance, including the implementation of the Equality Delivery System 2022, which comprises three domains (Patient, Workforce, and Leadership) for reporting purposes.

Progress is underway in gathering patient data and enhancing patient understanding of EDI, with collaboration across various teams and services. A comprehensive EDI Workplan is integrated into our corporate objectives, with regular updates provided to the Equality & Diversity Steering Group, the People Committee and Quality Committee.

Workforce Race Equality Standards (WRES) 1st April 2024 - 31st March 2025

Our representation of Black, Asian and Minority Ethnic (BAME) workforce demographic has increased to 29% a %1.7 increase from 2023/2024.

Workforce Employed by KMPT

Workforce Group (Clinical & non-clinical)	2021/ 2022 Total number	%	2022/ 2023 Total Number	%	2023/ 2024 Total Number	%	2024/ 2025 Total Number	%
BAME	822	23.5%	928	25%	1083	28%	1165	29.7%
White	2541	72.5%	2566	69.1%	2584	66.8%	2480	63.2%
Not stated	142	4.1%	218	5.9%	200	5.2%	280	7.1%
Total	3505		3712		3867		3925	

Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts. (1st April 2024 – 31st March 2025)

	BAME	White	Unknown
Number of shortlisted applicants	14800	5943	346
Number of appointed applicants	100	85	4
Appointment %	0.68%	1.43%	1.15%

The likelihood of white staff being appointed into KMPT slightly has decreased from 2.58 to 2.12 a decrease of 0.46 therefore indicating that BAME staff are less likely to be appointed in KMPT despite the number of candidates shortlisted.

Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

	BAME	%	White	%	Unknown	%
Workforce	1165	29.7%	2480	63.2%	280	7.1%
Number of disciplinaries	16	1.37%	13	0.52%	9	3.21%

BAME staff entering into formal disciplinary process has increased from a likelihood of 1.10 (2023/2024) to 2.62 (2024/2025). A value of 1.0 indicates an equitable disciplinary process, with white staff showing at 0.52% and BAME staff at 1.37%. This is a significant increase indicating BAME staff in the last 12 months have been disproportionality affected.

Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

	BAME	%	White	%	Unknown	%
Workforce	1165	29.7%	2480	63.2%	280	7.1%
Number of staff accessing non-mandatory training and CPD	861	73.9%	1569	63.3%	208	74.3%

The relative likelihood of white staff compared to BAME staff accessing non-mandatory/CPD training is 0.85. This indicates that BAME staff are accessing non-mandatory training and CPD at higher rate than white staff.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
BAME	466	35.7%	400	35.2%	491	42.8%	31.6%
White	1735	28%	1477	25.3%	1561	27.10%	21.3%
Total	2201		1877		2052		

491 **(42.8%)** of BAME staff who completed the staff survey stated that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. There is an increase in responses from last year of 1.22%. (91 responses from BAME staff). However, the percentage remains above the national average for BAME staff.

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Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
BAME	445	19.8%	393	20.6%	483	19.5%	21.2%
White	1731	16.2%	1479	19%	1555	17.6%	16.5%
Total	2176		1872		2038		

BAME staff who completed the staff survey stated that they have experienced harassment, bullying or abuse from staff in the last 12 months, a decrease from last year of 1.1%. (90 more responses from BAME staff). However, the percentage is below the national average for BAME staff.

Indicator 7: Percentage believing that Trust provides equal opportunities for career progression or promotion.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
BAME	443	50.8%	397	47.3%	482	50.6%	51.0%
White	1723	62.8%	1477	60.7%	1561	58.5%	60.9%
Total	2156		1874		2043		

50.6% of BAME staff stated that they believe the trust provides equal opportunities for career progression or promotion (85 more responses from BAME staff from previous year), an increase of 3.3% from the previous year.

*The data for this indicator does not correlate with indicator 2 showing an increase in BAME applicants being appointed from shortlisting or indicator 4 staff accessing non-mandatory training and CPD as this data shows that BAME staff are accessing training at a higher rate to white staff.

Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leaders or other colleagues?

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
BAME	444	10.8%	394	13.7%	477	10.3%	13.2%
White	1736	5.7%	1462	7.4%	1535	6.9%	6.08%
Total	2180		1853		2012		

10.27% of BAME staff stated that they had personally experienced discrimination. The staff survey indicates that this has decreased for our BAME staff from 13.7% to 10.27%.

Although the data is lower than the average of 13.9% across the NHS, it is significantly higher than our white staff at 6.97%.

The staff engagement score for BAME staff, compared to white staff and the overall engagement score for the organisation (out of 10)

The staff engagement score for BAME staff is **7.4** and increase of 0.1, compared with **6.6** white staff which has decreased by 0.2. This is an increase in BAME staff engagement and a decrease in white staff engagement.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	Score	2023/2024 Total Number	Score	2024/2025 Total Number	Score
BAME	449	7.4	403	7.3	494	7.4
White	1748	6.8	1484	6.8	1567	6.6
Total	2197		1887		2061	

Indicator 9: Percentage difference between the organisations' board voting membership and its overall workforce

Staff	Total Board Members	Voting board members	% of voting board members	Overall workforce
White	9	9	50%	2480
BAME	1	1	5.6%	1165
Unknown	8	6	44.4%	280

Proportion of voting Board Members of Black, Asian and Minority Ethnicities has decreased from 15.4% to 5.6% since last year, however there has been an increase in Board members ethnicity unknown status at 44.4% which is significantly higher than the trust workforce unknown status at 7.13%.

Workforce disability Equality Standard (WDES)

Metric 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.

The proportion of staff who have recorded a disability for 2024/2025 is 7.80% (306) an increase from 7.69% the previous year, however staff survey indicates 16.2% (637) staff indicated yes to having a disability. KMPT has 16.25% of staff declaring an unknown status for disability, a decrease of 5.5% from the previous year, however a campaign targeted at staff to update their diversity data on self-service ESR is currently taking place to reduce the percentage of unknown declarations to either disabled or not disabled.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%
Disabled	273	7.33%	299	7.69%	306	7.8%
Non-Disabled	2712	72.9%	2743	70.53%	2981	75.9%
Not stated	741	19.89%	847	21.78%	638	16.25%
Total	3726		3889		3925	

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Metric 2: Relative likelihood of staff being appointed from shortlisting across all posts.

	Disabled	Non-disabled	Not stated
Number of shortlisted applicants	493	4371	145
Number of appointed applicants	20	160	9
Appointment %	4%	3.66%	6.2%

Non-disabled staff are **0.90** times more likely to be appointed from shortlisting than those staff with disabilities. As the is figure below **1.00** this indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting.

Metric 3: Relative likelihood of staff entering the formal capability process

	Disabled	%	Non-Disabled	%	Not stated	%
Workforce	306	7.80%	2981	75.95%	638	16.25%
Number of capability/ disciplinaries	1	0.33%	21	0.70%	0	0%
of these were on the grounds of ill health	0	0%	0	0%	0	0%

Disabled staff are 0.46 times more likely than non-disabled staff to enter a formal capability process compared.

A figure above 1.00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

Metric 4a: patients, relatives, managers or colleagues in the last 12 months

32.7% of staff with disabilities report experiencing harassment, bullying or abuse from patients. This has increased from 30.6% last year.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	613	31.6%	581	30.6%	636	32.7%	26.6%
Non-Disabled	1582	28.8%	1296	26.2%	1410	30.21%	21.6%
Total	2195		1877		2046		

Metric 4b: managers

11.04% of staff with disabilities report experiencing harassment, bullying or abuse from managers. This has increased from 11.3% last year.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	613	11.3%	577	13.3%	634	11.04%	11.5%
Non-Disabled	1561	6.0%	1277	6.5%	1380	6.96%	6.07%
Total	2174		1854		2014		

Metric 4c: other colleagues

18.9% of staff with disabilities report experiencing harassment, bullying or abuse from colleagues. This has increased from 17.7% last year. KMPT are above the national average of 18.9%

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	609	17.7%	562	19.5%	630	18.9%	17.96%
Non-Disabled	1561	11.5%	1263	12.8%	1365	12.2%	11.81%
Total	2170		1825		1995		

Metric 4d: Percentage of staff saying that, the last time they experienced bullying or harassment at work, they or a colleague reported it.

66.2% of staff with disabilities say that the last time they experienced bullying or harassment at work, they or a colleague reported this. This is an increase from last year which was 60.7%.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	238	64.7%	242	60.7%	252	66.2%	62.9%
Non-Disabled	491	68.0%	409	65.5%	469	67.6%	64.4%
Total	729		651		721		

Metric 5: Percentage believing that Trust provides equal opportunities for career progression or promotion.

53.2% of staff with disabilities believe the Trust provides equal opportunities for career progression, a slight decrease from last year at 53.6%.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	608	59.5%	584	53.6%	633	53.2%	55.1%
Non-Disabled	1571	60.3%	1290	59.3%	1405	58.0%	60.7%
Total	2179		1874		2038		

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Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

19.25% of staff with disabilities say they have experienced pressure from their manager to attend work, compared with 10.7% of staff without disabilities. This is a slight decrease from the previous year.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	408	17.9%	366	19.6%	400	19.25%	17.9%
Non-Disabled	726	14.9%	560	11.4%	606	10.7%	11.86%
Total	1134		2060		1006		

Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

36.7% of staff with disabilities are satisfied with the extent to which the organisation values their work, compared with 52.8% of staff without disabilities. This could be linked to the above metric where staff feel pressure to come to work.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	615	45.2%	582	41.2%	635	36.7%	44.3%
Non-Disabled	1584	49.9%	1298	51.5%	1410	52.8%	54.4%
Total	2199		1880		2045		

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

78.3% of staff with disabilities consider that the organisation has made adequate adjustments. This percentage has remained the same as the previous year, despite an increase in disabled staff completing this question in the staff survey. The Trust has implemented a central Reasonable Adjustments (RA) process which was launched in April 2024, an increase in staff access the RA process between April and September would not have shown significant improvements due to new implementation.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	376	77.9%	365	78.3%	400	78.3%	79.6%

Metric 9: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation (out of 10)

The staff engagement score for disabled staff is **6.4**, compared with **6.9** for staff without disabilities. The national average for disabled staff is 6.8 and 7.2 for staff without disabilities.

Workforce Group (Clinical & non-clinical)	2022/2023 Number of staff	%	2023/2024 Total Number	%	2024/2025 Total Number	%	National Average
Disabled	616	6.7	584	6.8	637	6.4	6.7
Non-Disabled	1589	7	1300	7.2	1417	6.9	7.2
Total	2205		1884		2054		

Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated.

Staff	Total Board Members	Voting board members	Non-Voting Board Members	% of voting board members	Overall workforce
Disabled	0	0	0	0%	2480
Non-Disabled	5	5	0	27.78%	1165
Not stated	13	11	2	68.75%	280

Gender Pay Gap (GPG)

KMPT's workforce demographic is currently 75.16% female and 24.84% male. KMPT's gender pay gap highlights the key issues with regards to the gender pay differentials.

KMPT's Gender Pay Gap is 13.5% with the mean average of men earning an hourly rate of £22.37 compared to women who are earning an hourly rate of £19.35, although KMPT's gender pay gap average shows that the pay gap was reduced by 1.9%, it is important to note that it is above the national average of 13.1%. For the full report, please visit KMPT's website or Blink.

KMPT are required to analyse data and develop an improvement plan to understand pay gaps by protected characteristic. Plans are in place for our Gender Pay Gap and we are currently working on Ethnicity Pay Gap, we will be working on disability Pay Gap in 2025 and other protected characteristics by 2026. The Trust already report on gender pay gaps. This will be tracked and monitored by NHS boards.

Equality Impact Assessment (EqIA)

Our new Equality Impact Assessment (EqIA) template is a risk assessment tool designed to identify whether an existing or proposed (new) policy, procedure, project or service (the activity) affects people from minority groups differently, and whether it affects them in an adverse way. The EqIA will guide the lead of the project/activity to understand whether people from protected characteristic groups or vulnerable groups are disadvantaged by the activity in any way. It is also a way of identifying where we might better promote equality of opportunity. As an NHS Trust, KMPT needs to ensure that thorough consideration has been given to equality, diversity and inclusion in relation to all strategies, policies, services and functions, both current and proposed. The EDI team now facilitates once monthly Equality Impact Assessment Consultation Review Groups providing individuals with the opportunity to consult with members and representatives from our staff networks throughout the completion of their project.

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EDI Mandatory training

Equality and Diversity training forms part of the essential training for staff in an online e-Learning package that all new starters must complete.

Equality and Diversity is included in both the KMPT staff and managers induction. The compliance target for the EDI training is 90%.

Three years data updates - up to and including March 2024:

Essential Training Compliance Percentages for end of April 25	Equality and Diversity
Compliance Target	90%
Overall Compliance	97%
Acute Directorate	97%
East Kent Directorate	96%
Forensics and Specialist Services Directorate	99%
North Kent Directorate	97%
West Kent Directorate	97%
Support Services	95%

The KMPT induction also covers:

- Policies/Legislation
- Training and development
- Staff networks
- Workforce Race Equality Standards/Disability Equality Standard
- Workplace Reasonable Adjustments
- Where to get further support

Other training on Equality, Diversity and Inclusion:

- Consultant Psychiatrists CPD programme EDI Session
- Equality Impact Assessment Training eLearning
- Basic sign language 10 week accredited programme
- Deaf awareness and sign language workshop
- Disability awareness training
- Active ally workshops
- Protected characteristics data
- Cultural awareness
- Managers induction
- Listening into action sessions

Neurodiversity Network

The Neurodiversity Network was launched in November 2023 and currently has in excess of 140 members. The executive sponsor for the network is the Director of Nursing.

The launch of the network included the collaborative development of branding, communications as well as the development of a Neurodiversity policy and has supported in the development of a central process for reasonable adjustments.

The network provides support and advice to people applying and going through the Government run Access to Work scheme, as well as offering individual support to Neurodivergent staff members who may be struggling at work.

The network has developed a 12-month plan to continue its development and increase membership and has recently supported National Neurodiversity celebration week, raising awareness of Neurodivergence in the workplace.

DAWN (Disability and Wellness Network)

Membership to the DAWN (Disability and Wellness network) is currently 60 members. The Director of Finance is the Executive Sponsor for the network.

The Network has produced and implemented the Health and Wellness Passport and is currently collaborating on updating the reasonable adjustments process which will include up to date guidance and policy as well as having developed a 12-month plan for the network to improve and grow its membership and

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promote significant dates via campaigns.

Lesbian, Gay, Bisexual, Transgender, Questioning, Plus (LGBTQ+) Network

(Around 3.5% of workforce declared that they are lesbian, gay or bisexual and there is no current data recorded for employees disclosing or identifying as Transgender).

The Director of Partnerships and Transformation is the Executive sponsor for the Network. Membership for this network is currently 60 members. This has increased with LGBT+ History month held in February and is expected to increase with future plans and campaigns, including Pride events, Asexuality week and other events. The network has a 12-month plan, packed with campaigns and clear objectives to increase visibility and promotion of the network across the Trust.

Black Asian Minority Ethnic (BAME) Network

The Black, Asian, Minority Ethnic Staff Network is made up of 120 members and is currently working on a plan to increase its membership. The Chief Medical Officer serves as the network's Executive Sponsor, and the network has a committee that includes a Chair, 2 Vice Chairs, a Communication Officer, and a Secretary. The committee will also be recruiting another committee member to the position of 'person without portfolio'. These individuals volunteer their time for this work in addition to their regular roles. The Chair and Vice Chairs are given dedicated time to fulfil their important responsibilities, with the Chair representing the network at various committee and steering group meetings. The network has developed a 12-month plan that includes four campaigns to promote throughout the year, as well as at least three objectives to enhance and expand the network.

Faith Network

63.7% of all staff have declared a religion or belief, with 67% of those declared being Christian and 32.9% other religions. The Faith Network has approximately 70 members.

The networks Executive sponsor is the Chief Operating Officer, and has recently appointed a new network Chair outside of the chaplaincy team, however the Chaplaincy Team continue to promote the Faith Network to encourage wider awareness and understanding of faith related issues.

The Network's purpose is to benefit service users, patients and employees, offering a platform for identifying, promoting and addressing issues, as well as link in with the other Networks to promote intersectionality.

Menopause Network

As of 1st April 2024, Menopause will become a recognised network sitting under

Equality, Diversity and Inclusion.

A monthly 'Let's talk menopause' forum is held virtually, with regular guest speakers, and on average 20 staff members attend the 45-minute session. Following the meetings, a regular bulletin update is mailed out to the 186 staff members who have joined the menopause mailing list.

In addition, from January 2025 the Menopause Network host virtual quarterly specific sessions 'Empowering Men to support Menopause: Partners, Friends and Beyond' aimed at those who identify as male to offer education and support in a psychologically safe environment.

Staff also have the opportunity to find out how the EDI networks work collaboratively together to tackle issues which can affect members through drop in virtual sessions and from the EDI quarterly newsletter.

On the menopause friendly matrix KMPT are currently at level 4-integration and are keen to become fully involved within the Kent & Medway ICS Community of Practice as well as achieve accreditation. KMPT are training menopause advocates and champions and will contribute to raising awareness and utilisation of Reasonable Adjustments and the work and wellbeing passport.

Equality Delivery System (EDS) 2022

The Equality Delivery System (EDS) is an improvement tool for NHS organisations to assess the impact of discrimination, stress and inequality. The aim of the tool is to support improving services provided for local communities; providing better working environments, free of discrimination for those who work in the NHS, while meeting the requirements of the Equality Act 2010, including the Public Sector Equality Duty.

The EDS tool is made up of 3 domains:

The 2024-25 annual report was submitted to NHS England in February 2025 with achievements of the last year including:

KMPT has completed the EDS2022 template by providing detailed narratives and supporting evidence for eleven outcomes across the three domains. Each

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outcome has been assessed based on its alignment with equality, diversity, and inclusion (EDI) objectives, ensuring a comprehensive evaluation of the organisation's performance. Following this assessment, KMPT received an overall rating score of 19, categorising its progress as "Developing." This rating reflects the organisation's ongoing efforts to improve EDI practices while highlighting areas for further development and enhancement.

Domain 1: Patients (4 outcomes): overall score 4

- 1A: People can readily access the service. (1)
- 1B: Individual people's health needs are met, (1)
- 1C: When people use the service, they are free from harm. (1)
- 1D: People report positive experiences of the service. (1)

For Domain one; the 3 services identified by health inequalities data as priority areas to address disparity in patient/ service user experience, and meeting the EDS22 requirements are Memory Assessment Service, NHS 111 Option 2 Service, and Perinatal Mental Health Services, which has a total score of 4. Over the next 12 months will have a stronger focus on the collection of patient EDI data work that is currently underway as well as further patient/service user and community engagement work.

It is also anticipated that the scoring for Domain one will move from developing to achieving over the next 12 months.

Domain 2: Workforce (4 outcomes): overall score 7

- 2A: When at work, staff are provided with support to promote healthy lifestyles and manage their long-term conditions. (2)
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source. (2)
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19). (2)
- 2D: Staff recommend the organisation as a place to work. (1)

Domain 3: Leadership (3 outcomes): overall score 8

- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Accessible Information Standard - Interpreting and Translation

All providers of NHS care or other publicly-funded adult social care must meet the Accessible information Standard (AIS). The standard applies to people who

use a service and have information or communication needs because of a:

- disability
- impairment
- sensory loss

It covers the needs of people who are deaf/Deaf, or deafblind, or who have a learning disability. This includes interpretation or translation for people whose first language is British Sign Language.

There are five requirements to meet the standard:

1. **ASK** - Identify / find out if an individual has any communication / information needs relating to a disability or sensory loss and if so, what they are.
2. **RECORD** - Record those needs in a clear, unmistakable and standardised way in electronic and / or paper- based record / administrative systems / documents.
3. **ALERT/ FLAG/ HIGHLIGHT** - Ensure that recorded needs are 'highly visible' whenever the individual's record is accessed, and prompt for action.
4. **SHARE** - Include information about individuals' Information / communication needs as part of existing data sharing processes (and in line with existing information governance frameworks).
5. **ACT** - Take steps to ensure that individuals receive information which they can access and understand and receive communication support if they need it.

All KMPT services routinely seek information about service user communication needs and support needed. This information is recorded on the patient record system (RiO) and available to those providing care. British Sign Language interpreting is accessed via Kent Deaf Interpreting Service (KDIS) to meet the needs of hearing impaired and deaf service users. This service is monitored by Kent County Council, with quarterly reports provided regarding KMPT use of the service. Ongoing training and support is available to staff to ensure the Accessible information Standard is consistently met in practice. The Communications team provide Braille translation on request. Patient and carer feedback and complaints are also monitored to highlight areas for improvement regarding accessible information and communication. KMPT are members of the Deaf Community Forum, regularly meeting and collaborating with Kent and Medway healthcare providers and the Deaf community to achieve continuous improvement.

Spoken language interpreting and translation

The interpreting and translation services was commissioned from Word360 in October 2023. Information about access to and use of the service is available to all staff via KMPT's internet. Quarterly monitoring of language needs and provision of service provides a dynamic language profile for the Kent and Medway areas that informs service delivery with an aim to be responsive to local community needs. Quarterly performance reports are shared with the Equality and Diversity Steering Group.

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Patient and Carer Race Equality Framework

The Patient and Carer Race Equality Framework (PCREF) was officially launched in November 2023 and is the NHS' first anti-racism framework. PCREF is an organisational competency framework that is being implemented across all Mental Health Trusts and providers, with the mandatory reporting period commencing 1st April 2024. It aims to bring more transparency and accountability to the mental health sector with the ambition to end racial inequity.

Black Asian, Minority Ethnic (BAME) and culturally diverse groups experience disproportionately poorer access, experience and outcomes in mental health services, despite having a higher prevalence of mental health issues. PCREF requires patients and carers to be involved at every level of Mental Health Trusts' or providers governance structures, included in decision making and consulted about individual care and services accessed.

The framework aims to support mental health trusts to:

1. Improve their interaction with ethnically and culturally diverse communities.
2. Raise awareness of the organisations' own cultural and racial bias and provide a framework to reduce them.
3. Improve governance and accountability on improving experiences of care for racialised and ethically and culturally diverse communities.

The PCREF is split into three core components:

1. **Leadership & Governance** - Trusts accountable for Statutory & Regulatory Obligations, eg:

   - Human Rights Act 1998
   - Equality Act 2010
   - And supplementary frameworks incl: WRES, EDS 2022

   12 core pieces of relevant legislation have been identified that applies to all NHS mental health trusts and mental health providers in fulfilling their statutory duties. Leaders of Mental Health Trusts and providers will need to ensure these are complied with across mental health organisations.

2. **Organisational Competencies**

   - Cultural Awareness
   - Staff Knowledge and Awareness
   - Partnership Working
   - Co-production
   - Workforce
   - Co-learning

   Through a co-production process, six organisational competencies have been identified to improve working with racialised communities, patients and carers. Mental health providers are required to work with their communities, patients and carers to assess how they fair against the six organisational competencies (plus identified local priorities) and co-

develop a plan of action to improve them.

3. **Patient & Carers Feedback** - A patient and carer feedback mechanism which tracks progress over time.

Oversight of the framework will sit within the Transformation Directorate. The framework will support trusts and providers on their journey to becoming actively anti-racist organisations by ensuring that they are required to work in equal partnership with voluntary sector organisations, patients and carers, co-producing and implementing concrete actions to reduce racial inequalities across all mental health services.

Freedom to Speak Up (FTSU)

KMPT have used an independent company to provide the FTSU service for three years now. This works extremely well as it brings a degree of independence and reassurance for our staff when wanting to raise concerns that this can be done impartiality and confidentiality where requested.

This also means the role has dedicated protected time to handle concerns and promote the FTSU with a full time Guardian and easy access to the guardian network across the country. The service itself is 24/7 365 days a year, meaning it is accessible to all staff at any time of day or night should they need it.

It is important to add this role reports directly to the Chief Executive.

Engagement

We continue to promote the use of the service to our staff alongside other internal routes. This has been ongoing by making use of screensavers, email signatures, the intranet and distribution of posters and flyers throughout services. The guardian delivers a briefing within each corporate induction and features within managers' inductions to ensure all staff have an awareness of the service on joining the organisation. In addition to this the Guardian visits services to meet staff and raise awareness, delivers briefings within team meetings and carries out extensive additional promotions throughout Speak Up Month each year. The trust has also made NHSE Speak Up and Listen Up training mandatory for all staff and managers which shows a dedication to promoting an open culture within the organisation. Follow Up training is also available to senior leaders however this is not yet mandatory at this stage, it is one of our medium-term ambitions.

For April 24 to March 25 the Guardian has engaged in 205 briefings, promotions and communication meetings to support engagement and understanding of the service provided. These are a mix of online and on-site sessions reaching across all directorates within the Trust. During this period the service has taken 111 new FTSU cases. In total, the guardian has engaged with over 1,800 KMPT staff through site visits, briefings and promotions.

The reasons most frequently cited by staff for choosing to raise their concerns via

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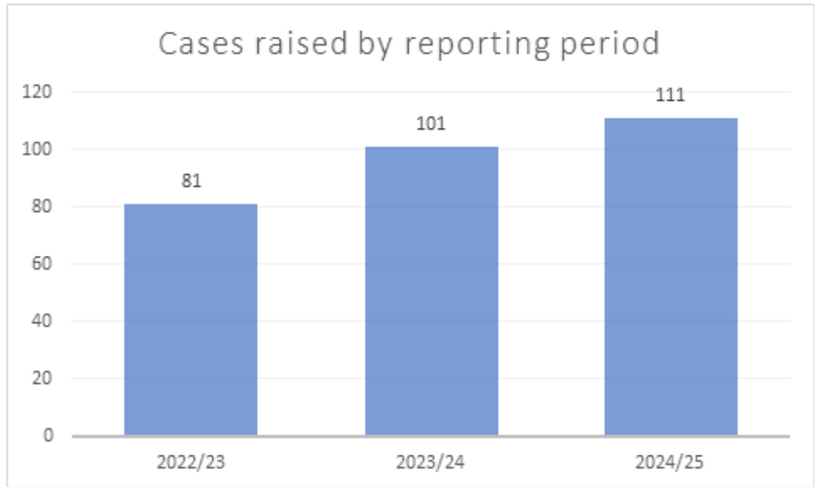
the FTSU guardian sadly relate to previous attempts to raise concerns internally having been unsuccessful (44.14%) with staff feeling they have not been heard or believe action has not been taken appropriately. Additionally (39.64%) of the cases are raised for impartial support. 15.32% report using the service through fear of reprisal or some form of detriment, which remains the same as the previous year.

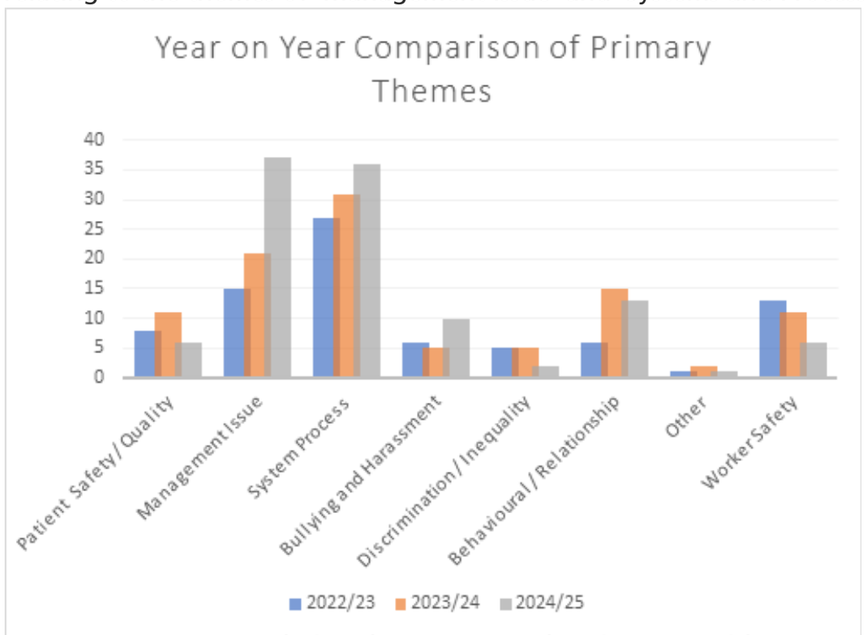
Last year the staffing group with the most engagement with the service was nursing followed closely by Additional Clinical Services. This has remained the same for this period with Nursing, Additional Clinical Services and Admin and Clerical being the top three staff groups to raise concerns. However, if we look at concerns raised by staffing group in relation to head count overall, we see the highest percentage of staff raising concerns in each group being within Allied Health Professionals (4.04%), Medical (3.3%) and Nursing (2.7%). Medical staffing has previously been one of the least likely staff groups to raise concerns and this increase should be seen as a positive step towards creating a more open culture where staff have previously reported not feeling safe to speak up.

Themes and Trends

The chart below shows the number of cases raised each year for the past 3 years that the service has been live.



We are now also able to look back and see themes clearly for the 3-year period. As shown in the chart below there has been a year-on-year increase in cases relating to the themes of 'Management Issue' and 'Systems and Process'.



'Management Issue' being the more prevalent increase with reports of staff feeling that management communication and behaviour lacked dignity and respect or that leadership style was lacking or having a negative impact on staff. When looking at both primary and secondary themes we can see that 47% of cases overall had an element of 'Management Issue'. More detail on these themes will be shared in the annual FTSU board report. The trust is already looking at management development in response to this theme and has this year put in place a suite of new management courses and is about to start on a new leadership programme for the senior leadership team in the Trust. This leadership development has been uniquely designed by the Trust and its leaders.

59% of cases contained an element of **'System/Process'** related concerns. Within this theme we saw staff raising concerns about their experiences of consultation processes feeling that communication or pre-engagement was lacking. Staff also raised concerns about the impact these processes had on them. In addition to these concerns were raised around internal processes including formal processes and investigations, work related stress risk assessments and probationary review processes. This feedback has been heard by staff at the regular Chief Executive monthly staff briefings for all staff, "Speak to Sheila" and the Trust is learning that we must engage with staff sooner than we have done in the past in relation to change and the impact this may have on staff. This will be fundamental for how we approach improvement and change going forward within the organisation.

We have seen a year on year decrease in cases relating to '**Worker Safety/ Wellbeing'**. This is extremely positive as the trust has focussed on a number of initiatives, for example reduce patient violence and aggression towards staff on inpatient wards, which absolutely implies a positive impact. When the service went live we saw the majority of cases relating to worker safety linked

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to patients making staff feel unsafe. The cases being reported now relating to 'Worker Safety/Wellbeing' relate predominantly to a perception of work-related stress. It is worth noting that 39% of cases contained an element of 'Worker Safety or Wellbeing' even if this was not the primary theme. At the time the staff reported impact on wellbeing due to the impact of their concerns or experiences in the workplace. Positive steps forward have happened in the last year so staff now feel safer.

Addressing concerns

Of the 111 cases raised this year, 93 have been closed, meaning that 18 cases remain open carrying over into the next reporting year. Open cases remain under active review by the guardian seeking resolution as soon as possible. Feedback is always shared with organisation or cases re-escalated where things are taking a longer than desirable time to resolve. Of the 93 closed cases, 73 were closed with a written or verbal outcome, and 1 staff member chose not to pursue their concern, either because management action was taken to resolve the concern, or because they were satisfied having talked their concern with an independent party and 19 ceased contact with the service having received impartial support. Of the 18 cases remaining open, 14 were newly raised in March.

We have sadly received similar feedback to last year from staff is that the trust needs to resolve issues more swiftly. An initial response on escalation is prompt with 50 out of 63 escalated cases being responded to on the same day and 93% within the agreed escalation timeframe, but sadly any investigatory work and follow up takes much longer than planned. In some cases, follow up and feedback has been lacking completely. Four cases exceeded the agreed escalation timeframes and needed prompting for response or action. In cases where there is urgency to act the guardian will re-escalate to someone else within the organisation to ensure action can be taken and any risk mitigated.

To ensure this is addressed we have set up a central investigation team (CIT) to support managers with addressing concerns in a timely manner. The following escalation timeline continues to be in place; For red concerns, 12 hours; For amber concerns, 48 hours; For all other concerns, 72 hours. In addition to this we have the following in place; named pastoral support is designated in all employee relations cases, and reviewing the style of HR communications whether this is verbally or written to ensure they set clear timeframe expectations and the approach is compassionate. The CIT investigated 13% of investigations since it was launched. There has also been a reduction in timeframes in cases investigated by the CIT. On average cases are being investigated within 31 days with continued improvement being seen on a quarterly basis. Cases falling outside of this team had an average timeframe of 98 days for the investigation with 11 of those cases taking over 100 days increasing the average figure quite substantially. This will be an area we focus on in the coming year to ensure we aim to get to an average of 30 days.

Conclusion and next steps

Over the last year the trust has undertaken a detailed programme of work on our brand and culture. This work is on-going and will continue for some time to ensure we see the shift in the culture of the trust and we can see (using our annual staff survey as a touch point) that it feels different for staff working

for KMPT. We have launched our new values this year following extensive engagement internally and externally to KMPT. These new values are Caring, Inclusive, Curious and Confident. There is already positive feedback from staff that these values are starting to be lived more and more on a daily basis. The work on FTSU is intrinsically linked to this, especially through the condiment value by being confident to speak up.

The trust has built a strong relationship with the guardian service and it is encouraging the staff to continue to access the services as a means to speaking up. It is good to see that staff are preferring to address concerns raised through informal resolution this indicates a move towards the early resolution approach KMPT advocates.

In addition to this the Chief Executive as the Accountable Officer responsible for this service will continue to take reports on a six-monthly basis to the trust Board. There is a detailed action plan directly related to the FTSU themes mentioned above which is overseen by the Chief Executive and the Chief People Officer.

Reporting on Deaths

Mortality update

Learning from deaths can help us improve the quality of the care we provide to patients and their families.

Findings from the Francis Inquiry report into the Mid Staffordshire NHS Foundation Trust led to significant changes in how healthcare providers learn from deaths. The inquiry highlighted the need for a systematic approach to reviewing deaths in hospitals and other healthcare settings. This led to the development of national guidance and polices for Learning from Deaths in 2017.

The trust has embedded robust systems for reporting and responding to mortality. This includes the Structured Judgement Review process, PSIRF and the monthly Mortality Review Group meeting, where mortality is monitored and analysed.

	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Trust total	431	387	392	530	1740
Acute	3	2	3	4	12
Forensic and Specialist	26	24	22	20	92
East Kent	174	158	141	234	707
North Kent	114	93	106	102	415
West Kent	114	110	120	170	514

Medical Examiner

The trust has embedded the Medical Examiner process into the Trust's Learning from Death Policy. The trust needs only to refer a death to the medical examiner

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if the patient death was expected on a KMPT mental health ward, where the KMPT doctor is responsible for completing the medical certificate cause of death.

Since the implementation of this process in 2023, there have been no mortality incidents where a referral to the Medical Examiner has been required.

Structured Judgement Review

The trust has worked hard to improve the Structured Judgement Review process in 2024/25, and so far, has had a positive response. This includes:

- A new cohort of trained staff (including doctors and nurses)
- A percentage of the backlog of SJRs has been completed in agreement with the ICB
- An SJR SOP has been produced
- Timely completion of SJRs by trained reviewers
- Amendments to how ratings of care are described to align with PSIRF language (steering away from poor and very poor care descriptions).

Suspected suicides and unexpected deaths

Unexpected deaths are reported to the CQC via the Trust's processes. This includes deaths where the national and local PSIRF priorities are met.

KMPT continue to participate in research studies for the National Confidential Inquiry into Suicide and Safety in Mental Health (NCiSH), The current study, which has been ongoing since 2024, is the real time data on suspected suicide deaths of patients during mental health inpatient admission or two weeks post inpatient discharge. The study is formed by a questionnaire, and will contribute to national research into suicide and inpatient admission. So far (since January 2023), there have been four KMPT patient mortality incidents where a questionnaire has been required.

The Trust has worked to embed the Suicide Prevention Approach into practice, and is working on aligning risk assessment processes to the national NICE guidance, NG225- Self-harm: assessment, management and preventing recurrence. This includes digital changes and staff training.

Your views

We want to know what you think. Therefore, if you have any comments to make
about this Quality Account, or you would like further copies, please contact us at
kmpt.communications@nhs.net

This report can be downloaded as a PDF from www.kmpt.nhs.uk

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