Kent and Medway
NHS and Social Care Partnership Trust
Information Governance & Records Management Department
Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9PH

Tel: 01795 514525

Email: kmpt.infoaccess@nhs.net
Website: www.kmpt.nhs.uk

Sent via email

Dear [redacted]

Request for Information

I write further to your request FOI ID 49711 under the Freedom of Information Act 2000 regarding: -

Trust's approach to organisational learning from medico-legal insights

Your request is set out below:

1. Organisational Briefings and Escalation Reports Please provide copies of any briefings, reports, or formal communications produced by or for your organisation regarding the research carried out by Medical Negligence Assist and/or NHS Resolution into mental health-related medico-legal cases and learning. This should include:

   a) Any "Triple A" (Alert, Advise, Assure) escalation reports submitted by Non-Executive Director (NED) Chairs from the Board Committee on Quality and Safety, or equivalent, to the Board (if these are embedded in board reports bundles , please kindly provide online links to the respective reports)

   KMPT do not produce such reports detailed above.

   b) Any stand-alone reports or briefings from the Executive or Medical Directors (or those accountable for medico-legal clinical insights) submitted to the Board regarding this research by Medical Negligence Assist and/or NHS Resolution into mental health-related medico-legal cases and learning.

   KMPT do not produce such reports detailed above.

2. Please provide any annual or stand-alone thematic analysis and trends analysis reports commissioned by Executive Leads or the Board regarding organisational learning from medico-legal insight data for your Trust, for the five-year period up to April 2024. This should include analysis of recurring themes (e.g., risk assessment, communication failures, family involvement), and any evidence of how learning from legal cases has informed workforce development, training, or changes in clinical practice.

   KMPT do not produce such reports detailed above.

3. Please provide the number of clinical claims and incidents of alleged negligence involving mental health or psychiatry lodged against your Trust via NHS Resolution for the period January 2015 to January 2021.

   b) Please provide this data in a tabular format, showing for each year:

• The total number of incidents and claims
• Number of settled claims
• Number of unsettled claims
• The corresponding amount of damages paid out

This information would be held by NHS Resolution and you would need to contact them to obtain this.

c) Please provide a breakdown of the leading causes of mental health and psychiatry negligence claims, as well as the leading types of injuries or harm alleged in these claims.

Top 3 Allegations of Negligence
Failure/Delay to treat
Unexpected Death
Inappropriate Discharge

Top 3 Conclusions
Attempted Suicide
Suicide
Exacerbation of mental health condition

4. Transformative Learning and Quality Improvement Please provide any documentation or information evidence of:

• How the Trust has used claims data, thematic analysis, or legal case insights to drive quality improvement, workforce development, or changes in risk management processes. For the period 2020 to 2025

No specific analysis of claim data is completed. Claims will come in much later than any SI investigation. The majority of claims will follow an SI investigation. Learning comes from the SI's which is managed by the directorates.

• Any information detail on Mechanisms for tracking and assuring the implementation of recommendations from SI investigations and organisational thematic reviews and briefings regarding trends analysis and cost implication of medical legal cases for this period.

The below steps are taken to ensure learning from Serious incidents, Legal claims and thematic reviews

→ Learning requiring immediate sharing or an action to address risk, is discussed by Governance team, Matrons & Head of Nursing & Quality/ AHP Lead via Daily Morning Safety Huddle
→ Where appropriate this will be immediately escalated to the senior management team for the directorate, by the Head of N&Q, who may also decide to escalate to execs, particularly relevant for Serious Incidents.
→ Matrons discuss with local management teams, for the relevant services -and will follow up on expected safety actions.
→ Local management teams share at suitable forums e.g. Daily RED Board Meeting / MDT review/Team meetings
→ All learning (from our directorate , other directorates, and from external partners etc) is shared via the directorate monthly Incident & learning report. This is shared with local teams, and discussed at each month

→ Quality & Patient Safety Meeting. Managers are expected to add this report to their team Business meetings.

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

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

Yours Sincerely

On Behalf of
The Information Governance Department