

MEETING WITH TRISHA BAIN, CHIEF QUALITY OFFICER, LAS

SEPTEMBER 28th 2017

ATTENDANCE: BEULAH EAST, MIKE ROBERTS, MALCOLM ALEXANDER, ATHAR KHAN

1) ACCESS TO PERFORMANCE DATA

We described our current and recent access to performance data and the decision of Brent CCG to stop sending their Weekly Performance Report to the Forum. The Forum does receive monthly performance data from the LAS PPI lead, Margaret Vander.

We explained that the Forum has received CCG data for many years and had suggested that we get the data in future from the LAS. Not reason has been given. Currently, the Brent CCG send the data to 200 CCG bodies in London and the document is not labelled to as confidential. It is unclear which sets of data are verified. Noted that the CCG has access to the LAS data portal.

Agreed that the Forum would send to Trisha a copy of the data it has been receiving from the LAS and CCG and that an agreement would be formulated about future data access.

2) SERIOUS INCIDENTS

The Serious Incident guidance (standard operational procedure) was discussed and in particular its complexity. The version we have has been updated and flow charts produced to ease the investigation process. Trisha explained that there is a tracking system for action plans following investigations and the production of recommendations for service development and staff learning. Immediate risk mitigations can also be specified to ensure that action is taken as soon as a risk is identified which may cause serious harm. Family Liaison Officers are appointed for each Serious Incident to ensure that there are effective communications with patients or families and to make sure that actions are appropriate. Meetings sometimes take place with patients or families.

Trisha said that a new Learning Framework is being produced by the end of October to assist staff in the process of learning from incidents and changing practice to prevent further incidents. She said that another aspect of this process is the protection of staff who may experience many traumatic incidents and potentially suffer from trauma themselves. Staff are also thanked for reporting incidents on Datix and advised of outcomes in a positive way.

Referring to the quality of reports, Trisha said that at the moment there is too much variation in how reports are laid out and how they demonstrate the right process of analysis and conclusions through root cause analysis.

We discussed possibility of Forum members having access to SI reports and being able to comments on their style, content and conclusions. We also discussed attendance by Forum members at the Serious Incidents Committee.

In relation to the process for SI report and other reports that are not SI but have been investigated using the Root Cause Analysis methodology, Trisha said that the same process is used but the reporting requirement was different.

The whole process is currently being reviewed by Jason Ranshane who is cleaning the data and ensuring proper reporting to the NRLS (National Reporting and Learning Service). Thematic analysis reports will be produced on SIs as well.

3) COMPLAINTS

We asked if the complaints system mirrored the SI investigation process in terms learning, transforming the delivery of care and communicating with patients and families. Trisha said that is the ambition but there is still some way to go. She agreed that the “You said: We did approach was a good one for complaints so that people who make complaints are seen to be contributing to service development.

The opportunity of Forum members to examine and comment on complaints was also being developed. The information sharing agreement was being processed and Stephen Moore will finalise the process within two weeks. The names of three members will be submitted to carry out the assessment.

4) COMPLAINTS CHARTER

The Charter has been discussed between Malcolm and Gary on two occasions and all of Gary’s comments have been included in the Charter. It was presented by Malcolm to the AGM and it is hoped that it can be finalised in the near future.

Note: Can the Charter to the Board for formal sign off?

5) BARIATRIC Care

Note that improvements to Bariatric Care were part of the LAS CQUIN, but it has been difficult for the Forum to get any update on implementation. The Forum was told that a paper has gone to the Executive Team but the outcomes are unknown. The Forum would like to gather information from patients and families about the quality and safety of bariatric care. Kevin Bate is leading on this. Malcolm will write to him requesting a copy of the paper, outcomes and action plans.

Trisha that that care plans for bariatric patients can be placed on the command points EOC system.

6) PATIENT FEEDBACK

We agreed that a system needs to be developed to collect on-going feedback from patients, e.g. those receiving care and treatment when in a mental health crisis.

7) SYSTEMS THINKING ?

8) FORUM MEETINGS

October – ACP

November AGM and Margaret Luce and Quality Account for 2017-18

9) FORUM ANNUAL REPORT

Trisha will feedback the LAS's response to our recommendations.