CRICKET GREEN MEDICAL PRACTICE

[redacted]

GP Registrar:

[redacted]

Westminster Coroner's Court
FAO: Susan Lord (Clerk to HM Coroner)
Inner West London
Horseferry Road
London
SW1P 2ED

11th December 2017

[redacted]

Re: Gillian O'Keeffe DOB 31/05/1966 Coroners Report 1100360.

Thank you for your letter, I sincerely apologise that you have had to contact us again regarding this enquiry.

We sent out the original correspondence 2 weeks ago which unfortunately seems you have not received, I have printed off the report again and enclosing with this letter.

If you require any further information please do not hesitate to contact me direct on 020 8685 2345.

Yours sincerely,

[redacted]

[redacted]

Practice Manager
Cricket Green Medical Practice

INVESTOR IN PEOPLE

[redacted]

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Coroner's Report (1100360) O'Keffe

REFERENCE: 'Matter of concern 5' on page 2 of the report stating there appeared to be no easy or appropriate way that family of a mental health patient could share information and/or concerns about the patient with the care team, particularly the patient's care-co-ordinator.

INFORMATION SOUGHT: is there a process in place whereby families can make information of concern formally known to a patient's care team - either a system-wide policy or specifically relating to the patient's GP practice (Cricket Green Medical Practice).

GP Practice Perspective

We have discussed the case with the GP practice and can confirm that a Significant Event Analysis (SEA) has been undertaken by the practice to identify lessons learned.

The issues raised were in relation to a process whereby families can raise concerns to a patient's care team. The GP is one option for patients' family to raise their concern. However, in this case there wasn't an issue with the family raising concerns with the practice as the GP practice were already aware of the concerns and had raised these directly at a liaison meeting with the Trust, and in addition, had re-referred the patient back to the Trust. The issue related to the Trust picking up the concerns and acting to address them.

CCG Perspective

Having discussed the case with the GP practice, we are satisfied that the practice raised their concerns about the patient via the correct process i.e. by raising at their quarterly liaison meeting with the Trust, and by re-referring the patient back to the care of the Trust. On reflection, the lessons learned include other processes that the practice could have utilised to raise their concerns about this lady, including the following:

- Via GP Alert system (Amber Alert for Merton CCG) – This enables GP practices and other healthcare professionals to raise concerns about patient care directly to the CCG. The CCG is very responsive to alerts received and

have evidenced outcomes in relation to quality improvement as a result of quality alerts.

- Via GP Clinical lead for the Trust, who could raise the concerns directly at the Clinical Quality Review meetings with the Trust.

In relation to patients' families, they could raise concerns:

- Directly with the Trust via their PALs and Complaints service; or
- Directly to the CCG stating that they have unsuccessfully raised their concerns with the Trust.

The CCG will be reviewing the Trust's action plan for addressing the issues raised by the Coroner, and a learning event will be undertaken to review the system-wide issues that the case as identified in order to ensure that the system is able to allow families easier access to health professionals should they need to raise care issues about their relatives.