London Ambulance Service NHS
NHS Trust

Being Open Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To ensure that the Trust meets its obligations to patients, relatives and the public in being open.

Sponsor Department: Patient Experience Department

Author/Reviewer: Head of Patient Experiences. To be reviewed by September 2012.

Document Status: Draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
05/10/10	3.1	Director of Corporate Services	Minor changes following approval
06/08/10	2.5	Head of Governance	Further amendments to process
15/07/10	2.4	Head of Records Management	Revised s.8.2
25/06/10	2.3	Head of Governance and Compliance/ Governance & Compliance Manager	Revised throughout
8/06/2010	2.1	Governance lead	Updated process and monitoring requirements
06/10/2008	1.2	Head of Patient Experience	Reformatted. Minor amendments.

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Whistleblowing Procedure	
TP004	Complaints and Feedback Policy	
TP013	Claims Handling Policy and Procedure	
TP054	Investigation of Incidents PALS Complaints and Claims Policy	
TP055	Learning from Untoward Incidents, PALS, Claims and Complaints Policy	
TP/006	SUI Policy	
HS011	Incident Reporting Procedure	
	NHSLA Risk Management Standards for Ambulance Services 2010/11	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

On September 2005 the National Patient Safety Agency (NPSA) advised that all NHS organisations should implement a "Being Open Policy". This policy describes how London Ambulance Service NHS Trust (LAS) will demonstrate its openness with patients and relatives when mistakes are made.

Being Open is a general concept the specific delivery of "Being Open" communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. In exceptional cases information may need to be withheld or specific legal requirements might preclude disclosure. Equally records of communications with patients and families would not normally be shared in the public domain.

The Trust aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of healthcare systems.

This policy is to be implemented following all patient safety incidents where serious actual harm has occurred or could have occurred (near miss).

Being Open relies initially on the stringent reporting of incidents. Staff who are concerned about the non-reporting or concealment of incidents, or about ongoing practices which present a serious risk to patient safety, are encouraged to raise their concerns under the Trust's Whistleblowing Policy (HR/07/22)

2. Scope

This document outlines the Trust's policy on openness and how the LAS meets its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst trust staff care for, treat and transport patients

This document is aimed at all staff working within the Trust who are responsible for patient care and for ensuring the infrastructure is in place to support openness between healthcare professionals and patients, their families and carers, following a patient safety event.

3. Aims and Objectives

The Trust's aim is to evidence a robust risk management system is in place which reflects the following:

3.1 Learning from mistakes with full transparency and openness

3.2 A proactive approach to clinical negligence with the onus on risk management systems and processes identifying incidents which require review and learning.

3.3 Working in partnership with all stakeholders

3.4 When mistakes happen, patients/relatives/carers/others should receive an apology and explanation as soon as possible and staff should feel able to apologise at the earliest opportunity. Saying sorry is not an admission of liability. A patient has a right to expect openness from their healthcare providers. Staff do not intend to cause harm in the majority of cases but unfortunately incidents do occasionally occur. Support for staff should be offered from the Staff Counselling and Occupational Health Services Manager or the Human Resources and Organisation Development Directorate.

3.5 Line managers should know that an individual or team might require support during the investigation and, after discussion should guide them to the appropriate support mechanism. This may involve external agencies.

3.6 Senior managers undertaking SUI investigations must follow the LAS SUI policy guidance (TP?) so that appropriate support is offered to the victim/families/carers/others. A single point of contact will be identified with the victim/carers/relatives to aid communication and feedback of information about the incident,

3.7 The LAS aims to comply with the requirements of the NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Services.

The Principles of Being Open are set out in full in Appendix 3.

4. Responsibilities

4.1 Trust Board

The Trust Board will be informed and ultimately assured that the processes work effectively in line with the board level public commitment to implementing the *Being open* principles.

4.2 Chief Executive

The Chief Executive is ultimately responsible for the process of managing and responding to the *Being open* process and for the delegation of this role when required.

4.3 Executive Directors

SMG are responsible for compliance with the *Being open* process. They are responsible to the Trust Board and the Chief Executive for managing an effective *Being open* process.

4.4 Learning from Experience Group

The Learning from Experience Group will have overall responsibility for managing the *Being open* process.

- The Group links with all the other relevant risk management committees and groups: Quality Committee, Risk Compliance and Assurance Group, Clinical Quality, Safety and Effectiveness Group, and Area Governance Groups;
- The Group is responsible for ensuring continuous development of the *Being open* document in accordance with national guidance;
- In reviewing SUIs and cases of significance to patient care, the Group monitors the *Being open* processes;
- the Group communicates both up to board level, and down to the local management levels; and
- The Group facilitates organisational learning and improvement as a result of effective *Being open* processes by making sure that any lessons learned are disseminated through the Trust; publishing case study examples and SUI reports on the Trust's website; and making any recommendations to the Trust Board.

The terms of reference for the Group can be found at appendix 4.

4.5 Head of Patient Experiences and Assistant Director of Corporate Services

The Head of Patient Experiences is responsible for the overall application of the policy and the Assistant Director of Corporate Services for supporting the Head of Patient Experiences in monitoring compliance and reporting on effectiveness to the Learning from Experience Group as part of the overall monitoring process.

4.6 Head of Legal Services, Head of Safety and Risk, Governance and Compliance Team

These managers are the recognised links with the NPSA.

4.7 It is the responsibility of all **Trust managers** to support staff so that they adhere to this policy

4.8 All **staff** working within the LAS are expected to adhere to this policy and demonstrate the principles of being open when a patient safety incident occurs.

5. Definitions

Definitions of the terms used within this document are consistent with those in the Trust's Incident Reporting Policy and SUI Policy

Patient Safety Incident
'...any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare' (Seven Steps to Patient Safety, NPSA 2003). This can be identified in the course of an incident report, complaint, and enquiry to Patient Experience Department or a claim.

Serious Untoward Incident
'...a situation in which one or more service users are involved in an event which is likely to produce a significant, legal media, or other interest and which if not properly managed, may result in loss of the Trust's reputation or assets.'(Seven Steps to Patient Safety, NPSA 2003)

Lead Manager
A staff manager who provides tactical level of management at or close to a specific incident whose function is to determine priorities in allocating resources in order to deliver effective resolution of the incident

6. Clinical support and advice

Clinical support and advice for staff involved in a patient safety incident is provided according to how serious the patient safety incident is classified as using the trust risk management matrix (TP035) with support from operational managers and the Medical Directorate as described below:

- The first level of support is provided by local managers (working at station level) for staff in a patient safety incident who will give advice so that they are able to manage the incident in real time as soon as possible after the incident has happened, and includes general advice. This includes advising on the being open process and general enquiries about how to communicate with patients, relatives and carers.
- The second level of support is provided by complex level managers (Ambulance Operations Managers) and may include guidance from clinical tutors and /or Duty Station Officers. Where authority and support is needed from the trust's senior operational managers then

the Assistant Director of Operations where the complex is located will be involved by the complex level managers.

- The third level of support is provided by the Assistant Medical Directors to the Assistant Director of Operations where they are based in conjunction with the Medical Director. For Control Services support is provided by the Deputy Medical Director. Both Medical and Deputy Directors manage and participate in a 24 hour on call rota so that advice can be provided when the incident happens and action implemented by staff “on scene”.

7. Being Open Process

The most appropriate staff are identified to meet with the patient and/or relatives and others.

The nominated lead manager will normally be the Ambulance Operations Manager as the most senior person responsible for the patient’s care and/or someone with the experience and expertise in the type of incident that has occurred. This person will be supported by at least one other member of staff within the department or Medical directorate. Links with the Patient Experiences Department, Legal Services and Risk and Safety Managers must be established at the earliest opportunity. The nominated lead and staff directly involved in the incident will hold a pre-meeting to establish the facts and agree/understand the aims of the meeting with the patient and/or relatives and others; the lead will use this opportunity to determine the needs of the patient and/or relatives in order to ensure that no-one will be disadvantaged in any way. The patients and/or relatives and others may not in all instances be present at this pre-meeting but feedback must be given at the earliest opportunity once the actual facts are known. No communication errors should arise by giving unsubstantiated facts as this can create anxiety.

A letter should be sent to the patient and/or relatives and others inviting them to meet with the nominated staff, offering them a choice of venues and times and advising of the independent advocacy service available to support and assist them (in accordance with the Trusts Complaints and Feedback Policy (TP004), SUI Policy (TP006), and Investigation of Incidents, PALS, Claims and Complaints Policy (TP055)).

The patient and/or the relatives and others should be given the opportunity to choose:

- Whom they would prefer to meet with;
- Where and when the meeting will be held;
- Whether they would like to bring a friend to the meeting.
- The date, time and venue should be confirmed in writing including email

Nominated staff may continue to meet with the patient/relatives and others to support continuity of communication and relationship building.

The meeting is held as soon as possible after the incident, taking into account the patient's and/or the relative's and others' wishes.

Any meeting should be held in deference to the patient/relative/advocate's wishes. The same applies as to any venue; it is usually for the patient/relative to decide and for the Trust to accommodate.

All learning from the incidents must be cascaded to the whole organisation, via Learning from Experience Group, anonymised Outcome Reports, Area Governance Committees, Trust communications systems including the website.

Details are shared with any other healthcare organisation or relevant stakeholder as appropriate.

7.1 Procedure for the nominated team

At the meeting with the patient and/or relatives and others, the nominated staff from the investigating team should follow the procedure below.

- Apologise for what happened
- If known, explain what went wrong and where possible, why it went wrong.
- Give the patient and/or relatives an opportunity to ask as to why they thought it went wrong.
- Ask the patient and/or carer and others why they thought the error occurred.
- Inform the patient and/or relative(s) and others what steps are being/will be taken to prevent the incident recurring.
- Provide opportunity for the patient and/or relatives and others to ask any questions.
- Agree with the patient and/or relatives and others any future meetings as appropriate.
- Suggest any sources of additional support and counselling and provide written information if appropriate.
- When full investigation is required because the incident has been coded as high or catastrophic, a full Root Cause Analysis will be undertaken (see Trust SUI Policy). The patient, relatives and others should be given this information and a contact person will be agreed

with the patient, relatives and others. The contact person will be responsible for keeping the patient, relatives and others up to date with how the investigation is progressing, maintaining a dialogue by addressing new concerns, sharing new information when available and providing information on counselling as appropriate.

- Create a record using the case management system used by the Trust according to the lead department with a complete, accurate record of all communications, including date and time of each entry, what the patient and/or relatives and others have been told, and a summary of agreed action plans.

7.2 Follow-up

The Medical Director or nominated deputy will send a letter of apology, within the timescales as outlined in TP004/TP006/TP055, explaining how and, if possible, why the error occurred. If this information is not available, they should provide an explanation as to how the error will be investigated and when they can expect to be provided with additional details. This letter will clarify the information previously provided, reiterate key points, and record action points and future deadlines.

8. Documentation

The requirements for documenting all communication are set out below;

8.1 The requirement for written records of discussions with patients/carers is set out in section 7.1.

8.2 Documentation regarding the Being Open discussion

Aside from offering any apologies the aims of the Being Open discussion are
principally:

- to share any facts that are known and agreed with the patient/carers;
- to explain any likely short and long-term effects of the incident;
- to inform the patient/carers that an investigation is being carried out and to agree how they will be kept informed of the progress and results of that investigation;
- to establish the patient's/carer's understanding of what happened;
- to identify what questions, if any, the patient's/carer's have; and
- to offer appropriate practical and emotional support to the patient/carers.

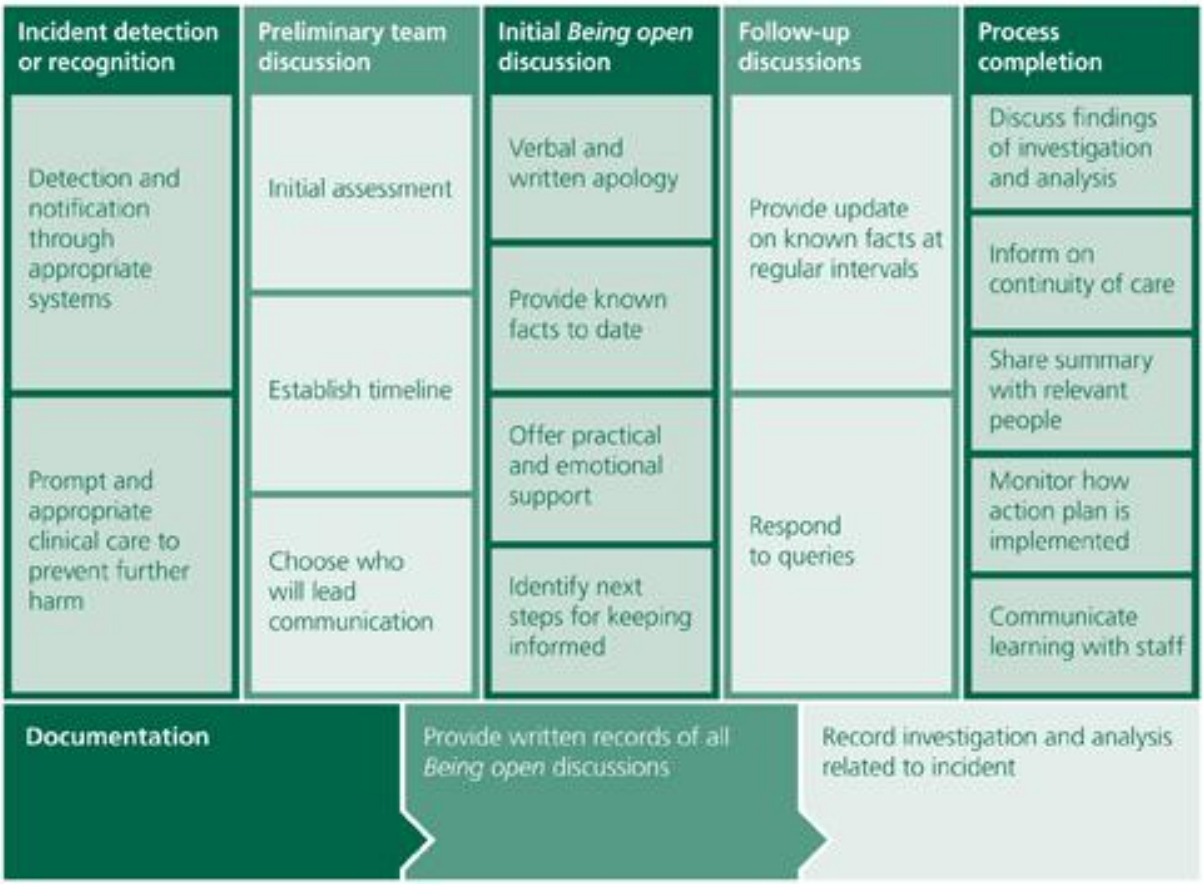
The documentation of the Being Open discussion should reflect the aims of the Being Open process.

Implementation Plan

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.
Training	Staff are encouraged to access the NPSA e-learning toolkit on being open (refer to Appendix 1 for an overview of the stages of the being open process). The trust also provides training on Incident Investigation and Root Cause Analysis with support from the Patient Experience Department.
Monitoring	Adherence to this policy will be monitored through the sample audits of records held by Patient Experiences, Legal Service and Patient Involvement. Reports will be provided for the Learning from Experience Group and any outcomes/ recommendation to RCAG. Appropriate dissemination of reports will also be made to area governance groups. For these reasons monitoring of compliance and effectiveness will be via confidential planned audit of Significant Events based on an agreed methodology using an appropriately sampled population. This audit will be carried out by the Head of Patient Experiences and the Assistant Director of Corporate Services. The results of the Audit will be included in the annual report. If any deficiencies are identified these will be fed back to the appropriate manager who will be responsible for producing and implementing an action plan. The action plans will be monitored by the Learning from Experience Group with any concerns being escalated to the Quality Committee or Risk Compliance and Assurance Group.

Appendix 1

Overview of the *Being open* process



NPSA. (2009). *Being Open. p.3*

- Stage 1: Patient safety event detection or recognition - This covers how patient safety events are recognised; the prompt and appropriate clinical care and prevention of further harm; and who to notify about the patient safety event.

- Stage 2: Preliminary team discussions - This covers the preliminary team discussion to establish the basic clinical and other facts; undertaking the initial assessment to determine the level of response required; the timing of the discussion with the patient, their family and carers; and choosing who will be the lead in communicating with the patient, their family and carers

Grading of patient safety incidents to determine level of response

Incident	Level of response
No harm (including prevented patient safety incident)	Patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of the *Being open* policy. Individual healthcare organisations decide whether 'no harm' events (including prevented patient safety incidents) are discussed with patients, their families and carers, depending on local circumstances and what is in the best interest of the patient.
Low harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Reporting to the risk management team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. Communication should take the form of an open discussion between the staff providing the patient's care and the patient, their family and carers. **Apply the principles of *Being open***
Moderate harm, severe harm or death	A higher level of response is required in these circumstances. The risk manager or equivalent should be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the *Being open* process**

NPSA. (2009). *Being Open.* p.21

- Stage 3: The initial Being open discussion - This covers the content of the discussion and what should not occur: speculation, attribution of blame, denial of responsibility and provision of conflicting information from different individuals.

- Stage 4: Follow-up discussions - This covers the subsequent discussions with the patient, their family and carers.

- Stage 5: Process completion - This covers repeating the apology; providing feedback on the findings of the investigation into the patient safety event; what the organisation will be doing to prevent occurrence; the ongoing clinical management plan (if appropriate); and communicating with relevant other community care providers what has happened. This also covers monitoring how the recommendations to prevent recurrence have been implemented and communicating with staff the recommendations to spread the learning.

Appendix 2

Being Open Flow Chart

1. Apologise to patient/carer/relative/others

2. Arrange a pre-meeting with all the health and social care professionals involved to ascertain the facts

3. Agree verbal review of the facts, which can be fed back to patient/carer/relatives/others. Reinforce empathy regarding the incident and for incidents coded as low or moderate using the Trust's Risk Matrix (TP035) arrange a meeting with the family in a more formal manner as appropriate, considering all points under responsibilities. Send a letter, within the timescales as outlined in TP004/TP006/TP055, acknowledging the incident and arranging a date and time to discuss this.

4. If the incident is coded significant or high patient experience, governance and risk management staff must be involved as early as possible. A RCA investigation should be considered and this process explained to the family. When the investigation is completed a meeting may be arranged with the family with a member of staff attending to feedback or an executive member of the trust , depending on the outcome of the incident review and the patient/carer./relatives' wishes.

5. Within 14 days of the investigation being concluded and the final report formally approved a copy will be sent to the patient/carer/relatives/others with identification of the incident, why the incident occurred, recommendations and any lessons learnt.

6. Legal Services Department must be made aware of any incident that may proceed to litigation

7. All Learning from incidents must be cascaded to the whole organisation via staff meetings electronic bulletins, trust website and intranet and staff conferences.

Appendix 3

The Principles of Being Open

Being Open involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

Principle of Acknowledgement

All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare staff that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. The Trust recognizes that denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

Principles of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety event must be given in a truthful and open manner by an appropriately nominated person. This is most usually the Patient Experiences department who receive the vast majority of service-user approaches but is not exclusive. Communication from Operational/Clinical staff must only be from Ambulance Operation manager grade staff or above. Communication should also be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place and that they will be kept up to date. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

Principle of Apology

Patients, their families and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event or that the experience was poor. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Both verbal and written apologies should be given. **Saying sorry is not an admission of liability and it is the right thing to do.** Verbal apologies are essential because they allow face to face contact, where this is possible or requested.. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, will also be given.

Principle of Recognising Patient and Carer Expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety event, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information about the Patient Experiences Department and Independent Complaints Advocacy Service is routinely offered accordingly; See also http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx
Information enabling to other relevant support groups will be given as soon as possible and as appropriate.

Principle of Professional Support

The Trust has set out to create an environment in which all staff are encouraged to report patient safety events. Staff should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the patient safety event. Resources are available are referred to within the respective Trust policies, (HS011, TP004), to assist ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of individual staff the relevant professional body and/or Human Resources department can be contacted for advice. Where there is reason to believe a member of staff has committed a punitive or criminal act, the Trust will take steps to preserve its position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

Principle of Risk Management and Systems Improvement

Root Cause Analysis (RCA) or similar techniques should be used to uncover the underlying causes of patient safety events. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness. *Being open* is integrated into patient safety event reporting and risk management policies and processes.

Principles of Multi-Disciplinary Responsibility

Being open document applies to all staff who have key roles in patient care. Emergency care provision is often a component of the totality of total healthcare and can involve multi-disciplinary teams. This is reflected in the way that patients, their families and carers are communicated with when things go wrong. This ensures that the *Being open* process is consistent with the philosophy that patient safety events usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the *Being open* process, especially if working with NHS trusts

in other sectors (e.g. acute care or mental health) it is important to identify clinical and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and senior clinicians will be asked to participate in the patient safety event investigation and clinical risk management as set out in the respective Trust policies and practice guidance.

Principles of Clinical Governance

Being open involves the support of patient safety and quality improvement through the Trust's clinical governance framework, in which patient safety events are investigated and analyzed, to identify what can be done to prevent their recurrence. It also involves a system of accountability through the chief executive to the board to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to staff so they can learn from patient safety events. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety event.

Principle of Confidentiality

Details of a patient safety event should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of the incident lead and those involved in the investigation ill be on a strictly need to know basis and, where practicable, records are secure and anonymised where released. Where possible, it is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

Principle of Continuity of Care

The Trust recognise that patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.

Appendix 4

Learning from Experience Group
Terms of Reference
September 2010

1. Authority

1.1 The Learning from Experience Group constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Quality Committee.

1.2 The Group is authorised by the Quality Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.3 The Group is authorised by the Quality Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

The primary focus of the Learning from Experience group will be the integrated review of incidents including SUIs, PALs enquiries, complaints and claims, in order to identify actual and emerging risk themes and to recommend changes to practice and for ensuring that the objectives of the Learning from Untoward Incidents, PALs, Claims and Complaints Policy are achieved.

2.1 Oversee the arrangements for investigation and action planning on incidents, claims and complaints.

2.2 Ensure that following investigations and serious case reviews, action plans to address root causes are drawn up and their implementation monitored and reported to the Quality Committee.

2.3 Ensuring arrangements for improvement in practice following serious incidents is implemented and evaluated.

2.4 Oversee and monitor arrangements for the dissemination of learning within the organisation and where appropriate, across the ambulance service network.

2. Objectives

3.1 Examine emerging themes and issues of significance from incidents including SUIs, complaints, claims, and PALs as a mechanism for service user and stakeholder feedback.

3.2 Seek assurance of action taken on, and implementation of, themes and issues and the lessons learnt and improvements made.
3.3 Seek assurance on the effectiveness and outcomes of lessons, improvements and changes to practice.

3.4 Consider ways of involving and engaging patients and the public in learning from issues and assessing the effectiveness of outcomes and improvements made.

3.5 Make recommendations to the Risk, Compliance and Assurance Group on any new risks emerging, or changes to existing risks.

3.6 Make recommendations to the Clinical Quality, Safety and Effectiveness Committee on action, monitoring or assurance required on emerging themes and risks.

3.7 Provide assurance to the Quality Committee.

3.8 Oversee the implementation and review of the following policies:

- Learning from Untoward Incidents, Claims and Complaints
- Investigating incidents, claims and complaints
- Complaints and user feedback policy
- Being Open.

4. Membership and attendance
4.1 The Learning from Experience Group shall comprise:

- Deputy Chief Executive (Chair)
- Assistant Director, Corporate Services (Deputy Chair) / Director of Corporate Services initially
- Head of Patient Experience
- Head of Legal Services
- Head of Safety and Risk
- Head of Patient & Public Involvement
- Deputy Director of Operations
- Assistant Medical Director
- Assistant Director, Employee Relations
- Assistant Director, Professional Education & Development
- Audit and Compliance Manager
- LAS Patient Forum representative.

Other members of staff may be required to attend for specific agenda items.

5. Accountability

5.1 The Learning from Experience Group shall be accountable to the Quality Committee.

6. Reporting

6.1 The minutes of the Learning from Experience Group meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Quality Committee.

6.2 The Chair of the Learning from Experience Group shall draw the attention of the Quality Committee to any issues that require disclosure to the full Trust Board.

6.3 The Learning from Experience Group shall receive regular reports from the Patient and Public Involvement Committee.

6.4 Recommendations and feedback shall be made to this group as appropriate.

7. Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the Learning from Experience Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

7.3 The draft minutes and action points shall be made available to Committee members within seven working days of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the Learning from Experience Group.

8. Quorum

8.1 The quorum shall be the Chair or Deputy Chair, and two other members.

9. Frequency of meetings

9.1 The Learning from Experience Group shall meet quarterly before the Senior Management Group and the Quality Committee.

9.2 The Deputy Chief Executive or the Director of Corporate Services may request a meeting if they consider that one is necessary.

10. Review of Terms of Reference

10.1 The Learning for Experience Group shall review these Terms of Reference annually.

10.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Terms of reference
2nd September 2010