London Ambulance Service NHS Trust

Being Open and Duty of Candour Policy & Procedure

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: Corporate Services

Author/Reviewer: Director of Corporate Services and the Assistant Director of Corporate Services. To be reviewed by September 2014.

Document Status: draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
19/03/2013	4.5 (3)	Director of Corporate Services	Update following EMT
08/03/2013	4.4	AD Corporate Services	Update following workshop
01/03/2013	4.3	AD Corporate Services	Update to include Contractual duties and Francis recommendations.
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29/09/2012	4.1	AD Corporate Services	Update to appendix 2 post ADG
07/09/2012	3.3	IG Manager	Document Profile & Control update
05/09/2012	3.2	Assistant Director of Corporate Services	Update and Inclusion of Monitoring plan
05/10/2010	3.1	Director of Corporate Services	Minor changes following approval
06/08/2010	2.5	Head of Governance	Further amendments to process
15/07/2010	2.4	Head of Records Management	Revised s.8.2
25/06/2010	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**
HR/07/22	Whistleblowing Procedure	
TP004	Complaints and Feedback Policy	
TP013	Claims Handling Policy and Procedure	
TP054	The Investigation and Learning from Incidents PALS Complaints and Claims Policy	
TP006	Serious Incident Policy	
HS011	Incident Reporting Procedure	
External	NHSLA Risk Management Standards for Ambulance Services 2012/13	
External	The NHS Constitution	March 2012
External	The NHS Mandate	
External	Technical Contract Guidance 2013/14	Feb 2013

1. Introduction

In September 2005 the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising all NHS organisations to implement a "Being Open Policy". In November 2009 a Patient Safety Alert was issued by the NPSA to ensure that providers of NHS funded care implemented the principles of *Being open.* Compliance with the requirements is subject to assessment by the NHS Litigation Authority. The NHS Standard Contract 2013-14 (Annex 4) specifically requires NHS provider organisations to implement and measure the principles of *Being open* under a contractual Duty of Candour. In addition, the Francis Report (2013) makes recommendations with regard to Openness, Transparency and Candour.

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 set of principles that healthcare staff should use when communicating with patients, their families and carers following an incident in which the patient was harmed (Appendix 1). The specific delivery of "*Being open"* communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. The Duty of Candour applies to those patient safety incidents which result in moderate harm, severe harm or death.

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

This policy is to be implemented following all patient safety incidents where moderate, severe harm or death has occurred.

Being open relies initially on its staff and the rigorous reporting of Patient safety incidents. The Trust endorses the Francis Report Recommendation 173;
'***Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be open, honest and truthful.'*** Therefore, 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 and sets out the infrastructure which is in place to support openness between healthcare professionals and patients, their families and carers, following a patient safety incident.

3. Objectives

The objectives of this policy is to evidence that a robust risk management system is in place which reflects the following:

3.1 A patient has a right to expect openness from their healthcare providers.

3.2 The Trust will learn from mistakes with full transparency and openness.

3.3 A proactive approach to patient safety with the onus on risk management systems and processes identifying incidents which require review and learning.

3.4 Working in partnership with all stakeholders

3.5 Staff do not intend to cause harm but unfortunately incidents do occur. When mistakes happen, patients/relatives/carers/others should receive an apology and explanation as soon as possible. Saying sorry is not an admission of liability and staff should feel able to apologise at the earliest opportunity.

3.6 Senior managers undertaking Serious Incident investigations must follow the LAS Serious Incident policy (TP006) guidance. They must ensure that appropriate support is offered to the patient/families/carers/others. A single point of contact will be identified with the patient/carer/relative to maintain communication and feedback of information about the incident.

3.7 Line managers should understand that an individual or team might require support during the investigation and, after discussion, should guide them to the appropriate support mechanism. Support for staff should be offered from the Staff Counselling and Occupational Health Services Manager or the Workforce Directorate. This will include contact details of both external and internal support.

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

3.9 The Principles of *Being open* are set out in Appendix 2

4. Responsibilities

4.1 Trust Board

The Trust Board have responsibility to obtain assurance that the processes work effectively to support the board level public commitment to implementing the *Being open* principles and Duty of Candour.

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

The Executive Management Team is responsible for compliance with the *Being open* process. They are accountable to the Trust Board and the Chief Executive for the implementation of an effective *Being open* process.

4.4 Senior Management Team
The Senior Management Team is responsible for monitoring compliance with the *Being open* and Duty of Candour policy and implementing the associated process.

4.5 Learning from Experience Group

The Learning from Experience Group will have overall responsibility for monitoring the *Being open* and Duty of Candour process.

- The Group links with the Area Quality Committees and reports to the other relevant risk management committees and groups: Quality Committee, Risk Compliance and Assurance Group, Clinical Quality, Safety and Effectiveness Group.

- The Group is responsible for ensuring continuous development of the *Being open* and Duty of Candour policy in accordance with national guidance;

- In reviewing Serious Incidents the Group will monitor the *Being open* process;

- the Group will communicate up to board level, and to the local management levels;

- 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.

- The terms of reference for the Group can be found at Appendix 3.

4.6 The Assistant Director of Corporate Services

The Assistant Director of Corporate Services is responsible for monitoring compliance with and reporting on the effectiveness of the management of *Being open* to the Learning from Experience Group. A quarterly report will be produced for the group and data will be collated for submission to the commissioners.

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

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

4.9 Patient and Family Liaison Manager
An appropriately trained and resourced member of Trust staff who will be the point of contact throughout an investigation between the patient and family and the Trust.

5. Definitions

Definitions of the terms used within this document are consistent with those in the Trust's Incident Reporting Policy (HS011) and Serious Incident Policy (TP006).

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 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)*
Openness – enabling concerns and complaints to be raised and disclosed freely without fear, and for questions to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked. (Francis 2013)

6. Clinical support and advice

Immediate clinical support and advice for staff involved in a patient safety incident is provided according to how serious the patient safety incident is classified. The incident is graded using the Trust's risk management matrix (TP035) with support from operational managers and the Clinical and Quality Directorate as described below:

- The initial level of support is provided by local managers (working at station level) for staff involved 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. This includes advising on the *Being open* process and general guidance 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 or Duty Station Officers. Further escalation may be required depending on the severity of the incident. Where support is needed from the Trust's senior operational managers then the Assistant Director of Operations where the complex is located will be informed.

- A further level of support is provided by the Assistant Medical Directors where they are sector based in conjunction with the Clinical Directors. For Control Services support is provided by the Deputy Medical Director. Both the Clinical and Executive Directors manage and participate in 24 hour on call rotas so that

advice can be provided when the incident happens and action implemented by staff “on scene”.

7. *Being open* and Duty of Candour Procedure

7.1 The patient or their family/carer must be informed that a suspected patient safety incident has occurred within at most **10 working days** of the incident being reported to the local systems, and sooner where possible.

7.2 The initial notification must be verbal and face to face where possible and will be followed by a letter from the appropriate manager.

7.3 An apology must be provided – a sincere expression of sorrow or regret for any suspected harm caused must be provided verbally and in writing.

7.4 The nominated operational 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 Clinical and Quality directorate. If the incident is serious and a confirmed grade of 15+ is agreed the Governance & Compliance investigation manager will identify and contact the Patient and Family Liaison manager.

7.5 The Patient and Family liaison manager will meet with the staff directly involved in the incident to establish the facts and agree/understand the aims of the meeting to be held with the patient and/or relatives and others. The Patient and Family liaison manager will use this opportunity to identify the needs of the patient and/or relatives in order to ensure that no-one will be disadvantaged in any way. Factual feedback must be given to the patient or representatives at the earliest opportunity. No communication errors should arise by giving unsubstantiated facts as this can create anxiety. All meetings and correspondence will be entered into the risk management system within 24 hours or at the time of drafting. Where appropriate the Patient Experiences Department, Legal Services and Safety and Risk Managers should be informed.

7.6 If the patient or family are aware of the incident then the immediate actions as stated above should be followed by a letter.
The 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), Serious Incident Policy (TP006), and The Investigation and Learning from Incidents, PALS, Claims and Complaints Policy (TP054).

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.

7.7 The Patient and Family liaison manager may continue to meet with the patient/relatives and others to support continuity of communication and relationship building.

7.8 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.

7.9 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.

7.10 The local management team will be kept up to date on progress with the investigation and contacts with the patient and family.

7.11 However should the LAS become aware of a patient safety incident which has taken place and the patient and family are not aware then steps 7.1 to 7.10 will be followed and the letter will be signed by the Clinical Directors.

All learning from the incidents must be cascaded to the whole organisation, via Learning from Experience Group, Area Quality Governance Committees, and Trust communications systems including the website. e.g anonymised case studies.

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

8. Procedure for the nominated investigation 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 and an error occurred. This may include relevant personal circumstances should staff agree these can be shared;
- 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 graded as 15+, a full Root Cause Analysis will be undertaken (see Trust SI Policy TP006).

The patient, relatives and others should be given this information and a Patient & Family Liaison manager will be appointed. The Patient & Family Liaison manager 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.

- Records will be created and maintained by the Governance & Compliance manager.

9. Follow-up

One of the Clinical Directors or nominated deputy will send a letter of apology, within the timescales as outlined in TP004/TP006/TP054, explaining how and, if possible, why the error occurred. If this information is not available, the letter should provide an explanation as to how the error will be investigated and when the patient/representative 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.

10. Documentation

The requirements for documenting all communication are set out below:

- the record of an open and honest apology;
- sharing any facts that are known and agreed with the patient/carers;
- an invitation to the patient/carers to participate in the investigation and to agree how they will be kept informed of the progress and results of that investigation;
- an explanation of any likely short and long-term effects of the incident;
- a clear response to questions the patient/carer may have;
- an offer of appropriate practical and emotional support to the patient/carer;
- An auditable record of contacts will be maintained with the Root Cause Analysis Report.

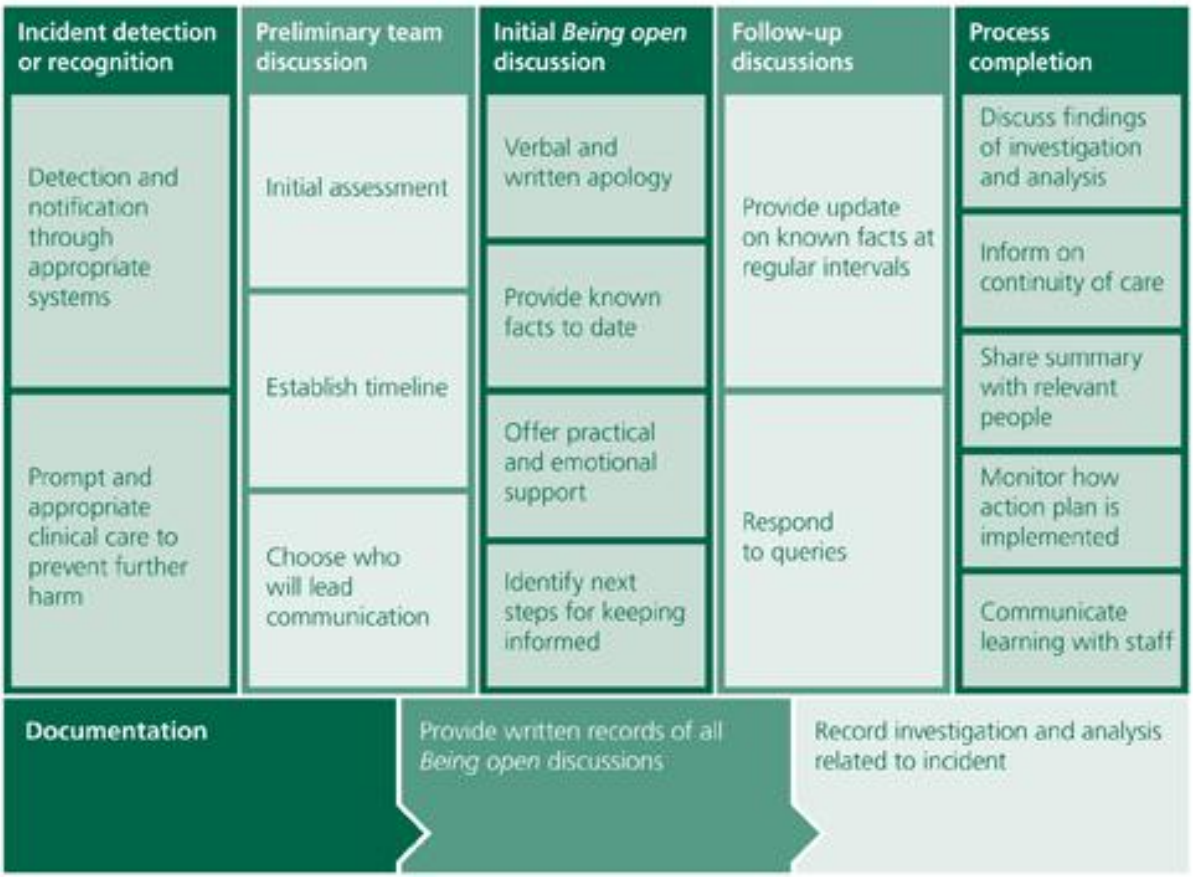
IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document. Consideration to be given to appropriate mechanisms for raising awareness amongst staff.
Training	The Trust provides training on Incident Investigation and Root Cause Analysis with support from the Governance & Compliance team. External Being open training is commissioned.

Monitoring:

Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
The Principles of Being Open (Appendix 2), including; • How communication between healthcare organisations, healthcare teams, staff, patients, their relatives and carers is encouraged (Section 7) • How all Communication is recorded (Section 8) • How staff acknowledge, apologize and explain when things go wrong • Requirements for truthfulness, timeliness and clarity of communication • How additional support is provided (Section 6)	Activity audit Activity audit Root cause Analysis report.	Governance & Compliance PED and GCT Operations Serious Incident Annual Report	Learning from Experience Group (and, if required Quality Committee)	Learning disseminated via Learning from Experience Group

Appendix 1

Overview of the *Being open* process



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

Stage 1: Patient safety incident detection or recognition - This covers how patient safety incidents are identified; 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

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 incident; what the organisation will be doing to prevent recurrence. The investigation report has to be shared with the patient or family within 10 working days of approval and sign off by the Trust.
It should include provision of an ongoing clinical management plan (if appropriate) and communicating with relevant community care providers and commissioners what has happened. This will also include monitoring how the recommendations have been implemented and communicating with staff the recommendations to spread the learning.

Appendix 2

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 recognises 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 incident must be given in a truthful and open manner by an appropriately nominated person. 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 incident, 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 event. Resources available are referred to within the respective Trust policies, (HS011, TP004), to 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 incident 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 incidents 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 incident 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 incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is 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 incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety incident.

Principle of Confidentiality

Details of a patient safety incidents 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 acknowledges that patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.

Appendix 3

Terms of Reference
Learning from Experience Group

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

2.1 The primary focus of the Learning from Experience group shall be the integrated review of incidents including SIs, 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 Incidents, PALs, Claims and Complaints Policy are achieved.

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

2.3 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.

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

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

3. Objectives

3.1 Examine emerging themes and issues of significance from incidents including SIs, 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 any Trust policies as delegated by the Quality Committee, including the following policies:

- Learning from 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:

- Director of Health Promotion and Quality (Chair)
- Assistant Director, Corporate Services (Deputy Chair)
- Director of Corporate Services
- 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.

4.2 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.

6.2 The approved minutes of each Learning from Experience Group meeting shall

be submitted to the next meeting of the Quality Committee together with a written report providing assurance on the areas covered within their terms of reference and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these. This report shall be given to the Quality Committee four times a year.

6.3 The Learning from Experience Group shall receive reports from the Patient and Public Involvement Committee four times a year

6.4 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.

6.5 Recommendations and feedback shall be made to this group as appropriate. Responsibility for monitoring action to be taken rests with the Chair of the Learning from Experience Group.

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 within four weeks 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. Learning from Experience Group members' attendance will be recorded in the minutes of each meeting and reviewed at the end of the year to ensure that this requirement is met.

9. Frequency of meetings

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

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.