



DUTY OF CANDOUR

Following the Mid Staffordshire Hospital review and Robert Francis' subsequent report there has been an ever increasing focus on NHS Trust's and their commitment to openness and honesty relating to when things go wrong.

West Midlands Ambulance Service NHS Foundation Trust (the Trust) prides itself on its approach to being open when things go wrong and ensuring that learning takes place to prevent further harm.

Quality Account

The Trust's Quality Account available via www.wmas.nhs.uk provides an assessment of the quality of care delivered during 2012/13 and presents the plans for improvement during 2013/14.

Being Open

The Trust set itself a priority within the 2012/13 Quality Account to achieve 100% compliance with the Trust's Being Open Policy.

The Trust committed to making contact with all patients or their relatives following incidents where things went wrong and harm occurred. The definition of harm includes all harm regardless of severity.

The Trust achieved 100% compliance and continues to monitor and report on 'Being Open' compliance through the Board of Directors Quality report.

Complaints

The number and type of complaints and subsequent learning is contained within the Trust's Quality Account, the Patient Experience Annual Report and Board of Director papers.

The Trust is considering how best to publish upheld complaint summaries as recommended in Robert Francis' report. Consideration is being given to themes (ie PTS delays) and examples of responses (with the complainant's permission) being published in a 'Quality Zone' on the Trust website.

Learning Review

The Trust has a group that meets at least 10 times each year to review high risk/serious incidents and emerging themes identified through incident reporting, staff and patient feedback, complaints, claims and clinical audit.

This group is responsible for ensuring learning is shared and appropriate actions are taken to reduce the likelihood of harm occurring.

The Learning Review and Serious Incident reports are published as part of the Board of Director's papers and are used to inform the Trust's Quality Account.

Patient Stories

The Trust encourages patients and relatives involved in incidents where things have gone wrong to attend the Board of Director's meeting to have the opportunity to discuss their experience and hear what has or could be done to reduce the likelihood of errors occurring again.

Patient Stories are also shared within internal Trust publications to ensure learning is shared with all staff.

Going Forward

The Trust will bring together all of the above into the 'Quality Zone' area currently being developed on the Trust website.

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