

South East Coast Ambulance Service NHS Trust: Core Standards Self Assessment Proposed Compliance Position

Ref	Element	Position	Compliance position
D	1	SAFETY: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients	
CS	1	a	Healthcare organisations protect patients through systems that: Identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents
E	1a	1	<p>Incidents are reported locally via the appropriate reporting route/s to the National Patient Safety Agency (NPSA), Healthcare products Regulatory Agency (MHRA), Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.</p> <p>All Incidents are now recorded on Datix Integrated Reporting Software systems and all report to the NPSA -NRLS system. Fair blame and open learning culture adopted by the trust. Staff can report incidents anonymously through a confidential hot line. Incident reporting policy agreed and new incident report form introduced and working well from 01/04/2008. The Trust has now installed the Datix system and work has been completed in linking to the NPSA -NRLS system. The MHRA are advised of any issues we have in relation to clinical equipment and we comply with any directions / advice that they give. Data is provided to the CFSMS regularly and upon individual requests. Any safety incident that requires reporting is reported to the appropriate regulatory body e.g. SHA, PCT, HSE.</p>
			Compliant

E	1a	2	Individual incidents are analysed rapidly after they occur to reduce further immediate risks, and where appropriate, individual incidents are analysed to seek to identify root causes, likelihood of repetition and actions required to prevent the reoccurrence of incidents in the future	All incidents are reviewed and are graded in line with Trust guidance. They are assessed both at station / office level and by the Risk Department upon receipt. Serious incidents are identified rapidly and allocated to managers to identify root causes. In addition the Trust has a risk analyst and an integrated recording system (Datix) which unifies incident reporting trust-wide. Through Datix reporting the Trust has an overall picture of trends which feeds in to the governance reporting processes of the organisation (e.g. RMCGSC and Trust Board). The trends include incidents, PALS, Complaints and FOI requests.	Compliant
E	1a	3	NEW ELEMENT: Reported incidents are aggregated and analysed to seek to identify common patterns, relevant trends, likelihood of repetition and actions required to prevent the reoccurrence of similar incidents in the future, for the benefit of patients / service users as a whole	All incidents are recorded on DATIX incident reporting system. This is analysed on a regular basis, information and trends of incidents and injuries by geographic area and type are provided to relevant committees within the Trust. This information is considered and, where necessary, actions are instigated to reduce their reoccurrence.	Compliant
E	1a	4	Demonstrable improvements in practice are made to prevent reoccurrence of incidents based on information arising from the analysis of local incidents and the national analysis of incidents by the organisations stated in element one	Where trends are identified via internal reporting, action is taken in conjunction with relevant departments to prevent a similar reoccurrence. Where guidance is received from outside bodies, e.g. CFSMS, this is integrated into the training within the Trust.	Compliant
CS	1	b	Healthcare organisations protect patients through systems that ensure patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales		COMPLIANT

E	1b	1	All communications concerning patient safety issued by the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) and the UK Public Health Link System are implemented within the required timescales	All alerts are received by the Risk, Health and Safety Manager and acknowledged and circulated as appropriate Trust-wide. Those which require action are then distributed via an agreed system and signed off upon return when action is complete to demonstrate an auditable trail. This is done within the timescales specified by the circulating body.	Compliant
CS	2		Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations		COMPLIANT
E	2	1	NEW ELEMENT: The healthcare organisation has made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled <i>Statutory Guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004</i>	Child protection / Vulnerable Adult policies and procedures approved for NHSLA and were compliant with level 1 assessment. New database created to analyse trend data and to ensure that procedures being followed. Child protection / Vulnerable Adult Activity reported on a bi-monthly basis to the Clinical Audit and Information Working Group and to Trust Board as part of dashboard. Approval to recruit Child protection / Vulnerable Adult Assistant to support processes / referrals	Compliant
E	2	2	The healthcare organisation works with partners to protect children and participate in reviews, as set out in <i>Working together to safeguard children (HM Gov 2006)</i>	Child Protection Lead Manager appointed. The Trust is a member of all Local Safeguarding Children's Boards and the Child Death Review Panel. Participation at multi agency training days.	Compliant

E	2	3	NEW ELEMENT: The healthcare organisation has agreed systems, standards and protocols about sharing information about a child and their family both within the organisation and with outside agencies, having regard to <i>Statutory Guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004</i>	Record kept of all appraisals. Part of responsibility of practice development manager. To date none have applied. When Practice Development Manager in place. Any that are appropriate to R&D WG, which is chaired by Medical Advisor.	Compliant
CS	3		Healthcare organisations protect patients by following NICE Interventional Procedures guidance		COMPLIANT
E	3	1	NEW ELEMENT: The healthcare organisation follows NICE interventional procedures guidance in accordance with <i>The interventional procedures programme (Health Service Circular 2003/011)</i> . Arrangements for compliance are communicated to all relevant staff.	Practice Development Manager responsible for the review of all NICE guidance and making recommendations to the Trust. Database maintained with all guidance from 2008/09 and its relevance to SECamb. NICE website is regularly reviewed by Head of Clinical Governance, and email alerts received notifying of new guidance being released. The Trust has a quarterly meeting with a representative from NICE, and has recently been asked to submit an article showing how SECamb implements NICE guidance as an example of best practice.	Compliant
CS	4	a	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that: the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA		COMPLIANT

E	4a	1	<p>The healthcare organisation has systems to ensure the risk of healthcare associated infection is reduced in accordance with <i>The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, 2006, revised January 2008)</i>.</p>	<p>The Trust complies with the requirements to keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infections (HCAI) to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, where applicable and so far as reasonably practicable. The Trust complies with the requirements to minimise the risks of healthcare infection to patients taking account of published practices and guidance from the Ambulance Service Association, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 and the Infection Control Nurses Association infection control practices for ambulance services, DoH Winning ways, DoH Saving Lives care bundles and Essential steps to safe, clean care: introduction and guidance. The Infection Control Working Group (chaired by the DIPC) meet bi-monthly to monitor and review current practices and assess the risks to patients and staff in relation to HCAI. Infection control audits have been undertaken with the findings fed back to the relevant parties through the ICWG for actioning. In attendance at the meetings as external specialists are nurse specialists from the Health Protection Agency to support the infection control programme. Minutes from these meetings are reported to the Risk Management & Clinical Governance Sub Committee (RMCGSC) and then to the Board. The Trust has in post an Infection Control Manager BSc (Hons) and Infection Control Advisor who report to the Director of Infection Prevention and Control (DIPC) as the internal specialists. The Trust has recognised the importance of communicating Infection Control information to staff, patients and the public. Information is published and accessible in the Weekly Bulletin and on the SECamb web site and intra-net. Training and Education for Infection Control takes place on the Corporate Induction Course and through key skills training for staff, an e-learning package is currently being sourced to further the scope and accessibility for staff and managers.</p>	Compliant
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CS	4	b	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised		COMPLIANT
E	4b	1	The healthcare organisation has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the MHRA.	An appointed director or board member with overall responsibility for medical devices management is in post - Director of Technical services and Logistics. An advisory group in the guise of TS&L team meeting and the Vehicles and Equipment development group is in place, including those staff involved in the use, commissioning, maintenance, decontamination and decommissioning of medical devices. An organisation-wide devices management policy that covers acquisition, record keeping and equipment inventories; availability of manufacturer's instruction for use; training; repair and maintenance; single use devices use; decommissioning; disposal and actions required on manufacturer's corrective actions notices exist within the trust - Medical device management policy recently updated and ratified by RMCGSC	Compliant
E	4b	2	NEW ELEMENT: The healthcare organisation has systems in place to meet the requirements of the <i>Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R]</i> and any subsequent amendment.	<p><u>Statute Application</u> These Regulations shall apply to the following medical exposures - (a) the exposure of patients as part of their own medical diagnosis or treatment; (b) the exposure of individuals as part of occupational health surveillance; (c) the exposure of individuals as part of health screening programmes; (d) the exposure of patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes; (e) the exposure of individuals as part of medico-legal procedures.</p> <p>Ambulance services do not undertake these actions, therefore this is not applicable to the Trust.</p>	Compliant
CS	4	c	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed		COMPLIANT

E	4c	1	NEW ELEMENT: Reusable medical devices are properly decontaminated in accordance with <i>The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections</i> (Department of Health, 2006, revised January 2008).	Compliant - procedures within the trust already fulfil this criterion, medical devices management policy, infection prevention and control policy to name but two. The operational model and Make ready model also support this in areas where established, alternatively the roles and responsibilities of operational staff require compliance to the policy when using medical equipment, or defecting medical equipment intended for reuse.	Compliant
CS	4	d	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely		COMPLIANT
E	4d	1	Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored including in accordance with the <i>Medicines Act 1968</i> (as amended and subsequent regulations, including the Medicines for Human Use (Prescribing) Order 2005), the Health and Safety at Work Act 1974, as amended, and subsequent regulations including the Control of Substances Hazardous to Health Regulations 2002; and the good practice identified in <i>The safe and secure handling of medicines: A team approach</i> (RPS, March 2005) should be considered and where appropriate followed.	Current policies and procedure comply with the standard, however procedures will vary across SECAMB to reflect legacy arrangements and existing contracts. The procurement and supply of pharmaceutical products will be re tendered and redesigned (to reflect the changing operational model and the development of make ready) in 09/10 in order to standardise the procedures and management of medicines across the Trust. This is a planned output from TS&L development, however a robust logistics structure needs implementing to fulfil this objective. There will then be a requirement to develop with other directorates Ops, Clinical and Corporate Affairs - Security and Risk Departments) common programmes for the auditing, dispensing, prescribing and use of medicines.	Compliant
E	4d	2	Controlled drugs are handled safely and securely in accordance with the <i>Misuse of Drugs Act 1971</i> and amendments, <i>Safer management of controlled drugs: Guidance on strengthened governance arrangements</i> (Department of Health, 2006) and <i>The Controlled Drugs (Supervision of Management and Use) Regulations 2006</i>	Several audits undertaken with Local Counter Fraud Specialists - reports currently being written. New pocket books for recording the use of CDs rolled out across SECAMB. Approval for 2 pharmacy assistants to undertake continually audits of CDs. Exception reports submitted to Local Intelligence Networks on a quarterly basis. Drug losses reported to FASC.	Compliant

CS	4	e	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that: the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment		COMPLIANT
E	4e	1	The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients / service users, staff, the public and the environment in accordance with all relevant requirements referred to in <i>Environment and sustainability Health Technical Memorandum 07 - 01: Safe management of healthcare waste (Department of Health, November 2006)</i> and <i>Environment and Sustainability: Health Technical Memorandum 07-05: The treatment, recovery, recycling and safe disposal of waste electrical and electronic equipment (Department of Health, June 2007)</i>	Existing policies and procedures apply - not yet SECAmb policies due to contractual obligations. PC confirms compliance. Contractors are responsible for the collection and transportation of waste. The contractor is responsible for the notification of 'origin' and 'destination'.	Compliant
D	2		CLINICAL AND COST EFFECTIVENESS: Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes		
CS	5	a	Healthcare organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care		COMPLIANT

E	5a	1	NEW ELEMENT: The healthcare organisation ensures that it conforms to NICE technology appraisals where relevant to its services. Mechanisms are in place to: identify relevant technology appraisals; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review and action plan for relevant technology appraisals.	Safeguarding Manager in post. CP/VA Procedures approved which include the sharing of information. Safeguarding Manager member of all relevant internal and external committees and participates in child death review panels and serious case reviews in which data and information is shared. CP/VA report forms include information about the patient and their family and social history which are shared with appropriate agencies. Safeguarding Manager member of LSCBs.	Compliant
E	5a	2	The healthcare organisation can demonstrate how it takes into account nationally agreed best practice as defined in national service frameworks (NSFs), NICE clinical guidelines, JRCALC guidelines, national plans and nationally agreed guidance, when delivery care and treatment. The healthcare organisation has mechanisms in place to: identify relevant guidance; take account of clinical views and current practice in decision-making; and develop, communicate, implement and review an action plan for appropriate guidelines.	Retrospective review still on going. Meeting held with NICE Regional Manager to develop automated altering system. Practice Development Manager due to start in March 2009. Head of Clinical Governance a member of the JRCALC National Guideline Group. In addition to the above to satisfy this criteria this is supported by the Clinical Audit and Information Working Group who monitors audit results and changes to clinical practice and their implementation. Clopidogrel introduced ahead of national implementation following representation from clinical advisors	Compliant
CS	5	b	Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership		COMPLIANT

E	5b	1	The healthcare organisation ensures that appropriate supervision and clinical leadership is provided to staff involved in delivering clinical care and treatment. Where appropriate, staff also have the opportunity to receive "clinical supervision"; and where appropriate, this is in accordance with guidance from relevant professional bodies. Arrangements for clinical leadership and supervision (including "clinical supervision") are communicated to all relevant staff. The effectiveness of these arrangements is monitored and reviewed on a regular basis and action is taken accordingly.	Clinical Team Leaders (or equivalent) in post across the Trust to provide support and supervision at local level. PDR's for clinical staff. Area Clinical Leads in post who provide update training. Practice Placement Educators (for Foundation Degree students). New staff undergo robust training programmes under supervision including hospital and community placements. Clinical Peer Review procedure approved by RMCGSC for implementation by CSM's but no evidence used so far. Reflection newsletters. PTS team Leaders in post. Limited evidence that tutors or clinical leads are members of decision making groups. ACL's are invited to attend COMS meetings but do not make decisions. ACL will be member of the newly formed Education, Development and Training working group, which is yet to meet. Clinical Simulation Suites. Instructional Methods courses provided. IHCD guidelines state Trainee Technicians must undertake 47 weeks training with a qualified professional. We deliver the 47 weeks but cannot evidence always with a qualified crew mate.	Compliant
E	5b	2	NEW ELEMENT: The healthcare organisation ensures that it provides opportunities for clinicians to develop their clinical leadership skills and experience.	Staff have opportunities to; become Peer Reviewers; undertake Instructional Methods Courses; PDPs will identify developmental needs.	Compliant
CS	5	c	Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work		COMPLIANT

E	5c	1	<p>The healthcare organisation ensures that clinicians from all disciplines participate in activities to update the skills and techniques that are relevant to their clinical work in accordance with relevant guidance and curricula. This includes identifying and reviewing skills needs and skills gaps; providing and supporting on-the-job training and other training opportunities; and where appropriate working in partnership with education and training providers to ensure effective delivery of training.</p>	<p>Training needs are identified both by line management/supervisory processes, personal development reviews and in response to PALS and complaints. There is a rolling programme of update (Key Skills) training: 1253 (81.62%) of operational staff have received their key skills updates, the remaining 18.32% need to receive training between Oct 07- Mar 09. Trust board agreed to deliver key skills training on a bi-annual basis for the period March 07 - March 09. A trajectory for the delivery of outstanding training has been developed in September 08 and agreed by the Executive Team. Plan submitted and agreed at the Oct 08 RMCGSC. Operations Directorate are committed to releasing the staff against the trajectory (3 x 12 staff per week) up to end March 09. Progress against the training trajectory to be reported to all Executive Team meetings. If staff are released as agreed, all training will be completed by mid February 09. Key Skills Course Programme details the clinical skills components for A&E staff. PTS Refresher Course programme does the same for non-emergency staff. Course registers demonstrating staff attendance. Achievement of outcomes can be evidenced with completed record books and assessment papers. SDP 08/09. Risk Register.</p>	Compliant
CS	5	d	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services	COMPLIANT	

E	5d	1	The healthcare organisation ensures that clinicians are involved in prioritising, conducting, reporting and acting on clinical audits	The Trust has a Clinical Audit Manager and support staff to oversee the audit activity. The Trust has established a Clinical Audit working group to oversee the Trusts audit activity - the membership of this group includes operational and clinical staff. Staff are also involved in trials and evaluations of new equipment. Clinicians are involved in individual audits and are named as contributors on the audit reports. The Trust has an annual clinical audit plan which is RMCGSC approved. The Trust also participates in national audits as defined by the DOCCS group. Protocol C and Overdose trials include auditing of clinical records and staff completing audit forms around their use.	Compliant
E	5d	2	The healthcare organisation ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research	Trust has an R&D working group with staff as members. Staff also identified to participate in local clinical evaluations e.g. CPAP, Activated Charcoal, Protocol C. Two R&D Managers, development opportunities provided for these staff; In year research proposals; Feedback from paramedics, pan SECAMB, re EZIO, CPAP Trial wasn't successful for funding. Currently working with Brighton and Sussex University Hospital to develop a SECAMB CPAP research project. Second R&D project being developed with member of ETD re spinal care, list of red projects approved by medical committee and RMCGSC, research project commenced relating to CPIs where interested staff participated following an advert in the weekly bulletin.	Compliant
CS	6		Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met		COMPLIANT

E	6	<p>1 The healthcare organisation works in partnership with colleagues in other health and social care organisations to ensure that the individual needs of patients / service users are properly managed and met where responsibility for the care of a patient is shared between the organisation and one or more other health and / or social care organisations and / or where the responsibility for a patient's care is moved (due to admission, referral, discharge or transfer) across organisational boundaries. Where appropriate these arrangements are in accordance with Section 75 partnership arrangements of the NHS Act 2006 (previously Section 31 of the Health Act 1999) and The Community Care (Delayed Discharges etc.) Act 2003 and <i>Discharge from hospital pathway, process and practice (DH, 2003)</i>. Where appropriate, these arrangements are in accordance with the relevant aspects of the following guidance, or equally effective alternatives: <i>Guidance on the Health Act Section 31</i> partnership agreements (DH, 1999), Guidance on partnership working contained within relevant National Service Frameworks and national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National</p>	<p>The Healthcare Organisation has, with PCT/Acute partners develop a system, known as the Directory of Service (DoS) which assesses and recommends eligible patients for referral to Intermediate care teams or falls teams. These PCT/Acute funded teams further assess the patient's home address and social conditions and take appropriate action to reduce/minimize the risk of further falls within the home. The DoS, uses the National Service Framework assessment tool for falls, to assure governance and appropriate referral. DoS requires 1 patient clinical record, 1 completed NSF assessment tool only to refer. For appropriate patients the attending clinicians (in hours) request a conference call (which is recorded) with the Intermediate care/fall teams via the Control Centres, providing a complete governance assurance. The management of the DoS is undertaken by the Dos Board which has members from PCT/Acutes, all issues including adverse incident (to date there have been none) are discussed. The DoS was implemented over a 12 week period. The pilot was formally assessed through an interim (December 2008) and final report (Due in February 2009). The basis of this report will ensure patient satisfaction and appropriate referral. The final stage is to implement SEC wide. The Healthcare organisation has a number of Direct Admission facilities available to it, including Coronary Care, pPCI and Stroke. In all areas locally agreed protocols and admission procedures have been agreed, this is not available across the whole SEC but the Healthcare organisation is committed to increase these facilities with Acute partners as and when they are available. The Service Development Team ensure that each pathway is</p>	Compliant
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Service Framework for Older People (DH, 2001), and the Cancer Reform Strategy (DH, December 2007)), The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).

implemented correctly using its experience and knowledge of implementing DoS/pPCI. The healthcare organisation has worked closely with local government and public health organisations to share information which is useful for clinical pathway development, especially those from ethnic or minority groups, as these groups can sometimes be small sharing larger datasets informs better decisions. These are clearly shared in respect of child abuse and vulnerable adults, where multiagency input is required. All policies and procedures are shared and made available to all internal staff, where appropriate media is used for recollection. All policies have appropriate staff side input. Where the healthcare organisation requires multiagency input into policies and procedures, these are developed at the appropriate programme board where external partners have the opportunity for input. Final sign off will be at the appropriate Board designated committee.

E	6	2 NEW ELEMENT: Staff concerned with all aspects of the provision of healthcare work in partnership with colleagues in other health and social care organisations to ensure that the needs of the patient / service user are properly managed and met.	<p>The Healthcare Organisation has, with PCT/Acute partners develop a system, known as the Directory of Service (DoS) which assesses and recommends eligible patients for referral to Intermediate care teams or falls teams. These PCT/Acute funded teams further assess the patient's home address and social conditions and take appropriate action to reduce/minimize the risk of further falls within the home. The DoS, uses the National Service Framework assessment tool for falls, to assure governance and appropriate referral. DoS requires 1 patient clinical record, 1 completed NSF assessment tool only to refer. For appropriate patients the attending clinicians (in hours) request a conference call (which is recorded) with the Intermediate care/fall teams via the Control Centres, providing a complete governance assurance. The management of the DoS is undertaken by the Dos Board which has members from PCT/Acutes, all issues including adverse incident (to date there have been none) are discussed. The DoS was implemented over a 12 week period. The pilot was formally assessed through an interim (December 2008) and final report (Due in February 2009). The basis of this report will ensure patient satisfaction and appropriate referral. The final stage is to implement SEC wide. The Healthcare organisation has a number of Direct Admission facilities available to it, including Coronary Care, pPCI and Stroke. In all areas locally agreed protocols and admission procedures have been agreed, this is not available across the whole SEC but the Healthcare organisation is committed to increase these facilities with Acute partners as and when they are available. The Service Development Team ensure that each pathway is implemented correctly using its experience and knowledge of</p>	Compliant
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D	3		GOVERNANCE: Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation	
CS	7	a	Healthcare organisations apply the principles of sound clinical and corporate governance	COMPLIANT
CS	7	c	Healthcare organisations undertake systematic risk assessment and risk management	

E	7ac	1	The healthcare organisation has effective clinical governance arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users	SECAmb Risk Management Policy and other supporting policies, ratified by Risk Management Clinical Governance Committees and/or the board. To ensure integrated Governance is adopted and embedded within the trust an Integrated Governance Committee enhances the risk management link between the Board and RMCGSC. This committee oversees the approval of any sub-groups and requires their minutes to be forwarded for inclusion in the agenda. This committee's main function is to performance monitor risk reduction through the risk register and ensures information is shared with relevant Board sub-committees. Risk Management Clinical Governance Committee with Chief Executive as a member. Existing trust policies clearly defined responsibility & accountability for risk management and all its aspects. Head of Clinical Governance in post. Assistant Clinical Director in post. Clinical Governance Objectives within SDP.	Compliant
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E	7ac	2	<p>The healthcare organisation has effective corporate governance arrangements in place that, where appropriate, are in accordance with <i>Governing the NHS: A guide for NHS boards (Department of Health and NHS Appointments Commission 2003)</i> and the <i>NHS trust model standing orders, reservation and delegation of powers and standing financial instructions March 2006</i>, (DH, 2006).</p>	<p>The trusts Standing Orders, Scheme of Delegation and Standing Financial Instructions are in accordance with the NHS model standing orders March 2006 and include the implications of the Health Act 2006. The SOs, SD and SFIs are reviewed annually by the trust and that review includes legal advice. Strategic aims set out in the Trust Business Plan which is monitored and reported quarterly via the Strategic Development Plan update. Strategic objectives contained within the assurance framework which is monitored by the Board. Exception reporting of SDP progress highlighted at the Risk Management and Clinical Governance Sub Committee with escalation process to the Integrated Governance Committee. Involvement and consultation events held in summer 2008 to engage stakeholders in refreshing the Strategic Development Plan - patients, public, staff, healthcare providers, PCTs, SHA and local authorities. The Trust has regular meetings with its commissioners via a joint commissioning system for A&E contracts and with a range of trusts for PTS contracts. Monitoring meetings along with involvement in the wider context of PCT operating frameworks routinely informs plans. The Integrated Governance Committee is constituted as the Trust's Audit Committee and has a full remit on internal control. The Committee meets bi monthly and reports to the Board. One of the NEDs has significant, recent and relevant financial experience and chairs the Finance and Audit Sub Committee of the IGC. There is a Remuneration and Terms of Service Committee constituted and reporting as specified. The trust has an effective assurance framework in a compatible format which is regularly updated and reported to the Board.</p>	Compliant
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E	7ac	3	The healthcare organisation systematically assesses and manages its risks, both corporate / clinical risks in order to ensure probity, clinical quality and patient safety.	The Trust has a Risk Management strategy that is reviewed on an annual basis and available to staff on the Trust's intranet. SECAMB now has a Trust wide risk register which is categorised by directorate (e.g. Clinical, Operations, Finance etc.) and is a standing agenda item on a number of committees and the Trust Board. In addition the risk register is routinely discussed at Exec meetings and any amendments must now be authorised by the appropriate Director and notified to the Head of Risk Management. The Risk Register is now available via SharePoint with open viewing but restricted editing rights. Risks to the Trust's strategic objectives are recorded in the Trust's Assurance Framework. Board received risk management training via the Trust's appointed internal auditors, meeting the ALE criteria.	Compliant
CS	7	b	Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources		COMPLIANT

E	7b	1	<p>The ambulance service actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the <i>Code of conduct for NHS managers (Department of Health 2002)</i>, <i>NHS Counter Fraud and Corruption Manual Third Edition (NHS Counter Fraud Service, 2006)</i> and having regard to guidance or advice issued by the CFSMS.</p>	<p>The Trust has a code of conduct policy in place which incorporates the code of conduct as well as the Nolan Principles. An effective counter fraud function is in place. Gifts and hospitality declarations along with declarations of interest are controlled by policy, widely communicated declaration process and the keeping of registers. Declarations are routinely invited at Board meetings. Staff conduct is set out in the adopted policy, the trust publicly sets out its performance and use of resources in public board meetings, accounts and annual report. The trust consults with Commissioners and the SHA regularly on performance, use of resources and service delivery and works through a PCT Lead Commissioner for A&E services. There is a lead LCFS function with appropriate training along with a security management function. Reporting is via the FASC up to the IGC. The Trust has a contract with South Coast Audit for supply of the Counter Fraud service, for which responsibility is retained by the Director of Finance and the Chief Executive.</p>	Compliant
CS	7	e	Healthcare organisations challenge discrimination, promote equality and respect human rights	COMPLIANT	

E	7e	1	<p>The healthcare organisation challenges discrimination and respects human rights in accordance with: the <i>Human Rights Act 1998</i>; <i>No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health, 2000)</i>; the general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the "public body duties"; "Employment and equalities legislation" including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time. "Acting in accordance with 'public body duties'" means: Acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following statutes: Race Relations (Amendment) Act 2000; Disability Discrimination Act 2005; Equality Act 2006; and, where appropriate, having due regard to the associated codes of practice. "Acting in accordance with 'employment and equalities legislation'"</p>	<p>The SES and Action Plans were published in April 2008. This covers 6 equality strands and reference to Human Rights. The SES summary was published to ensure wider awareness and launched at a series of high profile public and staff engagement events. A framework has been developed for the delivery of robust Equality Impact Assessment [EIAs]. We are ensuring that disabled people are involved in the EIA process and that consultation relating to race and gender takes place. Training for staff on EIA has been provided. Three staff led equalities networks have been established – Pride in SECamb [LGBT], Aspire [BME & Minority Faith] and Making Diversity Happen [Disability and Carers]. These groups will be involved through consultation in the EIA process. SECamb has been awarded the Two Ticks – Positive about Disability status and has become a Diversity Champion through Stonewall. In addition the Trust is a Pacesetters Wave 2 Site and has been awarded Positively Diverse Lead Status by the NHS Confederation. Through this work SECamb is making progress in looking at ways it can better address health inequalities and so challenge discrimination. The Trust has appointed two senior E&D Staff, who will contribute to promoting equality of access & opportunity, as well as supporting diversity in relation to our public and patient involvement work, as well as in the workforce - in line with our SES. SECamb has also developed a framework and guidance for the delivery of robust Equality Impact Assessments. SECamb's approach to Equality Impact Assessments is underpinned by the principles set down in the Codes of Practice. SECamb has decided to adopt an approach based on risk and proportionality. SECamb seeks to ensure where appropriate</p>	Compliant
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means: Acting in accordance with relevant legislation including: Equal Pay Act 1970 (as amended); Sex Discrimination Act 1975 (as amended); Race Relations Act 1976 (as amended); Disability Discrimination Act 1995; Employment Equality (Religion or Belief) Regulations 2003; Employment Equality (Sexual Orientation) Regulations 2003; Employment Equality (Age) regulations 2006; Part Time workers (Protection from Less Favourable Treatment) Regulations 2000; Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002); Employment Rights Act section 80F-I relating to the right to request flexible working); Working Time Regulations 1998 (as amended); and, where appropriate, having due regard to the associated codes of practice.

disabled people are involved in the EIA process and that there is appropriate consultation on issues relating to race and gender. Staff have been provided with access to training and are currently being offered guidance and experiential training on Equality Impact Assessments. In addition community groups are being invited to contribute to the delivery of effective equality impact assessments in the future. SECamb has provided support for the establishment of three staff led networks. The OD Manager is continuing to review the establishment of a wider Equality and Diversity training course. An Equality and Diversity Module continues to be offered to all new starters within the new starter induction programme and within Personal Skills Update days. This training includes reference to respect and dignity and promoting human rights. The PPI Manager -Diversity and Equality Manager, is working to ensure all the diverse groups served by SECamb are involved in the development of plans and services, especially in relation to the core strands: age, disability, ethnicity, gender, religion, sexual orientation, gender identity and human rights. The PPI Manager – E&D Manager is continuing to ensure that: equality and diversity is embedded into our work and service delivery; partnerships with a wide range of stakeholders are being put in place; the Patient Experience Team are developing an understanding of the full diversity of community need, ensuring that the perspectives of all of our communities are included in our work.

E	7e	2	<p>The healthcare organisation promotes equality, including by publishing information specified by statute, in accordance with: the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under: The Race Relations (Amendment) Act 2000; The Disability Discrimination Act 2005; The Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.</p>	<p>The SES and Action Plans were published in April 2008. This covers 6 equality strands and reference to Human Rights. The SES summary was published to ensure wider awareness and launched at a series of high profile public and staff engagement events. A framework has been developed for the delivery of robust Equality Impact Assessment [EIAs]. We are ensuring that disabled people are involved in the EIA process and that consultation relating to race and gender takes place. Training for staff on EIA has been provided. Three staff led equalities networks have been established – Pride in SECamb [LBGT], Aspire [BME & Minority Faith] and Making Diversity Happen [Disability and Carers]. These groups will be involved through consultation in the EIA process. SECamb has been awarded the Two Ticks – Positive about Disability status and has become a Diversity Champion through Stonewall. In addition the Trust is a Pacesetters Wave 2 Site and has been awarded Positively Diverse Lead Status by the NHS Confederation. Through this work SECamb is making progress in looking at ways it can better address health inequalities and so challenge discrimination. The Trust has appointed two senior E&D Staff, who will contribute to promoting equality of access & opportunity, as well and supporting diversity in relation to our public and patient involvement work, as well as in the workforce - in line with our SES. SECamb has also developed a framework and guidance for the delivery of robust Equality Impact Assessments. SECamb's approach to Equality Impact Assessments is underpinned by the principles set down in the Codes of Practice. SECamb has decided to adopt an approach based on risk and proportionality. SECamb seeks to ensure where appropriate</p>	Compliant
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CS	8	a	Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services	COMPLIANT
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E	8a	1	Staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position including in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198).	Whistle blowing policy in place. Summary of policy is given to all support groups (Listeners, Welfare Representatives and Bullying and Harassment Advisors). Whistle Blowing Posters in all stations, HQ and Area Offices. Whistle blowing information cards available on all stations, HQ and area offices. Summary of policy and poster available on the intranet. Reminders in the Bulletin.	Compliant
CS	8	b	Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups		COMPLIANT

E	8b	1	<p>The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the <i>Improving Working Lives</i> standard at <i>Practice Plus Level</i> and in accordance with "<i>employment and equalities</i>" legislation [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.</p>	<p>As part of work life balance, flexible approaches to working have been implemented throughout the Trust. This includes options such as annualised hours, part-time working, job shares, flexible retirement opportunities. Staff are involved in the drawing up of new rota parameters and shift patterns to support Call Connect requirements whilst adhering to AfC agreements. Operational Development Group attended by operational and clinical staff. Appraisal process developed by HR. Appraisals currently delivered in the clinical environment are as a result of performance issues with developmental programmes created as a result of these. Assistant Directors development programme. Trust Board development programme. Placements for some directors on the Kings Fund. Advertises for clinical care progression such as foundation degree, CCP's, PP's and instructional methods course do not discriminate. Evidence of BME staff selected for Instructional Methods course and BME staff on Instructor Qualifying Course. Qualifier course, however not able to evidence whether these numbers reflects the Trust BME staffing levels. The clinical directorate is not aware of any IWL Practice Plus follow up audits since accreditation. Training and Development opportunities are provided both through the Training Centres and through external resources. Staff are given protected time 'off the road' to attend training courses. Training is offered to staff at all stages of their careers from induction training when they first start through to preparation for retirement. This has included support for staff with literacy and numeric problems. Applications from staff for external management training are positively received and actively encouraged. This area of training provides the core skills for career development.</p>	Compliant
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E	8b	2	<p>Staff from minority groups are offered opportunities for personal development to address under-representation in the workforce compared to the local population in accordance with "employment and equalities" legislation [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.</p>	<p>The IPDR system now in place applies to all staff giving access to opportunities to develop to all. Clear criteria for approving funding and release from duty to attend training and development opportunities which do not take account of individual's status, gender, ethnicity etc. Support available for staff in minority groups to access further training and development</p>	Compliant
CS	9	<p>Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required</p>	COMPLIANT		

E	9	1	<p>The healthcare organisation has effective systems for managing records in accordance with <i>Records management: NHS code of practice (Department of Health April 2006)</i>, <i>Information security management: NHS code of practice (DH, April 2007)</i> and <i>NHS Information Governance (DH, September 2007)</i>. The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and demonstrate that they are complying with supplemental mandates and guidance if they are introduced during the assessment period.</p>	<p>The Trust has robust mechanisms in place for managing records in accordance with the Records Management Code of Practice. This is supported by staff training; confidentiality clauses in contracts; appropriate disciplinary procedures and information governance policies. These are readily accessible to staff on the Trust's Intranet. The Trust has centralised the management of health records; since mid April 2008, all records have been scanned and are held electronically. Data from these scanned records is downloaded and used to inform clinical audit. Data quality processes are in place to ensure the confidentiality, integrity and availability of records. Access to patient records are based upon a legitimate need to know and decisions are taken in accordance with Trust policies. The Trust has complied with the actions contained in the NHS Chief Executive's letter of 20th May 2008. Any information security issues/data losses are reported through the Trust's Incident Reporting Procedure and action taken to inform the SHA where appropriate. The Director of Corporate Affairs and Service Development is the Trust's appointed SIRO.</p>	Compliant
E	9	2	<p>NEW ELEMENT: The information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with <i>The NHS in England: the Operating Framework for 2008 / 2009 (DH, December 2007)</i></p>	<p>Strategy for recording NHS Numbers first approved in March 2008. V2 approved at Feb 2009 RMCGSC. Links have been established with the NHS Tracing Service and data exchanged to collect/validate NHS numbers. The new CAD system will also have an NHS number field in readiness for e-prf.</p>	Compliant
CS	10	a	<p>Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies</p>		COMPLIANT

E	10a	1	<p>The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and for staff in ongoing NHS employment in accordance with the NHS Employment Check Standards (NHS Employers 2008).</p>	<p>All newly appointed staff (new to the NHS or from an existing NHS employer) undergo pre-employment screening inline with the NHS Employment check standards 2008. Day to day responsibility for these checks being completed has been given to the Recruitment Coordinator/Advisor for the particular area of the organisation; these staff have a high awareness of the importance of this task and its link with patient safety. The checks comprise of the following: Criminal Record - Enhanced CRB's are requested for all patient interfacing staff inline with CRB guidance. Occupational Health - Questionnaires are completed for all new staff and telephone and/or face to face appointments arranged where deemed necessary by our health advisors. Following this the third party providers coordinate the necessary vaccinations for operational staff. Verification of Identity - Original copies of ID are reviewed and photocopied at either interview or assessment stage and held on an employee's personnel file. Registration and Qualification - Original copies of qualifications and registration are reviewed and photocopied at interview or assessment stage. HPC registration is checked online to confirm currency and/or restrictions in practice and held on personnel file/communicated to Clinical Education where appropriate. Employment History and References - References are sought from current and most recent employers. Any unexplained gaps in employment history are probed at interview and recorded accordingly. Where applicable the necessary immigration checks are also made in addition to our usual screening. Where an employee does not have employment references, an appropriate alternative referee will be approached. A folder with the current employment check standards (March 2008) is held by the Recruitment Services</p>	Compliant
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Manager located in the Trusts Recruitment Service Centre at HQ. The auditing arrangements for pre-employment screening have recently been jointly reviewed by the Assistant Director of HR (West) and the Recruitment Services Manager and incorporated within the revised Recruitment & Selection Policy (2008). Internal applicants are also required to complete pre-appointment checks, where they are changing role within the organisation. These typically include occupational health (where the role varies significantly from their previous post), a new CRB disclosure, line manager reference and fitness test. Volunteers are subject to the same checks as paid employees. In all cases, employment offers are subject to meeting the above screening checks and failure to do so will result in withdrawal of the offer.

CS	10	b	Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice	COMPLIANT
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E	10b	1	<p>The healthcare organisation explicitly requires all employed healthcare professionals to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate action when codes of conduct are breached.</p>	<p>Professional Codes of Conduct only exist for registered healthcare professionals: for SECAMB this means Doctors, Nurses, Paramedics. PTS, ECSWs and Technicians are not covered by professional codes of conduct and would therefore need to be bound to Trust Codes of Conduct by their contracts and job descriptions. Scope of Practice Policy describes the range of practice for each clinical role. Clinical Supervision Policy: Describes the mechanisms in place to ensure that clinicians stay within their scope of practice and the supervisory mechanisms in place to monitor and support this. Clinical Peer Review Procedure: Describes the mechanism by which errors can be reviewed and turned into learning events for all clinicians. It also describes the events that require report to the registering bodies. Verification of Professional Registration Policy: describes the mechanism for ensuring clinicians are registered. Investigation Procedure: Describes the process for investigating possible breaches of codes of conduct, amongst other possible issues. Disciplinary Procedure: describes the process by which punitive sanctions can be made against an individual found to have breached codes of conduct. Capability Policy: describes the process for responding to inability to achieve and sustain satisfactory performance at work arising from lack of skill or aptitude.</p>	Compliant
CS	11	a	<p>Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake</p>	COMPLIANT	

E	11a	1	<p>The healthcare organisation recruits staff in accordance with "employment and equalities legislation" [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.</p>	<p>The Recruitment function has been successfully centralised and a new Recruitment Service Centre set up at HQ. One of the key aims of the function is to ensure that all job applicants and employees receive equally favourable treatment regardless of sex, sexual orientation, race, colour, age, nationality, religious belief or disability. The Trust takes steps not just to avoid discrimination as required by law, but actively promote best practice. The only criteria used for assessing employees for recruitment, promotion and development is suitability, performance and merit. The procedure endorses best practice and has the full support for SECAMB's Trust board. The Trust has also launched a Single Equalities Policy and Action Plan and a summary of the scheme is freely available internally and externally. The scheme reinforces commitment to valuing diversity, equal access for patients and equality of opportunity for staff. As an employer, the Trust ensures that all employees work in an environment which represents and includes everyone and is free from discrimination, harassment and unequal treatment. Given the supply of UK based labour and internal staff development, it is rare to have to engage in international recruitment, however consideration is given to any individual and the Trust will advise overseas applicants regarding professional registration e.g. with the HPC when necessary. The HR department collates and monitors Equal Opportunities data on job applicants and this is reported to senior management on a regular basis. All of the recruitment service team have been trained by the Organisational Development department in best practice recruitment, including Equal Opportunities. Standards continue to be monitored on a day to day basis by the Recruitment Services</p>	Compliant
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Manager. Regular workshops are run for line managers involved in recruitment and selection interviewing, these have proved popular. Representatives of Recruitment Services have actively participated in Brighton & Hove Pride, a well attended event celebrating Gay, Lesbian, Bisexual and Transgender diversity. The Stonewall diversity champion logo is used on all advertisements. The Flexible Working Policy allows staff to request flexible working arrangements to enable them to care for children or dependants. This option is potentially available to all staff and details are available on the intranet. The Trust participates fully in the two-tick "Positive about Employing Disabled People" and has recently forged new links with Job Centre Plus's Disability Advisor and Shaw Trust, who assist clients of job centre plus in gaining employment. Application material can be made available in other formats that may be more accessible for some disabled people. The aim of this relationship is to promote the Trust to disabled applicants and ensure that they are supported and encouraged during and following their application. The logo appears on all recruitment advertisements. There are currently plans underway for key players in the employment and welfare process to meet and discuss support mechanisms for disabled staff joining the Trust i.e. for Managers of disabled staff and the staff themselves, this is an ongoing work stream. An Equality Impact Appraisal (EIA) has been conducted around Recruitment and Workforce, part of this will include consultation with under represented groups and diversity training for Recruitment staff has already taken place.

E	11a	2	<p>The healthcare organisation aligns workforce requirements to its service needs by undertaking workforce planning, and by ensuring that its staff are appropriately trained and qualified for the work they undertake.</p>	<p>The Trust adopts a multi-disciplinary approach to Workforce Planning involving all Directorates. The Trust developed an integrated 5-year Workforce Plan in 2007, which was included in the Workforce Plan of West Kent PCT, our Lead Commissioner, and subsequently presented to the South East Coast SHA. Further revisions have been made to this Plan, the most recent of which was due for submission on 23 January09. These updates are a requirement of the Workforce Planning round for all Trusts. This plan is supported by a schedule of training courses which have been organised by the Clinical Directorate, to ensure staff undertake the appropriate training and acquire the relevant qualifications to meet service delivery requirements. The Finance Directorate is involved in the Workforce Planning process, to ensure all proposed changes to Establishment and skill mix are fully costed and represent value for money. The Trust has established a cross-directorate Workforce Planning Forum, to enable there to be a formal process in place for reviewing and updating the 5-year Plan and for keeping abreast of changes and developments in models of service delivery, which impact on staff numbers and skill mix requirements and are key to the business planning process.</p>	Compliant
CS	11	b	<p>Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes</p>	COMPLIANT	

E	11b	1	<p>Staff participate in relevant mandatory training programmes as designed by the relevant sector-specific NHSLA Risk Management Standards.</p>	<p>Training needs are identified both by line management/supervisory processes, personal development reviews and in response to PALS and complaints. There is a rolling programme of update (Key Skills) training: 1253 (81.62%) of operational staff have received their key skills updates, the remaining 18.32% need to receive training between Oct 07- Mar 09. Trust board agreed to deliver key skills training on a bi-annual basis for the period March 07 - March 09. A trajectory for the delivery of outstanding training has been developed in September 08 and agreed by the Executive Team. Plan submitted and agreed at the Oct 08 RMCGSC. Operations Directorate are committed to releasing the staff against the trajectory (3 x 12 staff per week) up to end March 09. Progress against the training trajectory to be reported to all Executive Team meetings. If staff are released as agreed, all training will be completed by mid February 09. Key Skills Course Programme details the clinical skills components for A&E staff. PTS Refresher Course programme does the same for non-emergency staff. Course registers demonstrating staff attendance. Achievement of outcomes can be evidenced with completed record books and assessment papers. SDP 08/09. Risk Register.</p>	Compliant
E	11b	2	<p>Staff and students participate in relevant induction programmes</p>	<p>Corporate Induction programme fully in place. This is the first two days of any training programme for ECSWs, call takers, PTS staff, and non operational staff are allocated places on the first available corporate induction course after their start date. The Personal Orientation Pack is now also complete, and issued to every new member of staff on appointment</p>	Compliant

E	11b	3	NEW ELEMENT: The healthcare organisation verifies that staff participate in those mandatory training programmes necessary to ensure probity, clinical quality and patient safety (including that referred to in element 1). Where the healthcare organisation identify non-attendance, action is taken to rectify this.	Attendance on Mandatory training is planned by Clinical Scheduling using Promis Software. Attendance at the training event is recorded using a register signed by all attendees. Non-attendance is reported to Clinical Scheduling as per the Bob-attendance at Mandatory training Policy. Re-attendance then arranged by Clinical Scheduling	Compliant
CS	11	c	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives		COMPLIANT

E	11c	1	<p>The healthcare organisation ensures that all staff concerned with aspects of the provision of healthcare have opportunities to participate in professional and occupational development at all points in their career in accordance with "employment and equalities legislation" [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.; and in accordance with the relevant aspects of <i>Working together - learning together: a framework for lifelong learning for the NHS (Department of Health 2001)</i></p>	<p>The majority of staff who join the Trust do so as trainee technicians, trainee PTS staff, or trainee EMD staff. The first week of their training programme is a comprehensive induction programme, which is relevant to the needs of the member of staff. The first two days of this week forms the corporate induction and includes information on the Trust, health and safety, moving and handling, fire safety and infection control. Non-operational staff also attend the corporate induction alongside their operational colleagues. When staff are deployed "on station" or join their department (non operational staff) they have a local induction checklist to work through with their line manager. On completion, these forms are returned to the HR Department, who monitor their return and place them on the individual's personal file. The corporate induction course is mandatory for all new employees. Staff development has taken the form of ACAs developing as ECAs and Technicians, Technicians developing as Paramedics through the FD Programme and Paramedics developing as PPs and CCPs. Foundation degree has 207 students, with an additional 60 per year on the Tech-Para pathway. The PP programme is supporting 100 developing PPs. The current CCP cohort is 11, with a cohort of a maximum of 12 recruited for a November 2008 start. Continued activity at this rate will see requirements met by year-end for FD & PP programmes.</p>	Compliant
CS 12			Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	COMPLIANT	

E	12	1	The healthcare organisation has effective research governance in place, which complies with the requirements of the <i>Research governance framework for health and social care , second edition (Department of Health 2005)</i>	Membership of CLRN and appointment of R&D specialists. R&D Working Group established. R&D strategy and policy. Membership of DOCCs group. Membership of Sussex Research Consortium providing governance and guidance. Discussions held with HE research specialist to join the trust on an honorary basis.	Compliant
D	4		PATIENT FOCUS: Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing		
CS	13	a	Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect		
E	13a	1	The healthcare organisation ensures that staff treat patients / service users, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, identify, and take preventative and corrective actions where there are issues and risks with dignity and respect.	Lesson plans that reference dignity for vision or hearing impaired. Bad news training. Code of conduct for SET's, SOP's. SECAMB Code of Conduct. Professional Code of Conduct. Scope of Practice. SDP 2008/09. PP's Code of Practice. Scope of Practice. Bariatric vehicles. Palliative care policies agreed (external), rolled out in Sussex. Organisational objectives to develop codes of conduct and scopes of practice. Reviews undertaken by Critical Care Networks. A 'care of the elderly' session is delivered to all new entrants.	Compliant

E	13a	2	<p>The healthcare organisation meets the needs and rights of different patient groups with regard to dignity including by acting in accordance with the <i>Human Rights Act 1998</i>, and the general and specific duties imposed on public bodies in relation to race, disability and gender (including among other things, equality schemes for race, disability and gender, along with impact assessments under the following "public body duties" statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006. The healthcare organisation should act in accordance with the requirements for the National Service Framework for older people (Health Service circular 2001/007) to ensure that older people are not unfairly discriminated against in accessing NHS or social care services as a result of their age.</p>	<p>The Trust has a Single Equalities Scheme and Action Plans that cover the six equality strands including: Age, Disability, Gender and Race. Dedicated Equality and Diversity staff have been appointed, including an Equality & Diversity PPI Manager – Diversity, who is progressing work to support engaging, listening and responding to different patient and carer groups. An Equalities & Diversity Steering Group, which includes representation from across the Trust, is meeting and actively monitoring progress. In addition staff are provided with an hour module at induction, which includes Equality, Diversity and Human Rights. Issues around dignity and respect are taught as part of basic training and are included within our Clinical Strategy 2007-2012. All staff are required to attend Personal Skills Updates, which place significant focus on equality and diversity and human rights. Staff also have access to Language Line. Minicom system in use in Kent. A portable induction loop is available for use across our seventy sites. Multi Lingual Phrase books are distributed to each operational member of staff, as well as a guide to Cultural Diversity and Faith Awareness. Overshoes are located on all vehicles. Progress is being made to ensure the Equality Impact Assessment of key relevant policy and strategy including: Clinical Strategy, safeguarding policies, Organisational Development Strategy as well as policies relating to Patient and Public Involvement Strategy and related policies.</p>	Compliant
CS 13 b			Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	COMPLIANT	

E	13b	1	Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures, investigations and decisions in accordance with the <i>Reference guide to consent for examination or treatment (Department of Health 2001)</i> , and having regard to the <i>Code of Practice to the Mental Health Act 2007</i> and the <i>Code of Practice to the Mental Capacity Act 2005</i> .	Consent and capacity procedure finished and due to be submitted to RMCGSC, staff pocket guides and posters advertising valid consent practices being finalised with Comms team, new non conveyance includes consent and capacity assessment, MCA papers presented to Trust Board, RMCGSC and Medical Committee, 3 courses delivered training managers in the MCA and valid consent. This is evidenced through course attendance records, consent and capacity procedure, non conveyance form, staff leaflets.	Compliant
E	13b	2	Patients / service users, including those with language and / or communication support needs, are provided with appropriate and sufficient information suitable to their needs, on the use and disclosure of confidential information held about them, in accordance with <i>Confidentiality: NHS code of practice (Department of Health 2003)</i>	Patient leaflet agreed and quotations being sought by Comms team. Previous legacy leaflet for Surrey health Community available throughout the trust. PALS policy directs patients to PALS for specific queries about treatment; Language line; staff pocket guides and posters being finalised with Comms team. Course attendance records	Compliant
E	13b	3	NEW ELEMENT: The healthcare organisation monitors and reviews current practices to ensure effective consent processes.	New Consent and Capacity Procedure produced together with staff information pocket guides. PHT checklists checked to ensure that patient's signature obtained. CP/VA report form includes a consent section to be completed when appropriate. PCR contains patient consent to refuse / decline treatment and these forms will be audited as part of the documentation audit to ensure compliance. Non conveyance guideline also references the patient's option to consent to refuse . Decline treatment and the Non Conveyance Checklist requires a patient / carer signature to indicate consent.	Compliant
CS	13	c	Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary		COMPLIANT

E	13c	1	<p>When using and disclosing patients / service users' personal information staff act in accordance with the <i>Data Protection Act 1998</i>, the <i>Human Rights Act 1998</i>, the <i>Freedom of Information Act 2000</i> and <i>Confidentiality: NHS code of practice (Department of Health 2003)</i>, <i>Caldicott Guardian Manual 2006</i> (DH, 2006). The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and with supplemental measures and guidance if they are introduced during the assessment period.</p>	<p>Data Protection Policy. SIRO appointed (Dir of CASD); Subject Access request Policy & Procedure; Information Governance Policy; Internet and E-mail Policy; Information Security Policy; Physical and virtual access controls to areas containing confidential/sensitive information; Leaflets for staff: Confidentiality Explained; Data protection Best Practice Guidelines; Information Security and Confidentiality (DP & Caldicott principles); Staff contracts of employment; Confidentiality clauses with third parties; Head of IG holds ISEB qualification in Data protection; Requests for copies of PCRs channelled through web-based form in SharePoint which is fully auditable; All staff attend IG induction programmes; Articles in Staff Bulletin; Access to e-learning for staff; Up to date notification with the Information Commissioner.</p>	Compliant
CS	14	a	<p>Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services</p>	COMPLIANT	

E	14a	1	<p>Patients / service users, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system, including information about how to escalate their concerns; and the healthcare organisation acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.</p>	<p>The Trust triages most concerns and complaints via its Patient Advice and Liaison Service (PALS). Both PALS and the formal complaints process are explained to the enquirer and information is provided to enquirers and complainants about advocacy services such as the Independent Complaints Advocacy Service by both PALS staff and the Complaints Manager. Complaints acknowledgement letters also provide details of ICAS. The Complaints Policy and Procedure, PALS Policy and Procedure and the leaflet "How the Trust deals with Concerns and Complaints" are all available on the Trust's public website as well as its intranet. These documents can be made available in other languages and formats on request. Contact details for the Complaints Manager, PALS staff and the Head of Patient Experience are provided on the Trust's website. Questionnaires to assess complainants / 'enquirers' satisfaction with the handling of complaints and PALS were introduced in January 2009 and will be sent out following resolution of the complaint/concern. The Trust's complaints and PALS systems are explained to staff at induction sessions, where PALS / complaints staff have a 45-minute slot.</p>	Compliant
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E	14a	2	<p>Patients / service users, relatives and carers are provided with opportunities to give feedback on the quality of services.</p>	<p>The Trust had a well-established Patient Advice and Liaison Service, providing an excellent mechanism for the population to provide feedback on the service they have received (both positive and negative) and all such comments, as well as concerns and complaints, are logged on the Trust's integrated risk management database (Datix). This data is analysed and reports are provided to the Trust's Risk Management and Clinical Governance Subcommittee (RMCGSC) on a bimonthly basis, as well as to the Trust's commissioners. The Trust has three Public Opinion Groups (POGs) established in Sussex, Surrey and Kent, comprising mainly patients, carers and members of the public plus some voluntary sector representatives, each of which meets three times a year. The Trust held three events held in Kent, Surrey and Sussex in Sept/Oct 08, entitled 'Shaping the future of your ambulance service' with interactive sessions eliciting patient and public involvement in the development of the Trust's business plan. A public Open Day was also held at Lingfield Racecourse. At all four events members of the public had an opportunity to put questions and comments about the service to a panel including directors and the Head of Patient Experience. The Trust also held two workshops, one in August and a follow-up in December, where patients, public and staff put forward their views, ideas and suggestions for the three-year PPI strategy. A patient and public satisfaction survey was undertaken by IPSOS Mori in the summer of 2008, and the preliminary results were shared with all at the public Trust Open Day on 29 September. A board and senior management briefing will take place early in 2009 and survey results will be incorporated into 09/10 business planning. The Trust held a PTS (Patient Transport Service) workshop in August</p>	Compliant
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			<p>attended by PTS patients, staff, managers and the chief executive. The aim of the event was to listen to the views of those who use the service and those who provide it, with a view to incorporating comments and suggestions into the Trust's Non-emergency Strategy. Range of contact mechanisms listed on all recent corporate literature. PPI reps now on many Trust working groups, sub-committees, board. Questionnaires to assess complainants / 'enquirers' satisfaction with the handling of complaints and PALS were introduced in January 2009 and will be sent out following resolution of the complaint/concern. The Trust is building relationships with the newly-established Local Involvement Networks (LINKs) across the patch (there are six) and attended and spoke at a recent Cross Border LINKs event. The Trust has also offered to run an event specifically for LINKs members and host organisations about South East Coast Ambulance Service - its services, the way it operates, its ethos, plans for the future, etc.</p>		
CS	14	b	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made	COMPLIANT	
E	14b	1	<p>The healthcare organisation has systems in place to ensure that patients / service users, carers and relatives are not treated adversely as a result of having complained.</p>	<p>The Trust's Complaints and PALS policies state that people will not be treated any differently as a result of complaining or raising a concern, and this information is imparted to all staff at induction, where there is a dedicated PALS/complaints session. Were the Trust to become aware of an incident whereby a patient was treated adversely as a result of their having complained previously, an investigation would be undertaken and measures put in place to mitigate any recurrence. Such a concern may be raised via PALS or the formal complaints process.</p>	Compliant

CS	14	c	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery	COMPLIANT	
E	14c	1	<p>The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.</p>	<p>All complaints are acknowledged within two working days and, to date, the Trust has achieved 96% compliance in responding to complainants within 25 working days following investigation. If for any reason it is not possible to respond within 25 days, the Complaints Manager will contact the complainant explaining this to them. Concerns may also be investigated by the Trust's PALS should the enquirer prefer, which can provide a more speedy resolution. Whether handled by complaints or PALS, each stage of a complaint/enquiries is fully documented on the Trust's Datix database. In order to ensure that actions arising as a result of a complaint are implemented, the Complaints Manager keeps a Complaints Action Plans log. This log is circulated to investigating managers, assistant directors and directors on a monthly basis and the action is not removed from the log until the Complaints Manager receives confirmation that it has been implemented.</p>	Compliant
E	14c	2	<p>Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients / service users, relatives and carers</p>	<p>PALS concerns and formal complaints are used to effect change/service improvement and action plans are monitored to ensure completion. Reflections newsletter disseminates lessons learned from PALS concerns, complaints, incidents, etc to all staff. Patient experience reports (PALS and Complaints information) now go to each RMCGSC meeting, detailing trends, possible causes and recommendations where appropriate. 'Staff attitude' has been the highest category for both PALS and complaints recently, and an internal 'customer care' course has now been established in order to address this. Patient Experience Report also provided to commissioners and PPI Liaison Group members on a quarterly basis.</p>	Compliant

CS	16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care		COMPLIANT
E	16	1	<p>The healthcare organisation has identified the information needs of its service population, and provides suitable and accessible information on the services it provides in response to these needs. This includes the provision of information in relevant languages and formats in accordance with the general and specific duties imposed on public bodies in relation to race, disability and gender (including among other things, equality schemes for race, disability and gender, along with impact assessments under the following "public body duties" statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006. And, where appropriate, having due regard to the associated codes of practice.</p> <p>Region wide qualitative and quantitative research conducted into satisfaction and perceptions of patients and the public; part of this research looked at detail into how people find out about us now, and how they want to find out information about us moving forwards. This is being built into the Comms Strategy for 2009/10 which will go to the Trust Board on 26 March 2009; Shaping the future events: three interactive sessions with a range of patients, members of the public (including seldom heard groups) as well as staff. Discussion areas included access to services as well as ensuring equality for all. Feedback will be built into the business planning process along with the MORI results; All operational and EDC staff have access to Language Line as well as multilingual phrase books, allowing information about our services and treatment to be conveyed to patients whose first language is not English - both at the time of call, and at the time of treatment; Minicom and access to Enhanced Information Service for Emergency Calls (EISEC) ensuring that people who are unable to speak / hear, who call upon our service for help, still receive the same level of service. EISEC provides the information that auto populates the emergency call taker's screen with address and phone number if the caller isn't able to convey that information to us verbally or through type talk. We can therefore still send an emergency response; Research done into the six most commonly spoken languages in our region. Standard text about accessing information (corporate documents / website copy etc) is translated into these languages and is on the home page of our website and will also feature in all corporate literature from now on; SES and action plans been in place, and being implemented from 1 April 08. Three year plan currently being developed. Full and summary</p>	Compliant

				SES published on website. Summary published in hard copy and launched at StF events; EIAs - both standard and detailed have been conducted throughout the year and are published on our intranet and website; Increased engagement with seldom heard groups through E&D PPI lead.	
E	16	2	The healthcare organisation provides patients / service users and, where appropriate, carers with sufficient and accessible information on their individual care, treatment and after care, including those patients / service users with communication or language support needs. In doing so, healthcare organisations must have regard, where appropriate, to the <i>Code of Practice to the Mental Capacity Act 2005</i> (Department of Constitutional Affairs 2007) and the <i>Code of Practice to the Mental Health Act</i> (Department of Constitutional Affairs 1983).	All frontline staff, where appropriate, are required to tell the patient what treatment they are administering and what drugs the patient is being given to ensure they are fully aware of the side-effects of any treatment they receive. If a patient is unable to converse with the crew they are able under the Data Protection Act to ask to see their Clinical Patient Record at a later date. All operational staff adheres to the informed consent protocol. All operational staff have access to Language Line which enables staff to communicate with patients whose first language is not English. A multi lingual phrase book is available on all front line vehicles. Minicom guidance is available in EDC.	Compliant
D	5	ACCESSIBLE AND RESPONSIVE CARE: Patients receive services as promptly as possible, have a choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway			
CS	17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services			COMPLIANT

E	17	1	<p>The healthcare organisation seeks and collects the views and experiences of patients / service users, carers and the local community, particularly those who are seldom listened to, on an ongoing basis when designing, planning, delivering and improving healthcare services as required by Section 42 of the <i>NHS Act 2006</i> in accordance with <i>Strengthening Accountability, patient and public involvement policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003)</i> and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties” statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.</p> <p>The Trust has three Public Opinion Groups (POGs) established in Sussex, Surrey and Kent, comprising mainly patients, carers and members of the public plus some voluntary sector representatives, each of which meets three times a year. The Trust held three events held in Kent, Surrey and Sussex in Sept/Oct 08, entitled 'Shaping the future of your ambulance service' with interactive sessions eliciting patient and public involvement in the development of the Trust's business plan. A public Open Day was also held at Lingfield Racecourse. At all four events members of the public had an opportunity to put questions and comments about the service to a panel including directors and the Head of Patient Experience. The Trust also held two workshops, one in August and a follow-up in December, where patients, public and staff put forward their views, ideas and suggestions for the new, three-year PPI strategy. Then, in January a group of patients/public/staff, representing various diversity strands, convened to undertake an Equality Impact Assessment of the strategy. A patient and public satisfaction survey was undertaken by IPSOS Mori in the summer of 2008, and the preliminary results were shared with all at the public Trust Open Day on 29 September. A board and senior management briefing will take place early in 2009 and survey results will be incorporated into 09/10 business planning. The Trust held a PTS (Patient Transport Service) workshop in August attended by PTS patients, staff, managers and the chief executive. The aim of the event was to listen to the views of those who use the service and those who provide it, with a view to incorporating comments and suggestions into the Trust's Non-emergency Strategy. Range of contact mechanisms listed on all recent corporate literature. PPI</p>	Compliant
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reps now on many Trust working groups, sub-committees, board. Questionnaires to assess complainants'/enquirers' satisfaction with the handling of complaints and PALS were introduced in January 2009 and will be sent out following resolution of the complaint/concern. The Trust is building relationships with the newly-established Local Involvement Networks (LINKs) across the patch (there are six) and attended and spoke at recent Cross Border LINKs event. The Trust has also offered to run an event specifically for LINKs members and host organisations about South East Coast Ambulance Service - its services, the way it operates, its ethos, plans for the future, etc. The Trust appointed to a new post of PPI Manager, Equality and Diversity, in May 2008, who is proactively engaging with minority and seldom-heard groups. The Trust has attended various events and meetings for specific minority groups/communities, and is represented on several steering groups whose aim is to initiate contact with hard-to-reach groups and to ascertain their needs.

E	17	<p>2 The healthcare organisation demonstrates to patients / service users, carers and the local community, particularly those who are seldom listened to, how it has taken their views into account when designing, planning, delivering and improving healthcare services, in accordance with <i>Strengthening Accountability, patient and public involvement policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003)</i> and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties” statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.</p>	<p>All Trust board papers must evidence patient and public involvement before being approved by the board. The Trust’s PALS ensures that service user comments, suggestions and recommendations are forwarded to the appropriate department/manager and acted upon where appropriate. PALS enquirers and complainants are informed, either verbally or in writing of the outcome of their concern and what action has been taken to mitigate recurrence and improve future service for all. Those who attended the PPI workshop in August received a copy of the draft PPI strategy developed as a result. They were invited to comment further on this and to be part of a smaller focus group which met in December to refine the strategy. The full Equality Impact Assessments of, for example, the PPI strategy, PALS Policy and Complaints Policy, and any amendments to these documents as a result of engaging the public in this exercise, provides evidence of the Trust listening to and acting on their advice, comments and suggestions.</p>	Compliant
CS	18	<p>Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably</p>		COMPLIANT

E	18	1	<p>The healthcare organisation enables all members of the population it serves to access its services equally, including acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties” statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.</p>	<p>The Trust has a Single Equalities Scheme in place to assist in determining and addressing any potential inequity of access. New post (one of two new E&D posts) of PPI Manager, Equality and Diversity, appointed to in May 2008 in order to further the Trust's engagement with and involvement of marginalised groups across our catchment area. The Trust holds the "two tick" symbol for disability (Positive about disabled people). The Trust uses the AMPDS system to prioritise calls which ensures that the response to all calls is based solely on the patient's clinical needs. Language Line is available providing telephone interpreting for both operational and control centre staff when attending a patient whose first language is not English. In addition, staff have also been provided with a multilingual phrase book to help immediate communication. Community Responder Schemes have been established and continue to be developed to try to improve equity of response times across the Trust's catchment area, particularly in rural areas. In order to help to ascertain the needs of our population, the Trust's PPI Manager E&D has been making good progress in working with marginalised groups across the patch and is involved in a gypsy and traveller project in Brighton as well as a health-specific gypsy and traveller project in Surrey. Work is also underway with the Crawley Neighbourhood Network which works with vulnerable people, elderly people and the BME community. In Kent the Trust is working closely with Kent County Council on six different diversity strands, and in Brighton we are working with Spectrum, the local LGBT community forum. The Trust is also establishing a "People's Panel", which will be the forerunner to our FT membership, and giving out forms at all events attended. One of the Trust's PPI reps who is hard of</p>	Compliant
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				<p>hearing has assisted the Trust with the procurement of a hearing loop and its usage. All recently produced Trust documentation includes a statement informing people of its availability in other languages/formats on request. The Trust has developed a policy and procedure for The Treatment of Complex Needs Patient. This aims to ensure that there is sufficient provision for those patients who, owing to their weight, size, shape or mobility, are not able to be safely removed into and transported by standard ambulance service vehicles.</p>	
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E	18	2	<p>The healthcare organisation offers patients / service users choice in access to services and treatment, and those choices in access to treatment are offered on a fair, just and reasonable basis, including to disadvantaged groups and including acting in accordance with the general and specific duties imposed on public bodies as in Element 1 and including, where appropriate, having due regard to the associated codes of practice.</p>	<p>Callers who access the 999 system have their clinical need assessed utilising the AMPDS system, which ensures that, based upon the information provided by the caller, the most appropriate level of response is provided. If a call is categorised as a "green" call, the caller is passed to the Clinical desk, which is staffed by a suitably qualified clinician. If the caller agrees, and it is appropriate, the clinician will refer the caller to an alternative care pathway that will better suit the patients needs. Patients are also given the option not to be taken to hospital, for which they are asked to sign a "non-conveyance form". To support the Trust in offering access to services and treatment equitably, all crews and staff in the EDC have access to Language Line, providing translation services. In addition, it is recognised good practice, both within an A&E and PTS setting to allow a patient to travel with their assistance dog, where appropriate. With regards non-emergency transport, the Trust's Patient Transport Service provides the routine transportation for purposes such as outpatient appointments and day centre attendance. This service is developed to match the requirements of our commissioning authorities and it is anticipated that the care provider has already investigated and discussed the choices in relation to access to services with the patient. The Trust then facilitates those choices by providing transport at the time requested. With regards Category C calls, all 3 EDC's use AMPDS to determine the appropriate CAT C's that should be passed through PSIAM. Each EDC uses the PSIAM software and works within this and the SECamb PSIAM Policy.</p>	Compliant
D	6	<p>CARE ENVIRONMENT AND AMENITIES: Care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes of patients</p>			

CS	20	a	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	COMPLIANT	
E	20a	1	<p>The healthcare organisation effectively manages the health, safety and environmental risks to patients / service users, staff and visitors in accordance with all relevant health and safety legislation, fire safety legislation, the <i>Disability Discrimination Act 1995</i>, and the <i>Disability Discrimination Act 2005</i>; and by having regard to <i>The duty to promote disability equality: Statutory Code of practice (Disability Rights Commission, 2005)</i>. It also acts in accordance with the mandatory requirements set out in <i>Fire code – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety</i> (Department of Health, 2006), in so far as the requirements are relevant to the healthcare organisation, and follows the guidance contained therein, or equally effective alternative means to achieve the same objectives. It also considers, and where appropriate follows, the good practice guidance referred to in <i>The NHS Healthy Workplaces Handbook</i> (NHS Employers 2007) or equally effective alternative means to achieve the same objectives</p>	<p>The organisation has delegated the responsibility for overseeing health and safety risk management across the whole organisation to the Director of Corporate Affairs and Service Development. He is responsible for the Fire Policy, however the management and maintenance of fire equipment is under the remit of the Director of Technical Services and Logistics. The Trust has appointed 2 Risk, Health and Safety Managers and there are a number of Health and Safety Staff Representatives across the Trust. All adverse incidents are reported and recorded on the DATIX incident reporting system. Committees: Risk Management and Clinical Governance Sub Committee (RMCGSC), Central Health and Safety Committee and two local Health and Safety Working Groups. Policies in Place: Risk Management Policy, Health and Safety Policy, COSSH Policy, Slips, Trips and Falls Policy. Risk Assessment Procedure. Workplace Inspection Procedure. Fire risk assessment completed at all workplaces. Building risk assessments currently being undertaken at all trust sites and regular inspections being completed. Prevention of Occupational Exposure to the Blood Borne Viruses - including prevention of sharp injuries. Safe Handling and Disposal of Sharps Policy.</p>	Compliant

E	20a	2	<p>The healthcare organisation protects patients / service users, relatives, carers and staff and their property, and the physical assets of the organisation, by ensuring that vehicles are safe and secure, including in accordance with <i>Secretary of State directions on measures to tackle violence against staff and professionals who work in or provide services to the NHS</i> (DH, 2003) and <i>Secretary of State directions on security management measures</i> (DH, 2004, as amended 2006).</p>	<p>The Trust ensures the safety of staff and patients in ambulances by purchasing vehicles which are compliant with BS EN1789:2000. This forms part of the fleet procurement system. All staff are given induction training which includes information on the need to protect patients relatives and Trust property. The Trust gives all new operational staff information and practical conflict resolution training to minimise the potential of them or patients being assaulted. They are also given information on how to report the incident should they be subject of an assault or discover a security breach, e.g. theft. Security has been increased in respect of new vehicles and all new ambulances will be fitted with internal CCTV. All controlled drugs are kept in secure cabinets. Crime prevention surveys are completed to identify security concerns. Security breaches are reported and remedial action, if appropriate is taken. The trust takes account of a professional approach to managing security in the NHS and has appointed a Security Management Director, a NED for security and a Local Security Management Specialist. It complies with the guidance. The Trust has the following policies and procedures:- Security Management Policy, Lone Worker Policy, Policy for managing the physical security of premises, vehicles and other assets, The procedure for reporting incidents of physical assault and verbal abuse.</p>	Compliant
CS	20	b	<p>Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality</p>	COMPLIANT	

E	20b	1	The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation, access to private areas for religious and spiritual needs and for confidential consultations. This should happen at all stages of care and during transfers.	Compliant and evidenced as of last inspection. Vehicle design supports confidentiality, privacy and dignity. The trust seek further clarification relation to the requirements needed for compliance 'during transfer'. An ambulance is neither a facility, nor accommodation and as such it is argued should be exempt.	Compliant
E	20b	2	NEW ELEMENT: The healthcare organisation has systems in place to ensure that preventative and corrective actions are taken in situations where there are risks and / or issues with patient privacy and / or confidentiality.	The vehicle design enables the confidential treatment within its confines, with dignity and privacy. Information governance procedures and policies uphold the confidentiality of the patient, both the Risk Management and Complaints policy and procedure enable the trust to react to incidents should they arise.	Compliant
CS	21		Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises		COMPLIANT
E	21	1	The ambulance service has systems in place and has taken steps to ensure its fleet is well designed, including in accordance with the <i>Disability Discrimination Act 1995</i> , the <i>Disability Discrimination Act 2005</i> ; and have regard to <i>The duty to promote disability equality: Statutory Code of practice</i> (Disability Rights Commission, 2005).	The Vehicle fleet is designed to give safe environment to all users, however the need for safety does not necessarily comply with DDA. All vehicles have to be built to EN1789 and EN1865 which is European law, relating to safety. DDA ACoP and legislation do not specifically relate 'ambulances' but the elements have been included in the vehicle design, (tail lift access, high visibility handles and step edging, audible 'vehicle reversing 'alert).	Compliant

E	21	2	Care is provided in clean ambulances that meet the relevant requirements of duty four of <i>The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections (Department of Health, revised 2008)</i> .	The design of vehicles has developed to assist in the effective cleaning of vehicles. Staff are trained extensively how to decontaminate vehicles and equipment. SECAMB is in the process of implementing a trust wide deep cleaning regime on a six weekly basis. The trust also has two pilot sites for make ready in Hastings and Chertsey. Make ready refills, restocks and cleans the vehicle on a daily basis, in line with shift patterns. A single set of product for the cleaning and decontamination of vehicles and equipment is being implemented. ACTIV 8 is that product, it is approved by the HPA for this purpose.	Compliant
D	7		PUBLIC HEALTH: Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas		
CS	22	a & c	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by: a) cooperating with each other and with local authorities and other organisations; and c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.		
E	22ac	1	The healthcare organisation actively works with key strategic partners, such as coronary heart disease implementation groups and emergency care groups, to improve care pathways for patients.	Through the lead commissioner arrangements a system-wide group has been established to review clinical pathways across the SEC. These include Trauma, stroke, CHD/PCI and look to promote consistency and best practice in the pre/out of hospital phase of the pathway. Commissioners and clinical leads are involved ensuring that developments are communicated, supported and planned in a co-ordinated manner. SECAMB representatives also works at a local level to implement and monitor service change.	Compliant

E	22ac	2	NEW ELEMENT: The healthcare organisation contributes appropriately and effectively to nationally recognised and / or statutory partnerships such as the Local Strategic Partnership, children's partnership arrangements and, where appropriate, the Crime and Disorder Reduction Partnership.	The Trust is involved with partnership working as appropriate, some of which include: Involvement with Local Safeguarding Children's Boards; Attendance at Child Death Review Panels; Controlled drugs - Exception reports submitted to Local Intelligence Networks on a quarterly basis; Membership of Comprehensive Local Research Network; Membership of Sussex Research Consortium; Critical Care Networks attendance; Safe Drive, Stay Alive (with police, fire and schools); Bike Safe (with police and fire and local community groups); Prince's Trust work (Team and xcel); Links with Local Authorities on a host of different initiatives including Pacesetters etc; Involvement in Operation Rameses - a regular gold meeting at Kent police that monitors and makes decisions about operation stack. Partners in this meeting are Kent Fire and Rescue Service, Highways Agency, Dover Port Authority, Kent County Council, Local Councils, Health Emergency Planning and other key players; Shepway District Council - Community Safety Group (multi-agency group).	Compliant
E	22ac	3	NEW ELEMENT: The healthcare organisation monitors and reviews their contribution to public health partnership arrangements and takes action as required.	Director of Public Health appointed to SECAMB Medical Group; Links with PCTs on public health and information campaigns; Partnerships with the Stroke Association and BHF, as well as local stroke and cardiac networks.	Compliant
CS	22	b	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices		COMPLIANT

E	22	1	NEW ELEMENT: The healthcare organisation's policies and practices to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	Director of Public Health appointed to Medical Committee (now referred to as Medical Group). Practice Development Manager appointed (commences March 2009) who has responsibility for reviewing public health reports and implementing their recommendations. The Trust Clinical Director and Director of Corporate Affairs and Service Development have regular meetings with the SHA Director of Public Health regarding clinical issues that impact on the Trust, and the operationalisation of these. In addition, the Trust works with the Directors of Public Health in the local PCTs to consider the impacts of the Public Health agenda for SECamb. Issues around reductions of health inequalities and ensuring the delivery of safe, effective stroke, cardiac and trauma care have been identified and are being taken forward in the Trust's plans.	Compliant
CS	23		<p>Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections. These elements for ambulance services are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas: * Encouraging sensible drinking of alcohol * Reducing drug misuse * Improving mental health and well being * Preventing unintentional injuries</p>		COMPLIANT
E	23	1	The healthcare organisation collects, analyses and shares data about its patients / service users and services, including where relevant data on ethnicity, gender, age disability and socio-economic factors, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served.	Dashboard reports presented to Medical Committee and Trust Board, new liaison meetings held with commissioners looking at CPIs, Clinical Audit reports shared with medical advisors to the Trust. Trust participation in snapshots audits looking at self harm and audits of activated charcoal which was run in conjunction with Guys poisons unit, participation in national CHI audits	Compliant

E	23	2	The healthcare organisation contributes as appropriate to disease prevention or health promotion programmes in relation to the public health priority areas, to improve health and narrow health inequalities.	Three Heads of Dept are now members of JRCALC and inform JRCALC guideline developments. Sussex Cancer Network is informed by Head of Clinical Governance around palliative care. Work with MacMillan Trust to produce SECamb literature to educate and inform staff on the care of cancer patients. Pathways Coordinators appointed and in post. Work ongoing across SECamb in relation to palliative care and mental health, advertising leaflets put on vehicles in relation to when to call an ambulance for chest pain.	Compliant
E	23	3	The healthcare organisation implements policies and practices to improve the health and wellbeing of its workforce.	Policies in place relating to Stress, Welfare, Smoke Free, Flexible Working and Special Leave. The trusts occupational health provider is ATOS Healthcare. The Counselling provider for staff and families on a self referral or manager referral basis is First Assist. A pilot project to provide in house flu vaccinations via a team has proved successful, lessons learnt will be incorporated into a programme for 2009. The workplace stress group continues to take forward the stress action plan and the HSE review was favourable. A SECamb Workplace Stress Week is planned for September. The cycle to work scheme is receiving a good uptake from staff. There has been a review of the Smoke Free Policy, the implications for staff will be published via the bulletin, culminating in the smoke free (March 11th 2009) day activities. Articles are being produced around healthy living and the management of conditions such as asthma, by the Health, Childcare Carers coordinator and are published in the Bulletin and will be published in the staff magazine. There are health eating options in both canteens.	Compliant
CS	24		Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	COMPLIANT	

E	24	1	<p>The healthcare organisation protects the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with Civil Contingencies Act (2004), <i>The NHS Emergency Planning Guidance (Department of Health 2005)</i>, and associated supplements (Department of Health, 2005, 2007) and <i>Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic</i> (DH, November 2007).</p>	<p>The SECAMB has a Major Incident Plan which is distributed to all managers and locations within the Trust. SECAMB also has a Business Continuity Management Plan which has also been distributed to every manager and location within SECAMB. Both documents are available in electronic format and is able to be accessed through the SECAMB Intranet. SECAMB has a Pandemic Flu Response Plan which has been subject to scrutiny by the SEC SHA and has been further refined during a series of Flu Pandemic Exercises. The series of Flu Pandemic Exercises called Exercise "Polygon" were held within each of the Local Resilience Forum areas and were attended by all relevant managers from SECAMB. The Major Incident Plan is generic in nature and seeks to establish a "Major Incident Footprint" regardless of the type of incident. The Plan is supported by a "Special Contingencies" section which provides more specific guidance to incident managers in relation to arrangements applicable to individual incident types. A "CBRN and Major Incident Aide Memoire" has been produced and has been issued to every member of SECAMB. A leaflet called "How prepared are we ?" has been prepared and circulated to all members of SECAMB and provides information in relation to Business Continuity Management. A System of "Accreditation in Major Incident Management" has been introduced for all SECAMB managers. The system is a CPD method of ensuring that all SECAMB managers receive Major Incident training and development annually . The system requires all managers to obtain 12 Major Incident CPD points on an annual basis.</p>	Compliant
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E	24	2	<p>The healthcare organisation protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the <i>Civil Contingencies Act 2004</i>, <i>The NHS Emergency Planning Guidance 2005 and associated supplements (Department of Health 2005, 2007)</i> and <i>Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic</i> (DH, November 2007).</p>	<p>SECAmb links with the Resilience Forums of Kent, Sussex and Surrey and (in a limited way) North East Hampshire. Representation is achieved across the whole spectrum of groups and meeting cycles within each of the LRF areas. SECAmb is also represented at the Regional Resilience Forum and sub-groups dealing with Media, Health and CBRN. SECAmb is also represented on other groups supporting emergency planning activity in areas covered by other legislation such as the COMAH regulations, Safety at Sports Grounds and the Pipeline Safety Regulations etc. SECAmb seeks to provide participation by appropriate level managers and staff at Major Incident training and exercise events organised by our professional partners. SECAmb participates in working with key partner agencies to ensure appropriate plans are in place to respond to key risk sites such as Gatwick Airport, Channel Tunnel and top tier COMAH Sites. SECAmb carries out training for all CBRN Providers in accordance with DoH requirements.</p>	Compliant
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