

Status	No	Sub	S4BH Text	Elements	Known Actions/policies	Action Plan Suggested Requirements -	Exec Lead	Management Lead Name	Time scale	Update
Green	1	a	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	Element 1 Incidents are reported locally and to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System.	SUI Procedure in place	Procedure for SUI Reporting (to SHA/Board)	Chief Executive	Laila Abrahams	Jun-07	Complete
Green						Monitoring and Identification of trends and learning through LIGGs and IGC (including NPSA reports)	Chief Executive	Laila Abraham	Jul-07	Local reporting underway at LIGG - issues at Bedford due to resources now resolved
Green				Element 2 Reported incidents are analysed to seek to identify root causes, relevant trends and likelihood of repetition.		Evidence to show improvements in practice and prevention of re-occurrence of incidents	Chief Executive	Laila Abraham		Examples of incidents to evidence this
Green					CPD Programme 2007/2008 contains an element which includes how to learn from incidents	CPD to incorporate learning from incidents	Clinical Director	Emma Parker	Dec-07	CPD Programme
Green				Element 3 Demonstrable improvements in practice are made to prevent reoccurrence of incidents as a result of information arising from the analysis of local incidents and from the NPSA's national analysis of incidents	Regional H&S Committee in place, Cambs LCOO - LCOO rep on committee, RIDDOR analysis included in Committee's ToR. Trust H&S Lead provides locality monitoring reports to this Committee.	Trust wide RIDDOR Analysis & Action Plans, with a view to minimising.	Director of Operations	LCOOs	Dec-07	Evidence of identification of incidents, local reporting/discussion and actions taken (including but not exclusively RIDDOR) Complete
Green					Action plan agreed by TB. New PDR system introduced with training. New sickness absence and A/L policies being introduced. Call Connect addressed workload hotspots. Trust actively supporting prosecution of violent aggressors and staff told of successes	Implementation of Recommendations from Staff Survey	Director of HR		Various according to action plan	Complete
Amber				The Risk Management Strategy that was approved by the Board in Jan 2007 is to be placed on the internet. Updated version of RMS incorporating the comments and recommendations from NHSLA pilot assessment will go to IGC and Board in Jan 2008 which will be disseminated and implemented in the Trust.	Trust Risk Management Strategy requires dissemination/implementation	Chief Executive	Laila Abraham	Jul-07	Update presented to IGC (Jan 08) to be presented to Exec Team	
Amber					Approved Incident Management Policy to include Systematic Approach to Incident, Complaint and Claims Management, Analysis and Sharing Safety Lessons	Chief Executive	Laila Abraham		Presented to IGC (Jan 08) to be presented to Exec Team	

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Green						Procedure for Patient Safety incidents reporting (NPSA)	Clinical Director	Laila Abraham	Aug-07	Trust reporting underway across whole Trust in line with NPSA Guidance All reported to IGC - together with MHRA, Drug Alerts, SABS - report contains action points
Green						Evidence of NRLS evidence and reporting	Chief Executive	Laila Abraham		Trust reporting underway across whole Trust in line with NPSA Guidance - Certificate requested from NPSA
Green						Evidence of Root Cause Analysis investigations and outcomes	Chief Executive	Laila Abraham		Examples of incidents to evidence this
Green					NPSA has agreed to provide RCA training to the Trust at the three localities. The first one is scheduled to take place in Dec 07 in Norwich.	Common Root Cause Analysis training to be fully implemented for managers.	Chief Executive	Laila Abraham	Mar-08	Questions surrounding availability of Ops staff for planned 2 x 1 day training days
Green	1	b	ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales	Element 1 All communications, including drug alerts issued by the Safety Alert Broadcast System (SABS) are implemented within the defined timescales, in accordance with Chief executive's bulletin article		Formal procedure for SABS receipt, distribution, action and monitoring (including intranet)	Clinical Director	Ted ahrt	Sep-07	CSOP published - EqlA completed now complete as reported at Nov IGC SABS recorded by Ted Hart and actioned - all reported through IGC
Green						Formal procedure for drugs and medicines safety alerts receipt, distribution, action and monitoring (including intranet)	Clinical Director	John Scott	Sep-07	CSOP published - EqlA completed now complete as reported at Nov IGC Medicines Management Policy being reviewed by Archie Morson Drug alerts actioned and reported through IGC All PGDs now published on single intranet site (East24) Local arrangement in Norfolk area to cover OOH using Medicom
Green						Monitoring and identification of learning SABS/Drugs/Medicines through MMG, LIGGs and IGC (including Medical Directors Report)	Clinical Director	John Scott	Ongoing	Reported to MMG and ESCG on a regular basis, this in turn is fed through to the IGC Local reporting also underway through Local Integrated Governance Groups
Amber						Formalising, embedding and implement support for locality governance structures (eg Cambridgeshire to be incorporated into BH governance meetings)	Chief Executive	Laila Abraham	Sep-07	Implementation of Datix has commenced which will assist with this process

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Amber	2		Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	<p>Element 1 Effective processes are in place for identifying, reporting and taking action on child protection issues in accordance with Working together to safeguard children (HM Government, 2006).</p> <p>Element 2 The ambulance service works with partners to protect children as set out in Working together to safeguard children (HM Government, 2006).</p> <p>Element 3 Criminal Records Bureau (CRB) checks are conducted for all staff and students with access to children in the normal course of their duties, in accordance with CRB disclosures in the NHS (NHS Employers 2004).</p>		Evidence of Adoption of Trust Policy on Protection of Vulnerable Adults and Children Review Trust Policy on Protection of Vulnerable Adults and Children (including the recognition of abuse, 24/7 advice?)	Clinical Director	Jill Moseley	Mar-08	CSOP published - EqlA completed now complete as reported at Nov IGC The Regional Lead in Child Protection and vulnerable Adults has been appointed and took up post on 1st January 2008. The work plan includes drawing together the 6 county policies in preparation of April 2008. At present there is not a single practice between counties, but Trust will draw these together to create a single policy for staff to follow
Green						Confirmation of CP Lead	Clinical Director	Adrian Cooper		Regional Lead took up post in January 2008 - there is a county lead based in Operations in each county except Essex
Green					Policy approved by IGC (Sept 07)	Formal agreement on where Board has delegated responsibility of policy approval (Policy on Policies)	Chief Executive	Helen Edmondson	Sep-07	Complete
Amber						Formalise structure, reporting arrangements and local working arrangements (including County Leads, membership of LCSBS, evidence of local actions and partnership working)	Clinical Director	Adrian Cooper	Dec-07	This will become part of the work plan for the new regional lead - to establish formal Trust structures including links to LSCB by April 2008
Green					New Trust wide Induction process introduced in Sept 07. Pre-employment and CRB checks tightened up (all ops staff now undergo enhanced checks).	Standardise Corporate Induction (consider need for Child Protection Training as part of core training)	Director of HR	Emma Mynott	Sep-07	Complete
Green						Child Protection Training and Development Programme - CPD	Clinical Director	Emma Parker	Dec-07	Included in A&E CPD for year 2007/08 - to be included in the future as part of the BMJ e-learning CPD development
Green					All recorded in HR record system	Ongoing evidence of CRB checking	Director of HR	TBC	Ongoing	Complete
Green	4	a	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 Methicillin-Resistant Staphylococcus Aureus (MRSA)	<p>Element 1 The ambulance service has systems to ensure the risk of healthcare associated infection is reduced in accordance with The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, 2006).</p>	Infection control Policy approved - July IGC	Evidence of adoption/approval of Trust Infection Control Policy Review of Trust Infection Control Policy	Clinical Director	Sally-Jane Gooding	Mar-08	Complete
Green						Infection Control Action Plan (including audit) - monitored through Infection Control Group	Clinical Director	Sally-Jane Gooding	Mar-08	Ongoing
Green					New Trust wide Induction process introduced in Sept 07.	Standardised Corporate Induction (Infection Control)	Director of HR	Emma Mynott	Sep-07	Complete
Green						CPD to include infection control	Clinical Director	Emma Parker	Dec-07	Infection Control principles included in CPD 2007/08
Green						Annual Board Report (Infection Control)	Clinical Director	Sally-Jane Gooding	Sep-07	Annual report presented to the Trust Board - next report due May 2008

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Amber	4	b	all risks associated with the acquisition and use of medical devices are minimised	Element 1 The ambulance service 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	Terms of reference agreed for Trust OPG and its component sub groups, namely; vehicle group, medical devices group and Workwear/ppe group. Medical devices group met on 2 occasions in 2007, and is progressing an agreed work plan. Workwear group met on 3 occasions and is similarly progressing agreed work plan. Vehicle work group scheduled for 1st meeting on 4th October, objective of which is to develop common EEAS specification for A&E ambulances and response cars, number of meetings required to be defined. Trust OPG has had first meeting to establish and issue terms of reference for the sub groups and determine 07/08 work plans. Further meetings planned to review work group progress. SABS alerts; EEAS wide SABS alert system developed and currently in operation, policy is in CSOP format and will receive IGC ratification in November. Reported defects for medical devices are captured by Trust's incident reporting systems and are considered by the medical devices group as part of product selection. Recommendations for equipment are made from subgroups to OPD in the form of systematic approvals request.	Trust OPG and sub groups (establishment of meetings) to include, SABS alerts, identification of trends in defects of devices and link to replenishment program.	Director of Operations	Paul Henry	Jul-07	Production CSOPS agreed by Senior Ops Group and Executive include: 10.1 Medical Devices Management Strategy. 10.2 Medical Devices Repair and Maintenance Procedure. 10.3 Medical Devices Acquisition and Storage Procedure. 10.4 SABS Procedure. 10.5 Latex Policy. 10.6 Single Use Medical Devices Presented and approved by Senior Ops team on 16-10-07. All workgroups are undertaking the agreed workplans for 07/08. Minutes of workgroups attached as evidence of activity and progress. NB: CSOP 10.7 Loss and/or Disposal and Medical Devices has been drafted and is undergoing EQD assessment. CSOP will then be reviewed for approval by Senior Operations Group and Executive. Terms of Reference of all Workgroups attached for information. Please note involvement of PPI requested. Await Audit committee assurance - Paul Henry
Green					Medical devices strategy has been drafted and will be put into CSOP format (as other medical device policies) to be received by SDB and thereafter ratified by IGC in November 2007.	Medical Devices Strategy	Director of Operations	Paul Henry	Mar-08	CSOPs relating to Medical Devices, 10.1, 10.2, 10.3, 10.6 approved by Senior Mgmt Group and Exec Team
Green					EEAS policy drafted currently being presented and referenced into CSOP format Trust referencing and document control to be applied. Objective: to be received and approved by SDB and then to IGC committee Nov 07 - revised timetable based on meeting schedules.	Medical Devices Acquisition and Storage Policy (including risk assessments)	Director of Operations	Paul Henry	Jun-07	CSOPs relating to Medical Devices, 10.1, 10.2, 10.3, 10.6 approved by Senior Mgmt Group and Exec Team
Amber					EEAS policy drafted currently being presented and referenced into CSOP format Trust referencing and document control to be applied. Objective: to be received and approved by SDB and then to IGC committee Nov 07 - revised timetable based on meeting schedules.	Medical Devices Repair, Maintenance and Replacement Policy (including faulty equipment withdrawal system, database, link to SFI/asset register)	Director of Operations	Paul Henry	Jun-07	Policies relating to Medical Devices now in place. Database in place and implemented in BH, NSC, now being implemented in Essex
Green						Single Use Policy (including disposal)	Clinical Director	Jill Moseley	Aug-07	CSOP approved by Senior Mgmt Group and Exec Team
Green						Medical Devices Decontamination Policy	Clinical Director	Jill Moseley	Aug-07	CSOP approved by Senior Mgmt Group and Exec Team

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Green	4	d	medicines are handled safely and securely	<p>Element 1 Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored including in accordance with the statutory requirements of the Medicines Act 1968.</p> <p>Element 2 Controlled drugs are handled safely and securely in accordance with the Misuse of Drugs Act 1971, the Misuse of Drugs Act 1971 (Modification) Order 2001 and Safer management of controlled drugs: Guidance on strengthened governance arrangements (Department of Health, 2006)</p>		Trust Medicines Management Policy (to include procurement arrangements)	Clinical Director	Jill Moseley	Sep-07	CSOP published - Approved by ESCG as agreed by IGC Nov 07
Green						Evidence of Trust Licence for Prescription, Administration of Controlled Drugs.	Clinical Director	John Scott	TBC	At recent Trust Medicines Management Group it was agreed, following advice from Pharmacy Advisor, that the Trust did not need to apply for a licence
Green						Learning from adverse drug incident reporting (via MMG)	Clinical Director	Scott Turner	Dec-07	Reported to MMG and ESCG on a regular basis, this in turn is fed through to the IGC Local reporting also underway through Local Integrated Governance Groups
Amber						<p>Norfolk and Suffolk: Implemented a quarterly audit process of morphine withdrawal from each nominated local acute Trusts. The relevant acute trust pharmacy provides our clinical lead (Archie Morson) with a report of who has requested/restocked their morphine with dates and quantity, which in turn is sent to the relevant local manager and enables us to monitor this and raise/address and concerns. Also we have been monitoring the compliance of PGD signatories and have reduced the list of outstanding signatories to <30 in each locality.</p> <p>Cambs: Local Morphine audits as part of KPIs. We also have the QA system in place to check clinical quality standards.</p> <p>Essex: Weekly audit check of controlled drugs, emailed to LCOO by 10:00 each Monday, and a weekly random check on every ambulance and RRV.</p> <p>Beds and Herts: From July: Station managers to cross check paramedic morphine records on a monthly basis - KPIs tbc -</p>	Audit programme via CPIS to include POMs and CDs drugs and ensure continued compliance with Safer management of controlled drugs: Guidance on strengthened governance arrangements (Department of Health, 2006)	Director of Operations	LCOOs	Jun-07
Amber						Action plan to ensure continued compliance with Safer management of controlled drugs: Guidance on strengthened governance arrangements (Department of Health, 2006)	Clinical Director	LCOOs	Mar-08	3 clinical mgrs; Paul Kattenhorn, Tracy Nicholls and Archie Morson to provide Action Plans and updates from actions re internal audits on Med Mgmt

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Amber	4	e	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	Element 1 The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients, staff, the public and the environment in accordance with Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste (Department of Health 2006)		Waste Management Policy (including procedures to reflect any local variation and taking into account the five stages of waste management identified within the Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste (Department of Health 2006)	Director of Operations	Paul Henry	Jun-07	
Amber					Group in process of being set up, draft ToR completed awaiting approval Waste manager is developing terms of reference for EEAS waste management group and is currently liaising with other NHS trusts and the Healthcare commission to identify areas of best practice where these groups are already in operation. Objective still to have ToR to be in place by December with first meeting in January/February 2008, group will monitor implementation of the new policy.	Waste Management Group ToR and reporting structures, evidence of implementation and monitoring of policy	Director of Operations	Paul Henry	Dec-07	Meetings to commence in March 2008.
Green					Audit completed in June/July in NSC. DGSA audits have been completed for NSC. Audit has also been completed for Essex. Waste manager will develop an EEAS wide DGSA audit plan in November/December 2007 for implementation in 2008/2009. This objective is part of his annual work plan.	Ongoing DGSA/contract check audits in NSC/where required	Director of Operations	Paul Henry	Ongoing	
Green	5	a	they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care	Element 1 The ambulance service 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 delivering care and treatment.		Policy for implementation of NICE guidance - including reference to: How to put NICE guidance into practice (NICE, December 2005).	Clinical Director	Jill Moseley	Aug-07	CSOP published -EqIA completed now complete as reported at Nov IGC
Green					Documents to support the implementation of other national clinical guidance (eg JRCALC/NSFs)	Clinical Director	Jill Moseley	Aug-07	Reference to the introduction of JRCALC guidelines in Sept & Nov 06, and Jan 07 No new NSFs introduced for some years	
Green					Process for reviewing Trust Clinical Guidelines	Clinical Director	Steve Mortley	Mar-08	complete	
Green					Decisions to implement national guidance (or Trust decision not to adopt guidance) evidenced via MMG and Clinical Steering Group	Clinical Director	John Scott	Ongoing	All reported through Trust Expert Strategic Clinical Group	
Amber					Monitoring of local implementation and embedding of guidance	Director of Operations	LCOOs	Dec-07	QA1s - Audit Clinical Practice - Archie Morson, Paul Kattenhorn, Tracy Nicholls CPI Audits - Steve Mortley LCOOs hold signatures for receipts of JRCALC Guidelines and PGDs	

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Amber	5	b	clinical care and treatment are carried out under supervision and leadership	Element 1 Appropriate supervision and clinical leadership is provided to staff involved in delivering clinical care and treatment in accordance with guidance from relevant professional bodies.	New operations management structure being implemented	Trust Plan for Clinical Supervision (all clinical staff), including training plan for mentors and appropriate deployment of newly qualified staff - where does this come from???	Clinical Director	Marcus Bailey	Dec-07	Checks to be made with Marcus Bailey
Green						Job Descriptions for Senior Clinical Staff to include leadership responsibilities	Clinical Director	John Scott	Dec-07	JDs updated for Senior Clinical Lead Posts all contain references to leadership responsibilities
Green					Management and leadership learning programmes reviewed to include PDPs/KSFs PDR/KSF Training underway	Supervision and leadership to be supported by Learning and Development (e.g. Leadership and Management Programme linked with PDP/KSFs)	Director of HR	Emma Mynott	Dec-07	Complete
Green						Procedure for dealing with concerns and variations in clinical practice (including non attendance at CPD/completion of work based competencies)	Clinical Director	TBC in conjunction with HR	Sep-07	CSOP 1.2 Regulation of Healthcare Professions by the Council for Healthcare Regulatory Excellence (CHRE) CSOP 1.12 Performance Review Panel Whistleblowing Policy
Green						Clinical Advice Support Procedure	Clinical Director	Scott Turner	Mar-08	CSOP 2.5 Clinical Advice Support
Green	5	c	clinicians continuously update skills and techniques relevant to their clinical work	Element 1 Clinicians from all disciplines participate in activities to update the skills and techniques relevant to their clinical work	NSC: CPD in place for continuous updates (both formal and field based) General: CPD to be reported via SDB BH - Training issues reported through LIGG	Monitoring CPD attendance (all clinical staff) and sign off of Work Based Competencies (database). Trust Monitoring via LIGGS Scheduling hold a database of CPD attendance.	Director of Operations	LCOOs	Dec 07 (ongoing)	Evidence of monitoring of CPD attendance, sign off, etc
Amber						System in place to identify relevant training requirements for CPD	Clinical Director	Emma Parker		Executive Team have decided the time to be given to classroom teaching - have yet to agree the work-based competencies for 2008-09 for classroom element. It was recognised for A&E 17 hours was required but programme has been reduced to 11 hours to fit Executive decision.
Amber	5	d	clinicians participate in regular clinical audit and reviews of clinical services	Element 1 Clinicians are involved in prioritising, conducting, reporting and acting on clinical audits.		Clinical Audit Strategy / Policy (reflects national and local requirements)	Clinical Director	Steve Mortley	Mar-08	
Green					Audit Programme reflects national and local requirements	Clinical Audit Programme (reflects national and local requirements)	Clinical Director	Steve Mortley	Jul-07	Complete
Green				Element 2 Clinicians participate in reviewing the effectiveness of clinical services	Interim reports received at IGC	Monitoring and reporting of clinical audit programme via Expert Clinical Group	Clinical Director	Steve Mortley	Mar-08	Together with IGC - programme report was presented at Nov 07 meeting

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Green						Trust PTS ISO audits	Chief Executive	Laila Abraham	Mar-08	Trust passed this assessment - report available from Robin Forster (NSC)
Green	6		Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met	Element 1 Staff work in partnership with colleagues in other health and social care organisations to meet the individual needs of patients.		Evidence of joint working with health and social care in meeting individual patient's needs	Clinical Director	Jill Moseley	Mar-08	Evidence of partnership working in localities LR palliative care forms, LCOOs to send Laila examples of where particular patients conditions / special needs , Falls evidence
Green						Patient Survey? Positive response re exchange of information between Hospital and Acute Hospital staff.	Clinical Director	Steve Mortley	Mar-08	
Green	7	a & c	apply the principles of sound clinical and corporate governance undertake systematic risk assessment and risk management	Element 1 The ambulance service has effective arrangements in place for clinical governance Element 2 There are effective corporate governance arrangements in place that accord with Governing the NHS: A guide for NHS boards (Department of Health and NHS Appointments Commission 2003), and the Corporate governance framework manual for NHS trusts (Department of Health April 2003). Element 3 The ambulance service systematically assesses and manages its risks	Reported through Trust Board	Trust Assurance Framework - including Strategic Aims (Board April 2008) - regular reporting via IGC 3 times per year	Chief Executive	Laila Abraham	May-07	Assurance Framework has been updated to reflect Executive Team's review of the Corporate Risk Register - to be presented to IGC (Jan 08)
Amber						Further embedding of Clinical or Corporate Governance Structure in the Trust (Integrated Governance Handbook)	Chief Executive	Laila Abraham	Jun-07	Governance structure review is currently taking place
Green						Implementation of Trust Risk Strategy	Chief Executive	Laila Abraham	Jul-07	Review update to be presented to IGC (Jan 08)
Amber						Implementation of Trust Risk Register	Chief Executive	Laila Abraham	Aug-07	Included as part of the RMS, to be approved by IGC (Jan 08)
Green						Trust Business Plan	Chief Executive		May-07	Included within the Strategic Direction document
Amber						Effective arrangements for Clinical Governance to be embedded	Clinical Director	Laila Abraham	Mar-08	Working with the Clinical Director to achieve this. Will also be picked up by new Governance structure
Amber						Implementation of Trust Risk and Incident Management System	Chief Executive	Laila Abraham	Sep-07	Datix Project Managers appointed and System Administrator identified - Amber
Green	7	b	actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	Element 1 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 Code of conduct for NHS Managers (Department of Health, 2002) and NHS Counter Fraud and Corruption manual third edition (NHS Counter Fraud Service, 2006).		LSMS Workplan - Agreement, Implementation and Review - Evidence required	Chief Executive	Laila Abraham	Jun-07	Ongoing
Green					in use now. Honorary contracts under review	East of England contract agreed and issued to new new staff or on status change (eg promotion) [including reference to the Code of Conduct for NHS Managers amd]	Director of HR	TBC	May-07	Complete
Green						Counter Fraud workplan (in accordance with NHS Counter Fraud and Corruption Manual 3rd Edition - NHS CFS 2006) - regular review	Chief Executive	Kevin Smith	Jun-07	Counter Fraud report and work plan delivered to Audit Committee (Sep 06)
Amber						Trust Openness Policy and Publicity	Chief Executive	Laila Abraham	Sep-07	Draft complete. Updated with recommendations from NHSLA recommendations. To be approved by IGC (date to be allocated)

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Amber	7	e	challenge discrimination, promote equality and respect human rights	<p>Element 1 The ambulance service challenges discrimination and respects human rights in accordance with the Human Rights Act 1998, No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health, 2000), The Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, and The Employment Equality (Age) Regulations 2006.</p> <p>Element 2 The ambulance service promotes equality, including by publishing information specified by statute, in accordance with the general and specific duties of the Race Relations Act 1976 (as amended), the Code of practice on the duty to promote race equality (Commission for Racial Equality 2002), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Code of practice on the duty to promote disability equality, (Disability Rights Commission, 2005), the Equality Act 2006 and the Gender Equality Duty Co</p>	<p>New Equality and Diversity Steering Group formed (chaired by NED).</p> <p>Single equality scheme approved by TB + consultation papers</p> <p>Training on E&D under development.</p> <p>Equality Impact Assessment system for policies now in place - training started</p> <p>Workforce data quarterly reporting through IGC and Trust Board</p> <p>Equal Ops Policy</p> <p>EqlA Assessment Procedure in place</p> <p>E&D Trustwide Working Group</p> <p>Special Leave Policy</p> <p>Flexible Working Policy</p>	<p>Consolidation of all Equality and Diversity Schemes and policies in accordance with latest requirements (for example Employment Equality (Age) Regulations 2006 Act and Disability Discrimination Act 2005 (latter in operation from December 2006)</p> <p>Embedding of E & D Steering Group</p> <p>Evidence of collation of Trust workforce data on a quarterly basis</p> <p>Implementation of Recruitment & Selection Policy (incl. processes, approval to recruit etc)</p> <p>New Recruitment Policy developed - under consultation</p> <p>Evidence of policies to support staff in personal circumstances</p>	Director of HR	Sue Wilcox		AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber					<p>New Equality and Diversity Steering Group formed (chaired by NED) Single equality scheme approved by TB. Training on E&D under development. Equality Impact Assessment system for policies now in place - training started</p>	Embedding of Equality and Diversity Steering group and Sub groups	Director of HR	Sue Wilcox		AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Green					Workforce profile recorded and reported regularly to TB	Evidence of collation of Trust workforce data on a quarterly basis	Director of HR	Andree Weymouth		Complete
Green					New Recruitment policy developed - and consultation taking place	Implementation of Recruitment and Selection Policy (noting new guidance) - including processes, approval to recruit etc	Director of HR	Tracey Leghorn - operational HR	Jul-07	Policy in place and in use - now augmented by Positive action policy - and inspected during Race Relations Review
Green	8	a	having access to processes which permit them to raise, in confidence 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 delive	<p>Element 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).</p>	<p>One Trust policy now in place.</p> <p>HCC inspection confirmed we are compliant in this area.</p>	Consolidation of existing Whistle Blowing Policies (including monitoring)	Director of HR	Tracey Leghorn - operational HR	May-07	Policy in place and in use

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Green	8	b	organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	<p>Element 1 The ambulance service supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the Improving Working Lives standard at Practice Plus level.</p> <p>Element 2 Staff from minority groups are offered opportunities for personal development to address under-representation in senior roles.</p>	<p>Learning and Development Unit addressed this</p> <p>Trust PDR scheme/system (including monitoring)</p> <p>Learning & Development Policy approved at TB</p> <p>ESR now in use across Trust</p>	<p>Evidence that the Trust is continuing to achieve IWL Practice Plus standards (requires review in light of assessment date being 2005)</p> <p>Involvement of staff in the design and implementation of more flexible ways of working - where appropriate staff opportunity for flexible working / job sharing</p> <p>Roll out of ESR (OLM) to enable enhanced features (eg monitoring of training records, checking of registration etc)</p>	Director of HR			<p>3 previous Trusts all held IWL Practice Plus</p> <p>AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN</p>
Green					New system in place	Review of Learning & Development System and Needs	Director of HR	Emma Mynott	Mar-08	system now in place and linked to CPD and learning plans enables individuals and line managers to identify needs
Green					New PDR system agreed by SDB and implemented with training	Trust PDR scheme/system (including monitoring)	Director of HR	Emma Mynott	Jun-07	Complete
Green						Roll out of ESR to enable enhanced features (eg monitoring of training records, checking of registration etc)	Director of HR	Jill Whelan	Mar-08	Completed in July 2007
Green	9		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 for which it was collected	Element 1 The ambulance service has effective systems for managing clinical records in accordance with Records management: NHS code of practice (Department of Health, April 2006)	<p>Records Management Task Group has had initial meeting</p> <p>Records Management Strategy agreed at July 2007 IGC.</p> <p>Request gone to all departments to complete records inventory by mid-Oct (only at start of process).</p>	Ongoing evidence to support roadmap for implementation of the Record management NHS Code of Practice 2006 (including Records Lifecycle Management Strategy and Policy, reference to new CSOP, corporate/electronic records management, Trust Patient leaflets - what we do with information)	Chief Executive	Helen Edmondson	Dec 07 (note roadmap is ongoing process)	Some departmental inventories completed. Policy work will concentrate on Corporate Records in line with Connecting for Health toolkit
Green	10	a	undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies	Element 1 The necessary employment checks are undertaken for all staff in accordance with Safer recruitment - A guide for NHS employers (NHS Employers 2006) and CRB disclosures in the NHS (NHS Employers 2004).	<p>Checking systems all reviewed in July 07 and outcome reported to TB</p> <p>CSOP regarding registration in place</p>	Clinical Staff Registration Guideline (covering all clinical staff) and evidence of robust mechanisms for checking registration, to incorporate latest guidance.... Safer recruitment – A guide for NHS employers (NHS Employers 2006) and CRB disclosures in the NHS (NHS Employers 2004). [see also C2, C10b]	Director of HR	Tracey Leghorn - operational HR	Aug-07	Complete
Green	10	b	require that all employed professionals abide by relevant published codes of professional practice	Element 1 The ambulance service explicitly requires staff to abide by relevant codes of professional conduct and takes action when codes of conduct are breached		See C10a Procedure for dealing with concerns and variations in Clinical Practice (including professionals other than Paramedics?)	Clinical Director	TBC in conjunction with HR	Sep-07	<p>CSOP published -EqlA completed now complete as reported at Nov IGC.</p> <p>Also covered within approved HR Policy - Variations in practice</p>

Status	No	Sub	S4BH Text	Elements	Known Actions/policies	Action Plan Suggested Requirements -	Exec Lead	Management Lead Name	Time scale	Update
Green	11	a	are appropriately recruited, trained and qualified for the work they undertake	Element 1 The ambulance service recruits staff in accordance with relevant legislation and with particular regard to the Sex Discrimination (Gender Reassignment) Regulations 1999, The Employment Equality (Religion or Belief) Regulations 2003, The Employment Equality (Sexual Orientation) Regulations 2003, The Employment Equality (Age) Regulations 2006, Race Relations Act 1976 (as amended), the and the Equality Act 2006.		Workforce planning to meet needs of organisation Note the Disability Discrimination Act 2005 and Employment Equality (Age) Regulations 2006 now referenced -	Director of HR	Jill Whelan	Ongoing annually	Workforce plan provided for the Board, the SHA and the DH annually and refreshed mid year
Green					New induction programme and approach agreed and implemented Sept07	Review of Corporate Induction Programme (noting new guidance) and evidence of participation	Director of HR	Emma Mynott	Sep-07	New Corporate Induction Programme agreed and commenced
Green				Element 2 The ambulance service undertakes workforce planning which aligns workforce requirements to its service needs		Evidence that staff participate in local induction/work based training [programs to the work they undertake as defined by IWL Practice Plus standards] - note centralised system for corporate induction training now established	Director of HR	Emma Mynott	Sep-07	IWL achieved by 3 former Trusts - induction now taking place at local levels and monitoring system also in place
Green					New recruitment policy in place and implemented	See C7e (Recruitment policy)	Director of HR	Tracey Leghorn - operational HR	Jul-07	Complete
Green	11	b	participate in mandatory training programmes What are mandatory training courses?	Element 1 Staff participate in relevant mandatory training programmes. Element 2 Staff and students participate in relevant induction programmes	Learning and Development Unit addressed this Trust PDR scheme/system (including monitoring) Learning & Development Policy approved at TB ESR now in use across Trust	Documented agreement and subsequent implementation of Trust mandatory training (including evidence of training records) - via Training Review	Director of HR	Emma Mynott	Sep-07	Complete
Green	11	c	participate in further professional and occupational development commensurate with their work throughout their working lives	Element 1 Staff have opportunities to participate in professional and occupational development at all points in their career in accordance with Working together – learning together: a framework for lifelong learning for the NHS (Department of Health 2001).	CPD for all operations and clinical staff in place	Trust PDR scheme (including monitoring) in accordance with Working Together/Learning Together (NHS 2001)	Director of HR	Emma Mynott	Jun-07	3 previous Trusts all held IWL Practice Plus Trust PDR scheme in place and ongoing
Green					see above	Evidence that the Trust is continuing to achieve IWL Practice Plus standards [see also C8b]	Director of HR			as a continuation of the 3 previous Trusts who all held IWL Practice Plus, the Trust implemented a PDR scheme
Green	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	Element 1 The ambulance service has an effective research governance framework in place which complies with the requirements of the Research governance framework for health and social care, second edition (Department of Health 2005		Ongoing review of research in line with Research Policy and Strategy Noting new guidance Research Governance Framework for Health and Social Care (2005)	Clinical Director	Steve Mortley	Ongoing	

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Green	13	a	staff treat patients, their relatives and carers with dignity and respect	<p>Element 1 The ambulance service ensures that staff treat patients, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, takes action where dignity and respect have been compromised.</p> <p>Element 2 The ambulance service meets the needs and rights of different patient groups with regard to dignity including by meeting the relevant requirements of the Human Rights Act 1998, the Race Relations Act 1976 (as amended), the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, and the Equality Act 2006.</p>		Dignity Policy which include reference to new guidance Disability Discrimination Act 2005 , the Race Relations Act 1976 (as amended) and the Human Rights Act 1998 and taking into account NHS Chaplaincy Meeting the religious and spiritual needs of patients and staff (Department of Health, 2003). Employment policies established (eg Equal Opportunities, Dignity at Work) - further work needed to establish what is required for patients etc	Director of HR		Mar-08	HR Policies & CSOPs include, Codes of Conducts, Equal Opportunities, Dignity at Work, Single Equality Scheme, Human Rights Policy Statement (this needs dating)
Green					New induction programme and approach agreed and implemented Sept07	Corporate Induction (Trust Training in Customer Care)	Director of HR	Emma Mynott	Sep-07	Complete
Green						Monitoring of adverse complaints/comments to PALS re treatment of patients	Chief Executive	Laila Abraham	Sep-07	Information within the databases analysed and action plans discussed at locality levels
Green						Patient Leaflets including bereavement	Clinical Director		Aug-07	<p>Patient leaflets published on Web East 24 and 2nd group being published - Leaflets carried on ambulances in Essex.</p> <p>Bereavement leaflets in many languages carried on ambulances in B&H</p>
Green	13	b	appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	<p>Element 1 Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures and investigations in accordance with the Reference guide to consent for examination or treatment (Department of Health 2001).</p> <p>Element 2 Patients, including those with language and/or communication support needs, are provided with information on the use and disclosure of confidential information held about them in accordance with Confidentiality: NHS code of practice (Department of Health 2003).</p>		<p>Policies, procedures and other evidence related to consent and confidentiality</p> <p>Examples of how this is working within the Trust required</p>	Chief Executive	Laila Abraham	Sep-07	<p>Patient leaflets to be made available on website which also contains information on how we use and treat patient information.</p> <p>Implied consent is obtained for majority of patients through the nature of the work we undertake ie emergency care. Consent forms in place for thrombolysis, releasing patient information.</p> <p>CSOPs include subjects such as Consent, Confidentiality, Use of Information</p> <p>Multi-lingual booklets supplied to all vehicles</p>
Green						Trust licence on use of Language Line	Director of HR	Laila Abraham		Complete
Amber	13	c	staff treat patient information confidentially, except where authorised by	<p>Element 1 Staff act in accordance with Confidentiality: NHS code of practice</p>		Trust Guidance for Release of Information.	Chief Executive	Helen Edmondson	Jun-07	Draft release of Information policy to be approved at IGC on 14th Mar

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Green			legislation to the contrary	(Department of Health 2003), the Data Protection Act 1998, Protecting and using patient information: a manual for Caldicott guardians (Department of Health 1999), the Human Rights Act 1998 and the Freedom of Information Act 2000 when using and disclosing patients' personal information.		Staff Code of Conduct (Evidence implementation and monitoring)	Clinical Director	Jill Moseley		All CSOPs relating to staff Code of Conduct approved
Green						Trust Procedures - Use of Photography and Confidentiality?	Clinical Director	Jill Moseley	Aug-07	CSOP published - EqlA completed now complete as reported at Nov IGC
Amber						Trust leaflet on use of information, data protection and FOI in draft form. Available in relevant languages and accessible formats.	Chief Executive	Laila Abraham	Sep-07	Draft FOI policy to be approved by IGC on 14th March
Amber	14	a	have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services	Element 1 Patients, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system. Element 2 Patients, relatives and carers are provided with opportunities to give feedback on the quality of services.	Complete	Revised Complaints Policy (including implementation and support structure)	Chief Executive	Laila Abraham	Jul-07	Complete
Amber					Complete, information and patient leaflet on website	Trust leaflets created, published and distributed (available in relevant languages and accessible formats) - see also C14b	Chief Executive	Laila Abraham	Jul-07	Complete
Amber					Complete, information and patient leaflet on website	Clear information via TRUST website	Chief Executive	Laila Abraham	May-07	Complete
Amber						Staff training to include information on complaints and feedback process	Chief Executive	Laila Abraham	Jul-07	Complete
Amber	14	b	are not discriminated against when complaints are made	Element 1 The ambulance service has systems in place to ensure that patients, carers and relatives are not treated adversely as a result of having complained.	Complete	Revised Complaints Policy (including implementation and support structure) [see also C14a]	Chief Executive	Laila Abraham	Jul-07	Complete
Amber						Trust leaflets and communication material to be revised to take into account HCC recommendations on discrimination (include reference to interpretation?)	Chief Executive	Laila Abraham	Jul-07	Complete
Amber						Feedback mechanism to be established to evidence non discrimination	Chief Executive	Laila Abraham	Mar-08	Complete
Green	14	c	are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery	Element 1 The ambulance service acts on, and responds to, complaints appropriately and in a timely manner. Element 2 Demonstrable improvements are	Complete	Revised Complaints Policy (including implementation and support structure) [see also C14a]	Chief Executive	Laila Abraham	Jul-07	Complete

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Green						Trust must evidence that learning and changes to service delivery takes place	Chief Executive	Laila Abraham	Dec-07	
Amber	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 their treatment	<p>Element 1 The ambulance service provides suitable and accessible information on the services it provides and in languages and formats relevant to its service population which accords with the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Race Relations Act 1976 (as amended).</p> <p>Element 2 Patients and, where appropriate, carers (including those with communication or language support needs) are provided with sufficient and accessible information on their individual care, treatment and after care</p>	<p>Website implemented on 25th June.</p> <p>Faith Card</p> <p>EEAST annual report 2006-2007</p>	<p>TRUST website</p> <p>Trust Communications Strategy incorporating guidance from core standard (e.g. Disability Discrimination Act, developing local Communication Support Services and Strategies (DH 2004) include guidance on production of patient leaflets/information?</p> <p>Ensure Annual Report complies with core standard guidance</p> <p>Patient Leaflets</p> <p>EEAST Annual Report 2007/08</p>	Chief Executive	Helen Edmondson	May-07	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber					Awaiting approval of patient leaflets - JS	Trust Communications Strategy incorporating guidance from core standard (e.g. Disability Discrimination Act, developing local Communication Support Services and Strategies (DH 2004) include guidance on production of patient leaflets/information?	Chief Executive	Helen Edmondson	Jul-07	Leaflets drafted by Head of PPI. (HE) Awaiting approval of patient leaflets - (JS) AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber					Annual Report completed	Ensure Annual Report complies with core standard guidance	Chief Executive	Helen Edmondson	Jun-07	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber	17		The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services	<p>Element 1 The ambulance service seeks the views of patients, carers and the local community, including those from disadvantaged and marginalised groups, when planning, delivering and improving services in accordance with Strengthening Accountability, patient and public involvement policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003).</p> <p>Element 2 The ambulance service demonstrates to patients, carers and the local community how it has taken their views into account when planning, delivering and improving services for patients in accordance with Strengthening Accountability, patient</p>	<p>Evidence of PPI annual report that went to June 2007 Board and current work to discuss Strategic Direction with the Forums.</p> <p>Bi monthly meetings with PPI Chair and currently establishing quarterly meeting of CE and Chair with PPI Forum</p> <p>Evidence of current work to discuss Strategic Direction with the Forums.</p> <p>Patient Surveys including OOH</p> <p>Strategic Direction document</p> <p>PPI Annual Report</p>	<p>PPI Strategy</p> <p>Board accountability for Patient / User / Carer / PPI</p> <p>Ongoing dialogue with PPI via Trust PPI Lead (including feedback on declaration comments)</p> <p>Local consultation</p>	Chief Executive	Helen Edmondson	Sep-07	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber					As Above	Board accountability for Patient / User / Carer / PPI	Chief Executive	Helen Edmondson	Sep-07	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN

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Amber				Strengthening accessibility, patient and public involvement policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003).	As Above	Ongoing dialogue with PPI via Trust PPI Lead (including feedback on declaration comments)	Chief Executive	Helen Edmondson	Aug-07	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber	18		Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	<p>Element 1 The ambulance service ensures that all members of the population it serves are able to access its services on an equitable basis including acting in accordance with the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Race Relations Act 1976 (as amended) and the Equality Act 2006.</p> <p>Element 2 The ambulance service offers patients choice in access to services and treatment, where appropriate, and ensures that this is offered equitably.</p>	<p>ASA Multi-Lingual Book</p> <p>Intention to purchase multi-lingual books May and August 2007 E&D Steering Group meetings</p> <p>Staff awareness and information articles in Focus East</p> <p>Equality and Diversity Lead in post</p> <p>Ethnicity Data Collection Forms–Complaints</p> <p>Ethnicity reporting complaints</p> <p>CSOP Positive statement</p> <p>CSOP Equality Impact Assessment</p>	<p>Trust needs to evidence universality of service across area - including engaging local population in Service policies.</p> <p>Review of compliance with guidance related to equity</p>	Director of Operations		Dec-07	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Amber						Review of compliance with guidance related to equity	Director of HR	Sue Wilcox	TBC	AWAITING HCC FINAL ASSESSMENT PRIOR TO RATING - BELIEVE IT TO BE GREEN
Green	20	a	a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation	<p>Element 1 The ambulance service effectively manages the health, safety and environmental risks to patients, staff and visitors, including by meeting the relevant health and safety at work and fire legislation, The Management of Health, Safety and Welfare Issues for NHS staff (NHS Employers, 2005) and the Disability Discrimination Act 1995.</p> <p>Element 2 The ambulance service protects patients, relatives, carers and staff and their property, and the physical assets of the organisation, by ensuring that vehicles are safe and secure</p>	<p>Also refer to 4b regarding vehicle group</p> <p>All sub groups operate to annual work plan agreed at OPG (as specified in TOR). All meetings will be minuted. Specification of vehicles and equipment will be assessed by respective groups to ensure they meet any extant statutory or mandatory requirements (e.g. vehicles BS EN 1789:2000).</p> <p>Medical devices - the Trust will engage a technical review of any proposed new product to be conducted and reported upon by EBME technical specialists. These reports are maintained by the regional operations manager (resources).</p> <p>All working Groups operational and minuted. Operating to an agreed workplan for Trust priorities. British Standards applied, as required to vehicle, equipment and uniform procurement and NHS guidance, as appropriate, (ie., Workwear and Infection Control).</p>	<p>Embedding of OPG and Sub Groups (Vehicle Group) - including work programme and continued compliance with BS EN 1789:2000 Medical Vehicles and their equipment - road ambulances - replacement programme (via PASA and VCA approval)</p>	Director of Operations	Paul Henry	Aug-07	All Working Groups are now operational and minuted. Groups operate to an agreed workplan shown in the minutes of OPG. British Standards applied, as required to vehicle, equipment and uniform procurement and NHS guidance, as appropriate, (ie., Workwear and Infection Control). Minutes of all Workgroup meetings are attached for information.

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Amber						Risk Management - See C7a	Chief Executive	Laila Abraham	Dec-07	Draft security policy complete, awaiting approval prior to dissemination.
Green						Trust wide H&S Committee	Chief Executive	Laila Abraham	Jun-07	Now in place 2 meetings have been held
Green						Health & Safety Strategy	Chief Executive	Laila Abraham	Sep-07	Draft policy completed, awaiting approval
Green						Fire Safety	Chief Executive	Laila Abraham	Jul-07	HS & R Manager has Fire Safety within his responsibilities, Fire Risk Assessments have been undertaken across the whole Trust
Green					New induction programme and approach agreed and implemented Sept07	Review of Corporate Induction Programme (H&S) and evidence of participation	Director of HR	Emma Mynott	Sep-07	H&S covered within Corp Induction (awaiting full details) training records kept for all participants
Green						Evidence of managing Health, Safety & Environmental risks to patients, staff and visitors	Chief Executive	Laila Abraham	Mar-08	Incidents reported through regional and local governance groups
Green						Annual environment assessment at each Trust premises	Chief Executive		Mar-08	
Green	20	b	supportive of patient privacy and confidentiality	Element 1 The ambulance service provides services in environments, including on scene and in vehicles, which are supportive of patient privacy and confidentiality.	CSOP Patient confidentiality CSOPs Standards of Conducts CSOP Use of Photography	Policy to take into account patient privacy and confidentiality and demonstrate action plan/implementation in line with guidance	Clinical Director	Jill Moseley	Aug-07	CSOP published - EqIA completed now complete as reported at Nov IGC

Status	No	Sub	S4BH Text	Elements	Known Actions/policies	Action Plan Suggested Requirements -	Exec Lead	Management Lead Name	Time scale	Update
Green	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	<p>Element 1 The ambulance service has taken steps to ensure its fleet is well designed and well maintained including in accordance with the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and associated code of practice.</p> <p>Element 2 Care is provided in clean ambulances that meet the relevant requirements of The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, 2006) and National guidance and procedures for infection prevention and control: Managing Healthcare Associated Infection & Control of Serious Communicable Diseases in Ambulance Services (Ambulance Service Association, 2004)</p>	<p>Equipment provided are by nature for people by nature however there specific personal cases where the Trust has assessed issues such as hearing deficit and provided stethoscopes with acoustic enhancements for paramedics with that need, OH can advise.</p> <p>Further advice required as to scope of DDA regarding this requirement (patient needs) as vehicles designed with patients in mind who have a range of disabilities (ramps, tail lifts, seatbelt harnesses).</p>	<p>Embedding of OPG and Sub Groups (Vehicle Group) - including work programme to continue compliance with BS EN 1789:2000 Medical Vehicles and their equipment and Disability Discrimination Act, specialist advice required re DDA</p> <p>All working Groups operational and minuted. Operating to an agreed workplan for Trust priorities. British Standards applied, as required to vehicle, equipment and uniform procurement and NHS guidance, as appropriate, (ie., Workwear and Infection Control).</p>	Director of Operations	Paul Henry	Aug-07	<p>Evidence of minutes and work plan</p> <p>Infection Control Policy approved and in place</p> <p>CSOPs regarding Medical Devices approved at Exec Team (16/10/07)</p>
Green					<p>Norfolk and Suffolk has implemented a Local Infection control group with each county being represented. The group is chaired by our occupational health lead for infection control.</p> <p>Essex: Deep clean vehicles every 6 months and RRVs annually. Station cleaning contracts in place. Daily vehicle cleaning by staff.</p> <p>Beds and Herts: previously rolling contract to deep clean vehicles (current position tbc).</p>	Confirmation of cleanliness procedures in operation at Non Depot Stations	Director of Operations	LCOOs	Aug-07	As above. Cleaning procedures have now been issued to all areas.
Green					<p>The production team have prepared a EEAS cleaning procedure for non depot stations, developed in conjunction with OH and based upon new NHS cleaning standards. Draft procedure is now ready for operational review and thereafter to be implemented (now field ops responsibility to approve procedure) and monitored by LCOOs and locality management at non depot stations. As depot program unrolls vehicles will be managed within depot cleaning SOPs.</p> <p>Production team have produced guidance procedures for cleanliness and infection control on vehicles managed at non depot'd stations. These have been developed based on best practice and NHS infection Control/cleaning guidelines. Ops Managers to review. Senior Ops team to approve and monitor implementation and compliance.</p> <p>Cambs - Local Infection Control leads/links now in place. Cambs has now joined Norfolk& Suffolk Infection Control group</p> <p>Essex - attempting every 6 months but very slow progress as fleet capacity a big issue combined with airwave and now CAD test requirements in top of operational performance</p>	Review of process and procedure at non Depot Stations - consolidate best practice of the localities (National Guidance and Procedures for Infection Prevention and Control).	Director of Operations	Paul Henry	Sep-07	
Green					Infection control Policy approved - July IGC	Infection Control Audit Action Plan	Clinical Director	Sally-Jane Gooding	Mar-08	Approved by Trust Board

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Green					Also monitored through IGC	Infection Control Action Plan (including audit) - monitored through Infection Control Group [see C4a]	Clinical Director	Sally-Jane Gooding	Mar-08	Monitored via Trust ICG - mostly completed for this year
Amber	22	a & c	cooperating with each other and with local authorities and other organisations making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction	Element 1 The ambulance service actively works with key strategic partners, such as coronary heart disease implementation groups and emergency care groups, to improve care pathways for patients.		Evidence of partnership working with Cardiac Networks, PCI Networks and any other network groups which focus on care pathways for patients	Clinical Director	Paul Murray / Steve Mortley	Dec-07	Evidence required
Amber	23		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	Element 1 The ambulance service collects and shares data about its patients and services, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served. Element 2 The ambulance service 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.		Collection and analysis of information in line with guidance (link to C22a?)	Clinical Director	John Martin	Dec-07	Trust has appointed member of staff who will have Public Health as part of his remit
Green						Evidence of contribution to disease prevention/health promotion in line with guidance (link to C22a?) eg thrombolysis, stroke, falls?	Clinical Director	John Martin	Dec-07	Trust has appointed member of staff who will have Public Health as part of his remit
Green						Evidence of evaluation of disease prevention/health promotion in line with guidance (link to C22a?)	Clinical Director	John Martin	Dec-07	Has just started work in this area and will report back through Trust ESCG
Green					OH screening - public health messages in Trust publications	Trust policy and practice (review localities) to support health lifestyles amongst workforce in line with guidance and IWL Practice Plus	Director of HR	Tracey Leghorn - operational HR	Sep-07	information within the databases analysed and action plans discussed at locality levels
Green	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	Element 1 The ambulance service has 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 The NHS Emergency Planning Guidance and UK influenza pandemic contingency plan (Department of Health, 2005). Element 2 The ambulance service works 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 Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005, Beyond a major incident (Department of Health 2004) and UK influenza pandemic	In terms of major incident plan the new regional plan including action cards is in final draft waiting final planning team comment. Sign off is scheduled for end October 07. Regional BC plan is work ongoing due for sign off end January 08. Regional Pandemic Flu plan completed, Regional Heat wave plan completed, regional Prison plan completed, Regional winter plan in final draft. All other plans are under review. The Trust will in the mean time operate on the 3 old Trust plans should they be required. All plans are compiled and audited against CCA/DH guidance by the team prior to submission for sign off by the Trust. CBRN training is ongoing in line with the DH national structured approach including new ventilators and escape hood training, records available. All major incident / Decontamination equipment and vehicles are at a state of readiness to deploy. The NHS Emergency Planning Guidance Trust Major Incident and BC Plan (includes action cards) to be signed off by January Board) compliant with guidance. Audited by Civil Contingencies Act Audit team. UK influenza pandemic contingency plan (Department of Health 2005) and UK influenza pandemic	Consolidate locality evidence - Trust Major Incident Plan, Action Cards and Business Continuity Plan to include ongoing compliance with guidance, eg UK influenza pandemic contingency plan (Department of Health, 2005).	Director of Operations	Roy Wallis	Dec-07	Plan/Action Cards EEAST Version 1 Jan 08 CCA preparedness audit - final report 3 previous plans - reasonable assurance that these were compliant. Regional EEAST Flu pandemic plan Aug 07 Reference link to regional HPA Communicable Disease Plan EEAST Business Continuity Plan 30/1/08. Previously 3 plans - NSC signed off and compliant, BH and E first draft. Various example of local, regional and national County training exercises. Contributed to planning of such exercises. Resilience Department Management plan (work plan)

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Green				contingency plan (Department of Health, 2005)	<p>All localities are subject to the regional major incident planning / training programmes in line with the CCA/DH requirement and guidance. I Major incident / command training/exercising is ongoing records available.</p> <p>Civil Contingencies Act 2004, The NHS Emergency Planning Guidance 2005, Beyond a major incident (Department of Health 2004) and UK influenza pandemic contingency plan (Department of Health, 2005)</p> <p>Attend all LRFs (emergency planning managers), support groups and specialist area groups</p> <p>Regional resilience forum (RRF) attended by Head of Resilience and Emergency Planning/Dir Ops</p> <p>RRF support group/specialist areas attended by Head of Resilience and Emergency Planning</p> <p>Examples of the above working groups include health, CBRN, training.</p>	Work programme to include Exercises to test resilience and continuity plans MAJAX plan has been delayed	Director of Operations	Roy Wallis	Ongoing	<p>Minutes from meetings, exercise reports</p> <p>RRF - mass casualty plan exercised and signed off at regional level - commended by CCA audit</p>