History Marking Procedure

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1 Introduction

1.1. In order to fulfil its obligations to staff and patients, it is necessary for South East Coast Ambulance Service NHS Foundation Trust (the Trust) to have in place a system of recording, or marking the addresses, phone numbers and/or other means of identification (e.g. NHS number) of patients/members of the public where this information may be of benefit to their ongoing care or they are known or believed to represent an actual or potential risk to its staff.

1.2. This system ensures that relevant information is passed to ambulance staff called upon to respond to a marked address. This document sets out how those systems are to work.

1.3. History marker applications may come from several sources including staff, partner organisations, law enforcement bodies and other health professionals and each application is reviewed prior to the marker being placed/application declined.

1.4. Applications which have a legal requirement to share such information may not follow this procedure. For example, security alerts.

1.4.1. Markers are colour coded with Red and Amber (cautionary), Green (access and non-clinical) and Blue (clinical) markers.

1.5. A History Marking Group (HMG) exists to review each potential Red or Amber marker application and to validate and reassess markers as required. Applications for Blue and Green markers are reviewed by the EOCIT and placed on the CAD as appropriate. These are reviewed in line with day-to-day business.

1.6. The HMG will comply with the data protection principles and where applicable, the 'Data Protection Good Practice Note: The Use of Violent Warning Markers'.

1.7. This procedure applies to all Operational Ambulance Staff including EOC.

2 Procedure

2.1. This consists of the following elements:

- history marking categorisation system.
- information acquisition
- information/validation and recording
- crew/staff notification.
- data subject notification and rights of appeal
- marker review

2.2. **History Marking Categorisation System**

2.2.1. As outlined above, each marker will be categorised, and colour coded following review:

2.2.1.1. **Red** – Increased risk to staff safety. Identifiable information will be used to record where staff have been physically/sexually assaulted, a serious threat of violence or a victim of hate crime.

2.2.1.2. **Amber** – where information available makes it clear that there is a risk to staff of abusive/aggressive/inappropriate behaviour.

2.2.1.3. **Green** – where there is relevant information available such as how to find/gain access to premises or other information of non-clinical nature to assist staff.

2.2.1.4. **Blue** – where medical/clinical information is available that may affect treatment or referral actions by staff.

2.3. **Actions to be taken on receipt of calls from marked identified information.**

2.3.1. **Red** – Information will be transmitted to crew by Airwave (radio) and Mobile Data Terminal (MDT) where available. A dynamic risk assessment should be undertaken during the call and if a need for police attendance is evident during the call, then this should be requested. Without any identified risk prior to arrival, a further dynamic risk assessment should be undertaken by responding clinicians, considering the information available. This must consider both the potential risk and the nature of the emergency call. A decision to hold off may be made at this time.

2.3.2. **Amber** – Information will be transmitted to crew by Airwave and MDT prior to entering the address. A dynamic risk assessment should be undertaken.

2.3.3. Where a caller from a red or amber marked address becomes abusive or aggressive to an emergency medical advisor, they will be permitted to request assistance from an EMATL in line with normal EOC processes.

2.3.4. Green – Information to be transmitted to crew via MDT or Airwave where MDT is unavailable.

2.3.5. Blue – Information to be transmitted to crew via MDT or Airwave where MDT is unavailable.

2.3.6. It is the responsibility of each responding member of staff to review the MDT on arrival at scene to ensure that information transmitted during transit to the incident is received. In the case SRV's this information should be passed by EOC as per policy.

2.4. **Information Acquisition**

2.4.1. Red or amber markers will be initiated through the History Marker Application/Update Form History Marking Form and a Datix Cloud report must also be completed by the reporting member of staff or via SECAmb staff if the incident involves a Private Ambulance Provider (PAP) crew.

2.4.2. Cautionary information (i.e. information which may constitute the application of a red or amber marker) increases risk to staff safety and will be accepted from intelligence received directly by NHS Protect or Police. This must be in writing.

2.4.2.1. Online History Marking Form found within the SECAmb Zone A to Z directory of Forms.

2.4.2.2. History Marking Forms must be completed when there is any incident involving violence or abusive behaviour to staff and must be completed along with a Datix Cloud report.

2.4.2.3. A History Marking Form must be completed regardless of any current history marker.

2.4.3. Blue or Green markers will be acquired from a variety of sources including, but not exclusively, staff, carers, a patient's lead clinician, care line providers and patients themselves.

2.5. **Information/Validation and Recording**

2.5.1. History Markers will be applied to the address of the patient/attendance. In exceptional circumstances, and where the information can be reliably verified, telephone numbers may also be marked. If there is any doubt of the validity of the marker on a phone number, normal triaging and dynamic risk assessment will have to take place. The EOC Information Team (EOCIT) will utilise the most appropriate option when history marking, with the default position being to mark the patients home address, regardless of where the incident occurred. Where multiple options are available, the method of marking will be decided by the HMG.

2.5.2. The recording process of markers will be managed by the EOCIT. The steps used for dealing with information are listed below. A more detailed flowchart for red and amber markers is at Appendix 3.

2.5.3. The role of the EOCIT includes:

- Application of temporary marker.
- Formal entry on the Computer Aided Dispatch (CAD) system, with the appropriate colour coded category.
- Marker review (at not more than six-month intervals for red and amber markers) by the EOCIT, with escalation to the HMG as required.
- Notify the data subject (i.e. the person whose address has been marked as either Red or Amber) that a record is held unless it is decided by HMG, following discussion at the group, that it is inappropriate to do so (NB This should be used in exceptional circumstances only and the decision making be clearly recorded by the EOCIT).
- Co-ordinating information sent to the data subject where a decision has been reached that the threshold for a marker has not been met, that the occupant

of the address should be notified that behaviours reported by staff is unacceptable and will not be tolerated (i.e. sexualised comments etc.).

2.5.4. **EOCIT Action.** On receipt of a Marker Application/Update Form, the CDA (as above at 2.4.2.1) will add a temporary marker to the system, pending review by the HMG.

2.5.5. **Crew/staff action**: In all cases, the reporting crew/staff member must complete a Datix Cloud Report.

2.5.6. **Clinical.** This information may be provided to the Trust by the patient's lead clinician, the patient, or others. This information will be passed to the appropriate department for action.

2.5.7. **Access/ non-clinical.** This information may come from a wide range of sources. In each case the information received (including the source) will be securely stored using the Trust IT storage system and entered on the CAD.

2.6. **Crew/ Staff Notification**

2.6.1. Staff requesting history markers will in all cases be notified of the outcome of a marker application. If staff are dissatisfied with this outcome, they are entitled to appeal this decision to the HMG via their Operational Manager and this may be reviewed by the HMG if further supporting information is received.

2.7. **Data Subject Notification and Rights of Appeal**

2.7.1. Data subjects have a legal right to know that the Trust is holding information about them, what that information is, and are entitled to appeal against the holding of that information in accordance with Section 10 of the Data Protection Act 1998.

2.7.2. A formal letter will normally be sent to the occupier when a marker is applied to their address unless it is decided by HMG, following discussion at the group, that it is inappropriate to do so. This will detail the reason for the marker and the action the Trust will take on receipt of further emergency calls, because of the marker.

2.7.3. The data subject may consider that they are experiencing a data protection problem if any of the following apply to them:

2.7.3.1. They have been denied any of their rights, including their right to see the personal information an organisation holds about them.

2.7.3.2. Personal information about them is used, held or disclosed:

- unfairly
- for a reason that is not the one it was collected for
- without appropriate security

2.7.3.3. Personal information about them is:

- inadequate, irrelevant or excessive
- inaccurate or out of date
- kept for longer than is necessary.

2.7.4. Should any of the above concerns be the case the data subject may contact the Complaints Team at South East Coast Ambulance Service NHS Trust Headquarters, and explain the area of concern/complaint.

2.7.5. Should the data subject find they cannot accept the decision of the Trust, they must be advised to take their concern/complaint to the office of the Information Commissioner.

2.7.5.1. The Information Commissioner's office can be contacted via:

- www.ico.gov.uk
- Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF
- 08456 306060 ('Local Rate')
- 01625 545745 ('National Rate')

2.7.5.2. In exceptional circumstances the data subject will not be notified that the history marker has been placed against their address/phone. This will be decided by the HMG and will include circumstances whereby it is reasonably believed that notification will increase the risk to any attending staff i.e. following where extension/renewal of a marker has taken place and risk levels are high. The reason will be recorded on the action points from the meeting.

2.8. **Appeals Procedure**

2.8.1. There is an appeals panel consisting of 3 people, one of which would normally be the chair or the vice chair of the History Marking Group.

2.8.2. Wherever possible, appeals will be submitted in writing. Where appellants are unable to do this due to visual impairment, language barriers, learning disability etc., other forms of representation will be accepted.

2.8.3. The panel will consist of the following members;

- The Chair/Vice Chair of the History Marking Group.
- An OUM.
- The Caldecott Guardian or their nominated Deputy.

In addition, the following member is present to support the appeal process;

- A member of the EOC Information Team.

2.8.4. Upon receipt of an appeal from a data subject, an acknowledgement will be sent back within 2 working days of receipt by the Complaints/PALS Team and a resolution must be reached by the appeals panel within 21 days.

2.8.5. Minutes of the appeals meeting to be presented to the History Marking Group at the following meeting and a spreadsheet of all appeals are to be maintained by the EOC Information Team.

2.8.6. The appeals panel will consider all the relevant information, including any new information provided by the appellant, and make a decision based solely on the facts of the case, keeping the safety and security of both the patient and Trust staff at the forefront of this process.

2.9. **Marker Review**

2.9.1. All temporary markers and applications for markers will be reviewed by the HMG using appendices 2, 3 and 4 monthly.

2.9.2. All records will be anonymised before review.

2.9.3. Each red and amber marker is valid for six months only, at which time it will be reviewed by the EOCIT who will decide whether the marker is to be retained, reclassified or removed.

2.9.4. A flowchart of the decision process is included at Appendix 3 and 4.

2.9.5. Blue markers determined by the HMG will be reviewed every 12 months by the EOCIT.

3 Definitions

3.1. History marking is the process whereby information is obtained, validated and stored on a database, for onward transmission to ambulance resources despatched to an address about which information is held.

3.2. Data subject is the individual referred to by a history marker.

4 Responsibilities

4.1. The Chief Executive Officer is the responsible officer for all safety and security matters within the Trust.

4.2. Implementation responsibility lies with the Director of Operations who is responsible for ensuring that all Emergency Operations Centre and operational staff are familiar with the policy and procedures for dealing with patients and members of the public who are subject to the history marking process.

4.3. The Operations Managers have devolved responsibility for ensuring that all operational staff are familiar with the History Marking Policy & Procedure.

4.4. The Emergency Operations Centre Managers have devolved responsibility for ensuring that all Emergency Operations Centre staff are familiar with the History Marking Policy & Procedure.

4.5. The EOCIT is responsible for managing and maintaining records pertaining to the history marking.

4.6. Responsibility for the review of markers, at the appropriate time, lies with the EOCIT.

5 Competence

5.1. The Trust will ensure at local level all staff are competent in completion and admission of the history marking process.

6 Equality Analysis

6.1. The Trust has undertaken an Equality Analysis (EA) and those consulted were assured that a review of each application for a marker would be undertaken by the HMG.

6.2. Due regard is given to the link between this policy and the need for protocols to capture the incidence of hate crime, linked to protected characteristics, directed at Trust staff e.g. Racial abuse. The EA also identified positive impacts on those with the protected characteristics of Age, Disability, Gender reassignment and Pregnancy and maternity.

6.3. The possible negative impact of the system identifying addresses rather than individuals has been noted. At this stage limited alternative systems are available and this will continue to be monitored for development, as part of the EA Action Plan. In the meantime, it is considered that the policy seeks to balance risk and proportionality – risk to patient care against our statutory duty to provide a safe working environment for our staff.

7 Monitoring

7.1. The HMG has been established to:

7.1.1. reduce the risk of harm to staff and patients.

7.1.2. appropriately share information regarding risk where known. To ensure fairness and consistency based on the information provided to the HMG.

7.1.3. supply staff with the appropriate information to help inform their dynamic risk assessment.

7.1.4. assist in improving patient outcome and experience.

7.2. HMG will report to the appropriate working group which monitors compliance, in line with the trust's reporting agenda framework.

8 Audit and Review

8.1. The HMG will be responsible for considering requests for inclusion on the database and for periodic review of those records already held.

9 References

9.1. The Health and Safety at Work Act 1974

9.2. The Data Protection Act 1998

9.3. The Human Rights Act 1998

9.4. Data Protection Good Practice Note: The use of violent warning markers 2006

Section 2.12 – Reference Information

DCB 0129 and DCB 0160 are two standards issued by NHS Digital.
DCB 0129 applies to the manufacturers of health IT systems whereas DCB 0160 applies to the healthcare organisations implementing them.

They require manufacturers of health IT systems and healthcare organisations to carry out a particular type of risk assessment on the product This process determines whether or not the product is acceptably safe to go live. The requirements in the two standards are almost identical.

The organisation must:

1. Nominate a clinical safety officer
2. Define and document clinical risk management processes
3. Carry out a risk assessment and document that in a Hazard Log and Safety Case
4. Conduct clinical risk management activities during live service to keep the safety case up to date

1) Cloud Service Considerations

This section requires completing if a 'Cloud' based solution is involved.

This is not applicable as the process is managed in house. The data is stored on secure SECAmb servers with full RBAC in place

Question		Response	Comment
3.1	Why is a cloud based solution being considered over an in-house solution?	Provide details in comments section:	N/A

3.2	What type of data will be hosted in the cloud?	Provide details in comments section:	N/A
3.3	Will the cloud service be hosted on the N3 network?	Provide details in comments section:	N/A
3.4	What measures have been put in place in the event of the service provider ceasing to operate?	Provide details in comments section:	N/A
3.5	Has an assessment of the cloud service providers financial position and solvency been performed?	Provide details in comments section:	N/A
3.6	What measures have been put in place to repatriate data from the asset in the cloud service back to the Trust, at the end of the service contract?	Provide details in comments section, including any additional infrastructure requirements and associated costs to the Trust:	N/A
3.7	Has the legal team been consulted regarding the legal ownership of any data that is uploaded to the asset in the cloud service?	Provide details in comments section:	N/A
3.8	What security measures are in place for the asset in the cloud service, including protection from cyber security attacks, control of user access to the data,	Provide details in comments section:	N/A

	secure transfer of data between the cloud service provider and the Trust?		

2) Data Flow

This section describes the data owners and processors, and the flow of data between them.

History marker applications can be submitted from several sources including SECAmb staff.
External applications are received via email – see below*.

SECAmb staff can access the MS Form direct via the forms section on the intranet or via their Trust enabled iPad

*These may also come from partner organisations, law enforcement bodies and other health professionals, and sometimes from the data subject themselves, via email using a generic email address. Access to this email is only possible through allocation of RBAC by the folder 'owner'.

The information entered MS forms and received via email is extracted daily onto our History Marking Spreadsheet by a Clinical Data Assistant/member of the History Marking Team.

Markers are colour coded with Red and Amber (where there has been an incident of assault/aggression/abuse), Green (access and environmental information). A temporary marker is placed on the data subject and address at this time of application. However, this will be reviewed and confirmed later by the History Marking Group.

A History Marking Group (HMG) exists to review each potential Red or Amber marker application and to validate and reassess markers as required. Information of this nature is compiled to form an agenda for this meeting. A temporary marker will be applied, if this has not already been completed by EOC, for the purposes of staff and patient safety in the interim period.

Applications for Green markers are processed by the Clinical Data Assistant/History Marking Team and a marker is placed on the CAD. These are reviewed in line with day-to-day business.

The membership of the History Marking Group receives an appropriately redacted agenda and discusses each incident in turn within the meeting. This meeting includes representatives from EOC, Safeguarding, Frequent Caller Team, Staff Side Representatives, and Patient Representatives. The decision made is recorded within the minutes of the meeting which are presented in 2 separate formats.

1. Full meeting minutes unredacted, are provided to the Trust Security Team monthly

2. Redacted meeting minutes are forwarded to meeting attendees

Both types of meeting minutes are held within the IBIS team in a secure folder.

After the meeting, the decisions are actioned by a member of the History Marking Team, and a letter is sent to notify the data subject of the decision, unless the meeting has decided that such a letter would be inappropriate. This decision is rarely taken and is only applied if the panel feels that it would exacerbate a situation or place someone in danger. The data subject is notified of their rights of appeal within the letter.

Each red and amber marker is valid for six months only. If there have been no further incidents reported after that time, Red markers will be downgraded to Amber for another six months, and then removed. Amber markers can be removed after 6 months. Green Markers are curated daily as part of our process.

The record of the incident is kept within the spreadsheet, to aid future decision making.

3) Risk Management

An essential element of the DPIA process is the assessment of risks, and identification of actions that will mitigate the risk from occurring or make the situation acceptable if the risk materialised. Record any new risks identified from performing the DPIA here.

Description	Consequence on the data subject of the risk occurring (1-5)	Likelihood of the risk occurring (1-5)	Scor	Is the risk Accepted or Mitigated – give details	Consequence following mitigation (1-5)	Likelihood following mitigation (1-5)	Scor
History Making letter This is addressed to the 'Occupier' at the address which has been history marked. The Trust could inadvertently be causing a data breach if there is more than one indivdual within the household and the letter is addressed to the Occupier.	**3**	**3**	**6**	**Mitigated** History marking letters have now undertaken a full review and update following engagement with Trust Legal Services and IG portfolios.	**2**	**2**	**4**

Also, this may not be the current address, therefore the receipt of information may cause distress to the recipient if they are not the patient.				These were approved 15/09/2021			
History Marking Policy and Procedure Historic Trust Policy and Procedure is currently being reviewed and updated. This quoted former data protection legislation and require complete review update. This action is to be undertaken by History Marking lead with full collaboration with Legal Services and IG portfolios prior to formal approval.	**2**	**2**	**4**				

4) References

List any policies, procedures, guidance or legislation referred to within the DPIA here:

UK General Data Protection Regulation
Data Protection Act 2018
Common Law Duty of Confidentiality
NHSx Records Management Code of Practice 2021
Legitimate Interest Assessment form (ICO best practice)

Appendix 1 - History Marking Application/ Update Form

Background

This form must not be used to raise unsubstantiated issues, or to provide an opinion about a patient or place. Please consider whether an IWR-1 or Safeguarding Referral is more appropriate.

In regard to clinical information about patients, community professionals share information with SECAmb by uploading it directly to IBIS themselves. Therefore, crews should contact the patient's own case manager (e.g. GP or Specialist Team) and ask them to add the patient to IBIS in the first instance.

Any clinical information that is provided using this form will be clinically reviewed. If it is deemed suitable it may be uploaded 'internally' onto IBIS. As SECAmb do not case manage patients this will be reviewed / removed after 6 months.

This form should not routinely be used in your normal process of referral or discharge of non-conveyed patients.

Please ensure the form is comprehensively completed. Incomplete forms will be returned to originator and not processed.

Mandatory fields are marked*

Nature of Request

ACCESS / ENVIROMENTAL INFORMATION (Green Marker)	VIOLENCE / PHYSICAL ATTACK THREAT OF VIOLENCE VERBALLY ABUSIVE (Red / Amber Marker)	CLINICAL INFORMATION (Blue Marker / IBIS)
Complete Sections A ☐ B ☐ C ☐ **Click box to check off**	Complete Sections A ☐ B ☐ D ☐ **Click box to check off**	Complete Sections A ☐ B ☐ E ☐ **Click box to check off**

Section A – Patient/Subject Demographic information	
First Name*	
Last Name*	
Known as (if applicable)	
Date of Birth*	
Gender*	-- Select --
Phone number (used to call 999)	
NHS Number (May delay processing if absent)	
House Name / Number*	
Address*	
Postcode*	
Name of GP*	
GP Surgery*	

Section B – Operational Information	
CAD Reference (Last Incident)**:**	**Date** (Last Incident)**:** **Call Time** (Last Incident)**:**
Call sign (Clinician completing form)**:**	
Requesting Clinician 1*:	**Requesting Clinician 2:**

Section C – Access / Environmental Information
Non clinical information
To be completed for information such as: • Difficult access and egress arrangements • Key safe (location & code) • Environmental hazards (animals, nature of property, hoarding behaviour) **Type in shaded area – text box will automatically expand – 500 characters**

Section D – Violence / Physical Attack, Threats, Verbal abuse & Inappropriate Behaviour

Violence / Physical Attack	Threat of Violence	Verbally Abusive	Sexually Inappropriate
☐	☐	☐	☐
Click box to select	**Click box to select**	**Click box to select**	**Click box to select**

IWR-1 Reference Number* (Must be provided) **:**

Detailed description of actual incident occurred*

Please be specific and ensure the following is documented:

- If the patient assaulted you, was it clearly intentional?
- If the patient used foul language, document exact wording used.
- Was language directed at yourself or generalised?
- Was the patient under the influence of drugs or alcohol?
- What triggers, if any do feel potentially caused this behaviour.
- Any clinical information that may have been a factor in the behaviour?

Type in shaded area – text box will automatically expand – 10000 characters

Section E – Clinical Information	
Imperative clinical conditions (*Diagnosed, relevant to clinical history or potential future presentation to SECAmb*) ***Please use bullet points***	• • • • •
Allergies (if known)	
Is this patient a defined Frequent Caller? **Must be Over 18 <u>Only if</u> 5 or more calls in last 1 month or 12 or more calls in last 3 months**	○ Yes ◉ No
Clinical History and Associated Risks	
Reason why future SECAmb attendance may benefit from additional clinical information: **Type in shaded area – text box will automatically expand – 5000 characters**	

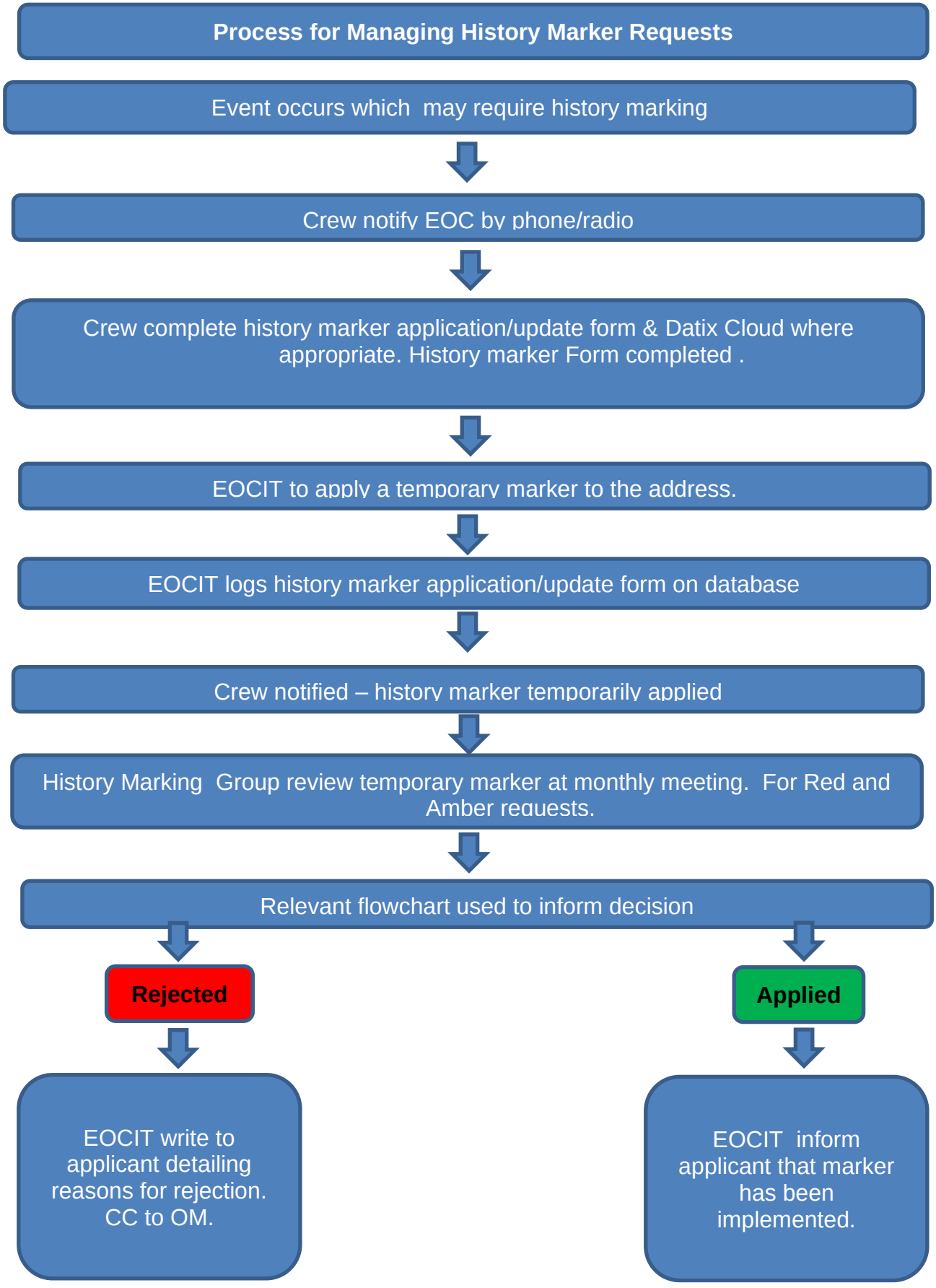
Actions

1. Ensure that Datix Cloud has been completed for all requests in relation to violence or aggression and that Datix Cloud reference number is included as above. Forms will not be processed without this information.
2. Ensure any clinical information provided is factual, relevant and without unsubstantiated opinion.
3. Attach form to an email (use @secamb.nhs.uk or NHS.net email only), ensuring that subject line states patient name and date of birth. Send to History Marking email address history.marking@secamb.nhs.uk

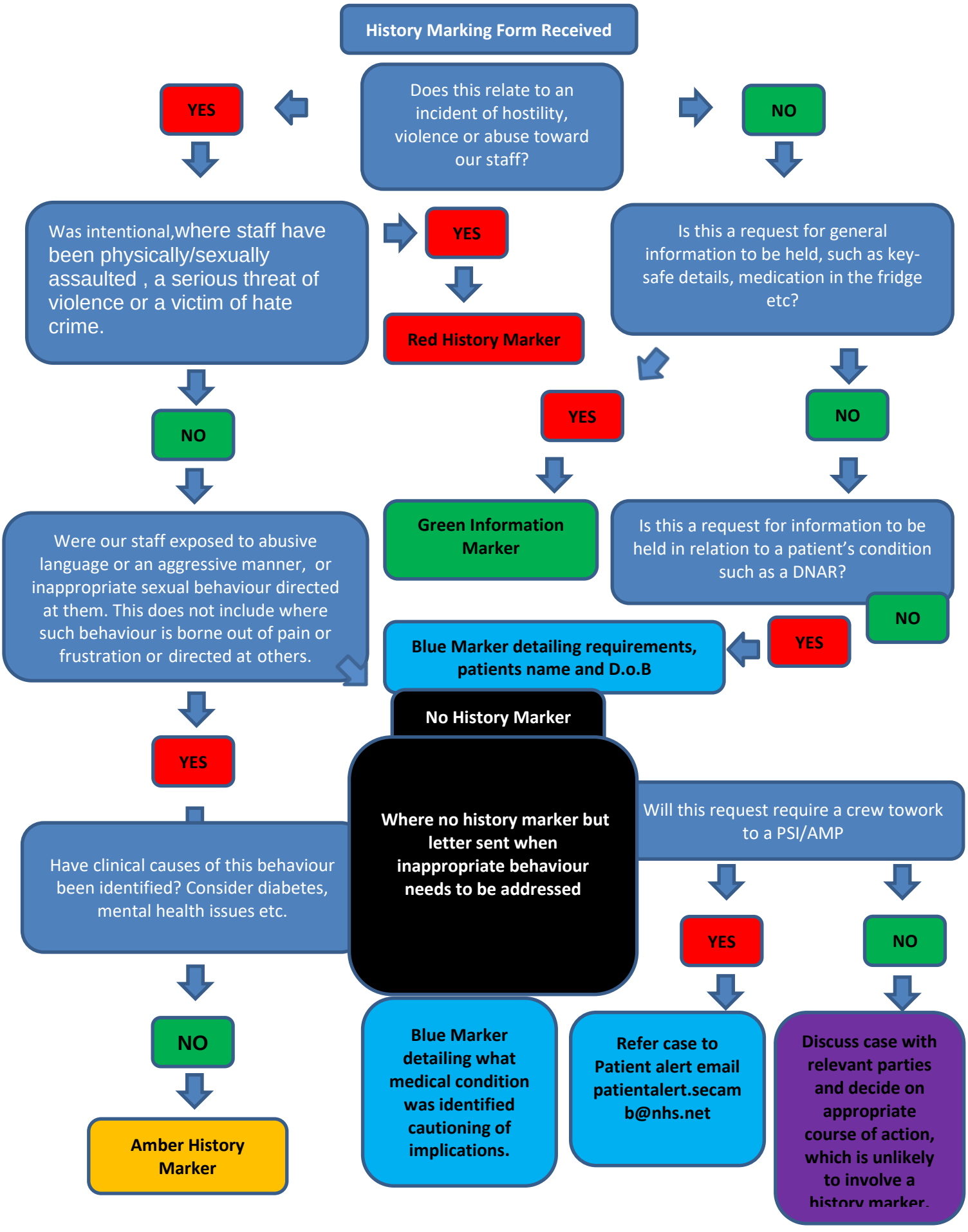
V5.01

South East Coast Ambulance Service NHS
NHS Foundation Trust

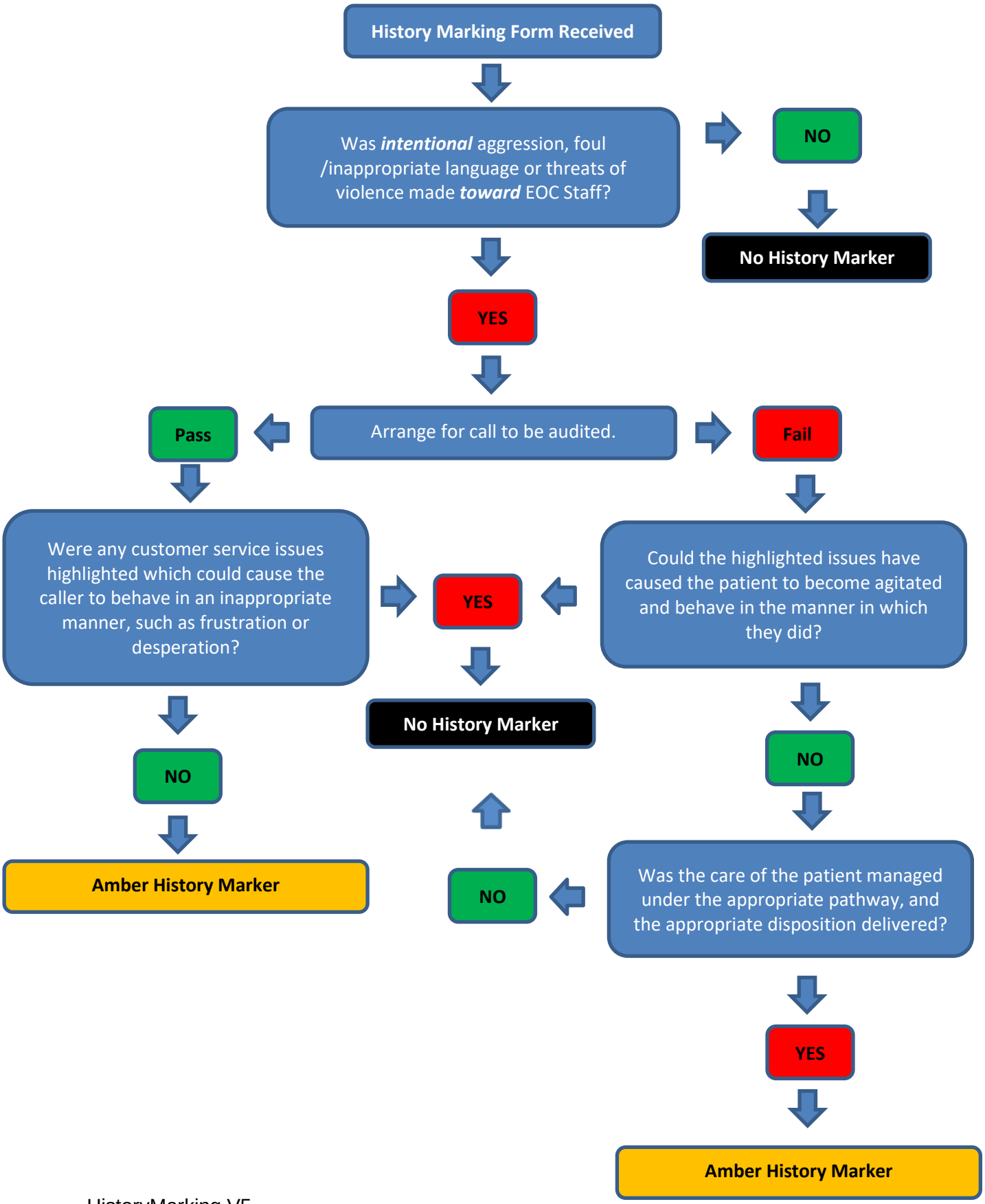
Appendix 2 – Process for requesting History Marker



Appendix 3: Front Line Decision Chart



Appendix 4 – EOC Decision Chart



Appendix 5 - Terms of Reference

History Marking Group

Terms of Reference

1. Constitution

2. Purpose

2.1. The Group is responsible for the implementation and monitoring of the Trust's history marking process identified within the History Marking Procedure underpinned by the History Marking Policy.

2.2. The primary function of the group is to consider information received in relation to patients and other parties to enable:

- Clear guidance and information can be shared with crews and dispatchers
- The most appropriate treatment to be provided utilising patient-specific protocols
- Protection of staff
- Protection of the Trust
- Protection and safeguarding of patients
- Data subjects are advised as to the information the Trust holds about them and its implications for potential future contact/treatment
- That statutory obligations and national guidance are met.
- Appropriate information is available to staff in relation to patients' End of Life status

3. Membership

3.1. The membership comprises:

- Operations Manager - Chair
- IBIS Lead Manager - Vice Chair
- Safeguarding Lead
- Staff-side representative)
- Patient Experience Lead
- EOC Information Team
- Patient/Public Representative
- Police representative
- Frequent Caller Lead
- EOC Representative

3.2. Other Trust managers and staff may be invited to attend the Group as determined by the agenda and matters arising.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Group shall be 5.

5. Attendance

5.1. The EOCIT will provide relevant information to the group.

5.2. Members unable to attend a meeting are required to send a fully briefed deputy.

5.3. The Chair of the Group will follow up any issues related to the unexplained nonattendance of members. Should non-attendance jeopardise the functioning of the Group the Chair will discuss the matter with the members and if necessary, seek a substitute or replacement.

6. Frequency

6.1. Meetings of the Group will normally be held every month. Extraordinary meetings may be called between regular meetings to discuss and resolve any critical issues arising.

7. Authority

7.1. The Group has no executive powers.

7.2. The Group is authorised by the Board to review and make recommendations regarding the use and effectiveness of the History Marking Policy and Procedure. It is authorised to seek any information it requires from an employee and all employees are directed to cooperate with legitimate requests made by the Group.

7.3. The Group is authorised by the Board to request outside legal or other independent professional advice via the relevant Committee, and to secure the attendance of experts with relevant experience if it considers this necessary.

8. Duties

8.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

8.1.1. Review of temporary history markers, categories or rejecting them. Ensuring that any risks to the Trust are appropriately escalated and placed on the Trust risk register as required.

8.1.2. Identification of vulnerable person’s concerns are referred to the safeguarding team.

8.2. This is not an exhaustive list, and the group will be responsible for other History Marking issues as required.

9. Reporting

9.1. The Group shall be directly accountable to the IUC 111/999 SLT.

9.2. The Chair of the Group shall report any significant issues that require escalation to the IUC 111/999 SLT.

10. Support

10.1. The Group shall be supported by, and duties shall include:

10.1.1. Agreement of the meeting agendas with the Chair of the Group.

10.1.2. Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings.

10.1.3. Providing a disciplined timeframe for agenda items and papers, as below:

i. At least twelve working days prior to each meeting, agenda items will be due from Group members.

ii. At least seven working days before each meeting, papers will be due from Group members.

iii. At least five working days prior to each meeting, papers will be issued to all Group members and any invited directors, managers and officers.

10.1.4. Recording formal minutes of meetings and keeping a record of matters arising, actions and issues to be carried forward, circulating approved draft minutes within five working days from the date of the last meeting.

11. Review

11.1. The Group will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

11.2. The Group shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Clinical Group for approval.

11.3. These Terms of Reference shall be approved by the IUC 111/999 SLT and formally reviewed at intervals not exceeding two years.

Review Date: February 2024

Appendix 6 - Compliance Reporting

1 The HMG will provide any reports in relation to compliance to the IUC 111/999 SLT as requested.

2 Where the IUC 111/999 SLT has concerns over the reporting process, or the contents of a report, the chair of the IUC 111/999 SLT will first pursue the matter with the chair of the HMG. This does not at any time override the right of the IUC 111/999 SLT to seek to vary the status of the process on the Trust Risk Register.