Clinical Outcome Indicator Policy and Procedure

Contents

1 Statement of Aims and Objectives

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to providing high quality patient care.

1.2. This policy and procedure defines the processes undertaken within the Trust to collect National Ambulance Clinical Outcome Indicator (COI) data for the purposes of quality assurance, clinical audit, and improvement.

1.3. The document is intended to enable:

- A consistent approach to data collection and processing.
- Quality assurance of data collection against the National Health Service (NHS) England (NHSE) and National Ambulance Service Clinical Quality Group (NASCQG) Clinical Outcome Indicator (COI) guidance (including when this guidance is amended).
- To provide governance to the Trust for retrospective amendments to COI data.

2 Principles

2.1. This document:

- Details the activity required to ensure high quality data that ensures patients cared for by the Trust when presenting within a National Audit patient care group, currently ST-Elevation Myocardial Infarction (STEMI), stroke, cardiac arrest (and return of spontaneous circulation (ROSC), or falls (in pilot only), receive effective clinical care.
- Focusses only on COIs as set by NHSE and the standards as defined by NHSE and the NASCQG.
- Defines how COI data should be used, including for local continuous improvement, reporting to Trust Board, and reporting to NHSE.
- Describes business as usual processes.

2.2 The standards and patient groups for data collection will be set by NASCQG and NHSE. Data will be collected in line with the local definitions as described in this document. These definitions detail how the national standards are applied to the Trusts patient clinical record systems.

2.3 Clinical audit falls under the banner of direct patient care when carried out by a registered clinician or by a non-registrant under the supervision of a registered clinician.

2.4 Data processing takes place under the following legal bases:

- GDPR Article 6(1)(e) – ‘the performance of a task carried out in the public interest’.

- GDPR Article 9(2)(h) – ‘medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems’.
- Special category 9(2)(i) – ‘public interest in the area of public health’.

2.5 Clinical audit data is recorded on the Trust’s information asset register. The Associate Director, Quality & Compliance is the Information Asset Owner, and the Head of Health Informatics & Records is the Information Asset Administrator.

2.6 Electronic Patient Care Record (ePCR) and validation of data from scanned paper care records facilitates automation of a proportion of COI data collection. This includes decisions to include or exclude records from samples and compliance decisions (for example, if oxygen administration is recorded on the ePCR, that element of a care bundle is automatically determined to be compliant). All automation should be tested before implementation and should produce a margin of error of no greater than 1%. CAQSG will be made aware of any system design features that produce a margin of error and will consider the impact of this against resource requirements for audit and business needs.

3 Definitions

Cardiac Arrest Data

3.1 Delivery of early access, early Cardio-Pulmonary Resuscitation (CPR), early defibrillation and early Advanced Life Support (ALS) is vital to reduce the proportion of patients who die from out of hospital cardiac arrest.

3.2 Ambulance services supply monthly incident-level data to the Out of Hospital Cardiac Arrest Outcomes (OHCAO) registry at Warwick Medical School. From April 2018 data, they have expanded this supply, so that Warwick Medical School can calculate and supply the data items in Section 2 in a single file to NHSE. Ambulance services also supply the count R0n to NHSE via OHCAO (Out of Hospital Cardiac Arrest Outcomes).

3.3 Cardiac arrest count (R0n) - count of all cardiac arrest patients receiving an organised Emergency Medical Services (EMS) response; whether resuscitation attempted, continued, terminated, or not attempted. Exclude successful resuscitation before arrival of EMS.

3.4 ROSC (R1n, R1r, R2n, R2r) - recording of return of spontaneous circulation (ROSC) on arrival at hospital indicates the outcome of the pre-hospital response and intervention.

- R1n - The number of patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest.
- R1r - Of patients in R1n, the number who had ROSC on arrival at hospital.
- R2n – Utstein: The number of patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was Ventricular Fibrillation (VF) or pulseless Ventricular Tachycardia (VT).
- R2r - Of patients in R2n, the number who had ROSC on arrival at hospital.

3.5 Survival at 30 days (R6n, R6s, R7n, R7s)

- R6n - The number of patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest during the month in question. Exclude patients for whom survival at 30 days is not known; for example, those unavailable via the Summary Care Record application (SCRa). R6n may therefore differ from R1n.
- R6s - Of patients in R6n, the number who, at least 90 days after the date of arrest, have no date of death, or have a date of death more than 30 days after the date of arrest.
- R7n - Utstein: The number of patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of hospital cardiac arrest, during the month in question, of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or pulseless VT. Exclude patients for whom survival at 30 days is not known; for example, those unavailable via the Summary Care Record application (SCRa). R7n may therefore differ from R2n.
- R7s - Of patients in R7n, the number who, at least 90 days after the date of arrest, have no date of death, or have a date of death more than 30 days after the date of arrest.

3.6 Post-ROSC care bundle (R5n, R5b) - First produced for April 2018. NHSE collect and publish R5n and R5b data for January, April, July, and October, however SECAmb currently submit data monthly aligned with the data submitted through Warwick University.

- R5n - The number of patients who had resuscitation (Advanced or Basic Life Support) commenced / continued by ambulance service following an out-of-hospital cardiac arrest and had ROSC on scene. Exclude Traumatic Cardiac Arrest, patients successfully resuscitated before the arrival of ambulance staff, ROSC achieved en-route or upon arrival at hospital, and patients aged less than 18 years.
- R5b - Of patients in R5n, the number who received the post-ROSC care bundle. If, for any component, no exceptions apply, and the component is not delivered, then the care bundle is not delivered, and the case should be included only in R5n If each component is

either met or has a valid exception, the care bundle is delivered, and the case should be included in R5b and R5n.

3.7 Equipment failure, or presence only of non-registered staff on-scene, are not acceptable exceptions for any of these post-ROSC care bundle components. If time of ROSC lost is unknown, it should be assumed that ROSC <10 minutes.

Component of post-ROSC care bundle	*Exceptions*	*Comment*
12 lead Electrocardiogram (ECG) taken post-ROSC	• Patient refusal • Patient re-arrested with ROSC < 10 minutes in duration	If patient in arrest on arrival, should assume 12 lead ECG is post-ROSC
Blood glucose recorded post-ROSC	• Patient refusal • Patient re-arrested with ROSC < 10 minutes in duration • Blood glucose measured prior to ROSC and within normal range	If blood glucose pre-ROSC is below normal range then a subsequent blood glucose is required
End-tidal CO_2 reading / waveform recorded post-ROSC / continuously	• Patient refusal • Patient re-arrested with ROSC < 10 minutes in duration • Not required: no advanced airway in situ	
Oxygen administered post-ROSC / continuously	• Patient refusal • Patient re-arrested with ROSC < 10 minutes in duration • Not required: oxygen saturations were 94-98% (88-92% if chronic obstructive pulmonary disease)	
Systolic blood pressure reading recorded post-ROSC or, if unobtainable, presence of radial pulse documented	• Patient refusal • Patient re-arrested with ROSC < 10 minutes in duration	
Administration started of a 250ml bolus of saline fluids post-ROSC	• Patient refusal • Patient re-arrested with ROSC < 10 minutes in duration • Not required: systolic blood pressure > 90 or presence of radial pulse where blood pressure is unobtainable, evidence of significant heart failure or hypervolemia clearly documented • All attempts to gain intravenous and intraosseous vascular access are unsuccessful	A flush of 10ml is not considered as fluids administered.

STEMI Data

3.8 Data for items M1n, M3n, M3m, and M390 are compiled and sent by ambulance services and acute NHS trusts to the Myocardial Ischaemia National Audit Project (MINAP) at the National Institute for Cardiovascular Outcomes Research (NICOR), who then send a combined file to NHSE. M1n, M3n, M3m, and M390 superseded STEMI indicators SQU03_5_2_1 and SQU03_5_2_2, which NHSE last collected for October 2017.

3.9 MINAP data should exclude patients:

- less than 20 years of age or with age not recorded
- where the call time, hospital arrival time or angiography time are not available or not realistic (time periods less than zero or more than 1000 minutes)
- already in hospital, repatriated after coronary intervention, self-presenters, inter-hospital transfers, and any other or unknown admission methods
- with cardiac arrest before arrival at hospital.

3.10 STEMI Time to pPPCI (M1n, M3n, M3m, and M390):

- M1n – The number of patients in the Myocardial Ischaemia National Audit Project (MINAP) directly admitted after transportation by an ambulance service in England, with a hospital admission date in the month in question, and an initial diagnosis of "definite Myocardial Infarction (MI)".
- M3n - The number of patients in M1n who have primary percutaneous coronary intervention (PPCI).
- M3m - For patients in M3n, the mean average time from call for help (999 call connect time) until catheter insertion for angiography.
- M390 - For patients in M3n, the 90th centile time from call for help (999 call connect time) until catheter insertion for angiography.

3.11 STEMI care bundle (M4n, M4b) - Items M4n and M4b are supplied by ambulance services to NHSE via SDCS. From 2018 NHSE will only collect and publish M4n and M4b data for January, April, July, and October

- M4n -The number of patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG.
- M4b - Of patients in M4n, the number who received the STEMI care bundle. If, for any component, no exceptions apply and the component is not delivered, then the bundle is not delivered, and the case should be included only in M4n. If each component is either met or has a valid exception, the bundle is delivered, and the case should be included in M4b and M4n.

Component of STEMI care bundle	*Exceptions*
Aspirin given	• Patient refusal • Contraindication to drug • Cautions if clear reasons provided • Doctor (for example GP or cardiologist) advised not to provide aspirin (General Medical Council number provided)
Glyceryl trinitrate (GTN) given	• Patient refusal • Contraindication to drug • No chest pain
Two pain scores recorded	• Patient refusal • Patient unable • Patient unconscious
Appropriate analgesia given – options available are Morphine, Entonox and Paracetamol	• Patient refusal • Patient not in pain • Contraindication to drug(s) • Cautions if clear reasons provided

Stroke Data

3.12 Stroke records are supplied by ambulance services and acute trusts to the Sentinel Stroke National Audit Programme (SSNAP), who then send aggregated data to NHSE.

3.13 Stroke: time to hospital arrival (K1 items) - The K1, K2, and K3 data items superseded data items SQU03_6_1_1 and SQU03_6_1_2, which NHSE last collected for October 2017.

- K1n - From April 2019 data onwards, K1n is the number of patients, transported by an ambulance service, and notified to SSNAP by acute trusts as having had a confirmed stroke. Acute trusts must have supplied sufficient information to SSNAP for the ambulance service to locate the patient in their records and supply the call time.
- Up until March 2019, K1n was the number of FAST positive or suspected stroke patients assessed face to face by the ambulance service, including patients with a previous stroke or TIA who had a new onset of symptoms. K1m For patients in K1n, the mean average time from call connect to hospital arrival.
- K150 - For patients in K1n, the median time from call connect to hospital arrival.
- K190 - For patients in K1n, the 90th centile time from call connect to hospital arrival. For K1 items, hospital arrival time is that supplied by the ambulance service to SSNAP.

3.14 Stroke: time to CT scan (K2 items)

- K2n - Number of stroke patients in SSNAP, transported by an ambulance service, with a hospital admission date in the month in question, where the stroke is recorded by SSNAP as having occurred before hospital arrival, who had a Computerised Tomography (CT) scan. Exclude patients with a final diagnosis of TIA.
- K2m - For patients in K2n, the mean average time from hospital arrival to CT scan.
- K250 - For patients in K2n, the median time from hospital arrival to CT scan.
- K290 - For patients in K2n, the 90th centile time from hospital arrival to CT scan. For K2 items, incidents with more than 1000 minutes from hospital arrival to CT scan are excluded. For K2 and K3 items, hospital arrival time is currently as recorded by the hospital. However, a date will be agreed when this will change to the time recorded by the ambulance service. Testing is ongoing during 2019 for ambulance services to supply their time of arrival to SSNAP.

3.15 Stroke: time to thrombolysis (K3 items)

- K3n - Number of stroke patients in SSNAP, transported by an ambulance service, with a hospital admission date in the month in question, where the stroke is recorded by SSNAP as having occurred before hospital arrival, who had thrombolysis. Exclude patients with a final diagnosis of TIA.

- K3m - For patients in K3n, the mean average time from hospital arrival to thrombolysis.
- K350 - For patients in K3n, the median time from hospital arrival to thrombolysis.
- K390 - For patients in K3n, the 90th centile time from hospital arrival to thrombolysis

Pilot and New COIs

3.16 NASCQG in liaison with NASMED (the National Ambulance Service Medical Directors) will occasionally request to retire and/or introduce new COIs. A representative from the Trusts Health Informatics Team attends quarterly national meetings where such changes are discussed and will also represent the Trust on any national technical guidance groups.

3.17 Once a change has been through national approval processes, details are shared with the Trusts Health Informatics team who then cascade through CAQSG.

3.18 A Falls diagnostic bundle is currently being piloted nationally. The data sample is 300 patient care records across the month, or all if fewer than 300.

- The numerator is: Patients ≥ 65 who have suffered a fall from below 2 metres and have been discharged on scene who have received an appropriate care bundle.
- The Denominator is: Patients ≥ 65 who have suffered a fall from below 2 metres and are discharged on scene.

3.19 If, for any component, no exceptions apply and the component is not delivered, then the bundle is not delivered, and the case should be included only in the denominator group. If each component is either met or has a valid exception, the bundle is delivered, and the case should be included in both the numerator and denominator group.

	≥ 65 Falls Metrics	Exception
F1	Detailed physical examination documented? *Exam to include more than one assessment (e.g. head, ribs, spine, hips, limbs, abdomen (trauma), skin integrity)*	• Patient refusal
F2	Detailed medical history recorded? Sub-elements: • History of falls • Description of events preceding fall	• Patient refusal • History not known to patient/carer
F3	Current medication documented?	• Patient refusal
F4	Observations recorded? • Pulse • Respiratory rate • Temperature • Level of consciousness	• Patient refusal
F5	12 lead ECG assessment documented?	• Patient refusal • Likely extrinsic cause of fall
F6	Postural Hypotension has been assessed? *To include one lying and one standing/sitting BP, OR assessment recorded as completed*	• Patient refusal • Likely extrinsic cause of fall • Patient unable

3.20 This is a pilot and may be subject to changes. It is anticipated the Falls COI data will be submitted quarterly, however the schedule has not yet been finalised.

4 Responsibilities

4.1. The **Chief Medical Officer** is the Executive lead responsible for the collection of COI data within the Trust.

4.2. The **Head of Health Informatics** is responsible for ensuring that this document and data collection practices meet any statutory, mandatory and/or external assessment requirements.

4.3. The **Health Informatics Managers** are responsible for managing the Health Informatics team and their compliance with this procedure to produce timely and high-quality clinical outcome indicator data. The **Health Informatics Manager (clinical**) provides clinical oversight to the COI process.

4.4. The **Health Informatics Managers** are responsible for management of the **Health Informatics Leads, Cardiac Arrest Analyst, and Health Informatics Support Workers** who ensure the timely auditing of incidents, quality assurance of the data collection process, data analysis and submission through the relevant online portal.

4.5. The **Health Informatics Leads, Cardiac Arrest Analyst, and Health Informatics Support Workers** and any other colleagues (ie, alternative duties staff/temporary staff) collecting COI data in the team, are responsible for timely data collection in line with the standards set out in this procedure. They will act up to the limits of their knowledge and seek clinical support where required.

4.6. The **Business Information Team** are responsible for publishing COI data for the Trust Board and in Power BI dashboards.

5 Procedure

Health Records Processing

5.1. The Health Informatics team sort and scan paper patient clinical records as per local procedures. At times patient records will be isolated for a defined period after delivery to prevent cross infection (e.g. during an epidemic or pandemic). Such decisions will be reached by agreement with the Head of Infection Prevention and Control and communicated to the team by the Health Informatics Managers.

5.2. Paper records will be available for validation in the Trusts validation app the next working day after scanning. Primary validation (validation of incident details, patient identifiers and CAD matching) should occur within three working days of records being made available in the system.

5.3. The Health Informatics Manager (non-clinical) will balance records scanned, versus records present in the Trusts validation system to ensure all records are present.

5.4. Secondary validation (validation of data fields required for calculation of audit inclusion and compliance) should occur within five working days of records being made available in the system.

5.5. Health Informatics staff performing primary validation should ‘skip’ (correct erroneous OCR data and PFI validate without CAD matching) a record for escalation to the Health Informatics Manager (non-clinical) if they are unable to carry out primary validation and CAD matching.

5.6. The Health Informatics Manager (non-clinical) will coordinate processing of all ‘skipped’ records at least weekly (except where CAD data is not immediately available due to CAD downtime etc.).

5.7. Health Informatics staff that are carrying out secondary validation and cannot confidently read or interpret a value recorded in a field should

leave this field blank to enable further review by a member of the team when data is displayed in the audit system.

5.8. If there is a delay, or any barriers to primary or secondary validation of paper records, the Health Informatics Manager should report this to the Head of Health Informatics & Records in the first instance. If there is likely to be a delay to the provision of data, this should be escalated to the Associate Director, Quality & Compliance (Medical) for escalation to the Chief Medical Officer, and reporting at CAQSG.

COI Auditing Process

5.9. The Health informatics Leads or the Cardiac Arrest Analyst will check for new incidents for audit. This will be done by downloading data from the Trust's Data Warehouse, via dedicated audit platforms located on the R; Drive. These platforms contain predefined logic tables for sampling and compliance.

5.10. Once downloaded the Health Informatics Support Workers will conduct an initial review on the data, removing any outstanding incidents that do not fit the predefined sampling criteria. They will also review 'Auto-non-compliant' incidents to determine whether care elements have been documented in the free text.

5.11. Where the Health Informatics Support worker is unable to decide during their analysis due to clinical complexity or some other compounding factor, this record should be marked for clinical review. Their query should be recorded in the notes field.

5.12. The Health Informatics Leads or the Cardiac Arrest Analyst will review all records marked for clinical review and the non-compliant records to make the final decision about compliance outcome, this can be with the support of the Health Informatics Clinical Lead (Clinical).

5.13. All members of the team are responsible for identifying incidents where actual or potential harm to the patient may have occurred. These are escalated directly to the Head of Health Informatics and Records for review and action if necessary. The Health Informatics Manager (clinical) should quality assure 10% of compliant, auto-compliant and removed incidents each month. This should be a random sample of incidents.

5.14 Anomalies in the data should be handled as follows:

- If there has been a one-off human misinterpretation of the data presented this should be corrected, details of the change noted on the record and feedback provided.

- Where a standard has been repeatedly misinterpreted (i.e. 3 or more times) by an individual throughout that month or where the same misinterpretation recurs on a monthly basis, all records where a misinterpretation might apply should be reviewed and amendments made as required. Noting the changes made on each record and providing feedback.

5.15 Where automation has calculated compliance incorrectly, all applicable records should be reviewed, and changes made as required.

5.16 Before calculation of compliance figures each month, the Health Informatics Manager (clinical) should carry out a final quality check to confirm that:

- all primary and secondary validation has been completed
- all required incidents have been audited.
- all duplicate incidents have been removed
- all hospital transfers have been removed
- all clinical reviews are complete
- all non-compliance checks are complete

5.17 After auditing is complete for a full month, the data is uploaded back into the Data Warehouse and compliance trends are analysed by the Health Informatics Leads or Cardiac Arrest Analyst.

5.18 The Health Informatics Manager (clinical) is responsible for submitting timely COI data for the Trusts Integrated Performance Report (IPR) and providing the narrative to accompany the data.

5.19 CAQSG are responsible for challenging data quality and integrity. They will assist in planning remedial actions where performance does not meet the level required.

5.20 The Health Informatics Managers will ensure that COI data is submitted to NHSE through the relevant portal within the timeframes published by NHSE on the Ambulance Quality Indicator section of their website.

Cardiac Arrest Survival Procedure

5.21 Patient details should be checked against the NHS Spine and any errors corrected in the registry.

5.22 Where NHS spine shows a date of death within 30 days of arrival at the receiving hospital, ‘Survival to 30 days’ should be marked as ‘no’ and the date of death from NHS Spine copied to the ‘Date of Death’ field.

5.23 Where resuscitation is stopped by EMS, ‘Death Confirmed by EMS’ should be marked as ‘yes’, ‘Survival to Discharge’ should be marked as

'no' and Date of Death should be populated with the date of recognition of life extinct (being mindful of incidents that cross midnight and using the date that recognition of life extinct was applied).

5.24 Where resuscitation is continued until handover at the receiving hospital or where there is a return of spontaneous circulation on handover at the receiving hospital (and there is no date of death within 30 days of arrival on NHS Spine) the hospital should be contacted using a secure email platform to determine either date of death or survival to 30 days.

5.25 Where the receiving hospital does not respond in a timely manner, the patient's GP practice should be contacted by secure email or telephone to determine the outcome following their cardiac arrest.

Learning from COI Data

5.26 Operational managers are responsible for the delivery of COI feedback to their team members. Ahead of one to ones and appraisals, operational managers should review the COI Power BI dashboard to identify incidents where their team member was senior clinician on scene.

5.27 Recognition should be offered by operational managers where incidents are compliant and best practice reinforced. Any necessary developmental feedback should be offered where incidents are non-compliant. This may include the provision of information on the clinical standards set out in JRCALC guidelines or guidance on the best way to document exceptions to clinical standards.

5.28 Further guidance on how best to document clinical care or exceptions can be sought from the Health Informatics team if required.

5.29 Where performance issues are sustained after feedback, this should be manged using the Trusts Capability Policy and Procedure.

Data Revisions

5.30 At set periods throughout the year, NHSE allow submission of data revisions. This enables ambulance trusts to update their performance figures where records have been received late (i.e. received after figures have been approved by CAQSG) or where data collection and analysis problems have occurred.

5.31 When a revision window is opened by NHSE, the Health Informatics Manager or other nominated individual will attempt to update all unknown survival to discharge data where a patient was still in hospital when the performance was first calculated.

5.32 The Health Informatics Manager (clinical) or other nominated individual will compare performance in the data submitted originally with revised data. Revisions will only be submitted where there is a difference of more than +/-1% between the old and the new data. Due to the significant difference that small variation in numbers can have to cardiac arrest outcomes, these figures will always be submitted for revision if there is any difference. The final decision whether revisions will be published lies with NHSE.

5.33 Updated data for the COIs will be added to local trackers and the Integrated Performance Report (IPR) by the Health Informatics Manager (clinical) irrespective of whether NHSE are given or approve revised data. This new data should be presented to CAQSG and the reason for the difference between local and national data should be recorded in the group minutes.

6 Education and Training

6.1 Staff who collect COI data must be adequately familiarised with this document, the local definitions, the principles of clinical audit and the software used for data collection.

6.2 Those who collect COI data must participate in local levelling at least quarterly. In this session, the whole team should discuss their interpretation of the care recorded for a patient encounter to determine whether it meets the standards as required.

6.3 Levelling decisions are approved and documented by the Head of Health Informatics & Records. Local procedural changes that arise from levelling are approved by the CAQSG.

7 Monitoring Compliance

7.1 The Head of Health Informatics & Records, in conjunction with the Health Records Managers are responsible for the oversight and monitoring of this document.

7.2 This document is to be updated as required following local levelling and as new guidance is released by NASCQG and NHSE. These changes should be presented to the CAQSG as tracked changes for approval. The updated document should then be submitted to the Corporate Governance team for ‘fast-track’ approval as per the Development and Management of Trust Policies and Procedures Policy.

8 Audit and Review (evaluating effectiveness)

8.1 The Head of Health Informatics & Records will carry out a three-yearly review of this document to ensure compliance against the objectives.

8.2 The CAQSG will review the document as appropriate in the event of any incidents, complaints or process issues regarding Clinical Outcome Indicators.

8.3 Any issues with the Clinical Outcome Indicator processes will be picked up through the Trust governance processes which, if necessary, can ask for a review or revision of this procedure.

8.4 All policies and procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy and procedure is approved and disseminated.

8.5 Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

8.6 This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the procedure is not working effectively.

9 References

9.1 National Ambulance Service Clinical Quality Group Clinical Outcome Indicator Technical Guidance

10 Financial Checkpoint

10.1 This document has been confirmed by Finance to have no unbudgeted financial implications.

11 Equality Analysis

11.1 The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

11.2 Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

12 Data Privacy Impact Assessment

12.1 This activity is encapsulated via the Trusts DPIA for the processing of patient clinical records as per the ‘Sharing audit compliance and outcome information to clinical staff and their management teams’ DPIA, that was approved July 2023; and updated further in November 2023 to include EOC colleagues (Emergency Medical Advisors [EMAs]), Private Ambulance Providers (PAPs), Community First Responders (CFRs) and staff responders using GoodSam.