NHS
Staffordshire and
Stoke-on-Trent
Integrated Care Board

Our Ref: PW/SJR/FOI/1224/1107

13th February 2025

Stafford Education & Enterprise Park
Weston Road
Stafford
ST18 0BF

Telephone: 0300 123 1461

Sent by email

Dear

FOI-1224/1107
Your request for information under the Freedom of Information Act 2000

Thank you for your request for information received on 10th December 2024. Firstly, we would apologise for the delay in providing our response to you, but as we advised there are elements of the request which are commercially sensitive and are therefore exempt under S.43 Commercial Interests and also S.40(1) Personal Information.

We can confirm that the Staffordshire and Stoke-on-Trent Integrated Care Board can provide the following information and we thank you for your patience whilst we carried out the Public Interest Test.

An anonymised copy of this response will be made publicly available on the ICB website.

If you have awarded a new contract which is in mobilisation but has not yet gone live, please provide relevant details for that contract, not your current contract in demobilisation.

If you do not commission these services, please advise which NHS organisation manages this on your behalf.

1. **Who provides (or has been awarded to commence) your patient transport services?**

2. **When does the current (or mobilising contract) contract end?**

3. **What is the value of this contract per annum (i.e. for 2023/24 or the tendered value if not yet live)?**

4. **Have you contracted jointly with other NHS organisations? If so, which organisations?**

5. **Who is the best person to contact regarding NEPTS for your organisation? Please provide a name, position and email address where possible.**

6. **Please share the tender submission for the awarded provider(s). This may be multiple if the service was tendered in lots.**

7. **For all current contracts, please provide the following KPIs by month for the 12 months of December 2023 to November 2024:**
   a. Inbound performance - % of patients arriving on time for their appointment (0 minutes late)
   b. Outbound performance - % of outpatients collected within 60 minutes of agreed / ready time

c. Outbound performance - % of discharges & transfers collected within 60 minutes of agreed / ready time

d. Outbound performance - % of patients attending haemodialysis collected within 30 minutes of agreed / ready time
e. The abort rate %

Please see our responses provided on the attached spread sheet.

The ICB has supplied the information requested, subject to certain elements having been deemed to fall within scope of applying the 'Qualified Exemption' ref. Section 43 of FOIA (commercially sensitive items of the tendering documentation). As well as the 'Absolute Exemptions' ref. Section 41 of FOIA (confidential information as submitted during the tendering process) and Section 40-2 (personal information of ICB or non-ICB employees, where redacted from overall tendering documentation supplied). These documents relate to question 6 and are in the attached "Zip-file".

To request an internal review
You can request an internal review by contacting the Staffordshire and Stoke-on-Trent ICB FOI team by emailing; staffsstokeFOI@staffsstoke.icb.nhs.uk or by post to the address at the top of this letter within 40 working days of the initial response.

If you are not content with the outcome of your internal review, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the Staffordshire and Stoke-on-Trent Integrated Care Board's FOI complaints procedure.

The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

www.ico.gov.uk

Yours sincerely

Paul Winter
Associate Director of Corporate Governance

Enc.

NHS
Midlands and Lancashire
Commissioning Support Unit

Annex 9: Part 1,2 & 3 Consortia or Sub Contractor Attachment

Invitation to Tender for the Provision of Non-Emergency Patient Transport Service across Staffordshire.

On behalf of:
6 NHS Staffordshire Clinical Commissioning Groups and NHS Midlands Partnership Foundation Trust.

ITT 769

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SQ1.2(a) (i) This annex is to be completed by all consortia members who are not leading the bid or sub-contractors who are viewed as essential to the delivery of the services. All questions must be answered even where the response is N/A. Failure to answer all questions will lead to a fail.

Please note that the Commissioners require any Prime Contractor/Provider to undertake their own due diligence and ensure that their sub-contractors/partners conform with all statutory compliance requirements.

If you do not intend to form a consortium or employ sub-contractors who are viewed as essential to the delivery services please indicate below, otherwise please complete the annex for each consortium member or sub–contractor**.**

Supplier Response:

We are tendering as the sole service provider to the CCGs and therefore are not required to complete the below.

Part 1 - Potential Supplier Information

SQ1.1(a)	Full name of the potential supplier submitting the information

Supplier Response:

SQ1.1(b)	Registered Office address Enter N/A if not applicable

Supplier Response:

SQ1.1(b) - (ii)	Registered website address Enter N/A if not applicable

Supplier Response:

SQ1.1(c)	Trading Status

Supplier Response:

Please indicate with an x:

public limited company	
limited company	

limited liability partnership	
other partnership	
sole trader	
third sector	
other (please specify)	

1.1(c) (g)	If you responded other to question 1.1(c) please specify your trading status Enter N/A if not applicable
Supplier Response:	
SQ1.1(d)	Date of registration in country of origin. Enter N/A if not applicable
Supplier Response:	
SQ1.1(e)	Company registration number Enter N/A if not applicable
Supplier Response:	
SQ1.1(f)	Charity registration number Enter N/A if not applicable
Supplier Response:	
SQ1.1(g)	Head office (DUNS) number Enter N/A if not applicable
Supplier Response:	
SQ1.1(h)	Registered VAT number Enter N/A if not applicable
Supplier Response:	

SQ1.1(i) - (i)	If applicable is your organisation registered with the appropriate professional or trade register(s) in the member state where it is established

Supplier Response:

Please indicate with an x:

Yes	
No	
N/A	

SQ1.1 (i) – (ii)	If you responded yes to SQ1.1 (i) – (i) please provide the relevant details including the registration number(s) Enter N/A if not applicable

Supplier Response:

SQ1.1 (j) – (i)	Is it a legal requirement in the state where you are established for you to possess a particular authorisation or be a member of a particular organisation in order to provide the services specified in this procurement?

Supplier Response:

Please indicate with an x:

Yes	
No	

SQ1.1 (j) – (ii)	If you responded yes to 1.1(j) – (i) please provide additional details of what is required and confirmation that you have complied with this. Enter N/A if not applicable

Supplier Response:

SQ1.1(k)	Trading name(s) that will be used if successful in this procurement Enter N/A if not applicable

Supplier Response:

SQ1.1(l)	Relevant classifications, (state whether you fall within one of these, and if so which one)

Supplier Response:

Please indicate with an **x**:

Voluntary Community Social Enterprise	
Sheltered Workshop	
Public Service Mutual	
N/A	

[A17]	Are you a Small, Medium or Micro Enterprise (SME)?

Supplier Response:

Please indicate with an x:

Yes	
No	

SQ1.1(n)	Details of Person of Significant Control (PSC) where appropriate: Name Date of Birth Nationality Country, state or part of the UK where the PSC usually lives Service address The date he or she became a PSC in relation to the company (for existing companies the 6th April 2016 should be used) Which conditions for being a PSC are met - over 25% (and including 50%); more than 50% and less than 75%; 75% or more Enter N/A if not applicable

Supplier Response:

SQ1.2(a)	Are you bidding as the Consortium member, sub-contractor or other in within your group of economic operators?

Supplier Response:

SQ1.3	I declare that to the best of my knowledge the answers submitted and information contained in this document are correct and accurate. I declare that, upon request and without delay I will provide the certificates or documentary evidence referred to in this document. I understand that the information will be used in the selection process to assess my organisation's suitability to be invited to participate further in this procurement. I understand that the authority may reject this submission in its entirety if there is a failure to answer all the relevant questions fully, or if false/misleading information or content is provided in any section. I am aware of the consequences of serious misrepresentation.

Supplier Response:

Please indicate with an x:

Yes	
No	

SQ1.3(a)	Contact Name

Supplier Response:

SQ1.3(b)	Name of organisation

Supplier Response:

SQ1.3(c)	Role in organisation

Supplier Response:

SQ1.3(d)	Phone number

Supplier Response:

SQ1.3(e)	Email address

Supplier Response:

SQ1.3(f)	Postal address
Supplier Response:	

Part 2 - Exclusion Grounds

Note	**Regulations 57(1) and (2)** The detailed grounds for mandatory exclusion of an organisation are set out on this [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/551130/List_of_Mandatory_and_Discretionary_Exclusions.pdf], which should be referred to before completing these questions. Please indicate if, within the past five years you, your organisation or any other person who has powers of representation, decision or control in the organisation been convicted anywhere in the world of any of the offences within the summary below and listed on the webpage.
SQ2.1(a) – (i)	Participation in a criminal organisation

Supplier Response:

Please indicate with an x:

If Yes, please provide details at SQ2.1(b)

Yes	
No	

SQ2.1(a) – (ii)	Corruption

Supplier Response:

Please indicate with an **x**:

If Yes, please provide details at SQ2.1(b)

Yes	
No	

SQ2.1(a) - (iii)	Fraud

Supplier Response:

Please indicate with an **x**:

If Yes, please provide details at SQ2.1(b)

Yes	
No	

SQ2.1(a) – (iv)	Terrorist offences or offences linked to terrorist activities

Supplier Response:

Please indicate with an x:

If Yes, please provide details at SQ2.1(b)

Yes	
No	

SQ2.1(a) – (vi)	Money laundering or terrorist financing

Supplier Response:

If Yes, please provide details at SQ2.1(b)

Please indicate with an x:

Yes	
No	

SQ2.1(a) – (v)	Child labour and other forms of trafficking in human beings

Supplier Response:

If Yes, please provide details at SQ2.1(b)

Please indicate with an **x**:

Yes	
No	

SQ2.1(b)	If you have answered yes to question SQ2.1(a), please provide further details. Date of conviction, specify which of the grounds listed the conviction was for, and the reasons for conviction Identity of who has been convicted If the relevant documentation is available electronically please provide the web address, issuing authority, precise reference of the documents. Enter N/A if not applicable

Supplier Response:

SQ2.2	If you have answered Yes to question SQ2.1(a), have measures been taken to demonstrate the reliability of the organisation despite the existence of a relevant ground for exclusion?
Supplier Response: Part 2 - Exclusion Grounds	
SQ2.3(a)	Regulation 57(3) Has it been established, for your organisation by a judicial or administrative decision having final and binding effect in accordance with the legal provisions of any part of the United Kingdom or the legal provisions of the country in which the organisation is established (if outside the UK), that the organisation is in breach of obligations related to the payment of tax or social security contributions?
Supplier Response: Please indicate with an x:	
SQ2.3(b)	If you have answered yes to question SQ2.3(a), please provide further details. Please also confirm you have paid, or have entered into a binding arrangement with a view to paying, the outstanding sum including where applicable any accrued interest and/or fines. Enter N/A if not applicable
Supplier Response:	

Yes	
No	

Part 3 – Grounds for discretionary exclusion

Note	Regulation 57 (8) The detailed grounds for discretionary exclusion of an organisation are set out on [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/551130/List_of_Mandatory_and_Discretionary_Exclusions.pdf], which should be referred to before completing these questions. Please indicate if, within the past three years, anywhere in the world any of the following situations have applied to you, your organisation or any other person who has powers of representation, decision or control in the organisation.
SQ3.1(a)	Breach of environmental obligations

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an x:

Yes	
No	

SQ3.2(b)	Breach of social obligations

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an x:

Yes	
No	

SQ3.1(c)	Breach of labour law obligations

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an x:

Yes	
No	

SQ3.1(d)	Bankrupt or is the subject of insolvency or winding-up proceedings, where the organisation's assets are being administered by a liquidator or by the court, where it is in an arrangement with creditors, where its business activities are suspended or it

	is in any analogous situation arising from a similar procedure under the laws and regulations of any State

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an x:

Yes	
No	

Sq3.1(e)	Guilty of grave professional misconduct?

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an **x**:

Yes	
No	

SQ3.1(f)	Entered into agreements with other economic operators aimed at distorting competition

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an **x**:

Yes	
No	

SQ3.1(g)	Aware of any conflict of interest within the meaning of regulation 24 due to the participation in the procurement procedure? Bidder guidance: Examples of circumstances in which potential conflicts could arise include (but are not limited to) where: A Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation has carried or is carrying out any work for the CCG or predecessor body in the last six months; A Relevant Organisation is providing services for more than one potential bidder in respect of this project or procurement process. A conflict of interest will not be deemed to arise solely by virtue of a person's employment or engagement by a Clinical Commissioning Group, Strategic Health Authority or other NHS body (although bidders are requested to disclose such relationships for information purposes only). For example, GPs engaged under a GMS contract will not be considered to have a conflict of interest by virtue of such practising arrangements.

Supplier Response:

If yes, please provide details at SQ3.2 and complete Annex 3

Please indicate with an x:

Yes	
No	

SQ3.1(h)	Been involved in the preparation of the procurement procedure

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an **x**:

Yes	
No	

SQ3.1(j)	Shown significant or persistent deficiencies in the performance of a substantive requirement under a prior public contract, a prior contract with a contracting entity, or a prior concession contract, which led to early termination of that prior contract, damages or other comparable sanctions

Supplier Response:

Please indicate with an **x**:

If Yes, please provide details at SQ3.2

Yes	
No	

SQ3.1(j) – (i)	The organisation is guilty of serious misrepresentation in supplying the information required for the verification of the absence of grounds for exclusion or the fulfilment of the selection criteria.

Supplier Response:

Please indicate with an **x**:

If Yes, please provide details at SQ3.2

Yes	
No	

SQ3.1(j) – (ii)	The organisation has withheld such information.

Supplier Response:

Please indicate with an **x**:

If Yes, please provide details at SQ3.2

Yes	
No	

SQ3.1(j) – (iii)	The organisation is not able to submit supporting documents required under regulation 59 of the Public Contracts Regulations 2015.

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an **x**:

Yes	
No	

SQ3.1(j) – (vi)	The organisation has influenced the decision-making process of the contracting authority to obtain confidential information that may confer upon the organisation undue advantages in the procurement procedure, or to negligently provided misleading information that may have a material influence on decisions concerning exclusion, selection or award.

Supplier Response:

If Yes, please provide details at SQ3.2

Please indicate with an x:

Yes	
No	

SQ3.2	If you have answered Yes to any of the above, explain what measures been taken to demonstrate the reliability of the organisation despite the existence of a relevant ground for exclusion? (Self Cleaning) Enter N/A if not applicable

Supplier Response:

Get to know us or get in touch

mlcsu

Midlands and Lancashire Commissioning Support Unit

midlandsandlancashirecsu.nhs.uk

ERS Transition Limited

Annual Report and Financial Statements
Year Ended 31 December 2018

Registration number: 10783395

ERS Transition Limited

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ERS Transition Limited

Company Information

Directors	Mr A Pooley Mr A J Fraser Mr J W Smyly
Registered office	2nd Floor Hetton Court The Oval Leeds LS10 2AT
Bankers	Lloyds Bank plc Royal Parade 8 Royal Parade Plymouth PL1 1DS
Auditors	PKF Francis Clark Statutory Auditor Centenary House Peninsula Park Rydon Lane Exeter EX2 7XE

ERS Transition Limited

Strategic Report

Year Ended 31 December 2018

The directors present their strategic report for the year ended 31 December 2018. Comparatives are presented for the period from incorporation on 22 May 2017 to 31 December 2017.

Principal activity
The principal activity of the company is the provision of ambulance transport and medical courier services.

Fair review of the business
During the period ERS Transition Limited has undergone a significant restructure to align the operations with the new business vision post acquisition. This has resulted in key personnel, process and method changes and streamlining back-office support through full utilisation of the newly implemented systems.

Throughout 2018 the focus has been on ensuring compliance, leadership decentralisation and strengthening the commercial position of the company. The systems and processes implemented see a decentralised well governed structure which allows for agile decision making within a framework of controls set by the leadership team. We have had four Care Quality Commissions inspections in each of the geographical areas of the business; North East, North, South and East. All of the inspections have gone very well with outcomes ranging from "Good" to "Good with Outstanding" and this provides assurance that the systems, processes and training implemented throughout 2018 is industry leading.

The market is still considered to be in excess of £500m with medium to large public sector contracts providing long term recurring revenues. The aim is to grow the business organically and utilise the infrastructure to be competitive and leverage overhead to increase profitability. We are executing our strategy to take the acquired contracts and operational infrastructure and grow commercially the more flexible on demand work in the various geographic regions. This enables greater utilisation of existing resources driving increased revenues and profitability.

The operating loss for the period before exceptional restructuring costs was £1,011,991 which was anticipated as outlined in our 2017 strategic report. After exceptional restructuring costs of £152,065 and interest of £147,896, the retained loss for the period was £1,311,952.

There are a few key underlying issues contributing to the losses which are detailed below:

Loss and End of contracts

We have seen a few key contracts end during 2018 impacting the overall profit of the business such as Croydon University Hospitals, Bassetlaw, Barnsley/Rotherham/Doncaster and Norfolk Courier. Some of these were open for tender pre transition of the trade and assets to ERS Transition Limited and the previous owner of the business did not actively engage in any new commercial opportunities. As a result, the business has reduced in size which has impacted 2018 and 2019 profitability. However with the growth achieved late 2019 and 2020, we will see overheads leveraged through our scalable business model returning to profit.

Efficiencies

It has proven to be more difficult than anticipated to drive efficiencies through the organisation on an operating level due to the significant changes in culture and management. It resulted in a change management process that took longer than anticipated to implement and for people to get accustomed to these changes in behaviour. The labour cost has been running higher than budgeted and given this is the highest cost component to delivering the service this has been contributing to the losses generated.

ERS Transition Limited

Strategic Report

Year Ended 31 December 2018

Inflation

National Minimum Wage increases of 4.7% and fuel inflation have had a significant impact on the profitability of the business.

Financial year 2019 will see the full impact of the changes implemented resulting in business growth. ERS has seen the ad-hoc work increase by almost £500,000 and ERS has been successful in three major tenders being Norfolk CCG's (retention), Nottingham (new business) and Homerton (new business). In conjunction with this ERS has not seen any retention issues except for a very small contract in London. The timing of the new contracts commencing was somewhat later then anticipated as the last contract will go live 1 December 2019.

The new contracts will have a significant impact on the business and will transform the business to a profitable position from 2020 onwards.

Principal risks and uncertainties
The company is subject to competition for key contracts which are let periodically in open tender. The company maintains close links with key customers and focuses on quality of service as well as price to maximise retention of contracts as appropriate.

Going concern
The company incurred a loss in its second period of trading as a result of a change management programme and exceptional restructuring costs which resulted in a net liability position on the balance sheet at 31 December 2018 of £1,430,589. The company arranged a loan as part of the acquisition to provide working capital. At 31 December 2018 the company had a cash balance of £1,995,507 and net current assets of £1,584,158. Despite the reported loss, the business experiences positive operating cashflow, increasing its cash balance by £922,000 in 2018 which affirms a strong position throughout 2018 and 2019.

In addition, business is successfully tendered and contracted with key customers which provides a degree of stability and certainty of income in the short and medium to long term. New contract wins for Homerton, Nottingham and retention of Norfolk will see guaranteed revenues and contribution for the next five to seven years. Through growth of the business overheads are being leveraged resulting in positive cashflow from the end of 2019.

Taking into account these factors, the directors have concluded that it is appropriate to prepare the financial statements on a going concern basis.

Approved by the Board on 10/09/19 and signed on its behalf by:

.....
Mr A Pooley
Director

ERS Transition Limited

Directors' Report

Year Ended 31 December 2018

The directors present their report and the financial statements for the year ended 31 December 2018.

Directors of the company
The directors who held office during the year were as follows:

Mr A Pooley

Mr A J Fraser

Mr J W Smyly

Financial instruments

Objectives and policies

The company uses financial instruments, other than derivatives, comprising cash, loans, trade debtors and trade creditors that arise directly from its operations. The main purpose of these financial instruments is to finance the company's operations.

Price risk, credit risk, liquidity risk and cash flow risk

Price risk
The company performs it services under agreed contract terms with clearly defined pricing structures, providing a high degree of certainty over pricing of work.

Currency risk
The company only maintains bank balances in Sterling and invoices and receives payment in this currency. The company is therefore not directly exposed to currency risk.

Liquidity risk
The company seeks to manage liquidity risk by ensuring sufficient liquidity is available to meet the foreseeable needs and to invest cash assets safely and profitably.

Cashflow risk
The company arranged a loan facility as part of its acquisition of certain trade and assets of SRCL Limited. This provided working capital to manage the timing of cash flows from key customers.

Employment of disabled persons
It is the company's policy to give full consideration to any suitable application for employment by disabled persons. Disabled persons are eligible to participate in all career development opportunities available to staff. Opportunities also exist for employees of the group who become disabled to continue in their employment or to be re-trained for other positions in the company.

Employee involvement
Two way communication with employees takes place on a formal basis through regular meetings of operational managers of all sites. There is also a formal Performance Development Plan in place for each employee with annual or bi-annual evaluation by both employee and employer which creates high levels of engagement. Additionally, informal consultations take place at all levels.

ERS Medical uses a number of channels to keep employees informed and engaged such as quarterly In-Touch magazine, Site TV monitors, social media and email correspondence.

ERS Transition Limited

Directors' Report

Year Ended 31 December 2018

Disclosure of information to the auditors
Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the company's auditors are aware of that information. The directors confirm that there is no relevant information that they know of and of which they know the auditors are unaware.

Approved by the Board on 10/09/19. and signed on its behalf by:

.....
Mr A Pooley
Director

ERS Transition Limited

Statement of Directors' Responsibilities

The directors acknowledge their responsibilities for preparing the Annual Report and the financial statements in accordance with applicable law and regulations.

Company law requires the directors to prepare financial statements for each financial year. Under that law the directors have elected to prepare the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under company law the directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the company and of the profit or loss of the company for that period. In preparing these financial statements, the directors are required to:

- select suitable accounting policies and apply them consistently;
- make judgements and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the company will continue in business.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the company's transactions and disclose with reasonable accuracy at any time the financial position of the company and enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

ERS Transition Limited

Independent Auditor's Report to the Members of ERS Transition Limited

Opinion

We have audited the financial statements of ERS Transition Limited (the 'company') for the year ended 31 December 2018, which comprise the Profit and Loss Account, Balance Sheet, Statement of Changes in Equity, Statement of Cash Flows, and Notes to the Financial Statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the company's affairs as at 31 December 2018 and of its loss for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Independent Auditor's Report to the Members of ERS Transition Limited

Opinion on other matter prescribed by the Companies Act 2006
In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Strategic Report and Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Strategic Report and Directors' Report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception
In the light of our knowledge and understanding of the company and its environment obtained in the course of the audit, we have not identified material misstatements in the Strategic Report and the Directors' Report.

We have nothing to report in respect of the following matters where the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of directors

As explained more fully in the Statement of Directors' Responsibilities set out on page 6, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

ERS Transition Limited

Independent Auditor's Report to the Members of ERS Transition Limited

Use of our report

This report is made solely to the company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the company and the company's members as a body, for our audit work, for this report, or for the opinions we have formed.

PKF Francis Clark

.....

Glenn Nicol (Senior Statutory Auditor)
PKF Francis Clark, Statutory Auditor

Centenary House
Peninsula Park
Rydon Lane
Exeter
EX2 7XE

Date: 17 September 2019

ERS Transition Limited

Profit and Loss Account

Year Ended 31 December 2018

	Note	Year ended 31 December 2018 £	22 May 2017 to 31 December 2017 £
Turnover	3	25,141,751	4,054,563
Cost of sales		(19,363,241)	(3,067,364)
Gross profit		5,778,510	987,199
Administrative expenses			
Administrative expenses (excluding exceptional items)		(6,790,501)	(920,540)
Exceptional administrative expenses	5	(152,065)	(282,245)
Administrative expenses (including exceptional items)	5	(6,942,566)	(1,202,785)
Other operating income	4	-	163,534
Operating profit (before exceptional items)		(1,011,991)	230,193
Operating loss (after exceptional items)	5	(1,164,056)	(52,052)
Interest payable and similar charges	9	(147,896)	(66,588)
Loss before tax		(1,311,952)	(118,640)
Loss for the financial year		(1,311,952)	(118,640)

The above results were derived from continuing operations.

The company has no recognised gains or losses for the year other than the results above.

ERS Transition Limited

Balance Sheet

31 December 2018

	Note	2018 £	2017 £
Fixed assets			
Intangible assets	11	744,379	827,655
Tangible assets	12	455,358	664,501
		1,199,737	1,492,156
Current assets			
Debtors	13	2,552,587	3,832,883
Cash at bank and in hand		1,995,507	1,073,610
		4,548,094	4,906,493
Creditors: Amounts falling due within one year	15	(2,963,936)	(2,450,698)
Net current assets		1,584,158	2,455,795
Total assets less current liabilities		2,783,895	3,947,951
Creditors: Amounts falling due after more than one year	15	(4,214,484)	(4,066,588)
Net liabilities		(1,430,589)	(118,637)
Capital and reserves			
Called up share capital	19	3	3
Profit and loss account		(1,430,592)	(118,640)
Total equity		(1,430,589)	(118,637)

Approved and authorised by the Board on 10/09/19 and signed on its behalf by:

.....
Mr A Pooley
Director

Company Registration Number: 10783395

ERS Transition Limited

Statement of Changes in Equity

Year Ended 31 December 2018

	Share capital £	Profit and loss account £	Total £
At 1 January 2018	3	(118,640)	(118,637)
Loss for the year	-	(1,311,952)	(1,311,952)
Total comprehensive income	-	(1,311,952)	(1,311,952)
At 31 December 2018	3	(1,430,592)	(1,430,589)

	Share capital £	Profit and loss account £	Total £
Loss for the period	-	(118,640)	(118,640)
Total comprehensive income	-	(118,640)	(118,640)
New share capital subscribed	3	-	3
At 31 December 2017	3	(118,640)	(118,637)

ERS Transition Limited

Statement of Cash Flows

Year Ended 31 December 2018

	Note	Year ended 31 December 2018 £	22 May 2017 to 31 December 2017 £
Cash flows from operating activities			
Loss for the year		(1,311,952)	(118,640)
Adjustments to cash flows from non-cash items			
Depreciation and amortisation		352,317	35,919
Profit on disposal of tangible assets		(7,600)	-
Finance costs		147,896	66,588
		(819,339)	(16,133)
Working capital adjustments			
Decrease/(increase) in trade debtors		1,280,296	(3,780,365)
Increase in trade creditors		513,238	2,421,571
Net cash flow from operating activities		974,195	(1,374,927)
Cash flows from investing activities			
Acquisition of trade/assets		-	(1,005,881)
Acquisitions of tangible assets		(84,898)	(258,507)
Proceeds from sale of tangible assets		32,600	-
Acquisition of intangible assets	11	-	(317,005)
Cash acquired though trade/assets acquisition		-	800
Net cash flows from investing activities		(52,298)	(1,580,593)
Cash flows from financing activities			
Proceeds from issue of ordinary shares, net of issue costs		-	3
Proceeds from other borrowing draw downs		-	4,000,000
Payments to finance lease creditors		-	29,127
Net cash flows from financing activities		-	4,029,130
Net increase in cash and cash equivalents		921,897	1,073,610
Cash and cash equivalents at 1 January		1,073,610	-
Cash and cash equivalents at 31 December	14	1,995,507	1,073,610

ERS Transition Limited

Notes to the Financial Statements

Year Ended 31 December 2018

1 General information

The company is a private company limited by share capital, incorporated in England and Wales.

The address of its registered office and principal place of business is:
2nd Floor
Hetton Court
The Oval
Leeds
LS10 2AT

2 Accounting policies

Summary of significant accounting policies and key accounting estimates
The principal accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

Statement of compliance
These financial statements were prepared in accordance with Financial Reporting Standard 102 'The Financial Reporting Standard applicable in the UK and Republic of Ireland'. There are no departures from FRS102.

Basis of preparation
These financial statements have been prepared using the historical cost convention.

The functional currency is considered to be pounds sterling because that is the currency of the primary economic environment in which ERS Transition operates.

Going concern
The financial statements have been prepared on a going concern basis.

The company incurred a loss in its second period of trading as a result of a change management programme and exceptional restructuring costs which resulted in a net liability position on the balance sheet at 31 December 2018 of £1,430,589. The company arranged a loan as part of the acquisition to provide working capital. At 31 December 2018 the company had a cash balance of £1,995,507 and net current assets of £1,584,158.

In addition, business is successfully tendered and contracted with key customers which provides a degree of stability and certainty of income in the short and medium to long term. New contract wins for Homerton, Nottingham and retention of Norfolk will see guaranteed revenues and contribution for the next five to seven years. Through growth of the business overheads are being leveraged resulting in positive cashflow from the end of 2019.

Taking into account these factors, the directors have concluded that it is appropriate to prepare the financial statements on a going concern basis.

2 Accounting policies (continued)

Key sources of estimation uncertainty
The key assumptions concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Goodwill arising on the acquisition of the trade and assets of SRCL Limited is being amortised over its useful life which has been estimated by the directors as 10 years. At the year end the carrying value of goodwill is £744,379 (2017 - £827,655).

Revenue recognition
Turnover is stated net of VAT and trade discounts and is is recognised when the significant risks and rewards are considered to have transferred.

Turnover is recognised to the extent that the company obtains the right to consideration in exchange for its performance. Specifically, revenue from the rendering of services is recognised when the service has been completed. Where customers are invoiced in advance of services an element of this income will be deferred at the year end.

Tax
Tax is recognised in profit or loss, except that a change attributable to an item of income or expense recognised as other comprehensive income is also recognised directly in other comprehensive income.

The current corporation tax charge is calculated on the basis of tax rates and laws that have been enacted or substantively enacted by the reporting date in countries where the company operates and generates taxable income.

Tangible assets
Tangible assets are stated in the balance sheet at cost, less any subsequent accumulated depreciation and subsequent accumulated impairment losses.

The cost of tangible assets includes directly attributable incremental costs incurred in their acquisition and installation.

Depreciation
Depreciation is charged so as to write off the cost of assets, other than land and properties under construction over their estimated useful lives, as follows:

Asset class	Depreciation method and rate
Buildings	Shorter of life of lease or 30 years
Furniture, fittings and equipment	Over 5 - 10 years
Plant and machinery	Over 5 - 10 years
Computer equipment	Over 3 - 5 years
Motor vehicles	Over 2 - 3 years

2 Accounting policies (continued)

Intangible assets
Goodwill arising on the acquisition of the trade and assets of SRCL Limited, representing any excess of fair value of the consideration given over the fair value of the identifiable assets and liabilities acquired, is capitalised and written off over its useful economic life, which is 10 years. Provision is made for any impairment.

Leases
Leases in which substantially all the risks and rewards of ownership are retained by the lessor are classified as operating leases. Payments made under operating leases are charged to profit or loss on a straight-line basis over the period of the lease. Leases are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee.

Assets held under finance leases are recognised at the lower of their fair value at inception of the lease and the present value of the minimum lease payments. These assets are depreciated on a straight-line basis over the shorter of the useful life of the asset and the lease term. The corresponding liability to the lessor is included in the Balance Sheet as a finance lease obligation.

Lease payments are apportioned between finance costs in the Profit and Loss Account and reduction of the lease obligation so as to achieve a constant periodic rate of interest on the remaining balance of the liability.

Defined contribution pension obligation
A defined contribution plan is a pension plan under which fixed contributions are paid into a pension fund and the company has no legal or constructive obligation to pay further contributions even if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods.

Contributions to defined contribution plans are recognised as employee benefit expense when they are due. If contribution payments exceed the contribution due for service, the excess is recognised as a prepayment.

2 Accounting policies (continued)

Financial instruments

Classification

The company holds the following financial instruments:

- Short term trade and other debtors and creditors;
- Amounts owed to group undetakings;
- Short and long-term loans; and
- Cash and bank balances.

All financial instruments are classified as basic.

Recognition and measurement

The company has chosen to apply the recognition and measurement principles in FRS102.

Financial instruments are recognised when the company becomes party to the contractual provisions of the instrument and derecognised when in the case of assets, the contractual rights to cash flows from the assets expire or substantially all the risks and rewards of ownership are transferred to another party, or in the case of liabilities, when the company's obligations are discharged, expire or are cancelled.

Except for bank loans, such instruments are initially measured at transaction price, including transaction costs, and are subsequently carried at the undiscounted amount of the cash or other consideration expected to be paid or received, after taking account of impairment adjustments.

Bank loans are initially measured at transaction price, including transaction costs, and are subsequently carried at amortised cost using the effective interest method.

3 Revenue

The analysis of the company's revenue for the year from continuing operations is as follows:

	2018	2017
	£	£
Provision of services - UK	25,141,751	4,054,563

4 Other operating income

The analysis of the company's other operating income for the year is as follows:

	2018	2017
	£	£
Other contract income	-	163,534

5 Operating loss

Arrived at after charging/(crediting)

	2018 £	2017 £
Depreciation expense	269,041	21,891
Amortisation expense	83,276	14,028
Operating lease expense - car rental	38,066	2,297
Operating lease expense - office equipment	4,081	3,600
Profit on disposal of property, plant and equipment	(7,600)	-
Exceptional administrative expenses	152,065	282,245

Exceptional costs relate to first year set-up and transition of the trade from SRCL Limited.

6 Staff costs

The aggregate payroll costs (including directors' remuneration) were as follows:

	2018 £	2017 £
Wages and salaries	15,211,486	2,346,677
Social security costs	1,057,203	154,807
Pension costs, defined contribution scheme	325,685	39,771
	16,594,374	2,541,255

The average number of persons employed by the company (including directors) during the year, analysed by category was as follows:

	2018 No.	2017 No.
Administration and support	857	830

In the prior period employee numbers varied significantly each month as it was the first period of account since incorporation. Therefore, the average employee number for the prior period is not considered representative. The figure stated above for 2017 is the employees contracted at the prior year end.

7 Directors' remuneration

The directors' remuneration for the year was as follows:

	2018 £	2017 £
Remuneration	149,787	74,617
Contributions paid to money purchase schemes	1,600	-
	151,387	74,617

During the year the number of directors who were receiving benefits and share incentives was as follows:

	2018 No.	2017 No.
Accruing benefits under money purchase pension scheme	2	2

8 Auditor's remuneration

	2018 £	2017 £
Audit of the financial statements	14,000	7,500

9 Interest payable and similar expenses

	2018 £	2017 £
Interest expense on other finance liabilities	147,896	66,588

10 Taxation

Tax charged/(credited) in the profit and loss account

	Year ended 31 December 2018 £	22 May 2017 to 31 December 2017 £
Current taxation		
UK corporation tax	-	-
	-	-

10 Taxation (continued)

The tax credit on the loss before tax for the year is lower than the standard rate of corporation tax in the UK of 19%(2017 - 19%).

The differences are reconciled below:

	2018 £	2017 £
Loss before tax	(1,311,952)	(118,640)
Corporation tax credit at standard rate	(249,271)	(22,542)
Effect of expense not deductible in determining tax loss	16,261	1,720
Tax increase from effect of unrelieved tax losses carried forward	233,010	20,822
Total tax charge/(credit)	-	-

11 Intangible assets

	Goodwill £	Total £
Cost or valuation		
At 1 January 2018	841,683	841,683
At 31 December 2018	841,683	841,683
Amortisation		
At 1 January 2018	14,028	14,028
Amortisation charge	83,276	83,276
At 31 December 2018	97,304	97,304
Carrying amount		
At 31 December 2018	744,379	744,379
At 31 December 2017	827,655	827,655

12 Tangible assets

	Furniture, fittings and equipment £	Motor vehicles £	Plant and machinery £	Total £
Cost or valuation				
At 1 January 2018	596,635	-	89,757	686,392
Additions	21,660	63,238	-	84,898
Disposals	-	(30,000)	-	(30,000)
At 31 December 2018	618,295	33,238	89,757	741,290
Depreciation				
At 1 January 2018	18,822	-	3,069	21,891
Charge for the year	236,092	6,788	26,161	269,041
Eliminated on disposal	-	(5,000)	-	(5,000)
At 31 December 2018	254,914	1,788	29,230	285,932
Carrying amount				
At 31 December 2018	363,381	31,450	60,527	455,358
At 31 December 2017	577,813	-	86,688	664,501

13 Debtors

	2018 £	2017 £
Trade debtors	2,257,241	2,915,248
Other debtors	3,939	393,091
Prepayments	291,407	524,544
	2,552,587	3,832,883

14 Cash and cash equivalents

	2018 £	2017 £
Cash at bank	1,995,507	1,073,610

15 Creditors

	Note	2018 £	2017 £
Due within one year			
Loans and borrowings	16	-	29,127
Trade creditors		651,692	768,861
Social security and other taxes		554,102	346,860
Outstanding defined contribution pension costs		301,351	65,623
Other creditors		20,674	29,223
Accrued expenses		1,436,117	1,211,004
		2,963,936	2,450,698
Due after one year			
Loans and borrowings	16	4,214,484	4,066,588

16 Loans and borrowings

	2018 £	2017 £
Non-current loans and borrowings		
Other borrowings	4,214,484	4,066,588

	2018 £	2017 £
Current loans and borrowings		
Finance lease liabilities	-	29,127

Other borrowings

Other borrowings represent a loan denominated in Sterling with a nominal interest rate of 1.5% above LIBOR%, repayable by 22 May 2021. The carrying amount at the period end is £4,214,484 (2017 - £4,066,588).

The loan is secured on the trade debtors of the company.

17 Obligations under leases and hire purchase contracts

Operating leases
The total of future minimum lease payments is as follows:

	2018 £	2017 £
Not later than one year	1,362,631	1,952,312
Later than one year and not later than five years	2,608,815	2,183,912
Later than five years	33,670	103,747
	4,005,116	4,239,971

The amount of non-cancellable operating lease payments recognised as an expense during the year was £2,205,043 (2017 - £340,788).

18 Pension and other schemes

Defined contribution pension scheme

The company operates a defined contribution pension scheme. The pension cost charge for the year represents employer contributions payable by the company to the scheme and amounted to £325,685 (2017 - £39,771).

Employee and employer contributions totalling £301,351 (2017 - £65,623) were payable to the scheme at the end of the year and are included in creditors.

19 Share capital

Allotted, called up and fully paid shares

	2018		2017	
	No.	£	No.	£
Ordinary shares of £1 each	3	3	3	3

20 Related party transactions

Summary of transactions with entities with joint control or significant interest

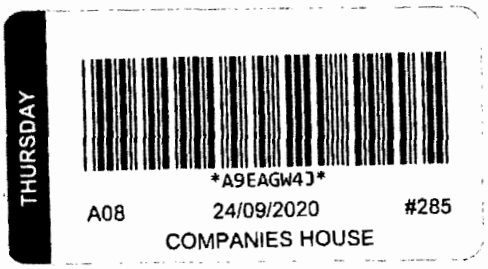
First Care Ambulance Limited

During the year ERS Transition Ltd made sales of £49,038 to and purchases of £25,866 from First Care Ambulance Ltd a company in which Mr A Pooley and Mr A Fraser are Directors. The balance owed to First Care Ltd at the year end was £6,000 (2017: £24,091).

ERS Transition Limited

Annual Report and Financial Statements
Year Ended 31 December 2019

Registration number: 10783395



ERS Transition Limited

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ERS Transition Limited

Company Information

Director	Mr A Pooley
Registered office	Angel Wings 1 First Floor Whitehouse Street Leeds LS10 1AD
Bankers	Lloyds Bank plc Royal Parade 8 Royal Parade Plymouth PL1 1DS
Auditors	PKF Francis Clark Statutory Auditor Centenary House Peninsula Park Rydon Lane Exeter EX2 7XE

ERS Transition Limited

Strategic Report for the Year Ended 31 December 2019

The director presents his strategic report for the year ended 31 December 2019.

Principal activity
The principal activity of the company is the provision of ambulance transport and medical courier services.

Fair review of the business

Revenue
Revenues have been impacted adversely year on year due to a contract ending in Essex in March 2018 and the loss of a smaller contract in London from September 2019.

However, ERS has seen significant growth in the last quarter of 2019 as a result of three major tenders which have been successfully mobilised for Norfolk CCG's (retention), Nottingham (new business) and Homerton (new business). Revenues have also been strengthened through continued ad-hoc growth and smaller contracts across the UK. Albeit the timing of these contracts commencing was somewhat delayed it will see a full year impact in 2020 with an estimated overall revenue increase of 35% versus 2019.

Going into 2020 we have seen a slowdown on NHS procurement earlier in the year due to the COVID-19 pandemic which will have a slight impact on ERS growth plans for 2021. We are seeing a slow recovery of procurement work being picked up again by NHS in the second half of the year with a view of new contracts starting late 2021 and 2022.

Business Performance
The incremental growth in revenue has had a positive transformation of business performance and underlines the business ability to leverage the overhead structure upon growth. From the last quarter in 2019 and continued into 2020 ERS has returned to profit with the 2020 outlook to be a significant improvement from prior years.

National Minimum Wage increases of 4.8% and other inflationary pressures have had a significant impact on the operating cost of the business. This has been largely offset by price increases through contract mechanisms.

ERS has proven resilient through the COVID-19 pandemic and reacted quickly and professionally to the crisis with clear guidance and communication to our stakeholders, staff and customers. New business opportunities have presented themselves during the pandemic which ERS has captured where possible.

Our financial position should not be impacted significantly due to the pandemic and we feel our original outlook for 2020 remains robust.

Principal risks and uncertainties
The company is subject to competition for key contracts which are let periodically in open tender. The company maintains close links with key customers and focuses on quality of service as well as price to maximise retention of contracts as appropriate. The COVID19 pandemic presents a risk both to volumes and potential delay of contracts coming to market. See above for further details.

Strategic Report for the Year Ended 31 December 2019

Going concern

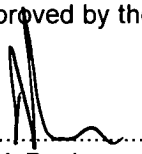
The company incurred a further loss in 2019 as a result of a change management programme commenced in 2018 and some exceptional restructuring costs which resulted in a net liability position on the balance sheet at 31 December 2019 of £2,408,318. At 31 December 2019 the company had a cash balance of £1,544,408 and net current assets of £498,173. Despite the reported loss, the business remains in a strong cash position which continued and improved throughout 2020.

In addition, business has successfully tendered and contracted with key customers which provides a degree of stability and certainty of income in the short and medium to long term. New contract wins for Homerton, Nottingham and retention of Norfolk will see guaranteed revenues and contribution for the next five to seven years. Through growth of the business overheads are being leveraged resulting in positive cashflow from the end of 2019.

The company arranged a loan as part of the acquisition to provide working capital. Post year end, ERS has agreed a settlement in respect of the loan balance ahead of the repayment date in June 2021. A new finance facility has been secured with Close Brothers to support the future business growth plans. The settlement and refinance has had a positive impact on the overall balance sheet for ERS.

Taking into account these factors, the directors have concluded that it is appropriate to prepare the financial statements on a going concern basis.

Approved by the director on 22 September 2020 and signed on its behalf by:



.....

Mr A Pooley
Director

ERS Transition Limited

Director's Report for the Year Ended 31 December 2019

The director presents his report and the financial statements for the year ended 31 December 2019.

Directors of the company
The directors who held office during the year were as follows:

Mr A Pooley

Mr A J Fraser (resigned 10 March 2020)

Mr J W Smyly (resigned 10 March 2020)

Financial instruments

Objectives and policies

The company uses financial instruments, other than derivatives, comprising cash, loans, trade debtors and trade creditors that arise directly from its operations. The main purpose of these financial instruments is to finance the company's operations.

Price risk, credit risk, liquidity risk and cash flow risk

Price risk
The company performs it services under agreed contract terms with clearly defined pricing structures, providing a high degree of certainty over pricing of work.

Currency risk
The company only maintains bank balances in Sterling and invoices and receives payment in this currency. The company is therefore not directly exposed to currency risk.

Liquidity risk
The company seeks to manage liquidity risk by ensuring sufficient liquidity is available to meet the foreseeable needs and to invest cash assets safely and profitably.

Cashflow risk
The company arranged a loan facility as part of its acquisition of certain trade and assets of SRCL Limited. This provided working capital to manage the timing of cash flows from key customers.

ERS refinanced and repaid the outstanding loan balance ahead of the repayment date in June 2021 on the 10th of August 2020. A new finance facility has been secured with Close Brothers on a minimum term basis of 30 months.

Employment of disabled persons
It is the company's policy to give full consideration to any suitable application for employment by disabled persons. Disabled persons are eligible to participate in all career development opportunities available to staff. Opportunities also exist for employees of the group who become disabled to continue in their employment or to be re-trained for other positions in the company.

Employee involvement
Two way communication with employees takes place on a formal basis through regular meetings of operational managers of all sites. There is also a formal Performance Development Plan in place for each employee with annual or bi-annual evaluation by both employee and employer which creates high levels of engagement. Additionally, informal consultations take place at all levels.

ERS Medical uses a number of channels to keep employees informed and engaged such as quarterly In-Touch magazine, Site TV monitors, social media and email correspondence.

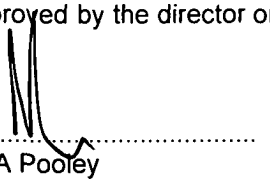
ERS Transition Limited

Director's Report for the Year Ended 31 December 2019

Disclosure of information to the auditors

The director has taken steps that he ought to have taken as a director in order to make himself aware of any relevant audit information and to establish that the company's auditors are aware of that information. The director confirms that there is no relevant information that he knows of and of which he knows the auditors are unaware.

Approved by the director on 22 September 2020 and signed on its behalf by:



.....

Mr A Pooley
Director

ERS Transition Limited

Statement of Director's Responsibilities

The director acknowledges his responsibilities for preparing the Annual Report and the financial statements in accordance with applicable law and regulations.

Company law requires the director to prepare financial statements for each financial year. Under that law the director has elected to prepare the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under company law the director must not approve the financial statements unless he is satisfied that they give a true and fair view of the state of affairs of the company and of the profit or loss of the company for that period. In preparing these financial statements, the director is required to:

- select suitable accounting policies and apply them consistently;
- make judgements and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the company will continue in business.

The director is responsible for keeping adequate accounting records that are sufficient to show and explain the company's transactions and disclose with reasonable accuracy at any time the financial position of the company and enable him to ensure that the financial statements comply with the Companies Act 2006. He is also responsible for safeguarding the assets of the company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

ERS Transition Limited

Independent Auditor's Report to the Members of ERS Transition Limited

Opinion

We have audited the financial statements of ERS Transition Limited (the 'company') for the year ended 31 December 2019, which comprise the Profit and Loss Account, Balance Sheet, Statement of Changes in Equity, Statement of Cash Flows, and Notes to the Financial Statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the company's affairs as at 31 December 2019 and of its loss for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

ERS Transition Limited

Independent Auditor's Report to the Members of ERS Transition Limited

Opinion on other matter prescribed by the Companies Act 2006
In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Strategic Report and Director's Report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception
In the light of our knowledge and understanding of the company and its environment obtained in the course of the audit, we have not identified material misstatements in the Strategic Report and the Director's Report.

We have nothing to report in respect of the following matters where the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of the director

As explained more fully in the Statement of Director's Responsibilities set out on page 6, the director is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the director determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the director is responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the director either intends to liquidate the company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Independent Auditor's Report to the Members of ERS Transition Limited

Use of our report

This report is made solely to the company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the company and the company's members as a body, for our audit work, for this report, or for the opinions we have formed.

PKF Francis Clark

.....

Glenn Nicol (Senior Statutory Auditor)
PKF Francis Clark, Statutory Auditor

Centenary House
Peninsula Park
Rydon Lane
Exeter
EX2 7XE

Date: 22 September 2020

ERS Transition Limited

Profit and Loss Account

Year Ended 31 December 2019

	Note	2019 £	2018 £
Turnover	3	23,768,533	25,141,751
Cost of sales		(18,153,353)	(19,363,241)
Gross profit		5,615,180	5,778,510
Administrative expenses			
Administrative expenses (excluding exceptional items)		(6,324,989)	(6,790,501)
Exceptional administrative expenses	4	(107,470)	(152,065)
Administrative expenses (including exceptional items)	4	(6,432,459)	(6,942,566)
Operating profit (before exceptional items)		(709,809)	(1,011,991)
Operating loss (after exceptional items)	4	(817,279)	(1,164,056)
Other interest receivable and similar income	8	288	-
Interest payable and similar charges	9	(160,738)	(147,896)
		(160,450)	(147,896)
Loss before tax		(977,729)	(1,311,952)
Loss for the financial year		(977,729)	(1,311,952)

The above results were derived from continuing operations.

The company has no recognised gains or losses for the year other than the results above.

ERS Transition Limited

Balance Sheet

31 December 2019

	Note	2019 £	2018 £
Fixed assets			
Intangible assets	11	660,211	744,379
Tangible assets	12	384,894	455,358
		1,045,105	1,199,737
Current assets			
Debtors	13	3,489,921	2,552,587
Cash at bank and in hand		1,544,408	1,995,507
		5,034,329	4,548,094
Creditors: Amounts falling due within one year	16	(4,112,530)	(2,963,936)
Net current assets		921,799	1,584,158
Total assets less current liabilities		1,966,904	2,783,895
Creditors: Amounts falling due after more than one year	16	(4,375,222)	(4,214,484)
Net liabilities		(2,408,318)	(1,430,589)
Capital and reserves			
Called up share capital		3	3
Profit and loss account		(2,408,321)	(1,430,592)
Total equity		(2,408,318)	(1,430,589)

Approved and authorised by the director on 22 September 2020

.....

Mr A Pooley
Director

Company Registration Number: 10783395

ERS Transition Limited

Statement of Changes in Equity

Year Ended 31 December 2019

	Share capital £	Profit and loss account £	Total £
At 1 January 2019	3	(1,430,592)	(1,430,589)
Loss for the year	-	(977,729)	(977,729)
Total comprehensive income	-	(977,729)	(977,729)
At 31 December 2019	3	(2,408,321)	(2,408,318)

	Share capital £	Profit and loss account £	Total £
At 1 January 2018	3	(118,640)	(118,637)
Loss for the period	-	(1,311,952)	(1,311,952)
Total comprehensive income	-	(1,311,952)	(1,311,952)
At 31 December 2018	3	(1,430,592)	(1,430,589)

ERS Transition Limited

Statement of Cash Flows

Year Ended 31 December 2019

	Note	2019 £	2018 £
Cash flows from operating activities			
Loss for the year		(977,729)	(1,311,952)
Adjustments to cash flows from non-cash items			
Depreciation and amortisation		323,893	352,317
Loss/(profit) on disposal of tangible assets		5,597	(7,600)
Finance income	8	(288)	-
Finance costs		160,738	147,896
		(487,789)	(819,339)
Working capital adjustments			
(Increase)/decrease in trade debtors		(937,334)	1,280,296
Increase in trade creditors		1,148,594	513,238
Net cash flow from operating activities		(276,529)	974,195
Cash flows from investing activities			
Interest received		288	-
Acquisitions of tangible assets		(196,410)	(84,898)
Proceeds from sale of tangible assets		21,552	32,600
Net cash flows from investing activities		(174,570)	(52,298)
Net (decrease)/increase in cash and cash equivalents		(451,099)	921,897
Cash and cash equivalents at 1 January		1,995,507	1,073,610
Cash and cash equivalents at 31 December	14	1,544,408	1,995,507

1 General information

The company is a private company limited by share capital, incorporated in England and Wales.

The address of its registered office and principal place of business is:
Angel Wings 1
First Floor
Whitehouse Street
Leeds
LS10 1AD

These financial statements were authorised for issue by the director on 22 September 2020.

2 Accounting policies

Summary of significant accounting policies and key accounting estimates
The principal accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

Statement of compliance
These financial statements were prepared in accordance with Financial Reporting Standard 102 'The Financial Reporting Standard applicable in the UK and Republic of Ireland'. There are no departures from FRS102.

Basis of preparation
These financial statements have been prepared using the historical cost convention.

The functional currency is considered to be pounds sterling because that is the currency of the primary economic environment in which ERS Transition operates.

2 Accounting policies (continued)

Going concern
The financial statements have been prepared on a going concern basis.

The company incurred a further loss in 2019 as a result of a change management programme commenced in 2018 and some exceptional restructuring costs which resulted in a net liability position on the balance sheet at 31 December 2019 of £2,408,318. At 31 December 2019 the company had a cash balance of £1,544,408 and net current assets of £498,173. Despite the reported loss, the business remains in a strong cash position which continued and improved throughout 2020.

In addition, business has successfully tendered and contracted with key customers which provides a degree of stability and certainty of income in the short and medium to long term. New contract wins for Homerton, Nottingham and retention of Norfolk will see guaranteed revenues and contribution for the next five to seven years. Through growth of the business overheads are being leveraged resulting in positive cashflow from the end of 2019.

The company arranged a loan as part of the acquisition to provide working capital. Post year end, ERS has agreed a settlement in respect of the loan balance ahead of the repayment date in June 2021. A new finance facility has been secured with Close Brothers to support the future business growth plans. The settlement and refinance has had a positive impact on the overall balance sheet for ERS.

Taking into account these factors, the directors have concluded that it is appropriate to prepare the financial statements on a going concern basis.

Key sources of estimation uncertainty
The key assumptions concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Goodwill arising on the acquisition of the trade and assets of SRCL Limited is being amortised over its useful life which has been estimated by the directors as 10 years. At the year end the carrying value of goodwill is £660,211 (2018 - £744,379).

Revenue recognition
Turnover is stated net of VAT and trade discounts and is recognised when the significant risks and rewards are considered to have transferred.

Turnover is recognised to the extent that the company obtains the right to consideration in exchange for its performance. Specifically, revenue from the rendering of services is recognised when the service has been completed. Where customers are invoiced in advance of services an element of this income will be deferred at the year end.

Tax
Tax is recognised in profit or loss, except that a change attributable to an item of income or expense recognised as other comprehensive income is also recognised directly in other comprehensive income.

2 Accounting policies (continued)

The current corporation tax charge is calculated on the basis of tax rates and laws that have been enacted or substantively enacted by the reporting date in countries where the company operates and generates taxable income.

Tangible assets

Tangible assets are stated in the balance sheet at cost, less any subsequent accumulated depreciation and subsequent accumulated impairment losses.

The cost of tangible assets includes directly attributable incremental costs incurred in their acquisition and installation.

Depreciation

Depreciation is charged so as to write off the cost of assets, other than land and properties under construction over their estimated useful lives, as follows:

Asset class	Depreciation method and rate
Buildings	Shorter of life of lease or 30 years
Furniture, fittings and equipment	Over 5 - 10 years
Plant and machinery	Over 5 - 10 years
Computer equipment	Over 3 - 5 years
Motor vehicles	Over 2 - 3 years

Intangible assets

Goodwill arising on the acquisition of the trade and assets of SRCL Limited, representing any excess of fair value of the consideration given over the fair value of the identifiable assets and liabilities acquired, is capitalised and written off over its useful economic life, which is 10 years. Development costs represent mobilisation costs for new contracts taken on during the year. These costs are written off over the life of the contract (5 years). Provision is made for any impairment.

Leases

Leases in which substantially all the risks and rewards of ownership are retained by the lessor are classified as operating leases. Payments made under operating leases are charged to profit or loss on a straight-line basis over the period of the lease.

Defined contribution pension obligation

A defined contribution plan is a pension plan under which fixed contributions are paid into a pension fund and the company has no legal or constructive obligation to pay further contributions even if the fund does not hold sufficient assets to pay all employees the benefits relating to employee service in the current and prior periods.

Contributions to defined contribution plans are recognised as employee benefit expense when they are due. If contribution payments exceed the contribution due for service, the excess is recognised as a prepayment.

2 Accounting policies (continued)

Financial instruments

Classification

The company holds the following financial instruments:

- Short term trade and other debtors and creditors;
- Amounts owed to group undertakings;
- Short and long-term loans; and
- Cash and bank balances.

All financial instruments are classified as basic.

Recognition and measurement

The company has chosen to apply the recognition and measurement principles in FRS102.

Financial instruments are recognised when the company becomes party to the contractual provisions of the instrument and derecognised when in the case of assets, the contractual rights to cash flows from the assets expire or substantially all the risks and rewards of ownership are transferred to another party, or in the case of liabilities, when the company's obligations are discharged, expire or are cancelled.

Except for bank loans, such instruments are initially measured at transaction price, including transaction costs, and are subsequently carried at the undiscounted amount of the cash or other consideration expected to be paid or received, after taking account of impairment adjustments.

Bank loans are initially measured at transaction price, including transaction costs, and are subsequently carried at amortised cost using the effective interest method.

3 Revenue

The analysis of the company's revenue for the year from continuing operations is as follows:

	2019	2018
	£	£
Provision of services - UK	23,768,533	25,141,751

4 Operating loss

Arrived at after charging/(crediting)

	2019	2018
	£	£
Depreciation expense	239,725	269,041
Amortisation expense	84,168	83,276
Loss/(profit) on disposal of property, plant and equipment	5,597	(7,600)
Exceptional administrative expenses	107,470	152,065

Exceptional costs relate to restructuring expenses.

5 Staff costs

The aggregate payroll costs (including directors' remuneration) were as follows:

	2019	2018
	£	£
Wages and salaries	13,917,191	15,211,486
Social security costs	963,788	1,057,203
Pension costs, defined contribution scheme	377,633	325,685
	15,258,612	16,594,374

The average number of persons employed by the company (including the director) during the year, analysed by category was as follows:

	2019	2018
	No.	No.
Administration and support	770	857

6 Director's remuneration

The director's remuneration for the year was as follows:

	2019 £	2018 £
Remuneration	175,359	149,787
Contributions paid to money purchase schemes	5,332	1,600
	180,691	151,387

During the year the number of directors who were receiving benefits and share incentives was as follows:

	2019 No.	2018 No.
Accruing benefits under money purchase pension scheme	1	2

7 Auditor's remuneration

	2019 £	2018 £
Audit of the financial statements	14,400	14,000

8 Other interest receivable and similar income

	2019 £	2018 £
Interest receivable	288	-

9 Interest payable and similar expenses

	2019 £	2018 £
Interest expense on other finance liabilities	160,738	147,896

10 Taxation

Tax charged/(credited) in the profit and loss account

	2019 £	2018 £
Current taxation		
UK corporation tax	-	-
Deferred taxation		
Total deferred taxation	-	-
Tax expense/(receipt) in the profit and loss account	-	-

The tax on profit before tax for the year is lower than the standard rate of corporation tax in the UK (2018 - lower than the standard rate of corporation tax in the UK) of 19% (2018 - 19%).

The differences are reconciled below:

	2019 £	2018 £
Loss before tax	(977,729)	(1,311,952)
Corporation tax at standard rate	(185,769)	(249,271)
Effect of expense not deductible in determining taxable profit (tax loss)	(21,222)	16,261
Tax increase from effect of unrelieved tax losses carried forward	206,991	233,010
Total tax charge/(credit)	-	-

11 Intangible assets

	Goodwill £	Total £
Cost or valuation		
At 1 January 2019	841,683	841,683
At 31 December 2019	841,683	841,683
Amortisation		
At 1 January 2019	97,304	97,304
Amortisation charge	84,168	84,168
At 31 December 2019	181,472	181,472
Carrying amount		
At 31 December 2019	660,211	660,211
At 31 December 2018	744,379	744,379

12 Tangible assets

	Furniture, fittings and equipment £	Motor vehicles £	Plant and machinery £	Total £
Cost or valuation				
At 1 January 2019	618,295	33,238	89,757	741,290
Additions	71,606	123,286	1,518	196,410
Disposals	-	(27,823)	-	(27,823)
At 31 December 2019	689,901	128,701	91,275	909,877
Depreciation				
At 1 January 2019	254,914	1,788	29,230	285,932
Charge for the year	181,662	33,024	25,039	239,725
Eliminated on disposal	-	(674)	-	(674)
At 31 December 2019	436,576	34,138	54,269	524,983
Carrying amount				
At 31 December 2019	253,325	94,563	37,006	384,894
At 31 December 2018	363,381	31,450	60,527	455,358

13 Debtors

	2019 £	2018 £
Trade debtors	2,178,608	2,257,241
Other debtors	11,312	3,939
Prepayments	1,245,001	291,407
Accrued income	55,000	-
	3,489,921	2,552,587

Details of non-current Debtors

£335,998 (2018 -£Nil) of Prepayments is classified as non current.

14 Cash and cash equivalents

	2019 £	2018 £
Cash at bank	1,544,408	1,995,507

15 Analysis of cash and cash equivalents and net debt

	At 1 January 2019 £	Cash flow £	Non cash changes £	At 31 December 2019 £
Cash at bank and on hand	1,995,507	(451,099)	-	1,544,408
Cash and cash equivalents	1,995,507	(451,099)	-	1,554,408
Other loans	(4,214,484)	-	(160,738)	(4,375,222)
Net debt	(2,218,977)	(451,099)	(160,738)	(2,830,814)

16 Creditors

	Note	2019 £	2018 £
Due within one year			
Trade creditors		1,497,090	651,692
Social security and other taxes		532,194	554,102
Outstanding defined contribution pension costs		142,171	301,351
Other creditors		220,665	20,674
Accrued expenses		1,720,410	1,436,117
		4,112,530	2,963,936
Due after one year			
Loans and borrowings	17	4,375,222	4,214,484

17 Loans and borrowings

	2019 £	2018 £
Non-current loans and borrowings		
Other borrowings	4,375,222	4,214,484

Other borrowings

Other borrowings represent a loan denominated in Sterling with a nominal interest rate of 1.5% above LIBOR%, repayable by 22 May 2021. The carrying amount at the period end is £4,375,222 (2018 - £4,214,484).

The loan is secured on the trade debtors of the company.

18 Obligations under leases and hire purchase contracts

Operating leases
The total of future minimum lease payments is as follows:

	2019 £	2018 £
Not later than one year	2,280,460	1,362,631
Later than one year and not later than five years	6,009,094	2,573,329
Later than five years	97,617	33,670
	8,387,171	3,969,630

The amount of non-cancellable operating lease payments recognised as an expense during the year was £2,053,936 (2018 - £2,205,043).

19 Pension and other schemes

Defined contribution pension scheme

The company operates a defined contribution pension scheme. The pension cost charge for the year represents employer contributions payable by the company to the scheme and amounted to £377,633 (2018 - £325,685).

Employee and employer contributions totalling £142,171 (2018 - £301,351) were payable to the scheme at the end of the year and are included in creditors.

20 Share capital

Allotted, called up and fully paid shares

	2019		2018	
	No.	£	No.	£
Ordinary shares of £1 each	3	3	3	3

21 Related party transactions

Summary of transactions with entities with joint control or significant interest

First Care Ambulance Limited

During the year ERS Transition Ltd made sales of £15,181 (2018: £49,038) to and purchases of £27,875 (2018: £25,866) from First Care Ambulance Ltd a company in which Mr A Pooley and Mr A Fraser are Directors. The balance owed to First Care Ltd at the year end was £4,158 (2018: £6,000).

Ambulance Sales & Hire Limited

During the year ERS Transition Ltd made purchases of £24,480 (2018: £nil) from Ambulance Sales & Hire Limited a company in which Mr A Fraser is a director. The balance owed to Ambulance Sales and Hire Limited was £2,520 (2018: £nil).

22 Controlling party

The controlling parties during the year were the Directors' who jointly own 100% of the ordinary share capital of ERS Transition Ltd. Since the year end Mr A Pooley has become the sole controlling party.

ERS Medical

BMS/5.01 Incident Reporting and Investigation

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.2	**Date Active:**	19.10.2020	**Review Date:**	31.03.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2	All	All	All	16/01/18	[redacted]	Review of whole doc to include insurance notifications.
2.1	7	14	9	24/01/18	[redacted]	Review to clarify this for witness statements
2.2	All	All	All	13/04/18	[redacted]	Addition of review date
3.0	All	All	All	11.03.19	[redacted]	Annual Review
3.1	All	All	All	14.10.19	[redacted]	Change of Broker Review
4.0	All	All	All	24.03.20	[redacted]	Annual Review
4.1	7 & 11	All	All	28.07.20	[redacted]	Clarification for TRN reporting
4.2	7	.16 & .17	10	19.10.20	[redacted]	Clarification on Initial Investigations

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Company Car Driving	BMS/2.04
Serious Untoward Incidents (SUI) Investigations	BMS/5.02
Statutory Notifications – A Registered Managers Guide	BMS/5.03
Business Continuity Plans	BMS/5.04
Incident Report Form	F5.01.01
Incident Report – Annex A	F5.01.01a
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Incident Report – Annex C	F5.01.01c
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Incident Report – Annex E	F5.01.01e
Accident / Incident Witness Statement	F5.01.02
Accident Information / Employee Liability Claim Information Form	F5.01.03
Motor Vehicle Claim Information Form	F5.01.04
Uninsured Loss Recovery	F5.01.05
Serious Incident Investigation	F5.01.06
Shared Learning	F5.01.07
Needle-stick / Bite / Scratch Injury Referral Form	F5.01.08
Incident Response Test	F5.01.11

3. Introduction

3.1 To ensure the systematic reporting of all on or off-site incidents and the collection of relevant data, to enable an appropriate investigation to occur and when necessary the implementation of suitable corrective actions so as to prevent a recurrence.

3.2 To define the responsibilities of personnel with regard to incident reporting and review and to ensure the systematic review of all incidents in order to trend, analyse and understand statistical performance within ERS Medical.

3.3 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.4 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 It is ERS Medical policy to ensure that all accidents, incidents and near misses are reported and investigated fully so as to identify immediate, underlying and root causes. Such that risk control measures can be identified so as to prevent recurrences and comply with legal obligations.

4.2 Please also refer to ERS Medical's Quality, Environmental, Safety and Health Policy.

4.3 Please also refer to ERS Medical's Business Continuity Policy.

4.4 Please also refer to ERS Medical's Information Security Policy.

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained, and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Health and Safety Manager and Advisors**	Are responsible for reviewing incident reports that have the potential to or have impacted the environment, injured a member of staff or the public and caused an information security breach. Additionally, responsible for liaising with any regulatory or legal bodies. Are responsible for providing training on ERS Medical requirements for incident reporting and investigation. Are responsible for writing to customers (as appropriate), requesting an investigation to be conducted and subsequently reviewing the customer's response to ensure they are satisfactory. Responsible for making the respective CQC Registered Manager aware of any CQC statutory notifications.
5.4	**Clinical Team**	Are responsible for reviewing incident reports that have the potential to or have caused injury to patients. Additionally, responsible for liaising with any regulatory or legal bodies. Are responsible for providing training on ERS Medical requirements for incident reporting and investigation. Responsible for making the respective CQC Registered Manager aware of any CQC statutory notifications and assisting them in the notification process.
5.5	**Care Standards Team**	Are responsible for reviewing incident reports that involve Company vehicles. Additionally, responsible for liaising with any regulatory or legal bodies.
5.6	**Senior Operations Managers, Operations Managers & Team Leaders**	Have day to day responsibility for ensuring that this procedure is put into practice within their areas of control and are responsible for ensuring that all incidents are reported and investigated.
5.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

This document forms part of the ERS Medical Ltd, BMS and as such is subject to controlled distribution and updating in accordance with: BMS/1.01 – Document Control and BMS/1.02 – Record Retention, Storage and Disposal. Uncontrolled when printed.

6. Definitions

6.1 **Accident / Incident** – unplanned event that results in personal injury or damage to property, equipment or the environment, theft of data etc.

6.2 **Near Miss** – unplanned event that has the potential to (but did not) cause:

- Harm to an individual or individuals;
- Harm to the environment;
- Damage to vehicles and property;
- A security or data protection breach.

6.3 **Health and Safety Incidents**:

- Injuries and accidents reportable to a health and safety regulator;
- Needle-stick / sharps injuries;
- Minor injuries;
- Threat (e.g. physical or verbal) to a member of staff by a customer or third party whilst conducted their duties;
- Security breach, fire or other similar events (but not a data security incident);
- A complaint from interested parties;
- A warning letter or notice is issued by a regulatory agency;
- Any other event that did cause or had the potential to cause injury, loss of life, or damage to plant and equipment.

6.4 **Transport Incident**:

- Any incident that occurred through the operation (driving) of a Company vehicle;
- Any other event that did cause or had the potential to cause injury, loss of life, or damage through the driving or operation of a Company vehicle.

6.5 **Clinical Incident / Accident -** Is an event or circumstance which did (or could have) harm(ed) a patient(s). This includes “no harm” events whereby the incident reached the patient but did not cause actual harm.

6.6 **Data Security Incident**:

- Loss of a laptop containing personal, Company, customer or patient information;
- Access of a computer program or information using someone else’s authorisation;
- Loss or disclosure of Customer information;
- Loss or disclosure of Patient information;
- Any incident which breaches Company confidentiality including data loss, e.g. confidential or personal information left on screen.

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6.7 **Significant / Serious Untoward Incident** - Is an incident that is exceptional which has (or has the potential to) caused a loss of life, major injury, business reputation and is likely to attract public and media interest.

6.8 **Immediate Cause** – the direct cause of the accident, incident or near miss.

6.9 **Underlying Cause** - unsafe acts or omissions.

6.10 **Root Causes** – the ultimate failings from which others emerge, usually organisational.

6.11 **Control Measures** – technical, procedural or behavioural measures.

7. Reporting and Investigation Process

7.1 The aim of this procedure is to ensure that all incidents that occur within ERS Medical's operations are reported and investigated including:

- Health and Safety incidents;
- Clinical / Safeguarding incidents;
- Transport incidents
- Information Governance / Data Security incidents;
- Environmental incidents;
- Near misses.

7.2 This procedure has been designed to identify corrective action in order to prevent similar occurrences happening again. All actions raised from this process will be documented in accordance with **BMS/1.04 – Action Plans** and tracked through [redacted]

7.3 For all incidents that occur off / away from an ERS Medical site all incident reports should be made via the Contact Centre of Operations (CCO) [redacted]

7.4 All incidents **MUST** be reported where practicable on the same day that the incident occurs. All late reporting was be explained at the point of reporting to the CCO. The only exception to this is Transport (TRN) incidents which need to reported immediately (**within 1 hour**), so that our insurers can control our third-party costs.

7.5 If staff members are directed to the answer service, they should leave their contact details / resource number so that the CCO call agents can call them back and take the incident details.

7.6 In support of the telephone reporting system ERS Medical operates an on-line incident reporting system, [redacted] This should be utilised to report all types of incidents, which occur on site or where contact with the CCO could not be made.

7.7 Once completed any electronic / paper incident documentation must be submitted as soon as possible and within 48 hours to the Site Management Team who will add the incident to [redacted]

7.8 [redacted] acts as a direct replacement for documents **F5.01.01a - F5.01.01e**.

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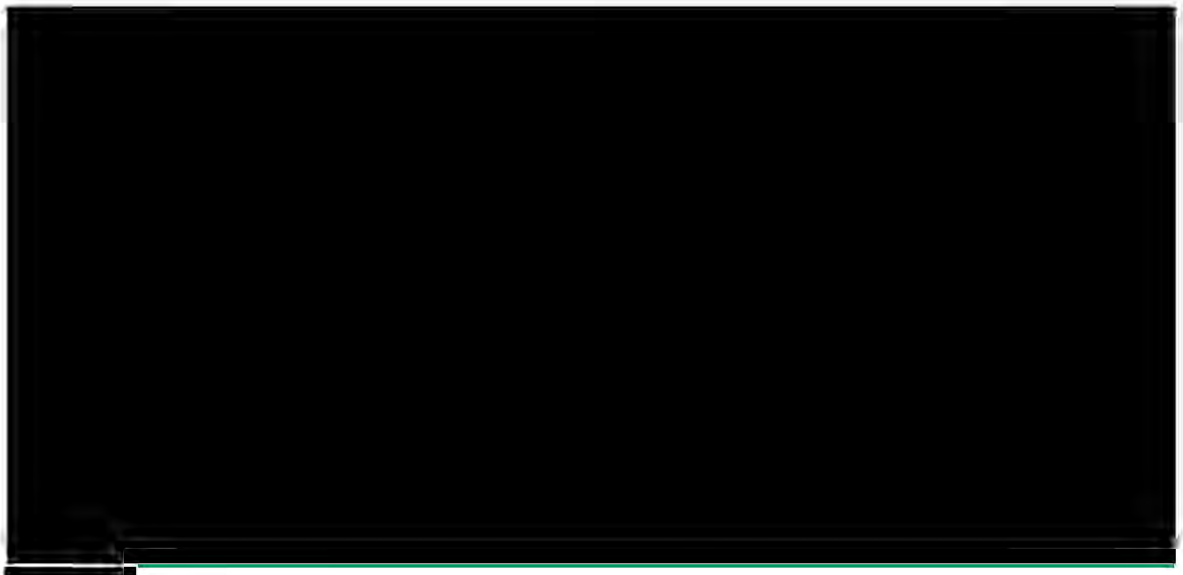
[redacted] Reporting

7.9 All ERS Medical Incidents will be recorded using the [redacted]

7.10 Once called into the CCO the agent will create a 'New Event' on [redacted] and assign this to the site that the reporting staff are assigned to on [redacted]

7.11 The CCO agent will also select the most appropriate incident 'Type' from the then available drop-down list. Further guidance on the correct selection type can come from either:

- [redacted] Incident Reporting Guide pdf
- [redacted] Incident Reporting Guide Mental Health Service pdf
- The on-call Care Standards Team member


[redacted] Event Screen

7.12 Once an incident has been recorded on the [redacted] it will automatically notify the appropriate Operational and Care Standards staff of the event and assign workflow for the event.

7.13 Any event, that has in the determination of the Care Standards Team, been categorised incorrectly will first be downloaded as a pdf, then abandoned on the system stating the reason. The pdf version will then be sent back to the CCO, with Operations copied in, stating that it has been raised incorrectly and detail which event type it should be categorised against.

7.14 The CCO Manager / Team Leader(s) are then responsible to ensure the CCO agent is informed of their error and that the incident is raised again, against the correct 'type' as soon as possible.

7.15 All pdf versions of the event are then to be deleted.

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Event Workflow

7.16 All events, with the exception of 'Concerns' will follow a standard workflow process as detailed below:

Workflow Stage:	Assigned to:	Days to Complete:
Initial Investigation	Operations Managers *This can be delegated to operational Team Leaders and Lead Drivers if required.*	14 Days
Initial Compliance Investigation	Relevant SME from the Care Standards Team	7 Days
Technical Review	Relevant SME from the Care Standards Team	14 Days from the completion of the Initial Investigation
Action Plan	Relevant SME from the Care Standards Team	14 Days from the completion of the Initial Investigation
Risk Score	Relevant SME from the Care Standards Team	14 Days from the completion of the Initial Investigation

7.17 When an event has been recorded on the [redacted] system for an operational site i.e. not a control room or CCO. The initial investigation can only be delegated by the site Operations Manager to an Operational Team Leader or Lead Driver. Operational incidents are NOT to be delegated to either control room Managers or Team Leaders.

7.18 The associated forms and any supporting documentation and photographs must be submitted to the incident system or the relevant compliance team as soon as possible or within 48 hours of the event occurring.

7.19 In the event of a transport incident in the UK, [redacted] should be notified as soon as is possible. This can be completed by the driver at the roadside or where this is not possible, the relevant Site Management Team Member or Control Centre (ERS Medical).

7.20 Significant / serious incidents must be reported immediately to your Site Management Team and the relevant Compliance Team member so that Senior Management can be notified, and the appropriate actions implemented.

7.21 When required (when the report cannot be made via the CCO), the staff member involved in an incident or near miss, is required to complete Parts A and B of the Incident Report (F5.01.02), before passing it to their Site Management Team within 48 hours of the incident occurring.

7.22 Copies of this documentation should be made and forwarded to the Site Management Team to allow for an investigation to be conducted and an entry made onto Radar Healthcare. Where possible / relevant, photographs should be taken and submitted.

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7.23 Additionally, the appropriate annex document must be completed by the Line Manager to accompany the Incident Report, these are:

Annex	Incident
Annex A	A member of staff, a contractor or visitor has been injured.
Annex B	An ERS Medical vehicle has been damaged or caused damage to another vehicle or property.
Annex B	A member of the public has been injured because of a collision with an ERS Medical vehicle.
Annex B	An ERS Medical vehicle (or part of) has been stolen.
Annex C	There has been an unauthorised release to the environment.
Annex D	An incident which results in the loss of sensitive confidential data or patient information.
Annex E	An incident which involves a patient.

7.24 A witness statements will be recorded using form **F5.01.03**, written in the witness's own hand, signed and dated. These statements must be recorded as soon as is practicable after the accident / incident, ideally within 24 hours of the event.

7.25 Upon receiving an Incident Report notification from [redacted] automated alert system, an initial investigation is carried out by the Site Management Team. The investigation will determine the primary root cause(s) of the incident as well as any contributing factors.

7.26 Additionally, the Site Management Team will identify and record, the immediate actions taken to control the situation as well as the actions to prevent a recurrence.

7.27 The relevant Compliance Team member will review the report and depending on the circumstances of the incident:

- May request further information from the Site Management Team;
- May make a recommendation to the relevant Senior Operations Manager (CQC Registered Manager) that a statutory notification to the CQC or other regulatory body is required;
- Undertake a more detailed investigation in person (e.g. incidents with major injuries);
- Refer the report to senior management for comment or further action.

7.28 All reporting of an H&S incident to a regulatory authority will be carried out by the H&S Team after having first considered the relevant regulatory guidance.

7.29 For more details on the requirements of making statutory notifications please refer to **BMS/5.03 – Statutory Notifications – A Guide for Registered Managers.**

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Incident Calls

7.30 A call will be arranged to discuss all incidents by the relevant compliance team member, 48-72 hours after the event with the following exceptions:

- **Health and Safety / Clinical / CQC Regulated Activity** - Only incidents which are reportable in UK & Ireland, or which have concerning aspects (repeated incidents or high potential risk), should have calls or within the notification requirements of the Care Quality Commission (Registration) Regulations 2009;

7.31 The attendee list for the call (notified by [redacted] (Notices) will be:

- Site Operations Manager and or Team Leader;
- Senior Operations Manager (CQC Registered Manager);
- H&S / Clinical Team Member (who will lead the call);
- Senior Leadership Team (for Serious Untoward Incidents (SUI));
- HR (Peninsula Group Limited) if required.

7.32 The agenda for the call will be:

- Care Standards Team Member will open the call and check attendance;
- Site representation will be asked to introduce the incident and walk through the findings so far;
- Statutory notification required;
- Initial actions taken;
- Initial root / contributing causes;
- Call then opened for questions;
- Training records discussed for individual / individuals affected or involved;
- Individual involved / affected is discussed to determine on-going support required;
- Decision reached on the need to investigate under disciplinary procedures;
- Compliance Team Member summarises actions and assigns to individuals on the call with timeframes agreed;
- Call is closed and if required a follow up call may be scheduled.

Incident Review

7.33 The Head of Care Standards in conjunction with the other Department Heads and other appropriate Company Managers will regularly review all incidents to identify employees who have been involved in two or more incidents in the previous 12-month period.

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7.34 Where the incidents are determined to have resulted from the actions, omissions, or negligence of a member of staff formal proceedings will be instigated in line with the following guidelines:

Incidents in a 12 Month Period	Action
2	The employee's Line Manager will hold informal discussions with the employee to determine if there is an underlying reason for the incidents and to identify additional support / training / guidance as appropriate. A file note will be placed on the employees file.
3	The employee's regional/ Site / Line Manager will hold a formal meeting with the employee to review the incidents and the support previously provided by ERS Medical. The required improvements will be identified. A Letter of Concern (Formal Improvement Notice) will be placed on the employee file.
4	Verbal Warning in accordance with the Company's Disciplinary Procedures.
5	Written Warning in accordance with the Company's Disciplinary Procedures.
More than 5	Final Written Warning, Demotion or Dismissal in accordance with the Company's Disciplinary Procedures.

7.35 Dependent upon the circumstances and the nature of incident/accident, the Company reserves the right to move straight to any of the sanctions above or not act in accordance with the prescribed actions.

8. Health and Safety Incidents

8.1 All incidents should in best practice follow the requirements of Section 7 of this procedure and follow the [redacted] system prompts and requirements.

8.2 If this is not possible then the reporter should complete a **F5.01.02**, when an injury has occurred, employees must also complete the facilities accident book, detailing specific information relating to the event.

8.3 The accident book page must accompany the Incident Report and be handed to the Site Management Team.

8.4 Upon receipt of the Incident Report and supporting documentation, the Site Management Team will complete Annex A, undertake an investigation into the event, gather any additional information (e.g. witness statements) and document their findings on **F5.01.02** in section C.

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8.5 Once completed **F5.01.02** and all supporting documentation will be attached to the [redacted] event for the relevant Compliance Team Member to review.

8.6 Once reviewed the relevant Compliance Team Member may request further information by way of additional paperwork or/and the re-interviewing of Staff/Visitors/Contractors/Patients.

8.7 The interviewing of Staff/Visitors/Contractors/Patients will be documented using **F5.01.03 - Accident Incident Statement.** The completed **F5.01.03** document will be dated and signed by both interviewer and interviewee.

8.8 In the case of a SUI interviews may be conducted using a Dictaphone. Recordings will be downloaded and attached to the relevant event in [redacted]. In the event of the case files being requested by insurers or regulatory bodies the recording will be transcribed to a reading document.

Notifiable Accidents

8.9 Legislation requires certain incidents to be reported to the relevant regulator, these include:

- Dangerous Occurrence (determined by the H&S Manager and/or Head of Care Standards);
- Major Injury (determined by the H&S Manager and/or Head of Care Standards);
- Fatality;
- UK - Over 7-day injuries (Site Management Team to notify relevant Care Standards Team Member).

Serious Untoward Incidents – RIDDOR.

8.10 If someone has died or has been injured because of a work-related accident this may have to be reported. Not all accidents need to be reported, other than for certain gas incidents, a RIDDOR report is required only when:

- The accident is work-related;
- It results in an injury of a type which is reportable.

8.11 Please refer to **BMS/5.02 – Serious Untoward Incidents (SUI)** for more details on the management and reporting requirements for any incident categorised as a SUI.

Specified injuries to workers:

- Fractures, other than to fingers, thumbs, and toes;
- Amputations;
- Any injury likely to lead to permanent loss of sight or reduction in sight;
- Any crush injury to the head or torso causing damage to the brain or internal organs;
- Serious burns (including scalding) which: covers more than 10% of the body;
- Causes significant damage to the eyes, respiratory system, or other vital organs;
- Any scalping requiring hospital treatment;
- Any loss of consciousness caused by head injury or asphyxia;
- Any other injury arising from working in an enclosed space which leads to hypothermia;
- Leads to heat induced illness;
- Requires resuscitation or admittance to hospital for more than 24 hours.

Over-seven-day incapacitation of a worker:

8.12 Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury. This seven-day period does not include the day of the accident, but does include weekends and rest days. The report must be made within 15 days of the accident.

Non-fatal accidents to non-workers (eg members of the public):

8.13 Accidents to members of the public or others who are not at work must be reported if they result in an injury and the person is taken directly from the scene of the accident to hospital for treatment to that injury.

SUI/RIDDOR reporting:

8.14 The Health and Safety Manager and/or the Head of Care Standards shall be responsible for overseeing the investigation and ensuring that sufficient resources are available to the Health and Safety Team Member to complete the incident investigation and implement the necessary actions to prevent a reoccurrence in accordance with **BMS/1.04 – Action Plans**.

8.15 In all instances, the H&S Manager and/or the Head of Care Standards will be responsible for ensuring the relevant regulatory body is notified.

Accident Books

8.16 To comply with legislation, a record of injuries that happen to employees must be maintained at each facility in an accident book. Employees, or people acting on their behalf, can enter details of accidents leading to injury. The book should be kept in a place where any employee can get to it at all reasonable times.

8.17 Employers are required under both statute and common law to keep personal information confidential. Information can only be disclosed if, for example, there is a statutory requirement to do so; or an individual has consented to their personal information being disclosed to a third party, such as a safety representative.

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8.18 If an injury is sustained at a customer facility, then the customer must be notified prior to leaving site and a record of the incident made in their accident book.

8.19 In order to achieve this Regional / Site / The Site Management Team must:

- Enter a number in the box on the front cover of the book to ensure identification;
- Enter the facility details on the inside cover of the accident book;
- Number each of the records and the corresponding box on the page stub;
- Keep completed books in a safe place, so the accident records can be matched to the stubs;
- Accident records, and each set of book covers, must be kept for at least three years;
- Ensure the safekeeping of completed records.

Needle-stick / Sharps Injury Reporting

8.20 In addition to the steps listed above, following the occurrence of a needle-stick / sharps injury, **F5.01.10 Needle Stick Injury Referral Form** must be completed and submitted to the relevant Compliance Team Member.

8.21 Additionally, the needle / package / container must be quarantined immediately. The needle / package / container must be brought to the attention of the customer if applicable, to enable the investigation to be completed.

8.22 Once the customer has been identified and the details of the incident fully understood, communication must be made to the customer explaining what has occurred and that a formal investigation and response is expected.

8.23 Once a satisfactory response has been received from the customer this must be uploaded onto the [redacted] event log to accompany the initial report and investigation. Once attached the event will be reviewed and closed by the relevant Compliance Team Member.

8.24 In the event that the response is not forthcoming, or is not satisfactory, the Compliance Team Member must notify the Head of Care Standards and the responsible Senior Operations Manager, who will take any action deemed necessary.

9. Clinical Incident

9.1 All incidents should in best practice follow the requirements of Section 7 of this procedure and follow the on-line incident system prompts and requirements.

9.2 If this is not possible then where a clinical incident / accident has occurred, employees must complete the **F5.01.02** document, detailing specific information relating to the event.

9.3 Upon receipt of the Incident Report and supporting documentation, the Site Management Team will complete the [redacted] event log and undertake an investigation into the event, gathering any additional information (e.g. witness statements) and document their findings on **F5.01.02** in section C.

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9.4 Once completed, **F5.01.02** and all supporting documentation will be added to the [redacted] event for the relevant Compliance Team member to review.

Serious Untoward Incidents

9.5 A serious untoward incident (SUI) is an incident that occurred, which resulted in one or more of the following:

- Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- A never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death;
- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- Allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

9.6 The preliminary determination as to whether an incident is a potential SUI will be made by the Head of Care Standards having due regard to the relevant health authority guidance. The determination is made independent of any decision made by the customer who commissioned the service as to whether the incident is a SUI.

9.7 The Head of Care shall be responsible for overseeing the investigation and ensuring that sufficient resources are available to the Compliance Team Member to complete the incident investigation and implement the necessary actions to prevent a reoccurrence in accordance with **BMS/1.04 – Action Plans.**

9.8 The outcome of the investigation of a potential SUI, together with the proposed Corrective and Preventative Actions, shall be reviewed by the regional Governance and Patient Safety (GaPS) committee.

Reportable Incidents

9.9 For statutory reportable incidents please refer to **BMS/5.03 – Statutory Notifications – A Registered Managers Guide**.

10. Information Governance / Security Incidents

10.1 All incidents should in best practice follow the requirements of Section 7 of this procedure and follow the on-line incident system prompts and requirements.

10.2 If this is not possible, whenever a data security incident occurs, employees must complete the **F5.01.02** document, detailing specific information relating to the event.

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10.3 Upon receipt of the Incident Report and supporting documentation, the Line Manager will complete Annex D, undertake an investigation into the event, gather any additional information (e.g. witness statements) and document their findings on **F5.01.02** in section C.

10.4 Once completed, **F5.01.02** and all supporting documentation will be added to the [redacted] event for technical review and closure by the Head of Care Standards.

11. Transport / Road Traffic Incidents

11.1 All incidents should in best practice follow the requirements of Section 7 of this procedure and follow the on-line incident system prompts and requirements.

11.2 Transport events must be reported immediately (within 1-hour) so that our insurers providers can control and limit any third-party costs associated with these types of incidents.

11.3 Photographic evidence (non-patient) should ideally be captured by ERS Medical staff at the scene as a record of any third-party damage. This must them be uploaded to the [redacted] and made available to our insurers upon request.

11.4 If the vehicle is fitted with the "Crystal Ball" recording system, then this must be submitted for inclusion in the investigation process.

11.5 Whenever a transport or road traffic accident has occurred, employees must complete the F5.01.02 document detailing specific information relating to the event.

11.6 Upon receipt of the Incident Report and supporting documentation, the Site Management Team will complete Annex B, undertake an investigation into the event, gather any additional information (e.g. witness statements) and document their findings on F5.01.02 in section C.

11.7 Once completed F5.01.02 and all supporting documentation attached to the [redacted] event for review by the relevant Compliance Team Member.

11.8 When a Fleet / Transport incident occurs, this should be initially reported through the CCO or Local Control and an incident raised on the [redacted] compliance platform.

11.9 The [redacted] system will prompt the CCO agent / Local Controller on which questions need to be answered. The most important priority is to identify if there are any patients on board and if either they employees or 3rd parties have been injured and if emergency services have been called in appropriate.

11.10 Once all the required fields have been completed and the incident submitted, the automated notification system should ensure that the relevant manager and compliance team manager has been informed. In addition to this the [redacted] system should automatically e-mail the insurance broker with all required initial information.

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11.11 The automated Fleet insurance brokers e-mail address is:

[redacted]

11.12 Once the insurance broker has received the notification email, they will e-mail back a notification reference to be added to the incident record. It will be the responsibility of the relevant Health and Safety Team member to do this.

12. Notifiable Incidents

12.1 Where a patient is injured follow the provisions of **BMS/5.03 – Statutory Notifications – A Registered Managers Guide** and or the requirements of RIDDOR.

13. Environmental Incidents

13.1 All incidents should in best practice follow the requirements of Section 7 of this procedure and follow the on-line incident system prompts and requirements.

13.2 If this is not possible and whenever an environmental incident has occurred, employees must complete the **F5.01.02** document, detailing specific information relating to the event.Upon receipt of the Incident Report and supporting documentation, the Site Management Team Member will complete Annex C, undertake an investigation into the event, gather any additional information (e.g. witness statements) and document their findings on **F5.02.02** in section C.

13.3 Once completed **F5.02.02** and all supporting documentation will be attached to the [redacted] event for review and closure by the Head of Care Standards.

14. Notifications to Company Insurance Brokers

14.1 It is essential that the ERS Medical insurance brokers are notified as soon as reasonably practicable for all incidents, irrespective of type, to ensure that there can be no dispute over awareness and possible coverage.

14.2 For each incident type and potentially broker there will be differences in the notification process to be followed.

14.3 Ultimate responsibility for ensuring that insurance brokers are notified in a timely fashion will fall to either the Health and Safety Team or the Care Quality Team, depending on the potential claim dynamics from the incident.

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14.4 As a rule, generally, this is broken down as follows:

- **Fleet / Transport Incidents** – Automated through [redacted] and verified by Health and Safety Team;
- **Medical Malpractice** – Care Quality Team;
- **All other Claim Types** – Health and Safety Team.

All Other Incident Types

14.5 For all other forms of incidents where a notification to the ERS Medical Brokers and Insurers is deemed necessary the following actions are to be taken.

14.6 These additional insurance types are:

- **Airside Insurance;**
- **D&O Insurance;**
- **Building & Contents;**
- **Medical Malpractice;**
- **Liabilities;**
- **Goods in Transit.**

14.7 It will not be the responsibility of either the Health and Safety Team or the Care Quality Team to determine which of these insurers should be notified, this will remain within the remit of the ERS Medical insurance broker: [redacted]

14.8 All Notifications to the insurance broker should ideally be within 48hrs of either the event or ERS Medical becoming aware of the event.

14.9 A single point of contact should be used, and all e-mail should be sent to our insurance provider, on the below e-mail address:

[redacted]

14.10 The E-Mail must contain the below information within the subject line:

ERS Medical – Site Name – Date of the Incident – Name of the Injured party

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14.11 The following is the minimum information required by [redacted] when being notified:

- Date;
- Location;
- Vehicle Involved;
- Summary of known facts;
- Accusations (Med Mal Only)
- Third Part Details;
- Any Witness Details;
- Key Contact.

14.12 Once [redacted] have received our notification, they will contact the relevant insurer and then forward their ref back to ERS Medical for adding to the [redacted] incident log.

14.13 Once on notification [redacted] will initial make contact within 1 month of notification to ascertain if there is any new information, this will then be done again at 3 months and 6 months.

14.14 If nothing has changed after 6 months then no further follow ups will be completed.

14.15 If ERS Medical becomes aware of any significant change to an incidents status that may have an effect on the claim status, then [redacted] must be notified as soon as practicable and the [redacted] log update.

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Question 1.10.2

Significant events

Please confirm if you have been subject to any serious events in the last 12 months and confirm any action taken and how learning was implemented to ensure the event does not re-occur.

The Bidder not been subject to significant events – Pass

The Bidder has been subject one or more significant events but has put in place actions to ensure the event does not re-occur – Pass

The Bidder has been subject to one or more significant events but has failed to put in place actions to ensure the event does not re-occur.

We can confirm we have not been subject to any serious events in the last 12 months

Question 1.10.3

Compliance to Legislation policies

Please provide your approach to ensure that relevant Legislation and best practice guidance updates are noted, communicated to staff and put into practice and audited against (please refer to NICE appropriate guidelines as well as other guidelines).

The Bidder has evidenced they have an appropriate approach in place– Pass

The Bidder does not have an appropriate approach in place - Fail

The Care Standards Team holds the responsibility for the issuing of all patient and other types of safety alerts. These alerts can be generated from numerous sources such as a result of an internal incident, subsequent investigation, recommendations and feedback, which requires a safety alert to be issued. The Care Standards Team also monitors external alerts through various sources such as but not limited to:

- National Institute for Health and Care Excellence (NICE)
- NHS Improvement – Patient Safety Alerts
- Medicines and Healthcare products Regulatory Agency (MHRA)
- Health and Safety Executive (HSE)
- Environment Agency (EA)

All ERS Managers receive comprehensive training from subject matter experts on regulatory matters including HR, Health & Safety, CQC compliance, vehicle licencing and safety legislation. Further to this our managers have direct access to these experts should their experience and guidance be required. Any best practice, legislative and regulatory updates are circulated by our subject matter experts to our management staff. This information is then disseminated through training sessions, toolbox talks, internal memos and 121's with staff members.

The new information is also shared with all employees through our HR system BambooHR. This ensures that all employees receive a notification regarding the updated information and must acknowledge its receipt.

Weekly webinars to all ERS staff enable best practice, latest news and policy updates to be disseminated throughout the business effectively. By disseminating information through multiple channels we can ensure that all staff members are made aware of any changes and able to access the relevant information easily.

Further to this we have a comprehensive Business Management System which is embedded across all ERS operations and follows a single process, providing consistency and reference. All relevant information regarding legislation and best practice is stored within our BMS and is accessible to all.

BMS/6.05 Safeguarding An adult at risk, Children and Young People

Document Author:	[redacted]		Care Quality Manager North		
Document Owner:	[redacted]		Head of Care Standards		
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Appendix A – Social Services Index

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3. Safeguarding Legislation

3.1 The safeguarding of Adults, Children and Young people is enshrined in both law and best practice and guidance. This procedure has been written in accordance with the following legal and advisory frameworks:

- The Children's Act 1989;
- The Children's Act 2004;
- The Care Act 2014;
- The Safeguarding of Vulnerable Groups Act 2006;
- The Modern Slavery Act 2015;
- The Children and Social Work Act 2017;
- The Sexual Offences Act 2003;
- The Serious Crime Act 2015;
- The Mental Capacity Act 2005;
- The Health and Social Care Act 2012;
- The Health and Social Care Act 2014;
- The Courts and Criminal Justice Act 2015
- Working Together to Safeguard Children (2018)
- The Care and Support Statutory Guidance;
- The Safeguarding Children and Young People – Roles and Competencies for Healthcare Staff Intercollegiate Document – 4th Edition January 2019;
- The Adult Safeguarding Roles and Competencies for Healthcare Staff Intercollegiate Document – 1st Edition August 2018.

4. Introduction

4.1 Safeguarding is the protection of members of society who may be more vulnerable due to age, illness, capacity or position in society. It incorporates children, an adult at risk, those with mental health issues and those suffering Domestic Abuse and forced marriages.

4.2 In order to respond appropriately where abuse or neglect may be taking place, anyone in contact with adults or children whether in a volunteer or paid role, must understand their own role and responsibility and have access to practical and legal guidance, advice and support.

4.3 Any member of ERS Medical or sub-contractors working for or on behalf of ERS Medical, employed on an ERS Medical contract or event that may come into contact with an adult at risk or children, has a duty to share and if necessary refer or report concerns regarding suspected abuse or neglect to Social Services.

4.4 For the purposes of visibility, audit and accountability ERS Medical requires all staff to refer initially through the CCO in Leeds on [redacted]

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4.5 NHS Ambulance Trust contracts have their own safeguarding procedures and forms. Advice also can be obtained from each Trust's control and clinical decision desks. This negates the requirements of paragraphs 8.4. These forms will be available from your local site or the respective NHS Ambulance Trust HEOC/EOC.

4.6 ERS Medical supports and takes a multi-agency approach to ensuring safeguarding vulnerable people. This is through working with NHS Trusts, County Councils, unitary authorities and governing bodies such as the Care Quality Commission across all aspects of our services and contract delivery.

4.7 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.8 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the ERS Medical's Care and Treatment Policy.

5.2 Please refer to the ERS Medical's Quality, Environmental, Safety and Health Policy.

5.3 Please refer to the ERS Medical's Information Security Policy.

5.4 ERS Medical is committed to the principles and activities which monitor, review, learn from, support and promote safeguarding.

5.5 ERS Medical recognises its legal and moral duty and responsibility to protect the welfare of children and adults by working in partnership and informing social services of any incidents where adults or children are perceived to be at risk

5.6 This policy is underpinned by national guidelines for child and adult safeguarding and is designed to align with the variety of local authority arrangements found across the country.

5.7 ERS Medical will ensure that all procedures and supporting documentation reflect current national guidance in relation to safeguarding and that any national enquiry recommendations are implemented appropriately.

5.8 Reporting mechanisms to ERS Medical's risk management team will work with the safeguarding process so that any areas which may be a potential risk to the business may be identified and placed on the risk register as needed.

5.9 ERS Medical will seek to increase awareness amongst staff of matters relating to Safeguarding Children and Adults through information, education and training programmes.

5.10 ERS Medical will monitor the effectiveness of the policy and procedures via audit and reporting to the Governance and Patient Safety Committee including the Senior Management Team.

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6. Monitoring

6.1 The policy will be monitored for its effectiveness by the Medical Director and Head of Care, through the following:

- Liaison with the Care Quality Manager and nominated Safeguarding Lead within the Care Standards Team;
- Production of reports showing trend analysis of reporting, broken down into the following:
- Type of incident reported;
- Grade of staff reporting;
- Feedback gained from social services department;
- Feedback from other relevant external agencies;
- Lessons learnt from any adverse incidents.

6.2 These will be monitored on a monthly basis and reports provided back to the Governance and Patient Safety Committee (GaPS).

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7. Responsibilities

7.1	**Managing Director**	Has overall responsibility for setting and directing quality, health & safety and environmental policy.
7.2	**Governance and Patient Safety Committees**	Will monitor the Safeguarding Adult and Child activity within ERS Medical and the effectiveness of this procedure and its outputs.
7.3	**Medical Director /Head of Care Standards**	Are responsible for the development, implementation and co-ordination of the consistent, quality, efficient and clinical based approach to the safeguarding vulnerable people process across the business.
7.4	**CCO Manager / Team Leaders/ Clinical Supervisors**	Is responsible for the training, coaching, measurement and reporting of the CCO staffs' approach to the safeguarding process and ensuring the process is followed at all times.
7.5	**Site Operations Managers & Safeguarding Lead / Care Quality Advisors**	Are responsible for the implementation and co-ordination of the safeguarding process at a site level. ERS Medical's safeguarding lead will also have responsibility for the periodic checking of all external customer policies and forms used within ERS Medical as a contractual or SLA obligation. The monitoring of ERS Medical Safeguarding procedures for their effectiveness.
7.6	**Location CQC Registered Manager (Senior Operations Managers)**	Are responsible for notifying all Safeguarding referrals to the Care Quality Commission and ensuring all reporting procedures for the Commission adhered to.
7.7	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.
7.8	**Human Resources**	Will ensure that all pre-employment checks will be undertaken by the recruitment and HR team.
7.9	**ERS Medical**	As an independent Ambulance Provider, the business provides ambulatory care across all fields of emergency 999 contracts, Patient Transport, mental health and events both within the NHS and wider sector. This means that our staff and sub-contracted staff may be the first to be aware of safeguarding concerns for adults and children. As a professional service and a provider of Pre-Hospital, urgent and non-urgent care the business is in a unique position to note important pre-disposing factors regarding the safeguarding concern due to first-hand experience at the incident. It should no longer be considered enough to merely mention concerns to hospital staff or other health care workers as being sufficient to protect a child or adult from risk of significant harm. The Companies responsibility is to ensure the appropriate professionals are made aware of the concerns.

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8. Definitions

8.1 **Abuse & Neglect** – Abuse and neglect can be found in many forms such as but not limited to:

- Physical abuse;
- Domestic Abuse;
- Sexual abuse;
- Psychological abuse;
- Financial or material abuse;
- Modern slavery and human trafficking;
- Discriminatory abuse;
- Institutional abuse;
- Neglect and acts or omissions;
- Self-neglect;
- Mental Health;
- Forced marriages;
- Female Genital Mutilation (FGM).

8.2 **Acopia** – A failure or inability to cope.

8.3 **Adult at Risk** – The term 'adult at risk' has been used as an exact replacement for 'vulnerable adult' as used throughout the Care Act 2014.

Someone who aged 18 or over:

- Who is, or may be, in need of community services due to age, illness or a mental or physical disability;
- Who is, or may be, unable to take care of himself / herself, or unable to protect himself / herself against significant harm or exploitation.

This is the recognition that the term 'vulnerable adult' may erroneously imply that any responsibility for the abuse lies with the adult who is the victim of the abuse.

8.4 **Capacity** – Is the ability to make an informed decision.

8.5 **Consent** – Is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of purpose, nature, likely affects and risks of that intervention; including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

8.6 **CCO** – Contact Centre Operations.

8.7 **Development** – Means physical, intellectual, emotional, social or behavioural development.

8.8 **Harm** – Means ill-treatment or the impairment of health development, including for example, impairment suffered from seeing or hearing the ill-treatment of another.

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8.9 **Health** – Means physical or mental health.

8.10 **Human Trafficking** - the illegal movement of people, typically for the purposes of forced labour or commercial sexual exploitation.

8.11 **Ill Treatment** – Includes sexual abuse and forms of ill-treatment that are not physical.

8.12 **Local Authority Designated Officer (LADO)** – The LADO role applies to paid, unpaid, volunteer, casual, agency and self-employed workers. They capture concerns, allegations or offences emanating from outside of work. The LADO is involved from the initial phase of the allegation through to the conclusion of the case. They provide advice, guidance and help to determine whether the allegation sits within the scope of the procedures.

8.13 The LADO helps co-ordinate information-sharing with the right people and will also monitor and track any investigation, with the aim to resolve it as quickly as possible.

8.14 The LADO work within Children's Services and should be alerted to all cases in which it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed a child;
- Possibly committed a criminal offence against, or related to a child;
- Behaved towards a child or children in a way that indicates he/she is unsuitable to work with children.

8.14 (a) **Making Safeguarding Personal (MSP) -** Practice approaches to adult safeguarding should be person-led and outcome-focused. The Care Act ethos and statutory guidance emphasise a personalised approach to adult safeguarding that is led by the individual, not by the process. It is vital that the adult feels that they are the focus and they have control over the process.

- This is not simply about gaining an individual's consent, although that is important, but also about hearing their views about what they want as an outcome.
- Sometimes, people may have unrealistic expectations of what can be achieved through the safeguarding procedures, and they should be supported to understand from the outset how their desired outcomes can be met.

8.15 **Mental Capacity** – Is the ability of an individual to make decisions regarding specific elements of their life. It is also sometimes referred to as competence.

8.16 **Mental Health** – May be defined as how we feel, behave and think. Mental health problems arise when there are difficulties with these areas that affect the way we live our daily lives, how we conduct relationships and out physical health.

8.17 **Non-Ambulance Personnel** – staff members or sub-contractors/ provider of services who do not have an ambulance background but are involved in the transport of ERS Medical patients. This can include volunteer drivers, taxi companies and outside providers.

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8.18 **Prevent**– Prevent is Safeguarding people and communities from the threat of terrorism. Responds to the ideological challenge that we face from terrorism and aspect of extremism, and the threat we face who promote these views. This training is used to identify those who are at risk of radicalisation.

8.19 **Safeguarding Vulnerable Groups Act 2006 -** The Safeguarding Vulnerable Groups Act 2006 is an Act of the Parliament of the United Kingdom. It was created following the UK Government accepting recommendation 19 of the inquiry headed by Sir Michael Bichard, which was set up in the wake of the Soham Murders.

8.20 **SST** – Social Services Team.

8.21 **Safeguarding** – Is the multi-disciplinary work we do to minimise and manage risk to adults and children who may be vulnerable. It employs a framework which brings together all aspects of an investigation into an allegation of abuse against a vulnerable adult or child.

It may also include (this list is not exhaustive):

- Someone who misuses substances or alcohol;
- Is a carer such as a family member / friend who provides personal assistance and care to adults and is subject to abuse;
- Is unable to demonstrate the capacity to make a decision and is in need of care and support.

8.22 **Vulnerable Child** – Is defined in the Children Act 1989 and 2004 respectively, as anyone who has not yet reached their 18th birthday. Children therefore means 'children and young people). Safeguarding and protecting the welfare of children for the purposes of this work instruction is:

- Protecting children from maltreatment;
- Preventing impairment of children's health and development; and;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and;
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

8.23 **Working Together to Safeguard Children** (2018) – is statutory guidance on inter-agency working to safeguard and promote the welfare of children.

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9. Capacity and Consent

Capacity

9.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

9.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

9.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

9.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

9.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

9.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

9.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

9.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

9.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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9.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

9.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2008.

9.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

9.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

9.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

9.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

9.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

9.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

9.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

9.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

9.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

9.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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9.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

9.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

10. Safeguarding General Guidance

10.1 As stated in this procedure vulnerability can be seen through a wide range of incidents and people.

10.2 Safeguarding concerns relate to potentially abusive situations where others, who are providing care (paid, or unpaid) may be neglecting a patient, or causing physical harm etc. Through their actions, or through their failure to act to keep a patient safe.

10.3 Social care concerns relate to incidents where patients may possibly require care in the home either because of increasing care needs, self-neglect or social deprivation and those demonstrating self-harm.

10.4 Observations about the condition of other adults or children in the household might suggest risk (e.g. living in an environment where Domestic Abuse has taken place or carers suffering from a mental health crisis or substance misuse). Staff may observe hazards in the home or find signs of distress shown by others in the home. These may alert ERS Medical staff to potential abuse or patient's in need of safeguarding to avoid suffering harm.

10.5 Ambulance staff may often be the first or only professionals on scene and the actions taken and accurate recording of information may be crucial to subsequent enquiries.

10.6 Staff should be mindful that they are not there to investigate concerns. The responsibility for ERS Medical is to be aware of the signs of potential abuse and to raise any concerns. They should ensure that any referral is escalated initially through the CCO in Leeds on **0333 240 4107**.

10.7 When a Safeguarding concern is due to a serious incident the CCO team member should urgently escalate the incident to the on-call Care Standards Team Member. This information can be found by accessing the Care Standards Teams SharePoint area for the on-call rota:

10.8 A serious incident can include, but not be limited to the following:

- Where a death of an adult or child is present;
- Where serious injury has been suspected or caused;
- Suspected / alleged child abuse.

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10.9 All referrals are logged with the ERS Medical Safeguarding and Care Standards Team. The Safeguarding lead will follow up all referrals and where possible provide feedback to the referring staff for their own development and acknowledgement. Once feedback has been obtained, the case will be closed on the safeguarding database. Records will be retained in a secure location and kept confidential in line with ERS Medical policy.

10.10 Further guidance on the referral process can be found in the ERS Medical work instruction **WI/6.05.01A** – **Safeguarding of Vulnerable Adults Reporting** and **WI/6.05.01C** – **Safeguarding Vulnerable Children and Young People Reporting**.

11. Physical Abuse

11.1 Physical abuse is a safeguarding concern, irrespective of whether the abuse is of a vulnerable adult or child and can include, but not limited to the following;

- Assault;
- Hitting;
- Slapping;
- Pushing and pulling;
- Misuse of medication;
- Restraint;
- Inappropriate physical sanctions.

12. Domestic Abuse

12.1 Domestic Abuse is not only experienced by adults at risk; children will be affected by the behaviour or violence and abuse by adults in the home either directly or indirectly. Domestic Abuse occurs across geographical boundaries, age, wealth, social status, gender and ethnicity and can include but not be limited to:

- Psychological,
- Physical,
- Sexual,
- Financial,
- Emotional;
- So called 'honour based' violence.

12.2 Children who reside in a household where domestic abuse occurs are affected either directly or indirectly. It is essential that all staff make a safeguarding child referral, in all circumstances where a child / children is present, when the abuse took place; or where the child / children may reside at the property but is/are absent at the time of the incident.

12.3 It is imperative that the presenting clinical condition is assessed and treated and the patient is transported to the appropriate medical facility if clinically indicated.

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12.4 Record keeping – Any observations of injuries and verbal abuse must be carefully documented. The Patient Report Form (PRF) may form a vital evidence base for prosecution of Domestic Abuse cases.

12.5 For specific details on when and how to complete a Patient Report Form please refer to the Care Standards Team SteriPoint page and access the Toolbox Talk named 'PRF Completion Guidance'.

13. Sexual Abuse

13.1 Sexual abuse is a safeguarding concern, irrespective of whether the abuse is of a vulnerable adult or child and can include, but not limited to the following:

- Rape;
- Indecent exposure;
- Sexual assault / harassment;
- Inappropriate looking or touching;
- Sexual teasing or innuendo;
- Sexual photography;
- Subjection to pornography;
- Witnessing sexual acts;
- Non consensual sex;
- Pressurisation into consenting.

14. Psychological Abuse

14.1 Psychological abuse is a safeguarding concern, irrespective of whether the abuse is of a vulnerable adult or child and can include, but not limited to the following:

- Emotional abuse;
- Threats of harm or abandonment;
- Depravation of contact;
- Humiliation;
- Blaming;
- Controlling;
- Intimidation;
- Coercion;
- Harassment;
- Cyber bullying;
- Isolation;
- Unreasonable and unjustified withdrawal services / supportive networks.

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15. Financial or Material Abuse

15.1 Financial or material abuse is a safeguarding concern, irrespective of whether the abuse is of a vulnerable adult or child and can include, but not limited to the following:

- Theft;
- Fraud;
- Internet scamming;
- Coercion in relation to an adult's financial affairs of arrangements;
- Misuse or misappropriation of property;
- Misuse of possessions or benefits.

16. Modern Slavery and Human Trafficking

16.1 Modern slavery and human trafficking is a safeguarding concern, irrespective of whether the abuse is of a vulnerable adult or child and can include, but not limited to the following:

- Slavery;
- Human trafficking;
- Forced labour;
- Domestic servitude.

16.2 Each year a number of migrants enter the UK legally to work in agriculture and other areas. Whilst visas are granted to allow this to happen, and regulations in relation to 'gang master' activity is more stringent than ever, they are particularly open to abuse, specifically around accommodation, pay, terms and conditions and their health needs.

16.3 More complex are the migrants who enter the country illegally, or those who stay in the country after their visas expire, quite often these people become invisible on the authorities radars.

17. Discriminatory Abuse

17.1 Discriminatory abuse is a safeguarding concern, irrespective of whether the abuse is of a vulnerable adult or child and can include, but not limited to the following:

- Harassment;
- Slurs (race, gender, gender identity, age, disability, sexual orientation or religion).

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18. Organisational Abuse

18.1 Involves the collective failure of an organisation to provide an appropriate and professional service to vulnerable people. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping.

18.2 Organisational abuse includes a failure to ensure the necessary safeguards are in place to protect an adult at risk / children and maintain good standards of care in accordance with individual needs, including training of staff, supervision and management, record keeping and liaising with other providers of care.

18.3 In the case of Organisational abuse being discovered or suspected, the Police should be notified to ensure that a criminal investigation is undertaken, as well as the incident reported through the ERS Medical safeguarding process.

19. Neglect and Acts of Omission

19.1 Neglect and acts of omission is a safeguarding concern, irrespective of whether this is of a vulnerable adult or child and can include, but not limited to the following:

- Ignoring medical, emotional or physical care needs;
- Failure to provide access to appropriate health, care and support, or educational services;
- Withholding the necessities of life (medication, nutrition and heating).

20. Self-Neglect

20.1 Self-neglect is a safeguarding concern and can include, but not limited to the following:

- Behaviours neglecting to care for one's own personal hygiene;
- Behaviour neglecting one's personal health or surroundings;
- Behaviour such as hoarding.

21. Mental Health

21.1 Mental health problems are common, affecting one in four people at some time in their lives, they cross all ages, genders, races and social backgrounds. The causes of mental health problems relate to individual responses to particular circumstances.

21.2 A number of patients who are treated or cared for by the ERS Medical may suffer from mental illness, which is recurrent and enduring, and may be exacerbated by alcohol and substance abuse. ERS Medical team members should have a higher index of suspicion for safeguarding for patients within this group.

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21.3 In some cases, the patient's condition may not warrant conveyance to hospital or the patient may refuse treatment. In these circumstances, serious consideration should be given to the sharing of information with the patient's GP, Social Services or Mental Health Services, in order to ensure continuity of care. It is important that crews gain consent where possible and when appropriate. There will be circumstances where this is not possible or safe to do so (please see section 9.14-9.23 for further guidance around this).

21.4 Services for those with mental health problems are locally defined and will vary in their access criteria. Referral pathways for ambulance staff may exist in a particular locality. Please seek advice from the relevant Social Services Team or gain advice from the on-call Care Quality Manager / Advisor. If working for an NHS Trust contract advice can be gained from the relevant clinical help desk.

21.5 Attention is drawn to the IPAP assessment tool in JRCALC 2019, for the assessment of suicide risk (appendix A).

21.6 Consideration should also be given to the effect that the patient's mental health is having on those for whom they have caring responsibility. Consideration should be given to a child protection or vulnerable adult referral if the patient is unable to care for their children or another person for whom they are the primary carer.

21.7 Safeguarding reporting should take place when parental self-harm/injury and or attempted suicide, including deliberate overdose occur in the same property or whilst otherwise caring for a child or young person.

21.8 In the context of safeguarding, crews should be mindful that patients who have mental health needs including dementia or a personality disorder are considered to be vulnerable people. Issues should be considered under safeguarding practice and a referral made where appropriate.

21.9 Some safeguarding referrals will have to be made without being able to gain consent. If in doubt, team members should make contact with the Care Standards Team, this contact can facilitate through the CCO on [redacted]

21.10 If necessary immediate action should be taken to manage the risk and a vulnerable adult referral should be made accordingly following the ERS Medical referral procedures, as detailed within **WI/6.05.01A – Safeguarding of Vulnerable Adults Reporting**.

21.11 If further guidance is needed on the capacity or safeguarding issues advice should be gained from the on-call Care Standards Team who can be contacted through Leeds CCO on [redacted]

22. Forced Marriages (Honour Abuse)

22.1 There is a difference between an arranged marriage and a forced marriage. In arranged marriages, families arrange the match but the choice of whether or not to accept the arrangement remains with the individual. Arranged marriage is a valuable, long established tradition based on compatibility, consent and retaining choice. In forced marriages, there is no choice. No culture or religion sanctions forced marriage.

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22.2 Planned or actual forced marriage places children and young people at risk of significant harm, which may include sexual, physical and emotional abuse, and is contrary to the United Nations Convention on the rights of the child.

22.3 Forced marriage is recognised in the UK as a form of domestic abuse and a serious abuse of human rights. It is possible that Ambulance personnel may become aware of such cases, as there is an increased risk of self-harm, attempted suicide, eating disorders and depression. It is imperative that any concerns are referred as a Child Protection and Safeguarding matter and that normal procedure are followed.

23. Female Genital Mutilation (FGM) (Honour Abuse)

23.1 In the UK FGM is a criminal offence under the Prohibition of Female Circumcision Act 2003. This act also makes it an offence for UK residents or nationals to carry it out, or knowingly allow it to happen abroad- even in countries where it is legal.

23.2 FGM has potentially serious health implications; it is unnecessary and can be extremely painful, both at the time and later on in life. It is typically carried out between the ages of 4 and 13. It remains relatively common across the world. In the UK alone it is estimated that up to 24,000 girls under the age of 15 are at risk of FGM.

23.3 If staff suspects FGM, where appropriate the patient needs to be taken to A&E. If you believe that a child is at risk of FGM urgent advice should be gained from the Safeguarding lead. A vulnerable child referral should also be made through the normal procedures.

23.4 It is highly unlikely the ERS Medical team members will encounter this type of safeguarding concern. However, they should always be vigilant to the possibility.

24. Prevent

24.1 The Government's counter-terrorism strategy is known as CONTEST. *Prevent* is part of CONTEST, and its aim is to stop people becoming terrorists or supporting terrorism.

24.2 The strategy promotes collaboration and co-operation among public service organisations. The Office for Security and Counter Terrorism in the Home Office is responsible for providing strategic direction and governance on CONTEST.

24.3 You can read the CONTEST strategy in full at www.homeoffice.gov.uk

24.4 **CONTEST** has four key principles:

- Pursue: to stop terrorist attacks;
- Prevent: to stop people becoming terrorists or supporting terrorism;
- Protect: to strengthen our protection against a terrorist attack;
- Prepare: to mitigate the impact of a terrorist attack.

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24.5 The health service is a key partner in *Prevent* and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

25. Child Protection

25.1 ERS Medical recognises that the law permits the disclosure of confidential information necessary to safeguard children in the public interest, with or without the permission of the child's parents.

25.2 The business also recognises that children are entitles to the same duty of confidence as adults provided that in the case of those under 16 years of age, they have the ability to understand the choices and the consequences relating to any treatment.

25.3 For the purposes of making a safeguarding referral a child is defined as being anyone under the age of 18.

25.4 If you are concerned about a child protection issue or the child/children make a disclosure to you, you have a legal responsibility to share information with the necessary bodies. Team members should avoid making promises that they will unable, due to this responsibility, to keep.

25.5 When considering any disclosure of information to other agencies, including the Police, staff should weigh up against the young person's right to privacy, the degree of current likelihood of harm, what any such disclosure is intended to achieve and what the potential benefits are to the young persons' well-being.

25.6 Decision making should be undertaken with full professional consultation, initially with the ERS Medical Safeguarding leads / Care Standards Team, and then with an outside agency such as the designated leads and Social Services departments in the appropriate counties.

25.7 Staff should be prepared, following a referral, to attend a case conference or for their evidence to be called to court.

25.8 Guidance on the recognition of non-accidental injuries within children can be found in Appendix B of this policy.

26. Sudden Unexpected Death or an Infant or Adolescent (SUDICA)

26.1 Each county and unitary authority has in place a 'rapid response procedure' for every unexplained child or infant death.

26.2 Ambulance personnel are obviously involved in the process. The first priority is clearly to preserve life wherever possible, in addition to this, Ambulance personnel should gather as much information related to the event as possible.

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26.3 Below are some examples of the information that can be useful in such a tragic event, in addition to a thorough clinical history:

- What position was the child in when you arrived;
- Do the parents/ carers know what position they found the child or infant in;
- Who else was present on the arrival of the ambulance crew;
- What as the patient wearing when you arrived;
- What was the temperature of the room? Was the temperature extreme;
- Where had the child been sleeping (particularly relevant to infants);
- Note and report any obvious 'old' injuries;
- Note any inconsistencies in the history;
- Be aware of the potential importance of preserving the scene / do not disturb the scene unnecessarily.

26.4 In all cases of SUDICA a safeguarding referral **MUST** be completed for the child affected and any other children or siblings of the household, regardless of whether they were present during the episode leading to the death of the patient.

27. Unforeseen Vulnerability

27.1 There will be situations where a person becomes vulnerable because the support that they rely on is no longer available. Examples of this might include where a person can no longer look after themselves because;

- A carer is taken ill, or to hospital;
- A couple living independently where one is taken ill or dies.

27.2 In these situations, we have a duty of care not only to the patient but also to anybody that suddenly becomes vulnerable, specifically because of these circumstances.

27.3 Many 'vulnerability' referrals are due to Acopia. Acopia covers a multitude of reasons which might include the following:

- General ill health or worsening of their health making them unable to cope;
- Medication issues;
- Alcohol issues;
- Where they are in need of a care plan, or where it is clear that modifications need to be made to their current plan;
- General deterioration;
- Sensory problems (deteriorating eyesight/Hearing etc);
- Financial concerns resulting in poor health (i.e. lack of warmth);
- Stress;
- Inability to cope with dependant spouse/ relatives any longer;
- Repeated falls.

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28. Allegations Made Against Employees

28.1 ERS Medical will take all necessary measures to ensure that it recruits staff who uphold the principles of the Care Act 2014 (effective date 01/04/2015), the Children Act 2004 and Safeguarding Vulnerable Groups Act 2006.

28.2 However, it is acknowledged that some staff may conduct themselves in a manner that is at odds with ERS Medical procedures and legislation, in this instance ERS Medical will treat all allegations against staff seriously.

28.3 When an allegation is made about a member of staff ERS Medical will investigate it under a breach of the **ERS Medical Staff Handbook**, in conjunction with this procedure.

28.4 The Manager who has been alerted to the allegation against a member of staff has a responsibility to ensure that the appropriate course of action is taken without delay, giving consideration to the following:

- Notify the Safeguarding Lead, who in conjunction with the Medical Director and the Head of Care make the determination if a safeguarding referral is appropriate;
- Where appropriate the safeguarding lead will refer the case to the Police if the suspected abuse is the crime. This will require a further notification to the CQC under regulated activity and possibly the HCPC if a Paramedic in involved;
- In line with the ERS Medical disciplinary procedures, suspend staff suspected of the safeguarding incident as appropriate and in discussion with the HR department;
- Inform the member of staff as they have a right to know in broad terms what allegations or concerns have been made about them;
- Consider raising the allegation as a Serious Incident;
- Maintain a high level of confidentiality, whilst meeting contractual requirements to notify Trusts;
- Provide support for the staff member involved in the safeguarding process.

28.5 All safeguarding allegations of abuse or maltreatment of children and adults by a professional, staff member, volunteer, or contractor must be taken seriously and treated in accordance with consistent procedures.

28.6 If the allegation against an employee or contractor of services involves a child, the 'Local Authority Designated Officer (LADO)' for that area shall be contacted by the Safeguarding Lead/ Care Standards Team Manager.

29. Whistleblowing (Raising a Concern at Work)

29.1 Employees or sub-contractors, who have concerns about a colleague's conduct in their personal life or their professional practice, in the context of safeguarding; they should report this using the procedures at **BMS/2.05 – Whistleblowing (Raising a Concern at Work)** and the Public interest Disclosure Act 1998.

30. Employee Assistance Program (EAP)

30.1 Employees or sub-contractors, who are affected by any aspect of either witnessing or reporting a safeguarding concern can access the Employee Assistance Programme provide through the ERS Medical. This can be accessed either through contacting the HR Team or calling the Freephone 24-hour support line on:

0800 030 5182

31. Training, Supervision and Review

31.1 Current guidance means that ERS Medical specifies Safeguarding adults and children at risk training as mandatory. The business will ensure that all staff receives training that is appropriate to their level of responsibility.

31.2 ERS Medical will ensure that clinical staff receives appropriate support which allows them to reflect on a challenging or traumatic call as well as reflect on their practice.

31.3 **ERS Medical has a role specific safeguarding training matrix which is at Appendix C of this procedure.**

31.4 This procedure and its associated work instructions and forms will be reviewed annually, or when legislation or regulations change, by the ERS Medical safeguarding lead, from the date on first publication to the BMS and or any subsequent review.

32. Statutory Notifications – Regulation 18

32.1 Any referral of 'Abuse' must also be reported to the Care Quality Commission (CQC), under the requirements of Regulation 18 of The Health and Social Care Act 2014.

32.2 The reporting to the CQC, will be coordinated between the locations Regional and Registered Manager and the Care Standards Team, using the Radar compliance system to track this reporting.

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APPENDIX A - SUICIDE AND SELF-HARM RISK ASSESSMENT FORM

Intent	Thoughts
Plans	Access to the means
Actions	Current and/or past
Protection	Family, social network, services

Ref: JRCLAC 2019 / General / Page 15

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APPENDIX B – RECOGNITION OF NON-ACCIDENTAL INJURIES WITHIN CHILDREN

This list is not exhaustive and team members **MUST** note that the presence of these types of injuries does **NOT** confirm that there is a safeguarding issue. Team members should have a heightened index of suspicion though if they encounter these patterns of injuries

Abnormal Bruising / Injuries – Over areas of the body not normally injured for example, abdomen, chest, back and perineum, spiral, rib injuries, bilateral injuries.

Any Groin, Anal or Genital Injury.

Bite Patterns – Bruising and abrasions in bite patterns on the child's limbs.

Black Eye – Bruising around one or both eyes could be caused by a fist or blow or, in the case of both eyes, possibly a blow across the bridge of the nose.

Bruises – To the soft part of the ear which could be caused by slaps to the side of the head. Especially of note are bruises to the forearms as a defensive measure.

Burn Marks – Caused by hot objects placed on the child's body.

Cigarette Burns – In various stages of healing. A combination of fresh, raw burns or healed pink circles; these are usually deep burns.

Delayed Admission to Hospital

Different Stages of Bruising – Could mean repeated assaults over a period of time.
Retinal Haemorrhages

Scalds with Inconsistent History – Is the history plausible '. Sock' burns without splashes?

Suspicious Patterns of Bruising – For example finger marks which could be caused by hard slaps to the body or the child being forcibly gripped or shaken (grab marks).

Torn Frenulum (The tissue attaching the inside of the top lip to the inner upper jaw) – Not a common injury but may be caused by a feeding bottle being rammed into a child's mouth, this would also cause dark red spots of blood beneath the membrane (petechial spotting) on the inside of the top lip.

Uncharacteristic Parental Response

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APPENDIX C - ERS Medical Safeguarding Training Matrix

This provision of training has been derived from the 'Safeguarding of Children and Young People: Roles and Competencies for Health Care Staff – Intercollegiate Document Fourth edition: January 2019

Level 1 - All staff working in health care settings.

Level 2 - All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers (this needs to include scenario-based discussions and should be appropriate to staff roles). Level 2 training needs to incorporate Female Genital Mutilation, Prevent training and trafficking.

Level 3 All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

Level 4 - specialist roles - named professionals.

Level 5 - Specialist roles - designated professionals.

Job Title	Training Requirements	Frequency
ACA	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
UCA	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
ECA	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
Technician	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
Paramedic / Nurse	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.

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Job Title	Training Requirements	Frequency
Doctor	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
Safeguarding Leads (Care Standards Team)	Adults and children Level 4	Level 4 requires a minimum of 24 hours per year engaging in training and a Serious Case Review.
Care Standards Team	Adults and children Level 3	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
Senior Operations Managers (CQC Registered Managers)	Adult and children Level 2	Level 2 Annually
Operations Manager	Adult and children Level 2	Level 2 Annually
Team Leaders / Supervisors	Adults and children Level 3 Training	Level 3 (minimum of 4 hours) training face to face on induction and thereafter every 3 years. Annually.
CCO Call Handler	Adult and children Level 3 online training	Level 3 online training is done every year.
CCO Call Handlers (Safeguarding call takers)	Adult and children Level 3 online training	Level 3 online training is done every year.
CCO Call Centre Managers	Adult and children Level 3 online training	Level 3 online training is done every year.
HR Officers	Adult and children Level 3 online training	Level 3 online training is done every year.

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Question 1.10.4

Safeguarding policies

Please provide details of your systems to ensure evidence of your compliance with statutory safeguarding policies by describing your organisation's safeguarding processes, how your organisation will safeguard vulnerable users of this service, how you will report safeguarding incidents within your organisation and to external organisations, the role of the executive

safeguarding lead and how safeguarding is monitored throughout the organisation.

ERS have specific adult and young person and children procedures and associated documents and provide comprehensive face to face Safeguarding training to all staff as part of their induction and annual CPD training. All staff receive Safeguarding training to level 2 and our Crews are trained to level 3. Further to this our Care Standards Team receive enhanced safeguarding training, equivalent to level 4. This training is refreshed annually.

We are confident that our staff understand their safeguarding responsibilities as over the last 12 months we have reported 179 safeguarding concerns. Where appropriate we feed back to the crews with any outcomes.

In line with these publications and standards a vulnerable adult is defined as someone who is aged 18 or over:

- Who is, or may be, in need of community services due to illness or a mental or physical disability
- Who is, or may be, unable to take care of themselves, or unable to protect themselves against significant harm or exploitation

It may also include;

- Someone who misuses substances or alcohol
- Is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
- Is unable to demonstrate the capacity to make a decision and is in need of care and support

A young person or child is defined in the Children Act 1989 and 2004 respectively, as anyone who has not yet reached their 18th birthday. Children therefore means 'children and young people). Safeguarding and protecting the welfare of children for the purposes of this work instruction is:

- Protecting children from maltreatment
- Preventing impairment of children's health and development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully

We have attached our Safeguarding policies.

Safeguarding training

Safeguarding training makes up part of our induction training for all staff. Prior to commencing any services on behalf of ERS Medical all staff must have completed their required level of safeguarding training and this must be signed off and recorded on our HR system, against their employee file. Refresher training via E-Learning is completed annually by all staff.

Staff support

All of our crews have direct access to our clinical leads who are available 24/7 on a rota basis to access any advice, answer any questions and for general support with safeguarding concerns. They also have access to Operational Managers, Team Leaders and HR to raise and discuss any concerns and for any support they need.

Every employee also has access to free counselling via our partnership with Heath Assured our Employee Assistance Plan which is available 24/7.

Staff reporting of concerns

If ambulance road staff identify a vulnerable person to be at risk, they must:

- Identify if there is an immediate risk of harm or ill treatment to a vulnerable child or young person;
- If the vulnerable person is deemed at immediate risk then the Police should be contacted without delay and it may be necessary to transport the vulnerable person to the nearest A&E department; if Police assistance is required then crews should either stay on scene or near scene, until the Police arrive. It is our policy to advise our employees not to put themselves or others at risks;

All safeguarding referrals, whether at immediate risk or not, must;

- Make the referral to the Leeds Head Office Contact Centre Operation (CCO)
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO, who in turn can contact either the Regional Care Standards Advisor or for out of hours the on-call Care Standards Manager;
- Once the referral has been made to the CCO, ambulance road staff MUST complete a Patient Report Form (PRF), providing as much detail as possible;
- They must also complete a Road Staff Safeguarding Referral Form;
- Both the PRF and Staff Safeguarding Referral Form must be returned to their site and handed into their line managers and or safeguarding secure drop box.

- All safeguarding referrals are reported to the CCG and CQC if required.

Our Safeguarding policy is written by our Care Quality Manager who is Deputy Safeguarding Lead for ERS and a Registered Nurse. The document is reviewed by our Head of Care Standards and Medical Director and approved by our Patient Safety Committee. All ERS documents on the BMS are reviewed annually.

WI/6.05.01A Safeguarding of Vulnerable Adults Reporting

Document Author:	[redacted]		Care Quality Manager North		
Document Owner:	[redacted]		Head of Care Standards		
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2.0	7	All	10	30.11.18	[redacted]	Addition of Capacity & Consent section
3.0	All	All	All	16.04.19	[redacted]	Annual Review
4.0	All	All	All	04.07.19	[redacted]	Level 4 – CPD Review
5.0	All	All	All	07.07.20	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Care to Care	BMS/6.01
Patients Who Deteriorate in Transit	BMS/6.02
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding of Vulnerable Adults, Children and Young People	BMS/6.05
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Risk Assessments	BMS/6.07
Patient Communications and Control (CCO)	BMS/6.08
Non-Emergency Patient Transport (NEPTS)	BMS/6.10
Renal Patient (NEPTS)	BMS/6.11
High Dependency (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Safeguarding of Vulnerable Children and Young People Reporting	WI/6.05.01C
Safeguarding Referral Form (Road Staff)	F6.05.01
Safeguarding Referral Form (CCO)	F6.05.02

Appendix A – Social Services Index

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3. Safeguarding Legislation

3.1 The safeguarding of Adults, Children and Young people is enshrined in both law and best practice and guidance. This procedure has been written in accordance with the following legal and advisory frameworks:

- The Children's Act 1989;
- The Children's Act 2004;
- The Care Act 2014;
- The Safeguarding of Vulnerable Groups Act 2006;
- The Modern Slavery Act 2015;
- The Children and Social Work Act 2017;
- The Sexual Offences Act 2003;
- The Serious Crime Act 2015;
- The Mental Capacity Act 2005;
- The Health and Social Care Act 2012;
- The Health and Social Care Act 2014;
- The Courts and Criminal Justice Act 2015
- The Care and Support Statutory Guidance;
- The Safeguarding Children and Young People – Roles and Competencies for Healthcare Staff Intercollegiate Document – 4th Edition January 2019;
- The Adult Safeguarding Roles and Competencies for Healthcare Staff Intercollegiate Document – 1st Edition August 2018.

4. Introduction

4.1 The purpose of this work instruction is to describe ERS Medical's process for road staff, who are working as part of non-NHS Ambulance Trusts, contracts and events, in reporting concerns relating to the safeguarding of vulnerable adults.

4.2 There may be contractual variations to these processes required from the NHS. On these occasions ERS Medical will comply with the relevant NHS Safeguarding reporting process, which will be managed at a local level, for training and implementation.

4.3 To describe ERS Medical's process for the Contact Centre Operations (CCO) and staff line managers, in dealing with reports relating to the safeguarding of vulnerable adults.

4.4 Safeguarding is the protection of members of society who may be more vulnerable due to age, illness, capacity or position in society. It incorporates vulnerable adults and those with mental health issues and those suffering domestic violence and forced marriages.

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4.5 Any member of ERS Medical or sub-contractors working for or on behalf of ERS Medical employed on a **Non-Ambulance NHS Trust** contract or event that may come into contact with vulnerable adult, has a duty to share and if necessary refer or report concerns regarding suspected abuse or neglect to social services. NHS Ambulance trust contracts have their own safeguarding procedures and forms. Advice can be obtained from each trust's control and clinical decision desks.

4.6 ERS Medical takes a multi-agency approach for ensuring the safeguarding of vulnerable adults and children. This is achieved through working closely with NHS Trusts, Local Authorities (Social Services Teams), Police and regulatory bodies such as the Care Quality Commission.

4.7 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.8 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

5.4 It is the policy of ERS Medical to ensure that all members of the public who are deemed vulnerable or at risk and under our care are safeguarded in accordance with **BMS/6.05(ERS) - Safeguarding Vulnerable Adults and Children** and all legal and regulatory requirements.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing quality, health & safety and environmental policy.
6.2	**Governance and Performance Review Committee (GaPR)**	Will monitor the Safeguarding Adult activity within ERS Medical and the effectiveness of the policy and procedures.
6.3	**Medical Director & Head of Care Standards**	Is responsible for the development, implementation and co-ordination of the consistent, quality, efficient and clinical based approach to the safeguarding vulnerable people process across the business.
6.4	**CCO Manager / Team Leaders/ Clinical Supervisors**	Is responsible for the training, coaching, measurement and reporting of the CCO staffs' approach to the safeguarding process and ensuring the process is followed at all times.
6.5	**Site Operations Managers & Safeguarding Lead / Care Standards Manager**	Are responsible for the implementation and co-ordination of the safeguarding process at a site level. ERS Medical's safeguarding lead will also have responsibility for the periodic checking of all external customer policies and forms used within ERS Medical as a contractual or SLA obligation. The monitoring of ERS Medical Safeguarding procedures for their effectiveness.
6.6	**Site CQC Registered Manager (Senior Operations Managers)**	Are responsible for notifying all Safeguarding referrals to the Care Quality Commission and ensuring all reporting procedures for the Commission adhered to.
6.7	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.
6.8	**Human Resources**	Will ensure that all pre-employment checks will be undertaken by the recruitment and HR team.

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6.9	**ERS Medical**	As an independent Ambulance Provider, the business provides ambulatory care across all fields of Patient Transport, mental health and events both within the NHS and wider sector. This means that our staff and sub-contracted staff may be the first to be aware of safeguarding concerns for adults. As a professional service and a provider of Pre-Hospital, urgent and non-urgent care the business is in a unique position to note important pre-disposing factors regarding the safeguarding concern due to first-hand experience at the incident. It should no longer be considered enough to merely mention concerns to hospital staff or other health care workers as being sufficient to protect an adult from risk of significant harm. The company's responsibility is to ensure the appropriate professionals are made aware of the concerns.
6.10	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Abuse & Neglect** – Abuse and neglect can be found in the many forms such as but not limited to:

- Physical abuse;
- Domestic violence;
- Sexual abuse;
- Psychological abuse;
- Financial or material abuse;
- Modern slavery and human trafficking;
- Discriminatory abuse;
- Organisational abuse;
- Neglect and acts or omissions;
- Self-neglect;
- Mental Health;
- Forced marriages;
- Female Genital Mutilation (FGM).

7.2 **Acopia** – A failure or inability to cope.

7.3 **Adult at Risk** – The term 'adult at risk' has been used as an exact replacement for 'vulnerable adult' as used throughout the DOH Policy No Secrets (2000). This is the recognition that the term 'vulnerable adult' may erroneously imply that any responsibility for the abuse lies with the adult who is the victim of the abuse.

- is someone who aged 18 or over:
- Who is, or may be, in need of community services due to age, illness or a mental or physical disability;
- Who is, or may be, unable to take care of himself / herself, or unable to protect himself / herself against significant harm or exploitation.
- It may also include (this list is not exhaustive):
- Someone who misuses substances or alcohol;
- Is a carer such as a family member / friend who provides personal assistance and care to adults and is subject to abuse;
- Is unable to demonstrate the capacity to make a decision and is in need of care and support.

7.4 **Capacity** – Is the ability to make an informed decision.

7.5 **Consent** – Is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of purpose, nature, likely affects and risks of that intervention; including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

7.6 **CCO** – Contact Centre Operations.

7.7 **Development** – Means physical, intellectual, emotional, social or behavioural development.

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7.8 **Harm** – Means ill-treatment or the impairment of health development, including for example, impairment suffered from seeing or hearing the ill-treatment of another.

7.9 **Health** – Means physical or mental health.

7.10 **Human Trafficking** - the illegal movement of people, typically for the purposes of forced labour or commercial sexual exploitation.

7.11 **Ill Treatment** – Includes sexual abuse and forms of ill-treatment that are not physical.

7.12 **Mental Capacity** – Is the ability of an individual to make decisions regarding specific elements of their life. It is also sometimes referred to as competence.

7.13 **Mental Health** – May be defined as how we feel, behave and think. Mental health problems arise when there are difficulties with these areas that affect the way we live our daily lives, how we conduct relationships and out physical health.

7.14 **Non-Ambulance Personnel** – staff members or sub-contractors/ provider of services who do not have an ambulance back ground but are involved in the transport of ERS Medical patients. This can include volunteer drivers, taxi companies and outside providers.

7.15 **Prevent**– Prevent is Safeguarding people and communities from the threat of terrorism. Responds to the ideological challenge that we face from terrorism and aspect of extremism, and the threat we face from those who promote these views. This training is used to identify those who are at risk of radicalisation.

7.16 **SST** – Social Services Team.

7.17 **Safeguarding** – Is the multi-disciplinary work we do to minimise and manage risk to adults and children who may be vulnerable. It employs a framework which brings together all aspects of an investigation into an allegation of abuse against a vulnerable adult or child.

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8. Capacity and Consent

Capacity

8.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia, or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

8.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

8.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

8.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

8.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

8.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

8.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

8.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

8.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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8.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

8.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2008.

8.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

8.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

8.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

8.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

8.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

8.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

8.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

8.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

8.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

8.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

8.22 Be aware that patients' friends and family may also try and exert and influence on any decision that is taken, and this can often be a subtle but powerful influence.

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8.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

9. Referral Process

9.1 This process only applies to ERS Medical safeguarding referrals. ERS Medical employees and sub-contractors working on NHS Trust Ambulance contracts will follow each specific Trusts own internal safeguarding procedure.

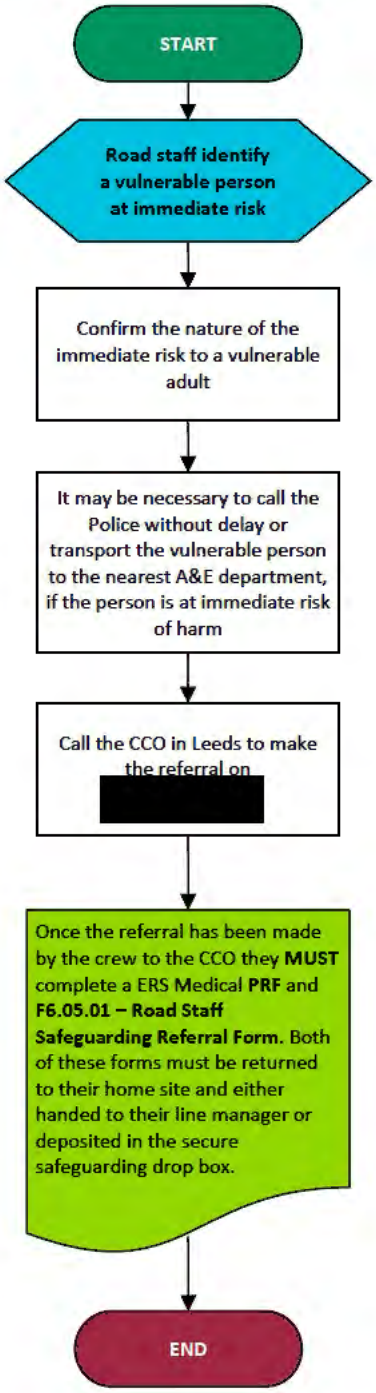
10. Ambulance Road Staff - Urgent

10.1 If ambulance road staff identify a vulnerable person (adult) to be at immediate risk, they must:

- Identify that there is an immediate risk of harm or ill treatment to a vulnerable adult;
- If the vulnerable person is deemed at immediate risk then the Police should be contacted without delay and it may be necessary to transport the vulnerable person to the nearest A&E department; if Police assistance is required then crews should either stay on scene or near scene, until the Police arrive. **DO NOT** put yourself or others at risks;
- Make the referral to the Leeds CCO on [redacted]
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO**,** who in turn can contact either the locality Care Standards member or for out of hours the on-call Care Standards Manager;
- Once the referral has been made to the CCO, ambulance road staff MUST complete a Patient Report Form (PRF), providing as much detail as possible;
- They must also complete a **F6.05.01 – Road Staff Safeguarding Referral Form;**
- Both the PRF and **F6.05.01 – Road Staff Safeguarding Referral Form** must be returned to their site and handed into their line managers and or safeguarding secure drop box.

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11. Key Steps – Ambulance Road Staff – Urgent / Immediate



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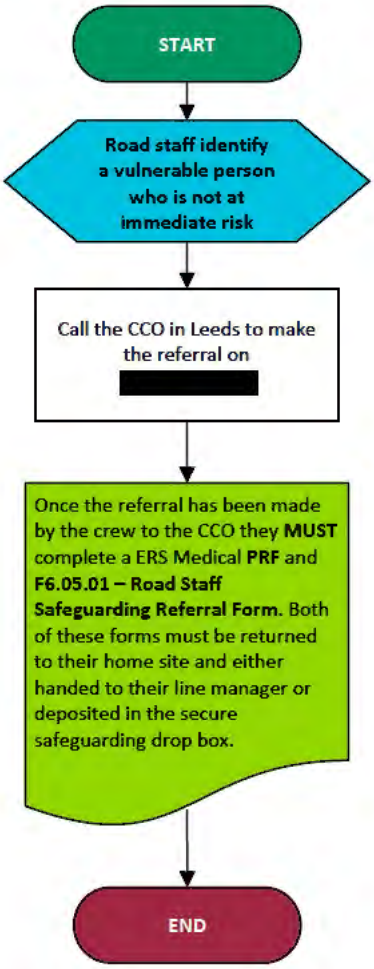
12. Ambulance Road Staff – Non-Urgent

12.1 If ambulance road staff identify a vulnerable person (adult) who is not at immediate risk, they must:

- Make the referral to the Leeds CCO on [redacted]
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO**,** who in turn can contact either the regional Care Standards Team member or for out of hours the on-call Care Standards Manager;
- Once the referral has been made to the CCO, ambulance road staff MUST complete a Patient Report Form (PRF), providing as much detail as possible;
- They must also complete a **F6.05.01 – Road Staff Safeguarding Referral Form;**
- Both the PRF and **F6.05.01 – Road Staff Safeguarding Referral Form** must be returned to their site and handed into their line managers and or safeguarding secure drop box.

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13. Key Steps – Ambulance Road Staff – Non-Urgent



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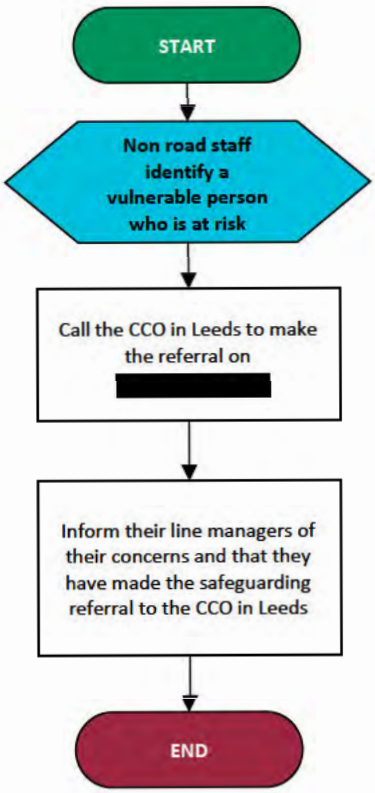
14. Non-Road Staff

14.1 If non road staff identify a vulnerable person (adult) who is at risk, they must:

- Make the referral to the Leeds CCO on [redacted]
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO**,** who in turn can contact either the regional Care Standards Team member or for out of hours the on-call Care Standards Manager;
- Inform their line manager of their concerns and that they have made the safeguarding referral to the CCO in Leeds.

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15. Key Steps – Non-Road Staff



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16. CCO Safeguarding Referral Inbound

16.1 The first step of ERS Medical safeguarding process is the concern being identified by a staff member. If a member of staff is concerned that a vulnerable person is at risk, a safeguarding referral must be made.

16.2 The next priority is to ensure there is not an urgent / immediate risk of harm or ill-treatment to the vulnerable person (adult).

16.3 If there is, the CCO call handler should advice the crew if they have not already done so, to call the Police. Advise the crew to remain on scene or near scene until the Police arrive.

16.4 The CCO call handler staff may also be required to advice the road staff to transport the vulnerable person at risk to the nearest A&E department.

16.5 The CCO call handlers can seek further safeguarding advice if required by contacting the regions Care Standards Team clinical member or for out of hours the on-call Care Standards Team Manager. Details for this can be found on the Care Standards Team's SharePoint Page:



16.6 The CCO call handler can then proceed to take specific details regarding their safeguarding concern, from the caller and complete the **F6.05.02 – CCO Safeguarding Referral Form.**

16.7 The CCO staff will annotate the **F6.05.02 - CCO Safeguarding Referral Form** with their name, the date and time of the safeguarding referral.

16.8 The CCO will obtain a contact number for the crew and confirm that they are happy for this number to be given to the Social Services Team if urgent and additional information is required.

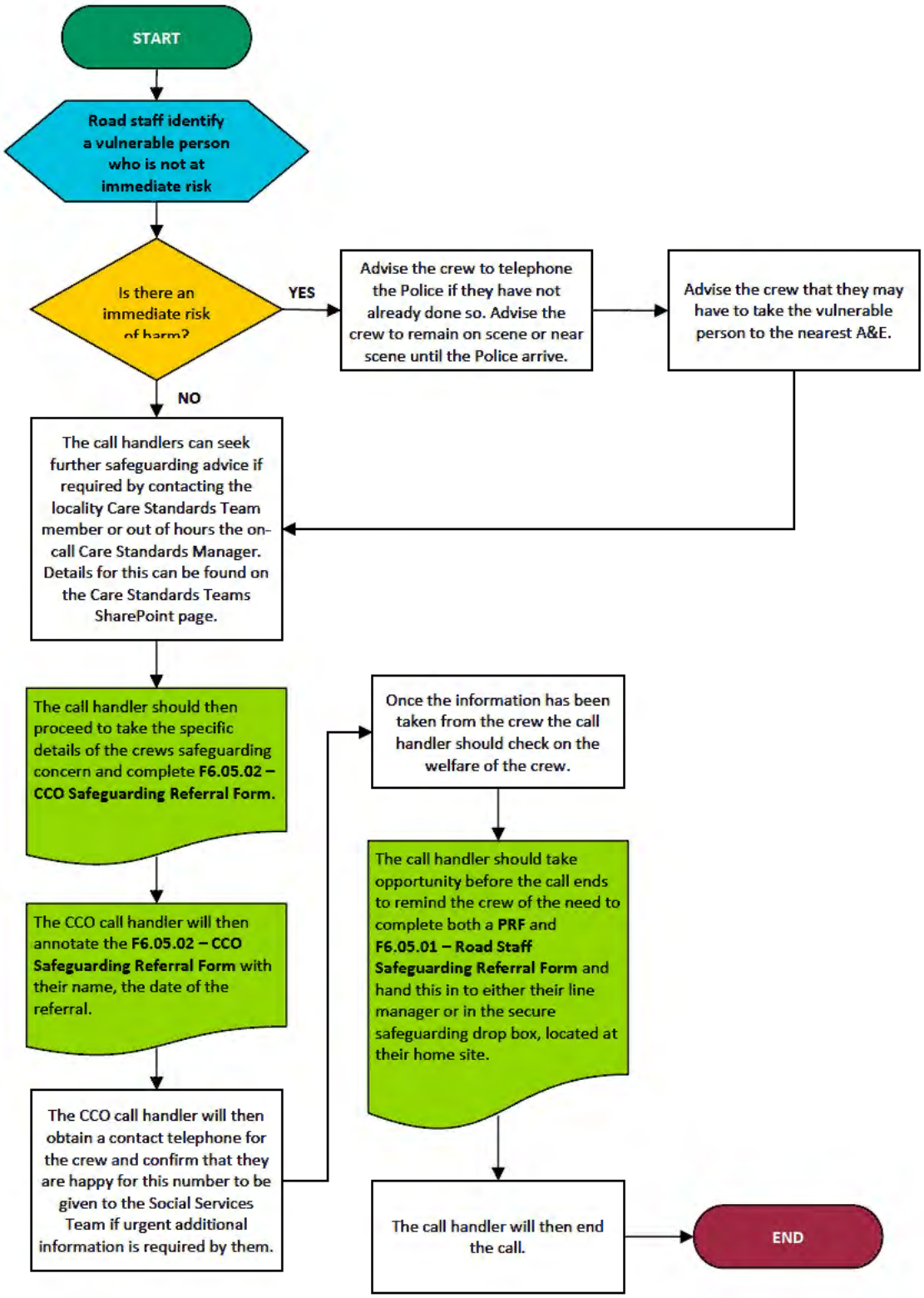
16.9 Once all information has been gained from the crew, the CCO call handler should make sure that the check on the welfare of the crew.

16.10 The CCO call handler should take this opportunity to remind road staff making the referral to complete an **F6.05.01 – Road Staff Safeguarding Referral Form** and a **PRF** and ensure that it is either handed in to either their line manager or dropped into the safeguarding secure drop box, located at their home site.

16.11 The call handler will then end the call.

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17. Key Steps – CCO Safeguarding Referral Inbound



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18. CCO Safeguarding Referral to Social Services (Urgent/Immediate and Non-Urgent)

18.1 If the call is deemed as 'Urgent/Immediate' the referral must be made as soon as possible.

18.2 The CCO will action the referral immediately by phone, using the ERS Medical Safeguarding Social Services Index to identify which Social Services Team (SST) needs to be contacted.

18.3 If the call is deemed as 'non-urgent' the referral can be made the following day during normal working hours.

18.4 The relevant SST can be found on the ERS Medical Safeguarding drive. Access to this drive is restricted to authorised personnel only.

18.5 When CCO agents make the referral to the relevant SST they are to state the following:

Adult Referral: '***It is ERS Medical belief that this referral meets the threshold of notification under the requirements of Section 42 of The Care Act 2014***'.

18.6 If once contacted the relevant SST they offer resistance to accepting the referral it is **ESSENTIAL** that the referral is still made. It is ERS Medical policy that we will report all referrals to Social Services and if they deem, after the referral process, not to act on the referral it is there decision.

18.7 **F6.05.02 - CCO Safeguarding Referral Form** once completed will be saved in the ERS Medical Safeguarding drive, under the folder '**Completed ERS Safeguarding Referrals / Year / Month'**.

18.8 The naming conventions should adhere to the following for all safeguarding referrals saved to this drive:

Example: **Jane Doe 08 09 2016**

All save files should be encrypted and password protected to ensure data security.

18.9 Once the nature of the safeguarding referral has been clarified i.e. urgent or non-urgent and the other steps have been completed as detailed in Section 18 of this Work Instruction a referral to the relevant SST can be made.

18.10 The ERS Medical Safeguarding index requires that a referral form is emailed/ faxed to a given address the CCO member must do the following:

- Take all referral details as normal and write them on the form **F6.05.02 - CCO Safeguarding Referral Form)**;
- Create a PDF file using 'cute pdf' (if you have any problems with this please contact the IS support team) or email a scanned pdf version to yourself using one of the scanner/printers available.

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- The form **MUST** then be emailed directly to the given council/NHS e-mail address, via a NHS.net secure e-mail account (if a CCO call handler does not have a NHS.net account they should identify a CCO team member who does);
- A point of contact for the SST should be given as the safeguarding e-mail address:

[redacted]

- If the SST team, ask if feedback is required to ERS Medical the answer should always be **YES**.

18.11 If the SST requires additional information, then the crew details should be given. Advice from the on-call Care Standards Team Manager can also be gained.

18.12 If the referral falls under a Serious Incident (SI) the CCO will contact the on-call Care Standards Team Manager and ERS Medical Safeguarding Lead, to inform them of the incident. A SI includes the following:

- **Where a death of an adult is present;**
- **Where serious injury has been suspected or caused;**
- **Suspected / alleged abuse.**

18.13 The CCO agents should also make contact with either the regional Care Standards Team member or on-call Care Standards Manager if they meet with resistance from an SST when making a referral.

18.14 The CCO will then email the Safeguarding / Care Standards Team on:

[redacted]

This e-mail will state that a referral has been completed and **MUST** contain the following information:

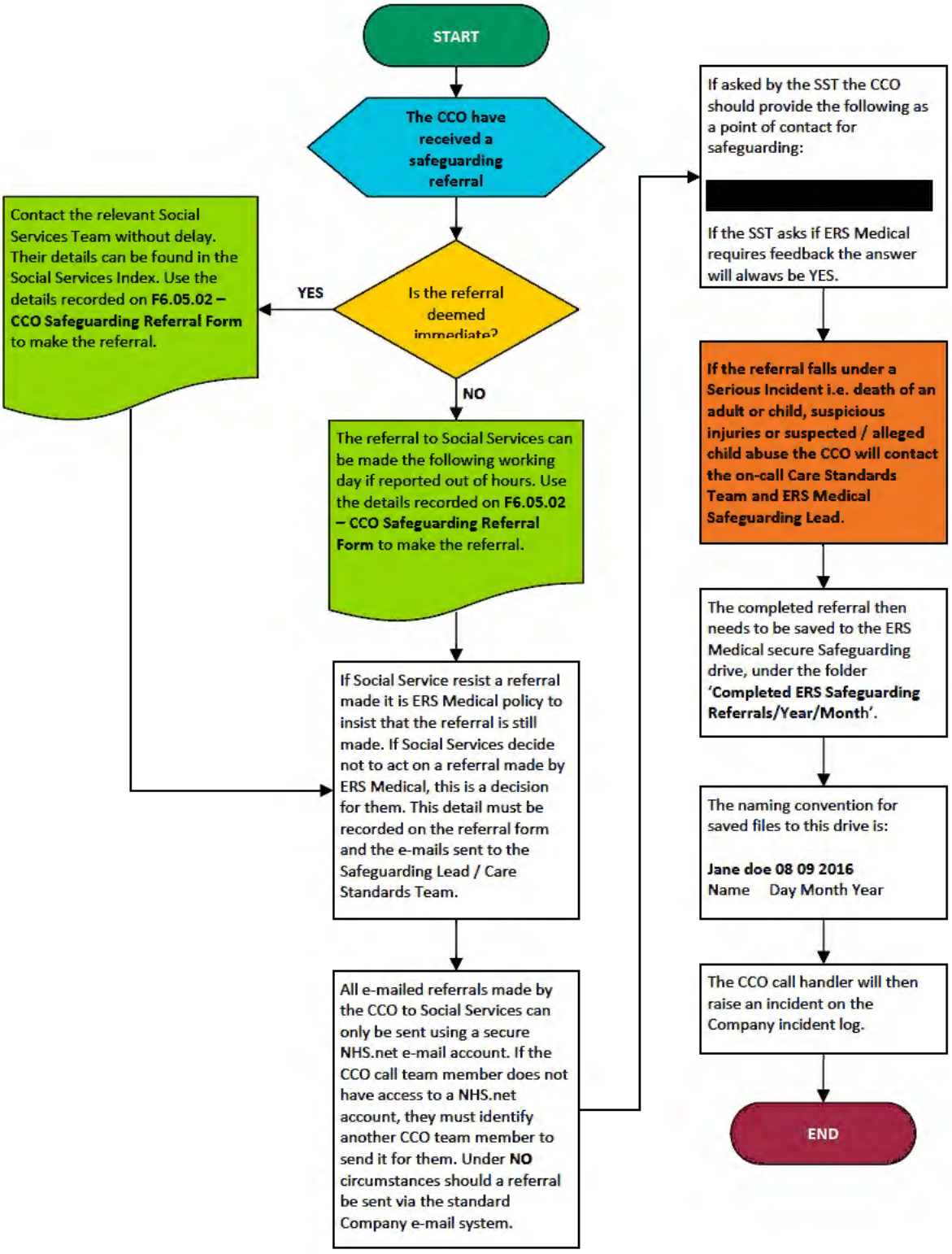
- Patients full name;
- Social Services Team referred to;
- Unique reference number of the referral;
- Crew that referred the incident with their base site.

18.15 The CCO call handler will then raise a safeguarding incident on the RADAR incident log, detailing all the information they have captured on the **F6.05.02 - CCO Safeguarding Referral Form.**

18.16 The Care Standards Team monitors the safeguarding inbox and the secure safeguarding drive on the ERS Medical SharePoint system & Radar compliance system.

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19. Key Steps – CCO Safeguarding Referral to Social Services



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20. Safeguarding Operations

20.1 The Operations Managers are responsible for ensuring that all new documentation – safeguarding workflow, safeguarding referral forms, ERS Medical Patient Report Forms (PRF's), safeguarding clinical memo for NEPTS and all non-ambulance Trust contracts are placed on all contract vehicles for the crews. The memos and poster should also be placed on all ERS Medical notice boards as an urgent and immediate action.

20.2 The Operations Managers are responsible for ensuring that the safeguarding secure drop boxes are attached securely to the wall and that access is restricted to the site Management Team.



20.3 The site Operations Team are to ensure that on the next working day any PRF/Statement or **F6.05.01 – Safeguarding Referral Form (Road Staff)** is scanned and uploaded to the incident raised by the CCO at the time of the referral.

20.4 The Operations Teams are responsible for ensuring that any patient identifiable safeguarding documentation is stored securely on site.

20.5 Site Operations Managers are responsible for the initial investigation of all safeguarding referrals, which are notified to them through the automated incident alert system. This initial investigation will also include the collection and uploading of crew PRF's and or statements, detailing their safeguarding concerns.

20.6 Additionally, the site Operations Managers will make contact with the reporting crew to acknowledge that the safeguarding referral has been made by the CCO. They will only be able to do this once they have been notified, by the relevant Care Standards Team member (see Section 21 of this work instruction.

20.7 This notification to crew must be recorded within the 'Actions' section of the initial investigation on the incident log and the incident cannot be closed until this has been completed.

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21. Safeguarding Process (Safeguarding Lead / Care Standards Team)

21.1 Once the Safeguarding Lead / Care Standards Team receive the e-mail notification of a safeguarding referral they will ensure that the incident is actioned as required by **BMS/5.01 – Incident Reporting and Investigation**.

21.2 The relevant Care Standards Team member must verify that the CCO has completed the safeguarding referral and that this has been communicated to the relevant Social Services Team. They should do this by checking the completed referrals folder of the secure 'Safeguarding' drive.

21.3 Once this is confirmed they will annotate the incident log with the required referral details and contact the sites CQC Registered Manager and Operations Manager to inform them that the referral has been completed and that this must be communicated to the reporting crew members with thanks.

21.4 Safeguarding Leads / Care Standards Team members are responsible for monitoring the safeguarding e-mail inbox and collating all the information received from CCO.

21.5 Safeguarding leads / Care Standards Team members are responsible for keeping the Company CQC Registered CQC Managers informed of safeguarding referrals on a monthly basis, unless it is for an SI, at the locality Governance and Performance Review (GaPR) Committee meetings.

21.6 SI referrals will be notified to the Company CQC Registered Managers as soon as practicable, so that a joint decision can be made if a particular referral meets the requirements of Regulation 18 of the Health and Social Care Act 2014.

21.7 The Head of Care Standards **MUST** be informed of all such referrals.

Contractual Variation for Norfolk CCG

21.8 For allegations made in the Norfolk CCG area the safeguarding lead will contact the Norfolk Local Authority Designated Officer (LADO);

LADO@norfolk.gov.uk

21.9 More information on contacting the Norfolk LADO can be found at:

Norfolk Local Authority Designated Officer (LADO)

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22. Appendix A – ERS Medical Adult & Child Safeguarding Process – Road Staff

Remember: **All Referrals low or high risk** are to be phoned through to CCO 24 hours a day on [redacted]

ERS Medical
SRCL Group Company

Adult & Child Safeguarding Referral Process for ambulance crews

Safeguarding concern identified low risk or high (immediate) risk

Ensure the individual's safety and the safety of others on scene.

If there is an **immediate** concern or risk call the police and/ or transport the vulnerable person to the nearest A&E.
If police assistance is required stay on or near scene until police arrive.
Do not put yourself or others at risk.

Call the **CCO** on [redacted] to make the Safeguarding Referral



For further advice you can contact the Leeds CCO on [redacted]

Crews must then complete F6.05.01 (ERS) Road Staff Safeguarding Referral form and a PRF (in black ink) and give the CCO as much information as possible. The CCO will make the referral on your behalf to social services.

Once the referral call has been made to the CCO both the PRF and F6.05.01 (ERS) Road Staff Safeguarding referral form that you have completed **must be** returned to the site line manager or safeguarding secure drop box.

Important things to remember

- Are others at risk?
- Have concerns been clearly documented?
- Are the right people and services informed?
- Consider professional accountability

Additional Notes:
Safeguarding referrals should be made in the following situations

- Domestic Violence
- Sexual Abuse
- Psychological Abuse
- Financial or Material Abuse
- Modern Slavery & Human Trafficking
- Discriminatory Abuse
- Female Genital Mutilation (FGM)
- Unforeseen Vulnerability
- Allegations made against Employees / Sub-contractors
- Organisational Abuse
- Neglect or Omission
- Self-Harm
- Mental Health issues
- Forced Marriages
- Prevent
- Child protection
- Whistleblowing

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23. Appendix B – ERS Medical Adult & Child Safeguarding Process – CCO

ERS Medical
SRCL Group Company

Adult & Child Safeguarding Referral Process for the CCO

Call received by the CCO for a safeguarding referral

The next priority is to ensure there is not an immediate risk of harm or ill-treatment to the vulnerable person (child or adult).

If there is, the CCO call handler should advise the crew if they have not already done so, to call the Police.

The CCO call handler may also be required to advise the road staff member to transport the vulnerable person at risk to the nearest A&E department.

Complete F6.05.02 (ERS) Safeguarding referral form (online version) for all referrals. Ensure that all the information is documented in the reporter's own words and get the reporter's contact details.

If the referral is **URGENT/IMMEDIATE** – telephone the relevant Social Services Team (SST) without delay.

If the SST requires copies of the referral form from the CCO it can only be sent from a secure NHS.net email account. If you don't have an NHS.net account you MUST identify another person within the CCO who does, to send the requested information.

Ensure that you provide the SST with our point of contact details as: [redacted]

Once the referral to SST has been made ensure that you email the details of the referral to the Safeguarding Care Quality Team on [redacted]
The email must contain details of the vulnerable person's name, home address the SST to which the referral was made and the reporter's contact details.

F6.05.02 (ERS) CCO Safeguarding Referral Form once completed **will** be saved in the ERS Medal Safeguarding drive, under the folder **'Completed ERS Safeguarding Referrals/Year/Month'.**

The naming conventions should adhere to the following for all safeguarding referrals saved to this drive, **Example: Jane Doe 08 09 2016.**
All saved files must be encrypted and password protected to ensure data security.

The CCO call handler will then raise a safeguarding incident on the Steripoint incident log, detailing all the information they have captured on the **F6.05.02 (ERS) – Safeguarding Referral Form.**



The CCO call handlers can seek further safeguarding advice if required by contacted the locality Care Quality Advisor or the out of hours the on-call Care Quality Advisor.

Details for this can be found on the Care Quality Team's Steripoint page.

Please remember welfare when making a referral. Do they need Operational or Care Team support?

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WI/6.05.01C Safeguarding of Vulnerable Children & Young People Reporting

Document Author:	[redacted]		Care Quality Manager North		
Document Owner:	[redacted]		Head of Care Standards		
Version:	5.0	**Active Date:**	07.07.2020	**Review Date:**	31.07.2021

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Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
1.1	All	All	All	13.04.18	[redacted]	Addition of review date
2.0	7	All	10	30.11.18	[redacted]	Addition of Capacity & Consent section
3.0	All	All	All	16.04.19	[redacted]	Annual Review
4.0	All	All	All	04.07.19	[redacted]	Level 4 – CPD Review
5.0	All	All	All	07.07.20	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Care to Care	BMS/6.01
Patients Who Deteriorate in Transit	BMS/6.02
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Risk Assessments	BMS/6.07
Patient Communications and Control (CCO)	BMS/6.08
Non-Emergency Patient Transport (NEPTS)	BMS/6.10
Renal Patient (NEPTS)	BMS/6.11
High Dependency (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Safeguarding of Vulnerable Adults Reporting	WI/6.05.01A
Safeguarding Referral Form (Road Staff)	F6.05.01
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Appendix A – Social Services Index

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3. Safeguarding Legislation

3.1 The safeguarding of Adults, Children and Young people is enshrined in both law and best practice and guidance. This procedure has been written in accordance with the following legal and advisory frameworks:

- The Children's Act 1989;
- The Children's Act 2004;
- The Care Act 2014;
- The Safeguarding of Vulnerable Groups Act 2006;
- The Modern Slavery Act 2015;
- The Children and Social Work Act 2017;
- The Sexual Offences Act 2003;
- The Serious Crime Act 2015;
- The Mental Capacity Act 2005;
- The Health and Social Care Act 2012;
- The Health and Social Care Act 2014;
- The Courts and Criminal Justice Act 2015
- Working Together to Safeguard Children 2018
- The Care and Support Statutory Guidance;
- The Safeguarding Children and Young People – Roles and Competencies for Healthcare Staff Intercollegiate Document – 4th Edition January 2019;
- The Adult Safeguarding Roles and Competencies for Healthcare Staff Intercollegiate Document – 1st Edition August 2018.

4. Introduction

4.1 The purpose of this work instruction is to describe ERS Medical's process for road staff, who are working as part of none-NHS Ambulance Trust, contracts and events, in reporting concerns relating to the safeguarding of vulnerable children and young people.

4.2 There may be contractual variations to these processes required from the NHS. On these occasions ERS Medical will comply with the relevant NHS Safeguarding reporting process, which will be managed at a local level, for training and implementation.

4.3 To describe ERS Medical's process for the Contact Centre Operations (CCO) and staff line managers, in dealing with reports relating to the safeguarding of vulnerable children and young people.

4.4 Safeguarding is the protection of members of society who may be more vulnerable due to age, illness, capacity, or position in society. It incorporates children and those with mental health issues and those suffering domestic violence and forced marriages.

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4.5 Any member of ERS Medical or sub-contractors working for or on behalf of ERS Medical employed on a **Non-Ambulance NHS Trust** contract or event that may come into contact with children and young people, has a duty to share and if necessary refer or report concerns regarding suspected abuse or neglect to social services. NHS Ambulance trust contracts have their own safeguarding procedures and forms. Advice can be obtained from each trust's control and clinical decision desks.

4.6 ERS Medical takes a multi-agency approach for ensuring the safeguarding of children and young people. This is achieved through working closely with NHS Trusts, Local Authorities (Social Services Teams), Police and regulatory bodies such as the Care Quality Commission across for the delivery of regulated activity within the healthcare setting.

4.7 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.8 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

5.4 It is the policy of ERS Medical to ensure that all members of the public who are deemed vulnerable or at risk and under our care are safeguarded in accordance with **BMS/6.05(ERS) - Safeguarding Vulnerable Adults and Children** and all legal and regulatory requirements.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing quality, health & safety and environmental policy.
6.2	**Governance and Performance Review Committee (GaPR)**	Will monitor the Safeguarding Children and Young People activity within ERS Medical and the effectiveness of the policy and procedures.
6.3	**Medical Director & Head of Care Standards**	Is responsible for the development, implementation, and co-ordination of the consistent, quality, efficient and clinical based approach to the safeguarding vulnerable people process across the business.
6.4	**CCO Manager / Team Leaders/ Clinical Supervisors**	Is responsible for the training, coaching, measurement and reporting of the CCO staffs' approach to the safeguarding process and ensuring the process is followed at all times.
6.5	**Site Operations Managers & Safeguarding Lead / Care Standards Manager**	Are responsible for the implementation and co-ordination of the safeguarding process at a site level. ERS Medical's safeguarding lead will also have responsibility for the periodic checking of all external customer policies and forms used within ERS Medical as a contractual or SLA obligation. The monitoring of ERS Medical Safeguarding procedures for their effectiveness.
6.6	**Site CQC Registered Manager (Senior Operations Managers)**	Are responsible for notifying all Safeguarding referrals to the Care Quality Commission and ensuring all reporting procedures for the Commission adhered to.
6.7	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.
6.8	**Human Resources**	Will ensure that all pre-employment checks will be undertaken by the recruitment and HR team.

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6.9	**ERS Medical**	As an independent Ambulance Provider, the business provides ambulatory care across all fields of Patient Transport, mental health and events both within the NHS and wider sector. This means that our staff and sub-contracted staff may be the first to be aware of safeguarding concerns for children and young people. As a professional service and a provider of Pre-Hospital, urgent and non-urgent care the business is in a unique position to note important pre-disposing factors regarding the safeguarding concern due to first-hand experience at the incident. It should no longer be considered enough to merely mention concerns to hospital staff or other health care workers as being sufficient to protect a child or young person from risk of significant harm. The Companies responsibility is to ensure the appropriate professionals are made aware of the concerns.
6.10	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Abuse & Neglect** – Abuse and neglect can be found in the many forms such as but not limited to:

- Physical abuse;
- Domestic violence;
- Sexual abuse;
- Psychological abuse;
- Financial or material abuse;
- Modern slavery and human trafficking;
- Discriminatory abuse;
- Organisational abuse;
- Neglect and acts or omissions;
- Self-neglect;
- Mental Health;
- Forced marriages;
- Female Genital Mutilation (FGM).

7.2 **Acopia** – A failure or inability to cope.

7.3 **Capacity** – Is the ability to make an informed decision.

7.4 **Consent** – Is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of purpose, nature, likely affects and risks of that intervention; including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

7.5 **CCO** – Contact Centre Operations.

7.6 **Development** – Means physical, intellectual, emotional, social or behavioural development.

7.7 **Harm** – Means ill-treatment or the impairment of health development, including for example, impairment suffered from seeing or hearing the ill-treatment of another.

7.8 **Health** – Means physical or mental health.

7.9 **Human Trafficking** - the illegal movement of people, typically for the purposes of forced labour or commercial sexual exploitation.

7.10 **Ill Treatment** – Includes sexual abuse and forms of ill-treatment that are not physical.

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7.11 **Local Authority Designated Officer (LADO)** – The LADO role applies to paid, unpaid, volunteer, casual, agency and self-employed workers. They capture concerns, allegations or offences emanating from outside of work. The LADO is involved from the initial phase of the allegation through to the conclusion of the case. They provide advice, guidance and help to determine whether the allegation sits within the scope of the procedures.

7.12 The LADO helps co-ordinate information-sharing with the right people and will also monitor and track any investigation, with the aim to resolve it as quickly as possible.

7.13 The LADO work within Children's Services and should be alerted to all cases in which it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed a child;
- Possibly committed a criminal offence against, or related to a child;
- Behaved towards a child or children in a way that indicates he/she is unsuitable to work with children.

7.14 **Mental Capacity** – Is the ability of an individual to make decisions regarding specific elements of their life. It is also sometimes referred to as competence.

7.15 **Mental Health** – May be defined as how we feel, behave, and think. Mental health problems arise when there are difficulties with these areas that affect the way we live our daily lives, how we conduct relationships and out physical health.

7.16 **Non-Ambulance Personnel** – staff members or sub-contractors/ provider of services who do not have an ambulance back ground but are involved in the transport of ERS Medical patients. This can include volunteer drivers, taxi companies and outside providers.

7.17 **Prevent**– Prevent is Safeguarding people and communities from the threat of terrorism. Responds to the ideological challenge that we face from terrorism and aspect of extremism, and the threat we face who promote these views. This training is used to identify those who are at risk of radicalisation.

7.18 **SST** – Social Services Team.

7.19 **Safeguarding** – Is the multi-disciplinary work we do to minimise and manage risk to children and young people who may be vulnerable. It employs a framework which brings together all aspects of an investigation into an allegation of abuse against a child or young person.

7.20 **Vulnerable Child** – Is defined in the Children Act 1989 and 2004 respectively, as anyone who has not yet reached their 18th birthday, children therefore means 'children and young people). Safeguarding and protecting the welfare of children for the purposes of this work instruction is:

- Protecting children from maltreatment;
- Preventing impairment of children's health and development; and;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and;
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

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8. Capacity and Consent

Capacity

8.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia, or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

8.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

8.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

8.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

8.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

8.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

8.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

8.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

8.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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8.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

8.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2008.

8.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

8.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

8.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

8.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

8.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

8.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

8.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

8.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

8.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

8.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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8.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

8.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

9. Referral Process

9.1 This process only applies to ERS Medical safeguarding referrals. ERS Medical employees and sub-contractors working on NHS Trust Ambulance contracts will follow each specific Trusts own internal safeguarding procedure.

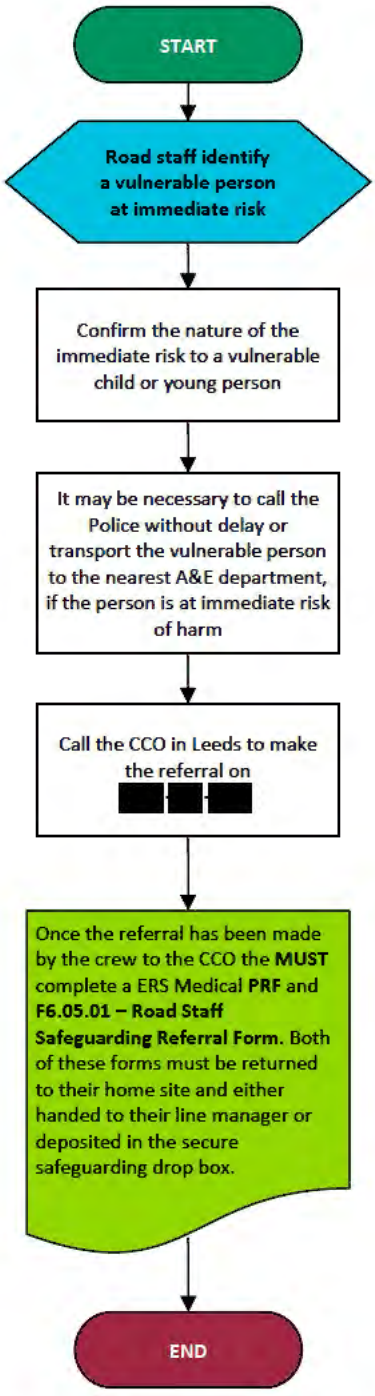
10. Ambulance Road Staff – Urgent / Immediate

10.1 If ambulance road staff identify a vulnerable person (child or young person) to be at urgent / immediate risk, they must:

- Identify that there is an immediate risk of harm or ill treatment to a vulnerable child or young person;
- If the vulnerable person is deemed at immediate risk then the Police should be contacted without delay and it may be necessary to transport the vulnerable person to the nearest A&E department; if Police if assistance is required then crews should either stay on scene or near scene, until the Police arrive. **DO NOT** put yourself or others at risks;
- Make the referral to the Leeds CCO on [redacted]
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO**,** who in turn can contact either the Regional Care Standards Advisor or for out of hours the on-call Care Standards Manager;
- Once the referral has been made to the CCO, ambulance road staff MUST complete a Patient Report Form (PRF), providing as much detail as possible;
- They must also complete a **F6.05.01 – Road Staff Safeguarding Referral Form;**
- Both the PRF and **F6.05.01 – Road Staff Safeguarding Referral Form** must be returned to their site and handed into their line managers and or safeguarding secure drop box.

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11. Key Steps – Ambulance Road Staff – Urgent / Immediate



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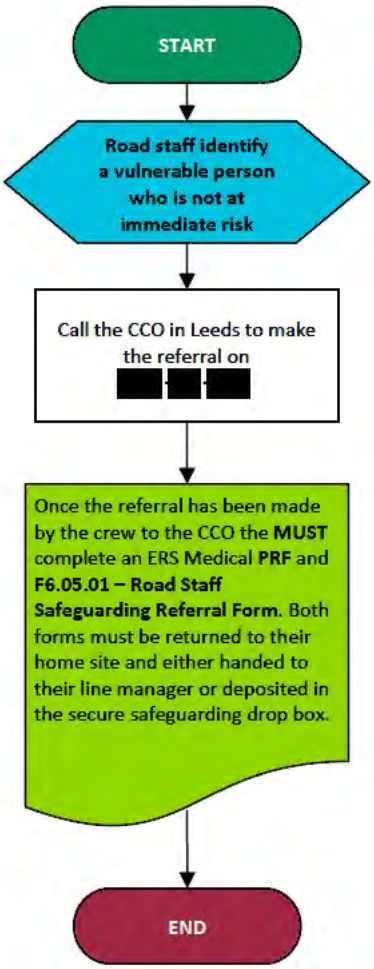
12. Ambulance Road Staff – Non-Urgent

12.1 If ambulance road staff identify a vulnerable person (child or young person) who is not at immediate risk, they must:

- Make the referral to the Leeds CCO on [redacted]
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO**,** who in turn can contact either the regional Care Standards Team member or for out of hours the on-call Care Standards Manager;
- Once the referral has been made to the CCO, ambulance road staff MUST complete a Patient Report Form (PRF), providing as much detail as possible;
- They must also complete a **F6.05.01 – Road Staff Safeguarding Referral Form;**
- Both the PRF and **F6.05.01 – Road Staff Safeguarding Referral Form** must be returned to their site and handed into their line managers and or safeguarding secure drop box.

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13. Key Steps – Ambulance Road Staff – Non-Urgent



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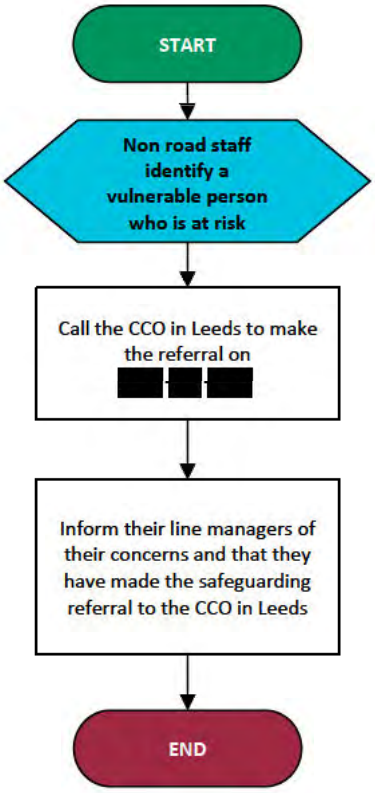
14. Non-Road Staff

14.1 If non-road staff identify a vulnerable person (child or young person) who is at risk, they must:

- Make the referral to the Leeds CCO on [redacted]
- Further safeguarding advice can be accessed, if required by contacting the Leeds CCO**,** who in turn can contact either the locality Care Standards Team member or for out of hours the on-call Care Standards Manager;
- Inform their line manager of their concerns and that they have made the safeguarding referral to the CCO in Leeds.

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15. Key Steps – Non-Road Staff



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16. CCO Safeguarding Referral Inbound

16.1 The first step of ERS Medical safeguarding process is the concern being identified by a staff member. If a member of staff is concerned that a vulnerable person is at risk, a safeguarding referral must be made.

16.2 The next priority is to ensure there is not an immediate risk of harm or ill-treatment to the vulnerable person (child or young person).

16.3 If there is, the CCO call handler should advice the crew if they have not already done so, to call the Police. Advise the crew to remain on scene or near scene until the Police arrive.

16.4 The CCO call handler staff may also be required to advice the road staff to transport the vulnerable person at risk to the nearest A&E department.

16.5 The CCO call handlers can seek further safeguarding advice if required by contacting the Regional Care Standards member or for out of hours the on-call Care Standards Manager. Details for this can be found on the Care Standards Team's SharePoint page:

[redacted]

16.6 The CCO call handler can then proceed to take specific details regarding their safeguarding concern, from the caller and complete the **F6.05.02 – CCO Safeguarding Referral Form**.

16.7 The CCO staff will annotate the **F6.05.02 - CCO Safeguarding Referral Form** with their name, the date and time of the safeguarding referral.

16.8 The CCO will obtain a contact number for the crew and confirm that they are happy for this number to be given to the Social Services Team if urgent and additional information is required.

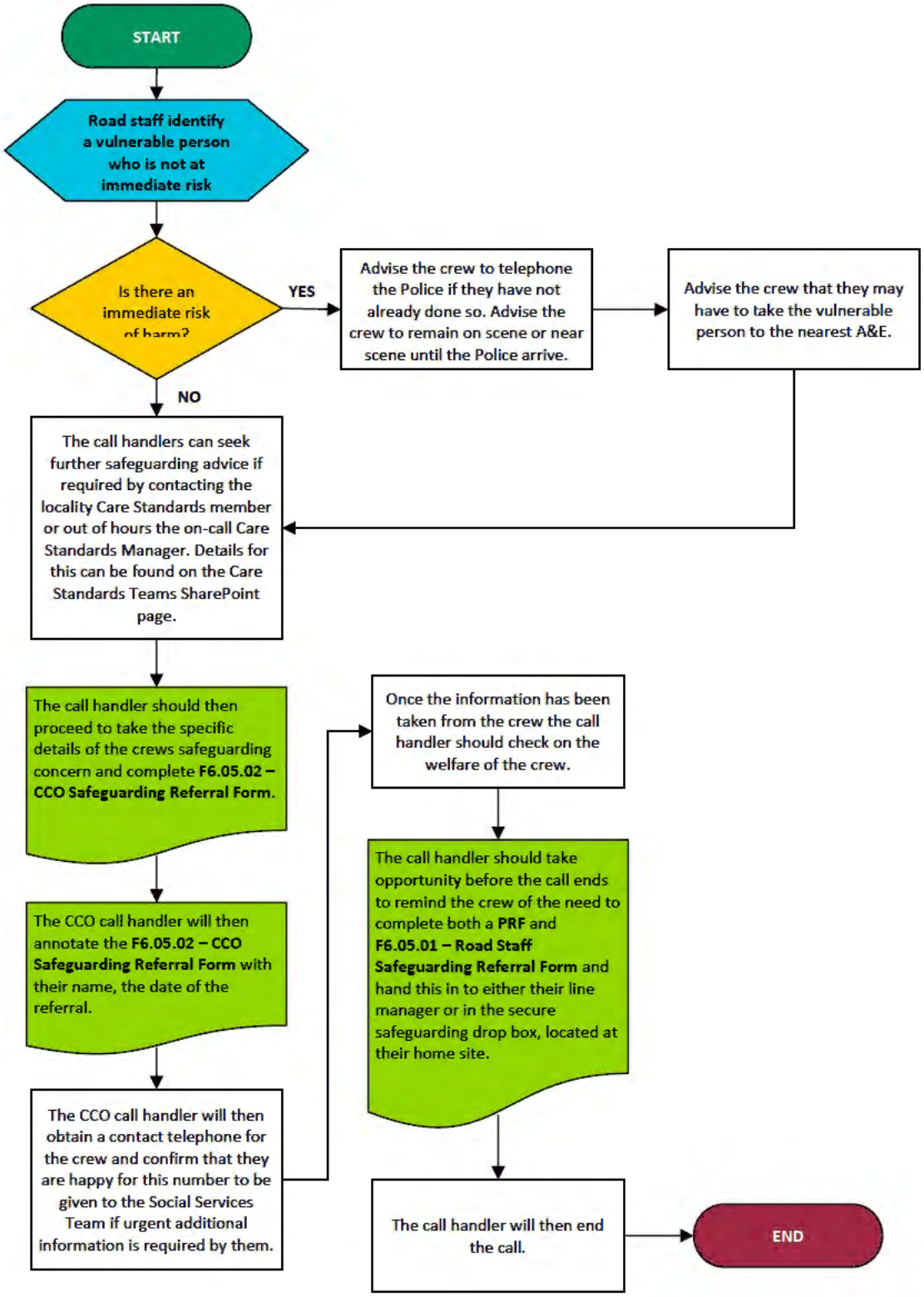
16.9 Once all information has been gained from the crew, the CCO call handler should make sure that the check on the welfare of the crew.

16.10 The CCO call handler should take this opportunity to remind road staff making the referral to complete an **F6.05.01 – Road Staff Safeguarding Referral Form** and a **PRF** and ensure that it is either handed in to either their line manager or dropped into the safeguarding secure drop box, located at their home site.

16.11 The call handler will then end the call.

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17. Key Steps – CCO Safeguarding Referral Inbound



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18. CCO Safeguarding Referral to Social Services (Urgent and Non-Urgent)

18.1 If the call is deemed as 'Urgent' the referral must be made as soon as possible.

18.2 The CCO will action the referral immediately by phone, using the ERS Medical Safeguarding Social Services Index to identify which Social Services Team (SST) needs to be contacted.

18.3 If the call is deemed as 'non-urgent' the referral can be made the following day during normal working hours.

18.4 The relevant SST can be found on the ERS Medical Safeguarding drive. Access to this drive is restricted to authorised personnel only.

18.5 When CCO agents make the referral to the relevant SST they are to state the following:

Child / Young Persons Referral: '***It is ERS Medical belief that this referral meets the threshold of notification under the requirements of Section 11 of The Children's Act 2004***'.

18.6 If once contacted the relevant SST they offer resistance to accepting the referral it is **ESSENTIAL** that the referral is still made. It is ERS Medical policy that we will report all referrals to Social Services and if they deem, after the referral process, not to act on the referral it is there decision.

18.7 **F6.05.02 - CCO Safeguarding Referral Form** once completed will be saved in the ERS Medical Safeguarding drive, under the folder '**Completed ERS Safeguarding Referrals / Year / Month'**.

18.8 The naming conventions should adhere to the following for all safeguarding referrals saved to this drive:

Example: **Jane Doe 08 09 2016**

All save files should be encrypted and password protected to ensure data security.

18.9 Once the nature of the safeguarding referral has been clarified i.e. urgent or non-urgent and the other steps have been completed as detailed in Section 18 of this Work Instruction a referral to the relevant SST can be made.

18.10 The ERS Medical Safeguarding index requires that a referral form is emailed/ faxed to a given address the CCO member must do the following:

- Take all referral details as normal and write them on the form **F6.05.02 - CCO Safeguarding Referral Form)**;
- Create a PDF file using 'cute pdf' (if you have any problems with this please contact the IS support team) or email a scanned pdf version to yourself using one of the scanner/printers available.
- The form **MUST** then be emailed directly to the given council/NHS e-mail address, via a NHS.net secure e-mail account (if a CCO call handler does not have a NHS.net account they should identify a CCO team member who does);

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- A point of contact for the SST should be given as the safeguarding e-mail address:



- If the SST team, ask if feedback is required to ERS Medical the answer should always be **YES**.

18.11 If the SST requires additional information, then the crew details should be given. Advice from the on-call Care Standards Manager can also be gained.

18.12 If the referral falls under a Serious Incident (SI) the CCO will contact the on-call Care Standards Manager and ERS Medical Safeguarding Lead, to inform them of the incident. A SI includes the following:

- **Where a death of an adult or child is present;**
- **Where serious injury has been suspected or caused;**
- **Suspected / alleged child abuse.**

18.13 The CCO agents should also make contact with either the regional Care Standards Team member or on-call Care Standards Manager if they meet with resistance from an SST when making a referral.

18.14 The CCO will then email the Safeguarding / Care Standards Team on:



This e-mail will state that a referral has been completed and **MUST** contain the following information:

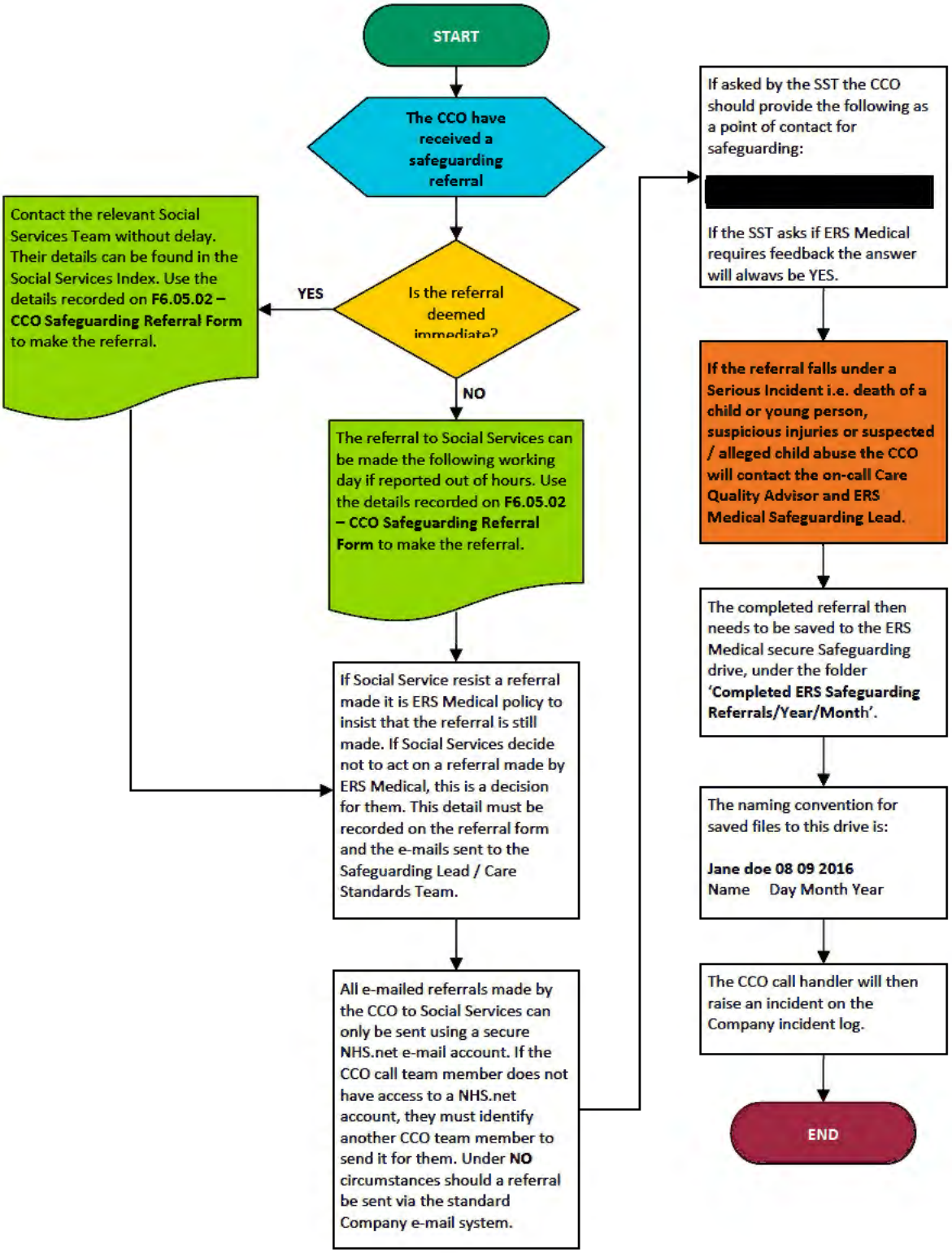
- Patients full name;
- Social Services Team referred to;
- Unique reference number of the referral;
- Crew that referred the incident with their base site.

18.15 The CCO call handler will then raise a safeguarding incident on the RADAR incident log, detailing all the information they have captured on the **F6.05.02 - CCO Safeguarding Referral Form.**

18.16 The Care Standards Team monitors the safeguarding inbox and the secure safeguarding drive on the ERS Medical SharePoint system.

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19. Key Steps – CCO Safeguarding Referral to Social Services



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20. Safeguarding Operations

20.1 The Operations Managers are responsible for ensuring that all new documentation – safeguarding workflow, safeguarding referral forms, ERS Medical Patient Report Forms (PRF's), safeguarding clinical memo for NEPTS and all non-ambulance Trust contracts are placed on all contract vehicles for the crews. The memos and poster should also be placed on all ERS Medical notice boards as an urgent and immediate action.

20.2 The Operations Managers are responsible for ensuring that the safeguarding secure drop boxes are attached securely to the wall and that access is restricted to the site Management Team.



20.3 The site Operations Team are to ensure that on the next working day any PRF/Statement or **F6.05.01 – Safeguarding Referral Form (Road Staff)** is scanned and uploaded to the incident raised by the CCO at the time of the referral.

20.4 The Operations Teams are responsible for ensuring that any patient identifiable safeguarding documentation is stored securely on site.

20.5 Site Operations Managers are responsible for the initial investigation of all safeguarding referrals, which are notified to them through the automated incident alert system. This initial investigation will also include the collection and uploading of crew PRF's and or statements, detailing their safeguarding concerns.

20.6 Additionally, the site Operations Managers will make contact with the reporting crew to acknowledge that the safeguarding referral has been made by the CCO. They will only be able to do this once they have been notified, by the relevant Care Standards Team member (see Section 21 of this work instruction.

20.7 This notification to crew must be recorded within the 'Actions' section of the initial investigation on the incident log and the incident cannot be closed until this has been completed.

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21. Safeguarding Process (Safeguarding Lead / Care Standards Team)

21.1 Once the Safeguarding Lead / Care Standards Team receive the e-mail notification of a safeguarding referral they will ensure that the incident is actioned as required by **BMS/5.01 – Incident Reporting and Investigation**.

21.2 The relevant Care Standards Team member must verify that the CCO has completed the safeguarding referral and that this has been communicated to the relevant Social Services Team. They should do this by checking the completed referrals folder of the secure 'Safeguarding' drive.

21.3 Once this is confirmed they will annotate the incident log with the required referral details and contact the sites CQC Registered Manager and Operations Manager to inform them that the referral has been completed and that this must be communicated to the reporting crew members with thanks.

21.4 Safeguarding Leads / Care Standards Team members are responsible for monitoring the safeguarding e-mail inbox and collating all the information received from CCO.

21.5 Safeguarding leads / Care Standards Team members are responsible for keeping the Company CQC Registered CQC Managers informed of safeguarding referrals monthly, unless it is for an SI, at the locality Governance and Patient Safety (GaPS) Committee meetings.

21.6 SI referrals will be notified to the Company CQC Registered Managers as soon as practicable, so that a joint decision can be made if a particular referral meets the requirements of Regulation 18 of the Health and Social Care Act 2014.

21.7 Safeguarding leads / Care Standards Team members will ensure that any child safeguarding concerns, regarding ERS Medical personnel, sub-contractor or volunteers that work with children or young people are reported to appropriate SST LADO, as a safeguarding referral as detailed at Section 18 of this work instruction.

21.8 The Head of Care **MUST** be informed of all such referrals.

Contractual Variation for Norfolk CCG

21.9 For allegations made in the Norfolk CCG area the safeguarding lead will contact the Norfolk Local Authority Designated Officer (LADO);

LADO@norfolk.gov.uk

21.10 More information on contacting the Norfolk LADO can be found at:

Norfolk Local Authority Designated Officer (LADO)

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22. Appendix A – ERS Medical Adult & Child Safeguarding Process – Road Staff

Remember: **All Referrals low or high risk are to be phoned through to CCO 24 hours a day on** [redacted]

ERS Medical
SRCL Group Company

Adult & Child Safeguarding Referral Process for ambulance crews

Safeguarding concern identified low risk or high (immediate) risk

↓

Ensure the individual's safety and the safety of others on scene.

If there is an **immediate** concern or risk call the police and/ or transport the vulnerable person to the nearest A&E.
If police assistance is required stay on or near scene until police arrive.
Do not put yourself or others at risk.

↓

Call the **CCO** on [redacted] to make the Safeguarding Referral

↓

Crews must then complete F6.05.01 (ERS) Road Staff Safeguarding Referral form and a PRF (in black ink) and give the CCO as much information as possible. The CCO will make the referral on your behalf to social services.

↓

Once the referral call has been made to the CCO both the PRF and F6.05.01 (ERS) Road Staff Safeguarding referral form that you have completed **must be** returned to the site line manager or safeguarding secure drop box.



For further advice you can contact the Leeds CCO on [redacted]

Important things to remember

- Are others at risk?
- Have concerns been clearly documented?
- Are the right people and services informed?
- Consider professional accountability

Additional Notes:
Safeguarding referrals should be made in the following situations

- Domestic Violence
- Sexual Abuse
- Psychological Abuse
- Financial or Material Abuse
- Modern Slavery & Human Trafficking
- Discriminatory Abuse
- Female Genital Mutilation (FGM)
- Unforeseen Vulnerability
- Allegations made against Employees / Sub-contractors
- Organisational Abuse
- Neglect or Omission
- Self-Harm
- Mental Health issues
- Forced Marriages
- Prevent
- Child protection
- Whistleblowing

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23. Appendix B – ERS Medical Adult & Child Safeguarding Process – CCO

ERS Medical
SRCL Group Company

Adult & Child Safeguarding Referral Process for the CCO

Call received by the CCO for a safeguarding referral

The next priority is to ensure there is not an immediate risk of harm or ill-treatment to the vulnerable person (child or adult).

If there is, the CCO call handler should advise the crew if they have not already done so, to call the Police.

The CCO call handler may also be required to advise the road staff member to transport the vulnerable person at risk to the nearest A&E department.

Complete F6.05.02 (ERS) Safeguarding referral form (online version) for all referrals. Ensure that all the information is documented in the reporter's own words and get the reporter's contact details.

If the referral is **URGENT/IMMEDIATE** – telephone the relevant Social Services Team (SST) without delay.

If the SST requires copies of the referral form from the CCO it can only be sent from a secure NHS.net email account. If you don't have an NHS.net account you MUST identify another person within the CCO who does, to send the requested information.

Ensure that you provide the SST with our point of contact details as: [redacted]

Once the referral to SST has been made ensure that you email the details of the referral to the Safeguarding Care Quality Team on [redacted]

The email must contain details of the vulnerable person's name, home address the SST to which the referral was made and the reporter's contact details.

F6.05.02 (ERS) CCO Safeguarding Referral Form once completed will be saved in the ERS Medal Safeguarding drive, under the folder **'Completed ERS Safeguarding Referrals/Year/Month'.**

The naming conventions should adhere to the following for all safeguarding referrals saved to this drive, **Example: Jane Doe 08 09 2016.**
All saved files must be encrypted and password protected to ensure data security.

The CCO call handler will then raise a safeguarding incident on the Steripoint incident log, detailing all the information they have captured on the **F6.05.02 (ERS) – Safeguarding Referral Form.**



The CCO call handlers can seek further safeguarding advice if required by contacted the locality Care Quality Advisor or the out of hours the on-call Care Quality Advisor.

Details for this can be found on the Care Quality Team's Steripoint page.

Please remember welfare when making a referral. Do they need Operational or Care Team support?

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ERS Medical

WI/6.05.02 Deprivation of Liberty Safeguards (DoLS) / Liberty Protection Safeguards (LPS)

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.0	Active Date:	22.10.2020	Review Date:	31.10.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
1.1	All	All	All	13.04.18	[redacted]	Addition of review date
2.0	All	All	All	09.11.18	[redacted]	Annual Review
3.0	All	All	All	23.11.19	[redacted]	Annual Review
4.0	All	All	All	22.10.20	[redacted]	Annul Review

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2. Related Documents

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Management and Reporting	BMS/5.01
Serious Untoward Incident (SUI) Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity	BMS/5.04
Care to Care	BMS/6.01
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
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End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Risk Assessment	BMS/6.07
Patient Communications and Control Operations (CCO)	BMS/6.08
Non-Emergency Patient Transport Services	BMS/6.10
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High Dependency Unit (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Patient Tissue Viability & Hydration Record	F6.07.02

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3. DoLS / LPS Legislation

3.1 Deprivation of Liberty legislation, regulation and guidance can be found at:

- The Mental Capacity (Amendment) Act 2019;
- Liberty Protection Safeguards (LPS)

3.2 The Mental Capacity (Amendment) Act 2019 was passed into law in May 2019.

3.3 Under the Mental Capacity (Amendment) Act 2019, the DoLS will be replaced by the Liberty Protection Safeguards (LPS).

3.4 The new LPS have been delayed due to COVID-19 to April 2022.

3.5 The government a currently drafting a code of practice that will clarify how the LPS will work in practice.

4. Introduction

4.1 Article 5 of the Human Rights Act 1998 states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'. The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

4.2 DoLS / LPS aim to make sure that people in care homes, hospitals and who have supported living are cared for and supported in way that does not inappropriately restrict their freedom.

4.3 The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005 and the only apply in England and Wales.

4.4 Care homes and hospitals must ask their local authority if they deprive a person of their liberty. This is called requesting a standard authorisation.

4.5 A Supreme Court judgement, which was made in March 2014, made reference to the ‘acid test’ to see whether a person is being deprived of their liberty.

4.6 This ‘acid test’ consists of 2 questions which are:

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

4.7 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.8 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical’s Capability and Disciplinary procedures.

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5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing quality, health & safety and environmental policy.
6.2	**Governance and Patient Safety Committees**	Will monitor the Safeguarding Adult and Child activity within ERS Medical and the effectiveness of this procedure and its outputs.
6.3	**Medical Director /Head of Care Standards**	Are responsible for the development, implementation and co-ordination of the consistent, quality, efficient and clinical based approach to the safeguarding vulnerable people process across the business.
6.4	**CCO Manager / Team Leaders/ Clinical Supervisors**	Is responsible for the training, coaching, measurement and reporting of the CCO staff approach to the safeguarding process and ensuring the process is followed at all times.
6.5	**Site Operations Managers & Safeguarding Lead / Care Quality Advisors**	Are responsible for the implementation and co-ordination of the safeguarding process at a site level. ERS Medical's safeguarding lead will also have responsibility for the periodic checking of all external customer policies and forms used within ERS Medical as a contractual or SLA obligation. The monitoring of Company Safeguarding procedures for their effectiveness.
6.6	**Location CQC Registered Manager (Senior Operations Managers**	Are responsible for notifying all Safeguarding referrals to the Care Quality Commission and ensuring all reporting procedures for the Commission adhered to.
6.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.
6.8	**Human Resources**	Will ensure that all pre-employment checks will be undertaken by the recruitment and HR team.
6.9	**ERS Medical**	As an independent Ambulance Provider, the business provides ambulatory care across all fields of emergency 999 contracts, Patient Transport, mental health and events both within the NHS and wider sector. This means that our staff and sub-contracted staff may be the first to be aware of safeguarding concerns for adults and children. As a professional service and a provider of Pre-Hospital, urgent and non-urgent care the business is in a unique position to note important pre-disposing factors regarding the safeguarding concern due to first-hand experience at the incident. It should no longer be considered enough to merely mention concerns to hospital staff or other health care workers as being sufficient to protect a child or adult from risk of significant harm. The Companies responsibility is to ensure the appropriate professionals are made aware of the concerns.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

8. Levels of Restriction & Restraint

8.1 Sometimes restrictions or restraints have to be placed on people for their own safety i.e. in the best interests of a person who lacks capacity to make decisions themselves. Any restriction or restraint must be proportionate to the harm the care giver is seeking to prevent.

8.2 Examples of restrictions and restraints can be, but not limited to:

- Using locks or keypads which stop a person going out or into different areas of a building;
- The use of some medication, for example, to calm a person;
- Close supervision in the home, or the use of isolation;
- Requiring a person to be supervised when out;
- Restricting contact with friends, family and acquaintances, including if they could cause the person harm;
- Physically stopping a person from doing something which could cause them harm;
- Removing items from a person which could cause them harm;
- Holding a person so that they can be given care, support or treatment;
- Bedrails, wheelchair straps, restraints in a vehicle, and splints;
- The person having to stay somewhere against their wishes or the wishes of a family member
- Repeatedly saying to a person, they will be restrained if they persist in a certain behaviour.

8.3 It is important for all ERS Medical ambulance crews to be aware, that a valid DoLS / LPS for a patient is **NOT** an authority to either transport that patient or force the patient to travel. DoLS / LPS are not typically valid for transport.

8.4 If a service user refuses to cooperate and travel, the ERS Medical crew can attempt to persuade the patient that it is in their best interest, but if the patient continues to refuse, they should liaise with care provider and if necessary, abort the journey.

8.5 It will be the responsibility of the care provider to take other measures to secure transport for the patient and then rebook this as required.

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9. ERS Medical's Responsibilities

9.1 ERS Medical will not be instrumental in requesting a DoLS / LPS order for a patient, but we will be requested to provide transport for patients who are subject to a DoLS / LPS order.

9.2 An ambulance may be requested to assist in transporting a patient subject to a DoLS / LPS order, to return the patient to the location specified in the DoLS / LPS order or to another location for care and treatment.

9.3 When requested to transport a patient with a booking requirement for DoLS / LPS, the attending crew must request to see the DoLS / LPS order (or formal record of best interest assessment relating to the DoLS / LPS) to ensure that it is valid. If neither of these are present crew must see clarification from their control / despatch.

9.4 Controllers and despatchers can contact the Safeguarding Lead or location Care Quality Advisor during normal working hours via the CCO in Leeds or the on-call Care Quality Advisor again via the CCO in Leeds.

10. Death of a Person Subject to a DoLS / LPS Order

10.1 In the event of the death of a patient with a valid DoLS / LPS order, the Police must always be called as the Coroner will treat this as a death in custody.

10.2 In addition to this crews must report this as an incident by calling Leeds on [redacted]

10.3 Registered Managers will also have to make a statutory notification to the CQC as part their responsibilities.

11. Further Information

11.1 For further information about DoLS / LPS staff can follow the below link:

http://www.scie.org.uk/publications/ataglance/ataglance43.asp

https://www.gov.uk/government/news/new-law-introduced-to-protect-vulnerable-people-in-care

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Question 1.10.5

Signposting

Please provide details of your systems to ensure staff understand how to access support and guidance and refer concerns relating to child and adults Deprivation of Liberty (DOLs), mental capacity, domestic abuse, child sexual exploitation, female gender mutilation evidence of your compliance with statutory safeguarding policies by describing your organisation's safeguarding processes, how your organisation will safeguard vulnerable users of this service, how you will report safeguarding incidents within your organisation and to external organisations, the role of the executive safeguarding lead and how safeguarding is monitored throughout the organisation.

The Bidder has evidenced they have appropriate systems in place – Pass

The Bidder has failed to evidence they have appropriate systems in place – Fail

All staff, road staff and control room staff, are required to undertake and complete annual safeguarding, prevent and DoLS (Liberty Protection Safeguards) as detailed by the ERS Medical Training Prospectus and as detailed for safeguarding within the 2 intercollegiate documents.

In addition to this ERS Medical's Business Management System (BMS) has 1 main procedure and 3 separate policies/work instructions which are:

- BMS/6.05 - Safeguarding of Vulnerable Adults, Children and Young People;
- WI/6.05.01A – Safeguarding of Vulnerable Adults;
- WI/6.05.01C – Safeguarding of Vulnerable Children and Young People;
- WI/6.05.02 – Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS);
- WI/6.05.03 – PREVENT.

These policies and procedures detail both specific training requirements for each subject and to which level, the types of issues and abuse which may require an intervention such as a safeguarding / PREVENT referral and or immediate actions such as calling the Police. These can include but not be limited to: Physical Abuse, Domestic Violence, Psychological Abuse, Modern Slavery and Human Trafficking, Financial or Material Abuse, Sexual Abuse, Forced Marriages (Honour Abuse) and FGM.

In support of the requirement and obligation of ERS Medical crews to make safeguarding / PREVENT referrals, ERS Medical provides a 24/7 incident reporting system and reporting line, manned by trained staff (level 2). Supporting these staff through the Clinical On-Call system, also operating 24/7 are level 4 trained and qualified members of the Care Standards Team.

ERS Medical operates a compliance system called *** REDACTED *** which has specific incidents within it for recording safeguarding and PREVENT concerns and the workflow directs staff within the call centres, receiving the referrals from crews to raise the concerns with the appropriate Social Services Team as soon as possible. The call centre staff are also able due to their training and access

to the Care Standards Team on-call Level 4 qualified manager, provide guidance and advice to the crews in real time.

The *** REDACTED *** system's workflow manages all referrals through 5 distinct stages to assure the ERS Medical process has been followed and adhered to and provide feedback and lessons learnt for all such incidents. These workflow stages are:

Initial Investigations:	Completed by the ERS Medical sites Operations Manager
Compliance Initial Investigation:	Completed by the level 4 Care Standards Team member
Technical Review:	Completed by the level 4 Care Standards Team member
Action Plan:	Completed by the level 4 Care Standards Team member
Risk Score:	Completed by the level 4 Care Standards Team member

All safeguarding, DoLS (LSP) & PREVENT incidents are reported (ONE Compliance Report) upon monthly within each regions Governance and Performance Review committee meeting, which is chaired by the locations CQC Registered Manager. In addition to this all regional reports (HEAD Compliance Report) are then brought together for the Senior Leadership Team (SLT) Monthly Performance Review meeting.

The ONE Compliance report is also made available monthly to contracted CCG and NHS Trust quality and governance leads for monthly review, comment and scrutiny.

Each HEAD Report is then also sent monthly to the members of the ERS Medical Patient Safety Committee (PSC), which sits quarterly and is chaired by the ERS Medical Safeguarding Lead & Medical Director.

WI/6.05.03 Prevent

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Care to Care	BMS/6.01
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Risk Assessments	BMS/6.07
Patient Communications and Control (CCO)	BMS/6.08
Non-Emergency Patient Transport (NEPTS)	BMS/6.10
Renal Patient (NEPTS)	BMS/6.11
High Dependency (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Safeguarding Vulnerable Adults and Children	WI/6.05.01
DoLS	WI/6.05.02
Safeguarding Referral Form (Road Staff)	F6.05.01
Safeguarding Referral Form (CCO)	F6.05.02
Prevent Referral Form	F6.05.03
Prevent Referral Road Staff	Annex A
Prevent Referral CCO	Annex B

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3. Introduction

What is Prevent

3.1 Prevent forms one part of the Government's overall counter terrorism strategy 'CONTEST' which is led by the Home Office.

3.2 CONTEST is primarily organised around four key principles or work streams, each with a specific objective:

PREVENT - To stop individuals becoming terrorists or supporting terrorism;

PURSUE - To disrupt or stop terrorist attacks occurring;

PROTECT - To strengthen our borders, infrastructure, buildings and public spaces from a terrorist attack;

PREPARE - To reduce the impact of an attack if an act of terrorism occurs.

3.3 Prevent is aimed at front line staff and is designed to help make staff aware of their role in preventing vulnerable people being exploited for terrorist purposes.

3.4 The Counter Terrorism and Security Act (2015) places a duty on a range of organisations to have due regard to the need to prevent people being drawn into terrorism.

3.5 Prevent has three National objectives:

Objective 1 – Respond to the ideological challenge of terrorism and the threat we face from those who promote it.

Objective 2 – Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support. Channel is a key part of the Government's work to prevent terrorism and is a multiagency approach to identifying and supporting vulnerable individuals.

Objective 3 – Work with sectors and institutions where there are risks of radicalisation which need to be addressed.

3.6 The Health sector contribution to Prevent focusses primarily on objectives 2 and 3.

Why Healthcare Staff?

3.7 ERS Medical aims to improve the health and wellbeing of service users through the delivery of healthcare services whilst safeguarding those individuals who may be vulnerable to any form of exploitation. Prevent is also concerned with protecting individuals.

3.8 Healthcare staff are well placed to recognise individuals, whether patients or staff, who may be vulnerable and therefore may be more susceptible to radicalisation. Staff must have an awareness of the risk of radicalisation, no matter how remote the risk appears, and the Prevent agenda which falls within ERS Medicals duty of care and safeguarding responsibilities to our patients.

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3.9 Radicalisation is usually a process, not a one-off event, and during that process it is possible to intervene to safeguard the vulnerable individual and prevent them from supporting terrorism or becoming terrorists themselves before any harm has occurred or crime has been committed.

3.10 There is no expectation for ERS Medical staff to take on an enforcement or surveillance role as a means of implementing the Prevent agenda. In contrast, ERS Medical must work in partnership with organisations and agencies to contribute to the prevention of terrorism by protecting and effectively safeguarding vulnerable individuals who may be at risk of exploitation.

3.11 This is a shared endeavour and every member of staff has a role to play in protecting and supporting vulnerable individuals and colleagues who may be at risk of radicalisation.

4. Purpose

4.1 This work instruction describes how ERS Medical implements the Prevent agenda.

4.2 The NHS Health Care Organisation Prevent Strategy and Policy (2014) outlines that the Prevent agenda ensures that:

4.3 NHS staff know how to safeguard and support vulnerable individuals, whether service users or staff, who they feel may be at risk of being radicalised by extremists.

4.4 Appropriate systems are in place within NHS organisation for staff to raise concerns if they think this form of exploitation may be taking place.

4.5 NHS organisations promote and operate safe environments where extremists are unable to operate.

4.6 Safeguarding and incident reporting policies are integrated with the Prevent strategy.

5. Policy Statements

5.1 ERS Medical is accountable for ensuring that there are “reliable systems, processes and practices in place to keep people safe and to safeguard them from abuse and neglect” (CQC, 2015).

5.2 This policy applies to all members of staff, whether paid or unpaid, student or volunteer.

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5.3 ERS Medicals Prevent policy is designed to complement the Multi- Agency Policies and Procedures of Local Safeguarding Children Boards and Local Safeguarding Adults Boards. This policy also links closely to other Trust policies including:

- Safeguarding Adults Policy;
- Safeguarding Children Policy;
- Confidentiality and Information Sharing;
- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS);
- Personal and Professional Boundaries;
- Disclosure and Barring Service;
- Speak Up (Whistleblowing).

6. Monitoring

6.1 The policy will be monitored for its effectiveness by the Medical Director and Head of Care, through the following:

- Liaison with the Care Quality Manager and nominated Safeguarding Lead within the Care Quality Team;
- Production of reports showing trend analysis of reporting, broken down into the following:
- Type of incident reported;
- Grade of staff reporting;
- Feedback gained from social services department;
- Feedback from other relevant external agencies;
- Lessons learnt from any adverse incidents.

6.2 These will be monitored on a monthly basis and reports provided back to the Governance and Performance Review Committee (GaPR).

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7. Responsibilities

7.1	**Managing Director**	Has overall responsibility for setting and directing quality, health & safety and environmental policy.
7.2	**Medical Director /Safeguarding Lead**	Is Responsible for safeguarding is responsible for reporting to the Board and providing executive leadership. He/she is accountable for the governance of safeguarding to the service, partners and regulators and ensuring effective implementation of the Prevent strategy across ERS Medical. Support members of staff, and the organisation to fulfil its obligations to service users and their carers to work effectively to prevent harm, abuse, and neglect, and to act positively to protect adults and children where there are concerns that the person may have been, or is at risk of radicalisation. Provide advice and support to all ERS Medical on all matters relating to Prevent. The Safeguarding Team must also assist staff members and managers to share concerns relating to Prevent with the appropriate agencies/authorities and maintain oversight of Prevent referral forms and outcomes. The Safeguarding Adults Team will keep a record of all Prevent related concerns as well as the outcome.
7.3	**Senior Operations Managers / CQC Registered Managers**	Are responsible for leading improvements, innovations and best practice; for providing support, responsive supervision, clinical leadership and practice advice. They also provide a link between directorates and ERS Medical and provide information in respect of compliance and performance updates. Are responsible for notifying all Safeguarding referrals to the Care Quality Commission and ensuring all reporting procedures for the Commission adhered to.
7.4	**Operations Managers**	Are responsible for ensuring that staff are aware of ERS Medical policy and offer support to those reporting abuse. Managers should also ensure that the level of responsibility for each staff member is explicit as a statement in all job descriptions to meet the expectations of each individual role. Good clinical leadership and high professional standards are paramount in the provision of care and the prevention of abuse. Managers must support staff members to escalate concerns relating to Prevent to ERS Medical 's Corporate Safeguarding Team and liaise with ERS Medical Human Resources (HR) Department if the concern raised relates to a member of ERS Medical

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7.5 **Care Quality Team**

ERS Medical Care Quality team has a responsibility to set safeguarding adults and children within their strategic objectives, ensure there is Board level leadership, an overall policy in place which incorporates the Prevent strategy and an organisational culture which places service users and their wellbeing at the centre of safeguarding, and endeavours to prevent harm, abuse, and neglect from occurring.

7.6 **ERS Medical**

NHS Clinical Commissioning Groups are a statutory member of the Local Safeguarding Adults and Local Safeguarding Children Boards. Health Services have a vital role to play in preventing harm, abuse, or neglect from occurring, identifying the signs of abuse or exploitation and reporting concerns to Local Authorities.

7.7 **All Personnel**

All employees (including bank and agency staff), volunteers and contractors are required to adhere to the policies, procedure and guidelines of ERS Medical, including their roles and responsibilities under this policy.

All members of staff are responsible for attending the relevant Prevent training for their role.

Staff must report all Prevent related concerns to their line Manager and ERS Medical 's Safeguarding Team to ensure a timely and proportionate response to concerns.

All staff should make sure that they have familiarised themselves with their PREVENT and safeguarding policy.

Staff must also work at all times within the guidelines of their professional codes of conduct and the policies of ERS Medical to prevent abuse through an act or omission to act. Omissions to act and poor professional practice can amount to neglect even if the abuse was unintentional.

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8. Definitions

8.1 **Radicalisation -** The Prevent Strategy (Home Office, 2011) defines the term 'radicalisation' as "the process by which a person comes to support terrorism and forms of extremism, leading to terrorism".

8.2 **Terrorism** - The current UK definition of terrorism is given in the Terrorism Act 2000 (TACT 2000). This legislation defines terrorism as "an action that endangers or causes serious violence to a person/people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause".

8.3 **Extremism** - The Home Office (2011) defines this term as "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs".

8.4 **Ideology** - An ideology is a set of beliefs. In the context of Prevent, there are a wide range of organisations and groups who may share a common ideology which motivates people associated with the group to become involved in or support terrorist related activity. Ideologies may be underpinned by beliefs about animal rights, environmentalist issues, politics, religion or conceptions of power and status, which are all relevant to the Prevent agenda.

8.5 **WRAP3 - Workshop to Raise Awareness of Prevent, Third Version** - WRAP3 is the national training programme currently provided for health staff which has been designed by the Home Office.

8.6 **Vulnerability** - Within Prevent, this term describes factors and characteristics which may make an individual more susceptible to radicalisation (Home Office, 2011).

8.7 **Safeguarding** - The process of protecting vulnerable people of all ages from crime, other forms of abuse or (in the context of this policy) from the risk of being drawn in or supporting terrorism.

9. Identifying an Adult or Child at Risk of Radicalisation

9.1 There is no single profile or indication of a person who is likely to become involved in or support terrorist related activity. To date, there is no universally accepted view or theory to help explain why vulnerable individuals can become involved.

9.2 The factors associated with exploitation are vast and unique to each individual person. "The increasing body of information indicates that factors thought to relate to personal experiences of vulnerable individuals affect the way in which they relate to their external environment" (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

9.3 Vulnerable children and adults can be exploited by radicalisers in variety of ways who seek to target these individuals on the basis of their vulnerability. Contact with radicalisers is also very variable and can range from taking a direct approach i.e. face to face, or can happen indirectly through virtual forums such as the internet, social networking or other forms of media. More commonly, contact appears to occur through a combination of the above (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

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9.4 It is generally more common for vulnerable people to become involved in terrorist related activity through the influence of others (NHS Health Care Organisation Prevent Strategy and Policy, 2014). Initial contact may be via siblings, peers, other family members or acquaintances, with the process of radicalisation often being a social process. This social interaction can take place in a range of unsupervised environments such as cafes, gyms, in private homes and via the internet. As such, staff need to be mindful of booking seminar rooms, meeting rooms/public areas etc. which may be potentially be used for terrorist purposes.

9.5 Access to extremist materials can often be through the use of leaflets and local contacts. However, the internet, and in particular social media, also plays a really important role in the communication of extremist views and is often used as a tool by radicalisers. The internet provides a platform for extremists to promote their cause widely and encourage debate through websites whilst disseminating propaganda material (NHS Health Care Organisation Prevent Strategy and Policy, 2014). ERS Medical must therefore be aware and have strategies in place to identify anyone making frequent visits to websites containing extremist material. This may include images such as armed conflict around the world and providing speeches and access to material from those involved in the radicalising process (NHS Health Care Organisation Prevent Strategy and Policy, 2014). Staff must also be aware of any inappropriate leafleting/canvassing which may be linked to the Prevent agenda.

9.6 Radicalisers usually try to attract people to their cause through a persuasive and convincing rationale which is contained within a narrative or storyline. This narrative then has the potential to influence others, their views and as a consequence, their actions or behaviour. “Inspiring new recruits, embedding the beliefs of those with established extreme views and/or persuading others of the legitimacy of their cause is the primary objective of those who seek to radicalise vulnerable individuals” (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

10. Capacity and Consent

Capacity

10.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

10.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

10.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

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10.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

10.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

10.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

10.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

10.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

10.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

10.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

10.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2008.

10.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

10.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

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Consent

10.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

10.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

10.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

10.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

10.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

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11. Factors that Make Someone Vulnerable

11.1 A wide range of personal and social factors could make individuals more susceptible or vulnerable to exploitation. None of the following factors are conclusive in themselves and, therefore, should not be considered in isolation but in conjunction with the person's wider circumstances and needs as well as any other signs or possible indicators of radicalisation.

Identity Crisis

11.2 Children, adolescents and adults who are exploring issues of identity can feel both distant from their parents, family or peers, their cultural or religious heritage and uncomfortable with their place in society around them (NHS Health Care Organisation Prevent Strategy and Policy, 2014). A perceived lack of belonging or identify can be exploited by radicalisers who seek to provide the person with a sense of purpose or meaning. As a result, changes may be noticed in the person's behaviour, their circle of friends, the way in which they interact with others, alter their appearance and spend their time.

Personal Crisis

11.3 This may, for example, include "significant tensions within the family that produce a sense of isolation of the vulnerable individual from the traditional certainties of family life" (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

Personal Circumstances

11.4 The experience of migration, events affecting families who remain in countries of origin or local tensions may all contribute to a sense of alienation or detachment from UK norms and values. This may in turn lead individuals to support terrorist groups or actively seek to cause harm to symbols of the community or state (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

Unemployment or under employment

11.5 Individuals may perceive their career and lifestyle aspirations to be undermined or restricted in some way by limited achievements or employment prospects. This can in turn translate to a generalised rejection of civic life and possibly an adoption of violence as a symbolic act (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

Criminality

11.6 In some cases, a vulnerable individual may have been involved in a group that engages in some form of criminal activity or, on occasion, a group that has links to organised crime. As a result, the individual may be further drawn into engagement with terrorist-related activity

Grievances

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11.7 The NHS Health Care Organisation Prevent Strategy and Policy (2014) provides the following examples of grievances and other factors which may play an important part in the early indoctrination of vulnerable individuals into the acceptance of a radical view or extremist ideology:

- A misconception and/or rejection of UK foreign policy;
- A distrust of Western media reporting;
- Perceptions that UK government policy is discriminatory (e.g. counter-terrorist legislation).

Other Factors

11.8 The following have also been found to contribute to vulnerable people joining certain groups supporting terrorist-related activity:

- Ideology and politics.
- Provocation and anger (grievance).
- Need for protection.
- Seeking excitement and action.
- Fascination with violence, weapons and uniforms.
- Youth rebellion.
- Seeking family and father substitutes.
- Seeking friends and community.
- Seeking status and identity.

12. Immediate Risks

12.1 If a staff member has concerns that an individual is presenting an immediate terrorist related risk to themselves, others or property they must contact:

- The National Counter Terrorism Hotline on **0800 789 321**

OR

- The Police on 999

13. Guidance for Raising a Concern

13.1 Prevent operates in the 'pre-criminal space'. It is about supporting individuals who are at risk of radicalisation *before* they commit acts of terrorism, or a terrorist-related criminal offence. Raising concerns that an individual may be vulnerable to radicalisation does not automatically mean that you think the person is a terrorist but rather that you are concerned that the individual may be prone to being exploited by others, is at risk of or potentially has been radicalised and as such, the concern is a safeguarding concern.

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13.2 The Prevent referral process can be described in three stages; notice, check and share.

Notice

13.3 Be aware of an individual's vulnerability to radicalisation, changes in behaviour, ideology and other forms of extremism:

Check

13.4 Check out your concerns with the individual where possible, and where safe, with your line manager, colleagues and Multi-Disciplinary Clinical meetings. Checking out your concerns with the ERS Medical Safeguarding Team will help to ensure a proportionate response to the concerns.

Share

13.5 Share your concerns with partner agencies, and as far as possible be open and honest with the individual about the duty to share your concerns.

13.6 Through the Prevent referral, information is shared to the Multi-Agency Safeguarding Hub (MASH) where it is screened for acceptance into the Channel process.

14. Channel

14.1 Channel is a multi-agency process, much like safeguarding adults, where partner agencies share expertise and resources to create a bespoke support package for vulnerable individuals.

14.2 If a service user is accepted into the Channel process, involved staff can be expected to be asked to become involved in the process, share relevant information and attend the multi-agency Channel panel if appropriate.

14.3 Staff must cooperate fully with the Channel panel, continue to support the service user to manage identified risks and to engage with the Channel process. Channel is a consensual process whereby agreement from the service user is fundamental to the provision of interventions. The service user is therefore a key partner in the process and staff must seek to empower the individual to play an active role in support planning processes.

14.4 Staff must escalate all concerns relating to Prevent to the ERS Medical Safeguarding Team.

14.5 As with any other Safeguarding incident, a [redacted] incident report **must be** completed under the cause group 'Prevent'.

14.6 If the concern relates to a member of ERS Medical, ERS Medical 's Human Resources (HR) Department must be contacted for advice and support following a discussion between the relevant Senior Manager and Safeguarding Professional. Any internal processes or forms of investigation will be deferred if a Police investigation is in progress to ensure there is no risk of compromising criminal proceedings.

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15. Information Sharing

15.1 ERS Medical 's Confidentiality and Information Sharing, Safeguarding Children and Safeguarding Adults Policies support ERS Medical to share information relating to children and adults where there are safeguarding concerns.

16. Training Requirements

16.1 Prevent awareness training is mandatory for all staff, at a basic awareness level for all non- clinical staff and a face-to-face WRAP3 course for all clinical staff. All staff must also undertake an annual Prevent refresher.

16.2 Please refer to the Training Prospectus for details on all Prevent training requirements.

17. Supporting References

CQC (2015) Statement on CQC's roles and responsibilities for safeguarding children and adults, London: Care Quality Commission.

- Home Office (2015) Counter Terrorism and Security Act 2015, London: TSO;
- Home Office (2011) Prevent Strategy, London: TSO;
- Home Office (2000) Terrorism Act 2000, London: TSO;
- NHS Health Care Organisation (2014) Prevent Strategy and Policy.

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NHS
Midlands and Lancashire
Commissioning Support Unit

Annex 10 Selection questionnaire Question 1.6.1 Contract Examples

Invitation to Tender for the Provision of Non-Emergency Patient Transport Service across Staffordshire.

On behalf of:
6 NHS Staffordshire Clinical Commissioning Groups and NHS Midlands Partnership Foundation Trust.

ITT 769

1. Relevant Experience and Contract Examples

1.1 This annex is to be completed by all consortia members and sub-contractors who are viewed as essential to the delivery of the services.

1.2 All questions must be answered even where the response is N/A.

1.3 Failure to answer all questions will lead to a fail.

1.4 Please provide details of up to three contracts, in any combination from either the public or private sector; voluntary, charity or social enterprise (VCSE) that are relevant to our requirement. VCSEs may include samples of grant-funded work. Contracts for supplies or services should have been performed during the past three years. Works contracts may be from the past five years.

1.5 The named contact provided should be able to provide written evidence to confirm the accuracy of the information provided below.

1.6 Consortia bids should provide relevant examples of where the consortium has delivered similar requirements. If this is not possible (e.g. the consortium is newly formed or a Special Purpose Vehicle is to be created for this contract) then three separate examples should be provided between the principal member(s) of the proposed consortium or Special Purpose Vehicle.

1.7 Where the Supplier is a Special Purpose Vehicle, or a managing agent not intending to be the main provider of the services, the information requested should be provided in respect of the main intended provider(s) or sub-contractor(s) who will deliver the contract.

2. Reference 1

Name of the Organisation completing the form	ERS Medical	
Name of customer organisation	Nottinghamshire and Bassetlaw NEPTS	
Point of contact in the organisation	[redacted]	
Position in the organisation	Contract Manager Patient Transport Services	
E-mail address	[redacted]	
Description of contract	Non-Emergency Patient Transport	
Contract Start date	1/12/19	
Contract completion date	[redacted]	
[redacted]	[redacted]	

3. Reference 2

Name of the Organisation completing the form	ERS Medical	
Name of customer organisation	Leeds Teaching Hospital	
Point of contact in the organisation	[redacted]	
Position in the organisation	Transport Manager	
E-mail address	[redacted]	
Description of contract	Patient Transport Discharge Service	
Contract Start date	01/07/2014	
Contract completion date	30/06/2019	
[redacted]	[redacted]	

4. Reference 3

Name of the Organisation completing the form	ERS Medical
Name of customer organisation	Norfolk CCGs
Point of contact in the organisation	[redacted]
Position in the organisation	Associate Director of Contracting and Procurement
E-mail address	[redacted]
Description of contract	Non-Emergency Patient Transport
Contract Start date	1st October 2019
Contract completion date	30th September 2026
[redacted]	[redacted]

[redacted] [redacted]

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Midlands and Lancashire Commissioning Support Unit

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Question 1.10.6

Safeguarding example

Please provide a fictitious or anonymous example of a safeguarding incident, the actions taken and the lessons learned.

The Bidder has provided an appropriate example of a fictitious safeguarding incident, the actions taken and the lessons learnt – Pass

The Bidder has failed to provide an appropriate example of a fictitious safeguarding incident, the actions taken and lessons learnt - Fail

Description

This is an adult safeguarding incident caused by an ERS Medical crew's failure to comply with standard operating procedures relating to the safe handover of a patient. The patient does not speak English and has been left at an acute hospital without and escort and without an appropriate handover by the crew. Below we have provided an overview of how we would respond to such an incident and how we would use the lessons learnt to prevent a reoccurrence.

Incident Detection

An incident can be detected in several ways, these can be reported by

- Crews
- Hospital Staff
- A member of the general public
- ERS will have a dedicated phone number for this contract for direct contact with local operational managers
- A 24/7 escalation protocol will be circulated to all stakeholders and ERS employees

Immediate Actions

Our initial handling of this incident would be to attempt to communicate with the patient, using either our language translation service, our translation cards or the translation App, which we have on our crews' tablets.

Once the patient's language is identified, we would try and ascertain the patient's name and where he/she was supposed to be. If the patient was found by another ERS crew they would then call into both the ERS Hospital Liaison Officer and Control Desk to have a check run on our Cleric system to confirm the patient's details and the ERS crew who left the patient without ensuring they were safe. It would be a priority to ensure that the patient was not left alone, escorted at all times and reassured that everything will be Ok.

If after checking the ERS CAD it identifies the patient as being brought in by ERS, our imbedded Hospital Liaison Assistant would make sure that the patient was taken to the correct department

and brief the medical staff about what had happened and the language barrier. We would also ensure that the hospital staff were aware at this time that ERS would be reporting this as an incident.

As part of this initial management of the incident our local Operations Team, would review any booked return journey for the patient and make sure that an escort was booked and resourced. A CAD note would also be made to ensure that a check is made for an escort for all future journeys.

The hospital team would also notify the local Dispatch and Control, who would identify the crew responsible and raise a Safeguarding incident on our [redacted] system. Once raised this would automatically generate notifications to the following positions:

- CQC Registered Manager
- Head of Care Standards
- Senior Operations Manager
- Care Standards Manager
- Team Leaders

In addition to this we would make contact, if appropriate to do so, with the patient's Next of Kin or primary care providers and make them aware of what had happened, reassure them that the patient was safe and being cared for and that ERS would be investigating how this happened. If the patient has capacity (we would assume that they did unless otherwise documented), we also ensure that they are made aware that they should not have been left alone.

The [redacted] auto notification would trigger this investigation which would be broken up into the 5 stages:

- Site Initial Operational Investigation
- Care Standards Initial Investigation
- Technical Review of the Operational Investigation conducted by the Care Standards Team;
- Action Plan, as a result of any changes to process, reviews, lessons learnt and shared learning
- Risk Score

Part of the initial investigation would be to identify the booking for the patient and listen to the call to see if an escort was required and requested. We would also contact the ERS crew and inform them of the incident and instruct them to complete a witness statement, which should also detail any interaction they had at both the collection address and the drop off at the acute NHS Trust. This must be completed at the end of their shift.

Once the incident has been logged onto the [redacted] system, by calling our designated Incident Reporting Line, our CCO agents will make the safeguarding referral to the relevant Social Service Team and record this referral on **F6.05.02 – Safeguarding of Vulnerable Adults and Children Referral Form**, which forms part of our suite of documents within our BMS, which documents ERS's Safeguarding policy. This completed referral form will then be saved and encrypted to a secure folder within the [redacted] compliance system for review by the Care Standards Manager.

The Care Standards Teams' initial responsibility within this incident is to identify if it is a notifiable event to either or both the CQC and Health and Safety Executive.

If the incident is assessed as being notifiable either under Regulation 18 of the CQC (Registration) Regulations 2009 and or the NHS England – Serious Incident Framework, additional reporting will need to be completed, without delay. This notification would include formal notification to the following:

- The CQC – Notification under Regulation 18 (self-referral);
- Relevant Social Service Team – Self-Referral
- The relevant CCG initially be telephone and then followed up by a submission on STEIS;
- Duty of Candour under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This will be conducted in accordance with our registration requirements in an open and transparent manner by the relevant person. A written record will be kept. It is also an opportunity for the patient and or NOK/primary care provider (relevant person) to ask specific questions and ERS will and is required to answer them in a reasonable time frame.

Lessons Learnt

As the local [redacted] investigation and SUI investigation commences, one of the main requirements of these investigations is to identify any potential system failings or errors and then identify lessons that need to be learnt.

These lessons can be, but not limited to:

1. The way in which we take and record bookings. Additional or differently worded questions
2. Additional follow up questions to more clearly identify the patient's specific needs and requirements and to identify vulnerable adults, young people and children
3. Changes to ERS Policy and procedure to better reflect the needs of vulnerable persons
4. Changes to ERS training to all staff, especially road crew and control room staff on caring for vulnerable groups
5. Individual staff targeted feedback
6. Changes to ERS risk assessments for dealing with vulnerable adults, young people and children
7. Lessons identified from the communication and feedback provided between ERS and the various stakeholders involved in the incident, so that lessons can be shared and communicated across multiple agencies
8. Submission and subsequent feedback and recommendations from the CCG on the submitted SUI, RCA Report

ERS communicates the lessons learnt in multiple ways

- 1:1 meetings with staff members
- Staff meetings, held by Operations and supported by the Care Standards Team
- Discussions and feedback provided during the monthly Governance and Patient Safety meetings (GaPS)

- Monthly Senior Leadership meetings
- Quarterly Patient Safety meetings
- Clinical/Care Notices/Care Quality Memo's being issued to sites, providing guidance
- [redacted] 'Notices' to specific individuals or groups
- The review, approval, issue and notification to all relevant persons that there has been changes made to ERS policy and procedure within our BMS
- An article written and published in our quarterly staff publication 'In Touch'
- Site TV displaying updates and changes
- Reminders sent out to on duty staff, periodically through our 'WhatsApp' messaging group

Safeguarding Policy

ERS has an integrated Business Management System (BMS), which is available to all staff through our [redacted]

We are required to have an up to date Safeguarding, Prevent and DoLs policy and procedure and this suite of documents sits within our BMS at Section 6.05 – Safeguarding of Vulnerable Adults and Children.

ERS has taken the decision to have a combined adult, young person and children procedure and associated documents, but acknowledge there are significant differences between the groups that are addressed both within these documents and the face to face Safeguarding training staff receive as part of their annual CPD training. All staff receive Safeguarding training to level 2 and the Care Standards Team receive enhanced safeguarding training, equivalent to level 4 as required by the RCN DG Intercollegiate Safeguarding document and the Safeguarding Children and Young People: Roles and Responsibilities for Health Care Staff Intercollegiate Document, third edition March 2014.

In line with these publications and standards a vulnerable adult is defined as someone who is aged 18 or over:

- Who is, or may be, in need of community services due to age, illness or a mental or physical disability
- Who is, or may be, unable to take care of themselves, or unable to protect themselves against significant harm or exploitation

It may also include

- Someone who misuses substances or alcohol
- Is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
- Is unable to demonstrate the capacity to make a decision and is in need of care and support

A young person or child is defined in the Children Act 1989 and 2004 respectively, as anyone who has not yet reached their 18th birthday. Children therefore means 'children and young people). Safeguarding and protecting the welfare of children for the purposes of this work instruction is:

- Protecting children from maltreatment
- Preventing impairment of children's health and development

- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully

Policy Review

Our Safeguarding policy is written by our Care Quality Manager who is Deputy Safeguarding Lead for ERS and a Registered Nurse. The document is reviewed by our Head of Care Standards and Medical Director and approved by our Patient Safety Committee. All ERS documents on the BMS are reviewed annually. Changes and updates to our BMS is achieved by Notices within our [redacted] compliance system, as these can be tracked as being delivered and acknowledged by the recipient.

Question 1.10.7

Safeguarding investigations

Has the Bidder been involved in any safeguarding investigations, involving the care provider, patients or staff in the past two years?

If yes please provide dates, details of the concern, the status of the investigation, any recommendations and what actions have been taken by the Bidder to remedy the situation.

The Bidder has not been involved in safeguarding investigations in the past two years – Pass

The Bidder has been involved in safeguarding investigations in the last two years and has evidenced they have taken appropriate actions to remedy the situation – Pass

The Bidder has been involved in a safeguarding investigation in the past two and has no provided adequate recommendations of the actions taken to remedy the situation – Fail

ERS Medical has had x1 safeguarding concern raised as a Section 42 request from Social Services.

This was in May 2019 and relates to a patient being discharged from a local acute Trust to a Care Home and being initially dropped off at a very similarly named Care Home in close proximity to the correct Care Home. This patient was accepted by the wrong Care Home staff initially but was soon identified and called through to the local ERS Medical control. The ERS Medical ambulance was then re-tasked to return to collect the patient and transport them to the correct Care Home.

The ERS Medical staff raised an incident themselves to report the event and the correct Care Home subsequently raised the safeguarding concern with the local Social Service Team (SST). ERS Medical was then contacted and provided the SST a copy of its internal investigation, remedial actions and lessons learnt. These included:

- A Care Quality Alert sent to all ERS Medical sites to remind staff of the importance of making sure that all patients are taken to the address booked on the CAD system.
- The x2 staff members both received some additional training on safeguarding and the requirements of Care to Care and this was recorded on their personnel files to this effect.
- ERS Medical offered up a duty of candour to the relevant person for the patient, but this was not wanted or required by them, further than the apology offered for the human error.

BMS 2.06 Disclosure and Barring Services (DBS) Checks Policy

Document Author:	[redacted]			Head of HR & Training	
Document Owner:	[redacted]			Managing Director	
Version:	4.0	**Date Active:**	31.01.2020	**Review Date:**	31.01.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 2 written for ERS Medical	[redacted]	25/01/2018
Approved by the Managing Director	[redacted]	

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
1	9.2		7	28/01/18	[redacted]	We have added Basic Checks to our DBS list at Capita
2	All	All	All	12.03.18	[redacted]	Annual Review
3	All	All	All	29.01.19	[redacted]	Annual Review
4	All	All	All	31.01.20	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS 1.01
Disclosure and Barring Service (DBS) Guidance	WI 2.06.01
Company Directors – Fit and Proper Persons	WI/2.06.02
DBS Supporting Documentation	F2.06.01
DBS Request Certification Letter	F2.06.02
DBS Referral and Risk Assessment	F2.06.03
DBS Basic Risk Assessment	F2.06.03a
DBS Form for Declaration	F2.06.04
DBS Application Process	F2.06.05
Company Director Fit and Proper Persons	F2.06.06

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3. Introduction

3.1 ERS Medical uses the Disclosure Service of DBS via the Capita recruitment vetting site to check the criminal records of all contractors and employees with direct contact with vulnerable groups in order to prevent unsuitable people working with vulnerable groups, including children.

3.2 Capita recruitment vetting site fully complies with GDPR requirements regarding the fair use and handling of disclosure information. It also complies with its obligations under this regulation and other relevant legislation in respect of the safe handling, use, storage, retention and disposal of disclosure information.

3.3 There is no statutory requirement for staff to be checked on a continuous basis however ERS Medical is a best practice employer and committed to the safety of vulnerable groups and children all staff identified as requiring DBS checks with in a 3 year cycle will reapply for DBS checks, site admin teams are responsible for reminders to be sent to Line Managers, who are responsible for engagement from staff.

3.4 To ensure ERS Medical fulfils its legal and governance responsibilities for ensuring that all staff with roles requiring Disclosure and Barring Service (DBS) checks are vetted as part of the recruitment procedure.

3.5 To protect the interests of team members, patients, customers, contractors, service users and the public.

3.6 To evidence on-going compliance for staff employed in ERS Medical.

3.7 The company pays for all such disclosures.

3.8 The company use different levels of disclosures depending on the requirements of the role.

3.9 To ensure a single work instruction is defined and utilised at all locations within ERS Medical.

3.10 Define the responsibilities of personnel with regard to DBS checking.

3.11 This policy applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.12 Failure to comply with the requirements of this policy may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statement

4.1 ERS Medical recognises and is committed to ensuring that all appropriate employees and contractors (broadly defined as those with direct contact with vulnerable groups and children), are checked for previous convictions, cautions or investigations that may reflect upon their suitability to undertake their assigned duties.

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting Company objectives and allocating adequate resources to meet those objectives.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Head of HR & Training**	Is responsible for ensuring ERS Medical HR procedures remain within the legislative framework, are fit for purpose and provide the necessary information to enable managers to undertake their duties.
5.4	**Senior Operations Managers & Operations Managers**	Are responsible for the implementation and management of this process. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
5.5	**DBS Panel**	Are responsible for reviewing, considering and determining a recommended course of action on a case by case basis, on the receipt of a serious positive disclosure being received by ERS Medical.
5.6	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

6. Definitions

6.1 **Disclosure** - Is the report received from the DBS detailing any previous convictions, cautions or investigations, if applicable.

6.2 **DBS Panel** - independent parties – The DBS Panel is made up from Operations (Managing Director), HR (Head of HR & Training) and Care Standards (Head of Care Standards) to review each serious positive disclosure that is referred to the panel and to provide objective analysis of the case and to determine the outcome.

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7. Policy Revision

7.1 Recruitment literature, including advertisements for roles that require DBS disclosure must contain a statement to the effect that DBS Disclosure at the required level will be required if offered work within ERS Medical.

7.2 Criminal Record Preliminary Declaration Form to be completed by the applicant in advance, brought to the interview / assessment and given to the Interviewing Manager in a sealed envelope.

7.3 Please refer to **F2.06.01** regarding a list of the documentation and other information which must be seen prior to commencement in the post, in order to process a DBS application.

7.4 Under Enhanced Disclosure, candidates will be interviewed, and will be given the opportunity to discuss any criminal conviction they have declared.

8. Overseas Applicants

8.1 Applicants with a substantial record of overseas residence or those with little or no previous United Kingdom (UK) residence, such as asylum seekers, may not be able to be checked.

8.2 Site Administrators will ask applicants with substantial overseas residence to apply for the equivalent of a Disclosure from that country, if it is available, having first checked the Disclosure website for information.

8.3 It will not be possible for ERS Medical to employ someone in a role requiring a Disclosure without having obtained a Disclosure or overseas equivalent.

9. Types of DBS Checks

9.1 There are 4 levels of checks available. These include the following:

- **Basic Check (BC)** – Shows unspent convictions only.
- **Standard checks (SC)** – To be eligible for a standard level DBS certificate, the position must be included in the Rehabilitation of Offenders Act (ROA) 1974 (Exceptions) Order 1975.
- **Enhanced checks (EC) –** To be eligible for an enhanced level DBS certificate, the position must be included in both the ROA Exceptions Order and in the Police Act 1997 (Criminal Records) regulations.
- **Enhanced checks with children's and/or adults' barred list check(s) (EC with CBL & ABL)** – To be eligible to request a check of the children's or adults' barred lists, the position must be eligible for an enhanced level DBS certificate as above and be specifically listed in the Police Act 1997 (Criminal Records) regulations as able to check the appropriate barred list(s).

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9.2 **The below table is not intended to provide an exhaustive list of roles that require DBS checks, please check with the Head of HR & Training.**

DBS DISCLOSURE REQUIREMENTS		
Job Title	**Type of Activity**	**Disclosure Level**
Paramedics	Regulated	EC with CBL & ABL
Ambulance Technicians	Regulated	EC with CBL & ABL
Trainee Ambulance Technician	Regulated	EC with CBL & ABL
Emergency Care Assistant	Regulated	EC with CBL & ABL
Ambulance Care Assistant	Regulated	EC with CBL & ABL
PTS	Regulated	EC with CBL & ABL
Advanced Care Practitioner	Regulated	EC with CBL & ABL
Ambulance Attendant	Regulated	EC with CBL & ABL
Ambulance Care Assistant	Regulated	EC with CBL & ABL
Regional Manager	Regulated	EC with CBL & ABL
Team Leader	Regulated	EC with CBL & ABL
Mental Health Team	Regulated	EC with CBL & ABL
Care Quality Team	Regulated	EC with CBL & ABL
Health and Safety Team	Regulated	EC with CBL & ABL
Courier Drivers (Where required)	Non-Regulated	SC

Finance and Business Services		
Financial Accountant	Financial	SC
Management Accountant	Financial	SC
Senior Management Accountant	Financial	SC
Financial Controller	Financial	SC
Assistant Accountant	Financial	SC
Business Process Manager	Financial	SC
Administration teams	Basic	BC
Office Staff (including Apprentices an Interns)	Basic	BC

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9.3 Before the Company can refer a person for a criminal record check through DBS, we are legally responsible for ensuring that we are entitled to submit an application for the job role. This means that the countersigning "officer", at the third-party designated provider organisation, must satisfy that the position is eligible under the current legal provisions before the application can be countersigned. The third-party designated provider organisation will ask for the reason for the application prior to submission.

10. Enhanced checks with children's and/or adults' barred list check(s) - Regulated Activity

10.1 It is illegal to knowingly employ an individual who is barred from working with children and or adults (Regulated Activity). Therefore, any individual who is to carry out Regulated Activity an enhanced check with children and / or adults barred list check(s) must be carried out. There are 3 different DBS checks depending on the type of regulated activity. These include the following:

- Enhanced checks with children's barred list checks;
- Enhanced checks with Adults barred list checks;
- Enhanced checks with children's and Adults barred list checks.

11. Regulated Activity for Adults

11.1 An adult is defined as a person aged 18 years or over.

11.2 There are six categories within the new definition of regulated activity for adults, please see below examples of activities which are regarded as Regulated for adults:

- Healthcare for adults provided by, or under the direction or supervision of a regulated health care professional;
- Personal care for adults involving hand-on physical assistance with washing and dressing, eating, drinking and toileting; prompting and supervising an adult with any of these tasks because of their age, illness or disability; or teaching someone to do one of these tasks;
- Social work - provision by a social care worker of social work which is required in connection with any health services or social services;
- Assistance with an adult's cash, bills or shopping because of their age, illness or disability arranged via a third party;
- Assisting in the conduct of an adult's own affairs under a formal appointment;
- Conveying (i.e. transporting) adults for reasons of age, illness or disability to, from, or between places, where they receive healthcare, personal care or social work arranged via a third party.

11.3 A person, whose role includes the day-to-day management or supervision of any person engaging in regulated activity, is also in regulated activity.

11.4 Please note regulated activity relating to adults excludes any activity carried out in the course of family relationships, and personal, non-commercial relationships.

12. Regulated Activity for Children

- Unsupervised activities (Please note supervision is a regulated activity);
- Teaching, training or instruction, care for or supervise children;
- Provide advice / guidance on wellbeing;
- Drive a vehicle only for children;
- A person, whose role includes the day-to-day management or supervision of any person engaging in regulated activity, is also in regulated activity;
- Health care for children provided by, or under the direction or supervision of a regulated health care professional. This is regulated activity even if the activity is only carried out once;
- Personal care for children involving hands-on physical assistance with washing and dressing, eating, drinking and toileting; prompting and supervising a child with any of these tasks because of their age, illness or disability; or teaching someone to do one of these tasks. This is regulated activity even if the activity is only carried out once;
- Registered Child-minding or Domestic premises for reward;
- Foster-Carers;
- Local authority, agency or private fostering;
- Moderating a public interactive electronic communication service used wholly or mainly by children.

13. Work for a Limited Range of Establishments (Specified Places)

13.1 These establishments are as detailed in Schedule 4 of the Safeguarding Vulnerable Groups Act 2006 with the opportunity for contact with children, including schools, hospitals and children's homes.

13.2 Work carried out by volunteers supervised to a reasonable level, in accordance with the statutory guidance on supervision, in these establishments is not regulated activity. However, a supervised paid employee working for a specified establishment does come under regulated activity.

13.3 Work carried out involving either an unsupervised activity or in one of the listed establishments is only regulated activity relating to children if done regularly.

13.4 Regularly means carried out by the same person frequently (once a week or more often), or on 4 or more days in a 30-day period (or in some cases overnight between 2am and 6am).

14. DBS and Check Monitoring

14.1 There is no statutory requirement for staff to be checked on a continuous basis however the Company is a best practice employer and committed to the principals of the safety of vulnerable groups and children, there will be a requirement that all staff in positions that require a Disclosure must be checked every three years to ensure they are compliant. The local site admin support will be responsible for monitoring this requirement.

14.2 The business will ensure that contractors are DBS checked before work engagement takes place and contractors will be re-checked if they leave the business for a prolonged period or have engaged with us for a long period of time and fit into the three-year checking period. We would not as a business re-check a contractor each time we re-engage a different piece of work.

14.3 Individual members of staff will continue to have responsibility for informing the Company if they incur any convictions, cautions reprimands or investigations, all offences must be declared. Failure to declare such offences could constitute a disciplinary offence.

14.4 Any offences declared during employment will be considered and reviewed by the Head of HR and Training.

14.5 The Company is a best practise employer and under the 'Safeguarding Vulnerable Groups Act', has a legal duty to refer information to the Disclosure and Barring Service if an employee or volunteer has harmed, or poses a risk of harm to vulnerable groups and where they have dismissed them, or removed them from working in a regulated activity with children or adults.

14.6 This duty equally applies where an individual has resigned before a formal decision to dismiss or remove them from their duties has taken place. The Head of HR and Training will be responsible in terms of ensuring the Company is compliant in regard to referring any such cases to the DBS. Legal counsel may be required prior to submitting such referrals.

15. Confidentiality and Security

15.1 The DBS demand a very high level of confidentiality and security and failure to comply with the following process may constitute a criminal offence and may incur disciplinary action.

15.2 Disclosure information must only be used for the specific purposes of which it was requested and for which the applicant's full consent has been given.

15.3 Full Disclosure information must never be kept on an applicant's personal file but must always be kept in a separate and secure location. Only the Head of HR and Training may have access to this storage.

15.4 The Head of HR and Training will only reveal Disclosure information to the DBS panel who must not share this with anyone else.

15.5 If the Company is asked to reveal details of a disclosure to a third party in connection with legal proceedings, Contracts or Employment Tribunal the Head of HR will oversee any such disclosure.

15.6 Any notes made in connection with positive disclosures must be shredded immediately the appropriate action has been taken. They must not be put in confidential waste bags or waste bins awaiting destruction. Risk assessments will be kept securely in HR personal files.

15.7 The local site admin support must only keep the following information on the applicant's file:

- Date of the Disclosure;
- Name of the subject;
- Level of Disclosure;
- Position applied for;
- Unique Disclosure Serial Number;
- Recruitment decision taken;
- Risk Assessment
- No other information must be kept.

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15.8 This information will be kept on a secure HR staff database (Bamboo HR).

15.9 The local site admin support must shred disclosures as soon as applicable and definitively after 6 months unless there is an unresolved dispute in progress. In such cases, the information must be destroyed as soon as there is an appropriate outcome.

15.10 Full disclosures must not be filed on the personal file.

16. Accountability and Responsibility

16.1 The Head of HR and Training has overall responsibility for overseeing and monitoring the DBS Policy and Guidance by randomly checking files.

16.2 The Counter-Signatories are responsible for:

- Ordering and holding secure all DBS stationery if required and providing candidates links to the third-party designated provider recruitment vetting site where applicants can access an online application;
- Checking all application documentation for compliance;
- Completing data capture forms;
- Maintaining a database of permissible information, including logging the serial number and date of the application;
- Holding all documentation, disclosures and other information secure;
- Shredding all disclosures and any other documentation as soon as practicable and definitively after six months;

16.3 The local site admin support is responsible for ensuring that all staff on recruitment into posts which are defined as requiring DBS checks are informed they will be required to apply for a Disclosure at the appropriate level, and that applicants / employees receive recruitment or information packs containing:

- Policy statement on recruitment or continued employment of ex-offenders;
- Preliminary declaration form;
- Details of documentation and other information required.

16.4 The local site admin support is responsible for ensuring that a disclosure is obtained for all staff as part of the recruitment process and is also responsible for keeping comprehensive records of this activity, advising managers of any problems or discrepancies, and reviewing the process in terms of effectiveness on a regular basis.

16.5 All members of staff who are involved in the Disclosure application process are responsible for maintaining complete confidentiality and security at all times, and for being aware that no-one other than the site Ops Management, Admin support, Head of HR and Training or the DBS panel may have access to any information about the candidate's potential criminal record.

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17. Monitoring and Review

17.1 Records will be kept by the local site admin support on Bamboo HR of all Disclosures applied for and obtained. This information will be uploaded on to the staff database which allows reports to be generated.

17.2 This procedure and all associated documentation will be reviewed following any changes made by the DBS.

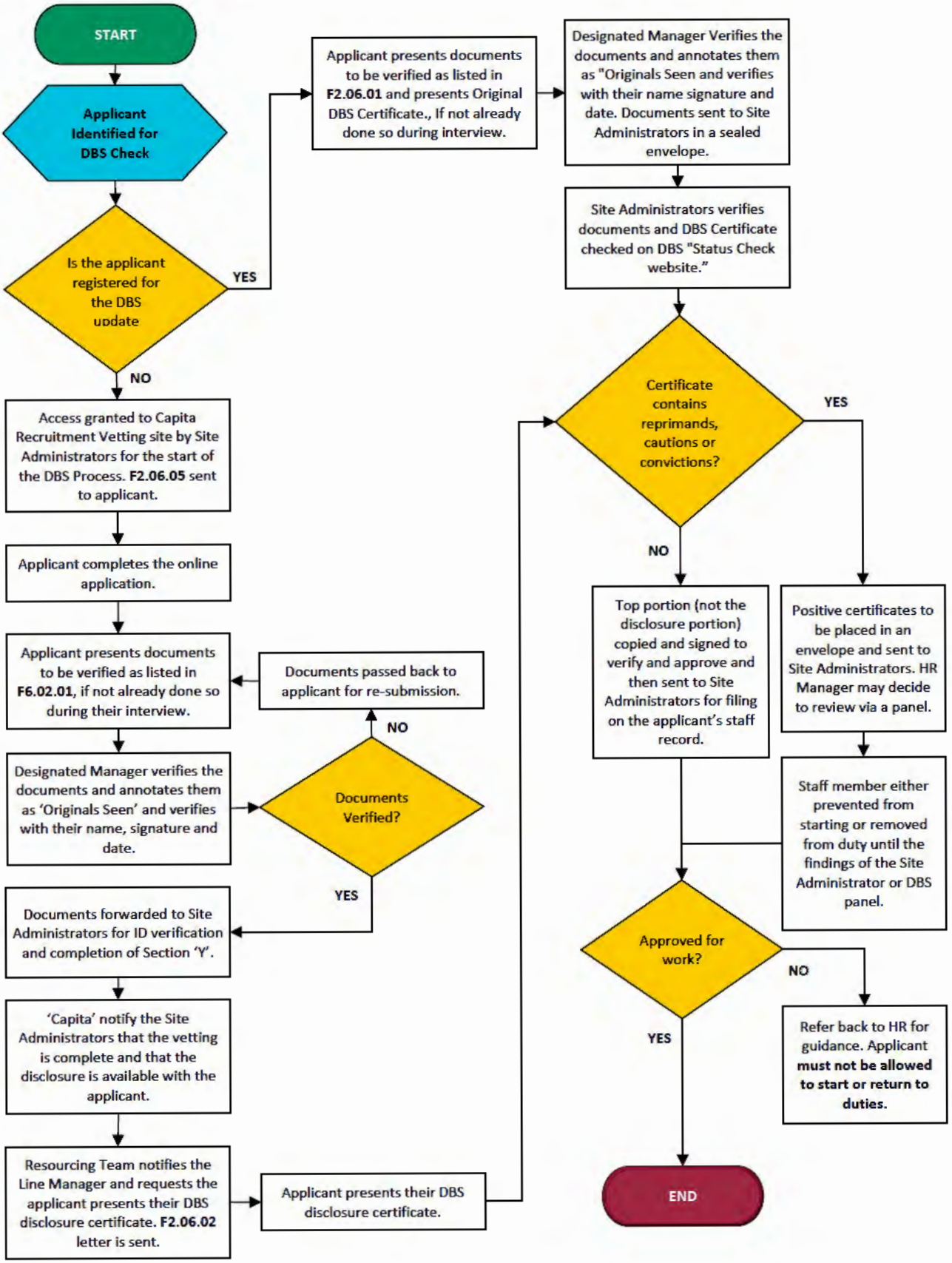
17.3 Following any changes made (and if appropriate) this procedure and associated documentation will be submitted to the DBS Panel for review.

18. Process

18.1 The process for Line Managers to follow when requesting employee disclosure and barring service checks is detailed in **WI 2.06.01.**

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19. Key Steps


START
Applicant Identified for DBS Check
Is the applicant registered for the DBS update
YES
NO
Applicant presents documents to be verified as listed in F2.06.01 and presents Original DBS Certificate., If not already done so during interview.
Designated Manager Verifies the documents and annotates them as "Originals Seen and verifies with their name signature and date. Documents sent to Site Administrators in a sealed envelope.
Site Administrators verifies documents and DBS Certificate checked on DBS "Status Check website."
Certificate contains reprimands, cautions or convictions?
YES
NO
Top portion (not the disclosure portion) copied and signed to verify and approve and then sent to Site Administrators for filing on the applicant's staff record.
Positive certificates to be placed in an envelope and sent to Site Administrators. HR Manager may decide to review via a panel.
Staff member either prevented from starting or removed from duty until the findings of the Site Administrator or DBS panel.
Approved for work?
NO
YES
Refer back to HR for guidance. Applicant must not be allowed to start or return to duties.
END
Access granted to Capita Recruitment Vetting site by Site Administrators for the start of the DBS Process. F2.06.05 sent to applicant.
Applicant completes the online application.
Applicant presents documents to be verified as listed in F6.02.01, if not already done so during their interview.
Documents passed back to applicant for re-submission.
NO
Documents Verified?
YES
Designated Manager verifies the documents and annotates them as 'Originals Seen' and verifies with their name, signature and date.
Documents forwarded to Site Administrators for ID verification and completion of Section 'Y'.
'Capita' notify the Site Administrators that the vetting is complete and that the disclosure is available with the applicant.
Resourcing Team notifies the Line Manager and requests the applicant presents their DBS disclosure certificate. F2.06.02 letter is sent.
Applicant presents their DBS disclosure certificate.

Question 1.10.9

Allegations

Please describe how you would robustly manage an allegation that a member of staff has abused or neglected a child or adult at risk (either in their personal or professional life).

The Bidder has clearly demonstrated they have appropriate systems in place to manage an allegation that a member or staff has abused or neglected a child or adult at risk – Pass

The Bidder has failed to demonstrated they have appropriate systems in place to manage an allegation that a member or staff has abused or neglected a child or adult at risk – Fail

ERS Medical will take all necessary measures to ensure that it recruits staff who uphold the principles of the Care Act 2014 (effective date 01/04/2015) and the Children Act 2004.

All ERS Medical staff (patient facing and support staff) are required to have an enhanced DBS prior to employment and is renewed every 3 years.

All staff who show a DBS with a marker on it are then risk assessed and if required boarded? for further risk management, before they are either allowed to become patient facing or return to patient facing duties.

However, it is acknowledged that some staff may conduct themselves in a manner that is at odds with ERS Medical procedures and legislation, in this instance ERS Medical will treat all allegations against staff seriously.

When an allegation is made about a member of staff ERS Medical will investigate it under the ERS Medical Disciplinary Procedures WI/2.01.04 – Discipline, in conjunction with BMS/6.05(ERS) - Safeguarding Vulnerable Adults and Children.

The Manager who has been alerted to the allegation against a member of staff has a responsibility to ensure that the appropriate course of action is taken without delay, giving consideration to the following:

- Notify the Safeguarding Lead, who in conjunction with the Medical Director and the Head of Care make the determination if a safeguarding referral is appropriate
- Log the incident onto our compliance system, [redacted]
- Where appropriate the safeguarding lead will refer the case to the Police if suspected abuse is the crime. This will require a further notification to the CQC under regulated activity and possibly the HCPC if a Paramedic is involved
- In line with the ERS Medical disciplinary procedures, suspend staff suspected of the safeguarding incident as appropriate and in discussion with the HR department
- Inform the member of staff as they have a right to know in broad terms what allegations or concerns have been made about them
- Consider raising the allegation as a Serious Incident

- Maintain a high level of confidentiality, whilst meeting contractual requirements to notify Trusts
- Provide support for the staff member involved in the safeguarding process

All safeguarding allegations of abuse or maltreatment of children and adults by a professional, staff member, volunteer, or contractor will be taken seriously and treated in accordance with consistent procedures.

If the allegation against an employee or contractor of services involves a child, the 'Local Authority Designated Officer (LADO)' for that area will be contacted by the Safeguarding Lead/Care Quality Team Manager.

We would then cooperate with any formal investigation undertaken by the relevant authority, being mindful that this could potentially result in a criminal charge and case being brought to prosecute and we would need to be mindful to not interfere in any on-going investigation.

Any subsequent actions, other than updating stakeholders, would be wholly dependent on the outcome and actions post investigation.

BMS/6.01 Care to Care

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	3.1	**Date Active:**	16.07.20	**Review Date:**	30.04.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
This procedure replaces CSOG 01 – Care to Care Guidance. This document does not need to be replaced on sites of vehicles whilst this procedure is at version 1.0.		
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
1.1	All	All	All	13/04/18	[redacted]	Addition of review date
2.0	All	All	All	05.04.19	[redacted]	Annual Review
3.0	All	All	All	21.04.20	[redacted]	Annual Review
3.1	10 & 11	10.10 & 11.2	13 & 14	16.07.20	[redacted]	Addition based on CONC-338 Radar

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2. Related Documents & Legal References

BMS Manual	
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Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Management and Reporting	BMS/5.01
Statutory Notifications	BMS/5.03
Care to Care	BMS/6.01
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding of Vulnerable Adults and Children	BMS/6.05
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High Dependency Unit (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Patient Tissue Viability & Hydration Record	F6.07.02

3. Introduction

3.1 The purpose of this procedure is to establish and define actions, responsibilities and standards that ERS Medical, our contractual partners, the Care Quality Commission and our patient's, require and have an expectation of when receiving care, treatment and transportation.

3.2 Its purpose is give guidance on the care expected and required by ERS Medical to, but not limited to:

- Operational Ambulance Crews;
- Operational Managers;
- CCO Call Handlers;
- CCO Despatchers;
- CCO Planners;
- CCO Helpdesk Team Members;
- Care Standards Team (Clinical);
- Care Standards Team (Health and Safety)
- Complaints Administrator.

3.3 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.4 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting Company objectives and allocating adequate resources to meet those objectives.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Head of Care Standards**	Is responsible for setting the strategic direction and interpretation of the Health and Social Care standards as they relate to the regulated activity the ERS Medical is registered with the CQC to provide.
5.4	**Senior Operations Managers & Operations Managers**	Have the responsibility to ensure that this procedure is available on all operational ambulances work for or on behalf of ERS Medical.
5.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions and Abbreviations

6.1 **Accident / Incident** - unplanned event that results in personal injury or damage to property, plant, equipment or the environment, theft of data etc.

6.2 **Capacity** – The Mental Capacity Act 2005 states that capacity is a person's ability to make their own choices and decisions. Healthcare professionals have a responsibility to ensure that all patients are assumed to have capacity. A person may lack capacity if they:

- A mental health condition;
- Have dementia or chronic memory problems;
- A severe leaning difficulty;
- A brain injury;
- A stroke;
- Incapacity through the use of alcohol and drugs.

(This is list is not exhaustive)

6.3 **Consent** – An informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

6.4 **Contact Centre Operations** – CCO.

6.5 **Continuation Bias** – is the unconscious cognitive bias to continue with the original plan in spite of changing conditions.

6.6 **Belongings** – For the purposes of this document the term belongings refers to all patient personal effects, their prescribed medication, including TTO's and NHS paperwork such as Notes, Appointment Letters, DNAR / RESPECT's and Discharge summary letters.

6.7 **Front Line Ambulance** – An ambulance manned by a crew clinically qualified as a Paramedic, Technician or Emergency Care Assistant (ECA), employed for the purposes of responding to 999 emergency calls.

6.8 **Near Miss** – unplanned event that has the potential to (but did not) cause:

- Harm to an individual or individuals;
- Harm to the environment;
- Damage to vehicles and property;
- A security or data protection breach.

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6.9 **Medical Records** – A chronological written account of a patient's examinations and treatments that include the patient's history and complaints, the physician's physical findings, the results of diagnostic tests and procedures, and medications and therapeutic procedures. Medical records can cover a wide range of materials including:

- Handwritten notes;
- Computerised records;
- Correspondence between health professionals;
- Laboratory reports;
- Imaging records, including x-rays;
- Photographs;
- Video and other recordings;
- Printouts from monitoring equipment;
- Patient Report Forms (PRF's) and associated documents.

6.10 **Next of Kin** – N.O.K.

6.11 **Patient Report Form** – PRF.

6.12 **Running Call** – For the purposes of ERS Medical a running call is defined as providing care or treatment to any patient that is or has not been booked onto ERS Medical transport. That is a patient who requires treatment or care by flagging down or having an ERS Medical ambulance flagged down on their behalf.

6.13 **To Take Out (TTOs)** – A term commonly used to refer to medication prescribed and provided by the hospital for patients to take home after discharge.

6.14 **Wheelchair Tiedown Occupant Restraint System (WTORS)** – A system to secure both patients and their wheelchairs safely into a vehicle.

7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

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7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2008.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

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7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

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8. Continuation Bias

8.1 We have seen through experience that patients have been put at risk or had poor experiences of care due to crews' actions or omissions, or from insistence of control teams which doesn't fit the picture crews see.

8.2 There is a focus from our crews to manage the patient's wishes, and in the majority of cases this is absolutely the way we want care to be delivered. However, we have seen cases where various factors have led to sub optimal care or even putting the patient at risk.

8.3 Continuation bias is where we try to follow a plan even when it becomes clear that it isn't going to work, and there are clear indicators which should direct us to change the plan. Examples of these factors are, the task we are being asked to do, the patient wishes and the crews experiences amongst others.

8.4 There is always a primary plan to manage a patient, for example transporting home and using the lift at the property to move them upstairs and access their property. However, what happens of the lift doesn't work, and the patient's injuries don't allow the use of a carry chair but wants to go home. The crew can become fixed on getting them home, spending time and effort trying to achieve that goal. In reality the crew should take advice from the care or operations teams and the patient returned to the hospital if necessary.

8.5 To manage the 'bias' of the crew the advice is to step back take stock of the situation and see if you need further help or advice, or a different course of action. This is called situational awareness and is important to give yourself time and review the options focusing on the safety and wellbeing of the patient at all times, which we have to accept may be not what they want to do.

8.6 We see incidents where there is a clear causal link to the actions of the crew, however well intentioned, and a lack of following procedures. The advice from the care team is do a 15-minute review. If you are 15 minutes into a plan and it is not working review and if necessary, take advice. We already do this in terms of patient collection, if they are not ready in 15 minutes, we say to consider aborting the journey and moving on to the next job. I would like to see this replicated in other areas to manage the patient safely and with the dignity and respect that they deserve.

8.7 Continuation bias is similar to escalation of commitment, this refers to a pattern of behaviour in which an individual or group, when faced with increasingly negative outcomes from some decision, action, and investment, will continue rather than alter their course—something which is irrational, but in alignment with decisions and actions previously made.

9. Stage 1 - Booking a Patient Journey

9.1 A thorough, detailed and comprehensive booking of patient's details, prior to any ambulance journey, is an essential part in ensuring that the requested journey is undertaken is a safe, effective and caring manner.

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9.2 The initial contact at the point of booking should be used to determine essential information such as, but not limited to:

- Confirmation of the collection address i.e. home address, ward or outpatients department etc;
- Confirmation of the destination address; i.e. home address, ward or outpatients department etc;
- Escort details, if required, the name of any NOK, specialist carer / worker;
- Are there any access or egress issues at the collection of destination points;
- Confirmation of the patients mobility at the time of booking and if there have been any changes i.e. walks with a stick or frame, history of mechanical falls;
- Confirmation of the booking requirements, notification to change the booking if the circumstances have changed;
- The infectious status of the patient and any additional IPC precautions that may be required;
- Reason for the admission / transport;
- Any on-going medical treatments, i.e. O2 therapy;
- Are there any cognitive issues such as dementia;
- Has the patient been known to be violent or aggressive, especially in the last 48hrs;
- Confirmation of the address the patient is to be taken to, and the name of any specialist carer / worker (homeless shelter);
- Journeys for patients with a mental illness should also be processed through the mental health risk assessment tool;
- Any additional, relevant information should also be taken at this point.

10. Stage 2 – Collection of the Patient

10.1 When arriving at the address to collect your Patient, the three most important things to remember are:

- **INDENTIFICATION;**
- **INTRODUCTION;**
- **INFORMATION.**

Crews should always work from and to the information provided at the time of booking. For example, if a patient is booked as a wheelchair patient, a wheelchair should be taken to the patient.

Identification & Introduction

10.2 Has the Patient been correctly identified to you by a responsible person active in the Patient's care?

10.3 It is the responsibility of the crew to state clearly to the hospital staff which patient they are to collect. **Do not presume** the staff know who you are to collect as this is a common point of failure.

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10.4 It remains the responsibility of the patient's current care provider, i.e. the staff on the ward, department, care or nursing home to correctly identify the patient of the ambulance crew who have arrived to provide transport.

10.5 Have you introduced yourself to the Patient and confirmed their identification? This may help reduce the likelihood of the wrong patient being collected.

10.6 "Hello, my name is ……., what is your name please"? I'm from ERS Medical, I will be taking you to …… address', it is useful to add context here by verifying if the address is their home, care home, relatives etc.

10.7 It is also good practice to ask the patient what they like to be known as, don't just assume that all patients will want or be happy with you calling them by their first name.

10.8 It may also prove useful to verifying a patient's identity by checking their hospital ID bracelet, if it has not already been removed prior to discharge / transfer.

Information

10.9 Do you have all the correct and necessary information related to the Patient for their next place of care and has and does this information differ from that provided to you from control?

10.10 In order to remember all the information required, below is a checklist to help you:

- Has the person who has been responsible for the Patients care given you a **handover.** More details on the type of information can be found contained within **BMS/6.10 – Non-Emergency Patient Transport Services,** Section 19;
- Does the Patient have any **cognitive issues** such as Dementia or Alzheimer's;
- Does the Patient have their **keys or key safe code** if being taken home;
- What is the **access** like to their property? Any challenges or difficulties;
- What is the Patient's **mobility** like, how best can we assist them;
- Does the patient have mobility aids such as walking stick, crutches or a frame;
- Is the Patient **dressed appropriately** for their dignity, the weather conditions and mobility requirements? Especially check their footwear and its appropriateness;
- Do you have all their **belongings** with you;
- Does the Patient have a **DNAR / RESPECT order** in place? Does the Patient have it with them;
- Does the Patient have **medications** to take with them? (TTO's);
- Is there a **care package/plan** in place for the Patient? Are the Family aware;
- Is the **destination on the booking** safe to leave the Patient and are they expecting them?

10.11 If you are able to gain answers to all the questions above, you will help to ensure that our Patients are given the highest standard of care whilst they are your responsibility.

10.12 When handing patients over to the next person in the patient's pathway of care, similar accurate and relevant information needs to be relayed by the ERS Medical crew.

10.13 If for any reason you are unable to gain answers to the questions above, this must be documented, either with the incident hotline or control. A PRF or statement should also be completed.

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10.14 In cases where crews feel that patient care and safety is or maybe compromised, they can call either regional Care Quality Manager or the on-call Care Quality Manager if after normal working hours and weekends.

10.15 If the patient is ambulatory without assistance they should be encouraged to walk to the ambulance and gain entry to it either by the ramp system or the side door. The crew will need to complete a dynamic risk assessment on the patient's mobility to determine which is appropriate, but if any doubt they should use the ramp access and an assisted walk.

11. Patient Belongings

11.1 Where a patient has 'capacity' and is physically able to do so, it will be and remain their responsibility to look after and secure their belongings.

11.2 Belongings within the 'Care to Care' guidelines are deemed to be, but not necessarily limited to:

- The patient's personal effects, such as clothing, toiletries, jewelry, money, mobile phones etc;
- Does the patient have mobility aids such as but not limited to walking sticks, crutches or a walking frame;
- Medical notes;
- Appointment letters;
- DNAR / RESPECT documentation;
- Discharge summary letters;
- Non-prescription medication;
- Prescription medication including hospital TTO's.

11.3 Patients who lack 'capacity' will be transported with either a booked escort or on a double crewed ERS Medical ambulance. In the case of a patient travelling with a booked escort, the responsibility of looking after and securing 'patient belongings' will fall to the booked escort.

11.4 However, if the patient who lacks 'capacity' is travelling without a booked escort and on a double crewed ERS Medical ambulance, this responsibility will fall to the attendant of that crew.

11.5 ERS Medical crews who take this responsibility are to ensure that when collecting the patient from hospital or other locations, they check with the nursing and care staff to clarify the following:

- Do they have all of the patients belongings and Is there some form of inventory of their effects to check off against;
- Can they obtain a copy of this inventory for the other end when they hand the patient over;
- Are they clearly identifiable as belonging to the patient;
- Are they, where appropriate i.e. medications, in sealed bags with the patient's identity clearly visible?

11.6 When they arrive at their ambulance the crew are to ensure that the patient's belongings are secured and seperated from any other patients belongings that may be transported at the same time.

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11.7 In the event of any belongings being lost or not being delivered at the same time as the patient i.e. they have been left on the ambulance, the crew must take all reasonable steps to find the belongings and /or return them to on the same day.

11.8 The crew must also notify their control room so that any additional journeys can be planned for.

11.9 The crew must also report this error, as an incident, so that it can be properly documented, recorded and investigated. This reporting must also be made, where appropriate, to the NHS body which has contracted the service.

11.10 For the management of Controlled Drugs, please refer to **BMS/6.04(ERS) – Medicines Management**.

12. Stage 3 – Transporting the Patient

12.1 The transportation phase of care begins after the patient has been safely identified and collected from the pick-up location and ends with handover of the patient at the receiving facility or when the patient is safely delivered to their home or other destination.

12.2 If anything happens to effect the safety of a patient to their destination it should immediately be reported to the CCO in [redacted] as either an incident or a near miss.

12.3 Before boarding the patient onto the ambulance the crew should take into account information from a number of sources, this can include but not be limited to:

- The Patient;
- Medical or Nursing staff;
- Carers;
- Patient Relatives;
- Friends or the patient.

12.4 The crew should use this information to ascertain the best seating method to be used for the patient as well as how the patient will get from their current location to the ambulance. The following questions should be asked.

1) How will the patient get to the ambulance;
2) How will the patient get into the ambulance;
3) How will the patient be seated once on-board the ambulance;
4) How will the patient exit the ambulance?

12.5 Crews should also consider minimising disruption to patients when deciding upon how they load and unload their ambulances. Try not to create a need for patients to move unnecessarily.

12.6 Patients who are being transported on an ambulance stretcher should **NOT** be left alone at any time.

12.7 Patients who are being transported in wheelchairs should be assessed by the crew for their suitability for being left unattended. Where possible patients should be grouped in a suitable location within hospitals, so their time left on vehicles, waiting prior to departure is minimised.

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12.8 In all cases when patients are left unattended, no matter how long this if for, staff should ensure that:

- Patients fully understand the reasons why;
- Patients know where the crew are going and an estimated time this should take;
- Patients are not left exposed to extremes of weather and temperature;
- Patients are wearing the wheelchair lap belt;
- Wheelchair brakes are applied and are working.

Moving to the Ambulance

12.9 It may be possible for the patient to walk to the ambulance if they have been assessed and or booked as fully mobile. The crew should ensure that they conduct a dynamic assessment of the patient's mobility as detailed with **BMS/6.07 – Safer Person Handling and Dynamic Risk Assessment**, as part of this the distance to the ambulance must be a consideration.

12.10 Patients that usually use walking aides to mobilise such as frames or sticks should use them as they normally would. Do not hurry or rush patients who need aids to mobilise as this can invariably lead to falls and or injuries.

12.11 When self-mobilising to the ambulance the patient should at all times be escorted by a member of the ambulance crew. This should include additional, if needed, support when moving on uneven surfaces and going up and down stairs/steps, curbs and ramps.

12.12 The patient should be requested to inform the ambulance crew if at any time they feel uncomfortable unsafe or dizzy at any time during this transfer.

12.13 The patient should be urged to sit down if they feel dizzy, unwell and or unsafe at any time.

12.14 Ambulance staff should ensure that they are as close to patient as possible and at no time more than an arm's reach away from the patient at all times. This is to ensure that if the patient appears at all unsteady on their feet they can react and assist as needed.

12.15 Some patients will not be able to self-mobilise to the ambulance and will require to be transported by ambulance stretcher, wheelchair or carrychair. Under **NO** circumstances are patient mobility scooters to be transported on ERS Medical ambulances.

12.16 Patients who are not mobile are best transferred by ambulance stretcher, in most cases where patients are collected from hospitals and other care establishment's access to the patient's bedside will be possible by ambulance stretcher.

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12.17 In these cases, the patient will require a bed to stretcher transfer. Bed to stretcher transfers can be achieved in numerous ways, such as, but not limited to:

- The patient can be asked to move themselves from their bed to the stretcher. Staff should ensure that both the 2 surfaces are as close as possible to each other and that the brakes are on and functioning on both the bed and the stretcher;
- The patient can be slid from their bed to the stretcher using either a PAT slide of glide/slide sheets, as taught and advocated as best practice in safer person manual handling;
- The patient can be hoisted from their bed to stretcher. ERS Medical staff are not trained or authorised to participate in hoisting operations and as such **MUST NOT** hoist patients;
- In some cases, particularly in residential properties ambulance staff will not be able to get the stretcher to the patient bedside. In these cases, a wheelchair or carry chair will be needed.

12.18 Under **NO** circumstances should patients be lifted using bed sheets or linen from bed to stretcher or vice versa.

12.19 Patients, who require the use of a carry chair to mobilise to the ambulance should, as soon as it is practicable, be transferred to a stretcher or ambulance seat for both their comfort and safety.

12.20 Only Carrychairs should be used for moving patients up and down multiple stairs and steps in or out of properties, unless the premises are fitted with a working stair lift or the ambulance is equipped with a stair climber.

12.21 Wheelchairs are not designed for this purpose and using them is this manner presents a significant safety hazard for the patient. Wheelchairs should **NOT** be used in this manner.

12.22 At all times the ambulance crew should seek to ensure that the patient feels both safe and comfortable.

12.23 Crews should discuss the tasks they wish to undertake with both the patient and their crew partner. It is essential, that where possible, patient's play an active part in any decision-making process that affects their care and as such consent must be sought from patients who have capacity.

12.24 Patients should be aware of the journey plan that they have made, and ambulance crews should take into consideration the wishes of the patient, the patient's family and care staff.

12.25 ERS Medical ambulance crews must not undertake any task, activity or movement that they know to be unsafe to simply follow the patients or other wishes.

12.26 The ambulance crew should discuss any conflicts that arise and seeks a suitable solution. If this cannot be easily achieved, then they should escalate to their line management or a member of the Care Quality Team before undertaking the patient movement.

Securing Patients Prior To Departure

12.27 After placing each patient into the ambulance safety checks must be made on all patients prior to the ambulance departing.

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12.28 These checks will include both a physical and visual check to confirm that all patients are wearing their seatbelts and that they are fastened in the correct manner i.e. the three-point strap over the shoulder and the Lap belt male attachment secured into the female seat or seat attachment.

12.29 It is a legal requirement for all passengers and therefore patients to wear seat belts. Unless the patient has in their possession a valid medical exemption certificate they must comply. Failure to do so will result in them rendering themselves ineligible for ERS Medical services.

12.30 It is the driver's legal responsibility to ensure that all patients and or passengers to wear a seatbelt.

12.31 Ambulance crews politely inform patients of this legal requirement and should **NOT** engage in any heated discussion with a patient refusing to comply. They should escalate this to the control / line managers who will advise them on what action is to be taken next.

12.32 The safest place for any patient to travel is in one of the fixed vehicle seats. This should be considered the preferred seating of choice and patients should be encouraged, if practicable to transfer to one of these seats before any decision is made for them to travel in their own wheelchair secured by the use of a Wheelchair Tiedown and Occupant Restraint System (WTORS).

12.33 Patients who are being transferred whilst seated in their own or ERS Medical wheelchairs **MUST** be secured by the following elements which make up the WTORS:

- X2 front clamps;
- X2 rear clamps;
- Three-point seatbelt harnesses fitted and adjusted to the patient.

12.34 Unless all the above are in place the patient should be not be moved in the wheelchair.





Typical WTORS systems

12.35 Patients who are transported in ambulance stretchers should be secured to the stretcher using the four-point patient harness which should be adjusted to fit snugly.

12.36 The patient's lower legs should be secured with the lower legs belt.

12.37 Checks on the harness and leg belt should be undertaken prior to departure and at periodic points during the journey.

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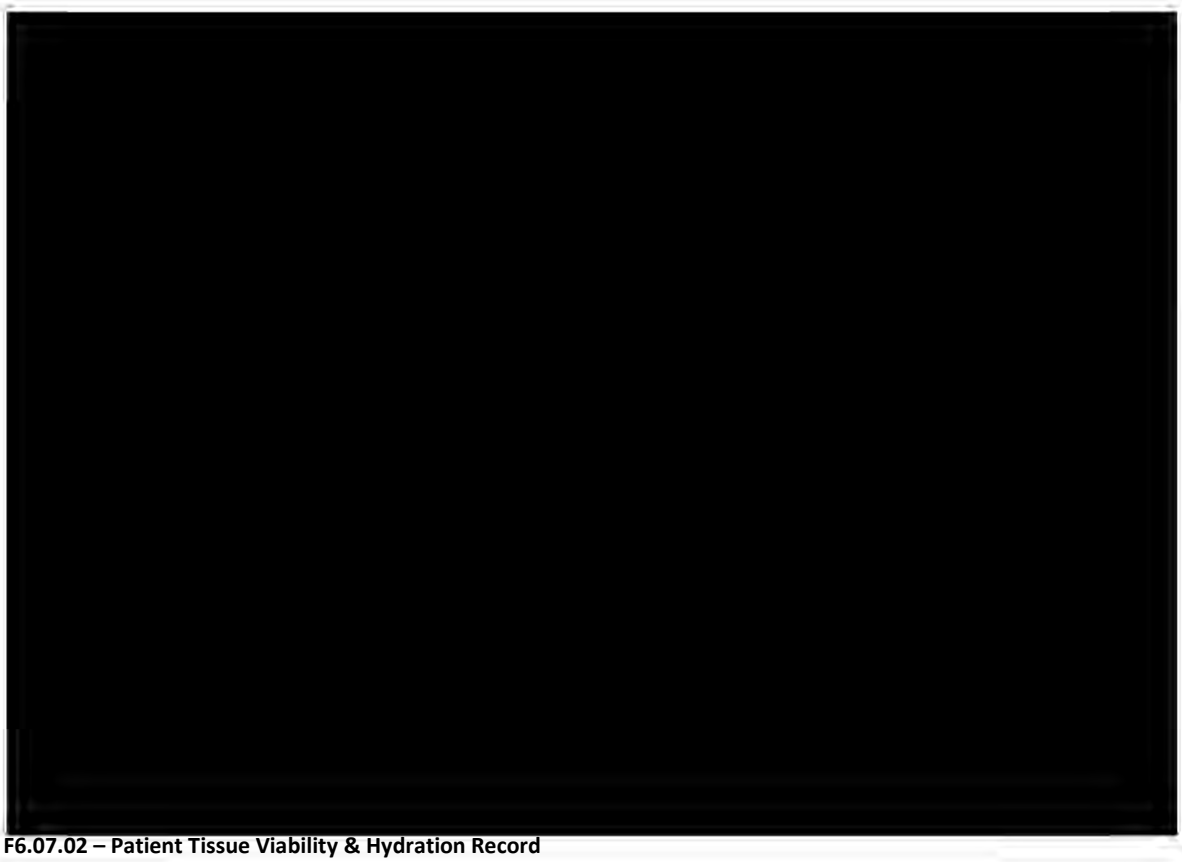
12.38 The stretcher should always be checked to ensure that it is seated correctly in the clamps and is fully secure. This requires a physical and visual check and must be conducted each and every time the stretcher is removed from the clamps and as part of the stretchers daily pre-use checks.

12.39 Consideration should be given to all patients during any journey over 2 hours for tissue viability. The hydration needs of the patient must be considered in a more dynamic manner based on their needs, but as a baseline this should be considerd every hour and immediatley if requested directly from the patient. The only exception to this will be if they are nil by mouth.

12.40 This may require the vehicle to be stopped in a safe place and the patient turned to releave any pressure areas and maintain a good blood supply and patient comfort. Any newly developing hotspots should be recorded on **F6.07.02(ERS) - Patient Tissue Viability & Hydration Record Chart.**

12.41 Consideration should also be given to patients hydration needs for the taking of medication and to quench thirst, especially in hot weather. Thermal comfort should also be taken into consideration, so crews should leave the heater on durring cold weather and the ambulance well ventilated durring hot weather, especially if patients are being left unattended for any period.

12.42 More details on mobility and tissue viability can be found in **BMS/6.07 - Safer Person Handling and Dynamic Assessments.**



F6.07.02 – Patient Tissue Viability & Hydration Record

12.43 Patients should be closely monitored during all journeys in order for the crew to be aware of any changes to the patient's clinical presentation, in both the negative and positive.

12.44 If at any point during the transfer the patient's condition deteriorates and or any intervention is required i.e. the administration of O2 or calling for the emergency services, a **PRF** must be fully completed documenting the patients' condition, actions taken and patient handover.

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12.45 All completed PRF's should contain all relevant patient identifiable information, details of any physical examination that has taken place, applicable to clinial grade of the attending crew, a basic chronology as they occur, details of any additional services that attend and who the crew handed the patient over to.

12.46 More details on how to complete a PRF can be found at Section 9.7 of this guidance document and on the Care Quality Team'sSteriPoint page, under 'Toolbox Talks'.

12.47 Patient care, safety, dignity and comfort should be paramount at all times.

12.48 Any adverse events should be communicated by contacting the Leeds CCO to report an incident on:

[redacted]

13. Stage 4 – Arrival at the Destination

13.1 On arrival at the destination the ambulance should be parked with due regard for the safety of staff and patients in the vehicle as well as other road users. Thought for activity of unloading the patient should remain a priority.

13.2 When working as a two person crew the attendant should remain in the vehicle whilst the driver opens the doors and prepares the exit. Wherever possible the attendant should remain as close as possible to the patient to assist where required and prevent / guide the patient from doing something which may present a risk to them.

13.3 Under **NO** circumstances should patients be allowed to attend the ward / department independently of the ambulance service and be expected to provide their own handover.

13.4 The crew should escort patients to the ward and department, making sure they arrive safely and that hospital staff are aware of their arrival. This becomes especially important when we are transporting multiple patients and walkers who attend departments such as Renal Dialysis.

13.5 When taking patients out of hospital it is essential that all patients and especially those who have any cognitive impairment due to conditions such as Alzheimers or Dementia, are taken to the exact address as per their booking and that they are either assisted safely inside in a manner that is appropriate to their booked and observed mobility or observed to safely enter their premises.

13.6 It is not acceptible for crews to drop patients at any other locations other than those booked, as this can lead to a safeguarding issues and significant distress to the patient and their families, as well as other carers.

13.7 Another important principle to remember that if a patient has capacity they have the right to make what we believe to be wrong choices and decisions. Therefore if they insist that they are going to go inside later there is little crews can do, other than try and persuade.

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13.8 When dealing with patients who have been booked or dynamically assessed as having mobility issues or require the use of mobility aids such as, but not limited to:

- Walking Sticks;
- Frames;
- Wheelchairs.

Ambulance crews should encourage patients to mobilise as booked. However, in the real world and given the patients right to make choices, patients may insist on self mobilising to and from the ambulance.

13.9 If patients do decide to self mobilise, attending crews should manage the risks by dynamically assessing the situation and providing an assisted walk for all patients. This decision by the patient should be communicated and recorded to your despatch. This can be completed by either sending a message via the CAD tablet or by calling despatch and requesting a note to be placed on CAD.

13.10 **It is vital for all ERS Medical ambulance crews to be aware that any decision made by a patient to self mobilise does not absolve the crew from their responsibilities of ensuring the patient gets to their destination without incident.**

13.11 Crews should always prioritise assisting patients with mobility issues above the personal effects or TTO's. These can be secured on the ambulance and given to the patient after they are safely in their care location or taken in first, during the assessment of the location prior to taking the patient off the ambulance.

13.12 Crew should be free of bags, personal effect and TTO's to give help immediately if needed and this will also require them to be as close to the patient as possible during and mobilisation.

Key Safes

13.13 If you are required to access a patient's premises by a key that is secured within a key safe at the property you must ensure that when you leave, both the key and key safe are secured again.

13.14 If you experience any difficulties or changes in instructions for accessing the patient's address, you should contact your contact centre /despatch for further guidance and advice.

13.15 Ideally when you first gain access to the premises, secure the key and key safe in the presence of the patient so that they can be re-assured.

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13.16 The rationale behind this is to prevent anybody casually walking past the premises and observing the unlocked key safe and therefore potentially the combination to the key safe, which could be used at a later date or time to gain unathorised access to the patients address.



A typical 'Key Safe' that you might find at a patient's address.

14. Documentation and Reporting

14.1 When providing care to patients there will be certain circumstances when additional documentation is required and reports need to be made. These can be, but not be limited to:

- CAD tablet or manual patient booking information;
- Patient Report Forms (PRFs);
- Do Not Resuscitate Orders – Commonly referred to as DNAR / RESPECTs;
- Patients Medical Records;
- When an incident or near miss occurs.

14.2 For the purpose of this 'Care to Care' guidance we will look at each of these in turn.

CAD Tablet or Manual Patient Booking Information

14.3 CAD tablets and or manual paperwork will contain patient identifiable information and therefore should be secured at all times, when not being used.

14.4 This could mean simply locking the CAD tablet when not in use and ensuring that any manual paperwork is turned face down so it can't be read or stowed in a position within the ambulance cab where it can be read.

14.5 Information off any of these platforms must not be shared with anyone who does not have a genuine reason to have this information i.e. staff involved directly in their care and treatment.

14.6 Any breaches of this confidentiality must be reported to the Company in line with the guidance provided within these guidelines and **BMS/5.01 – Incident Reporting and Investigation**.

Patient Report Form (PRF)

14.7 Patient report forms are legal documents that can be used as evidence in any legal, investigatory or internal proceedings.

14.8 As legal documents they must be clearly written so they can be read and understood and only a black ballpoint pen is to be used.

14.9 Some circumstances which require a PRF to be completed are, but not limited to:

- A Patient becomes unwell or injured in your care;
- You call for Emergency services for your Patient;
- If your Patient discloses a safeguarding concern or you have a safeguarding concern;
- If you come across a running call or are flagged down by a member of the public/Police etc.

14.10 Further guidance on the completion of a PRF can be found within the 'PRF Completion Guidance for ACA's' toolbox talk, which is available on the Care Quality Teams SteriPoint page, under Toolbox Talks.

Do Not Resuscitate Orders (DNAR / RESPECTs)

14.11 Do Not Resuscitate Orders (DNAR / RESPECTs) are commonly put in place when patients are categorised as palliative care only or end of life care. There are exceptions to this, but they are uncommon.

14.12 End of life care can by its very nature be stressful for all involved in the patients care and as such crews should be sensitive to this when involved in their care and transportation.

14.13 In order for a DNAR / RESPECT to be valid for transfer it needs to be signed and in date. Crews must see the original DNAR / RESPECT to confirm these details. Any failure to produce a valid DNAR / RESPECT will place the crew in a position where they must commence CPR if clinically indicated.

14.14 Crews should refrain from having heated and protracted conversations, in front of the patient and or his/her next of kin, if there is some delay or difficulty in providing the original DNAR / RESPECT. Crews should remain professional and sensitive to the thoughts and feelings of all concerned.

14.15 If the crew experience any difficulty in seeing the original DNAR / RESPECT they should attempt to move any conversation away from the patient and or next of kin.

14.16 Ideally the DNAR / RESPECT will be transported with the patient, but in some circumstances, this is not possible. If this is the case, they may take a certified copy of the DNAR / RESPECT, as long as they have seen the original and it is valid.

14.17 Being provided with just a copy, without seeing the original is not acceptable.

14.18 If crews are in any doubt or have concerns relating to the validity of a DNAR / RESPECT they can either contact the CCO on [redacted] and ask for the local or on-call Care Quality Team Advisor to call them back and provide further advice and guidance.

Patient Medical Records

14.19 On some occasions patient medical records may be given to crews for transporting with their patients.

14.20 These records contain both patient identifiable and patient sensitive information and as such should be treated with upmost confidence and sensitivity to their security.

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14.21 In most NEPTS settings there will be no need or requirement for crews to read anything contained within these records, as they should have been provided with all the necessary information about their patients during the handover from other care staff.

14.22 In the unlikely event that they do need to access these records they should limit this access to only relevant information about the patient. Going into areas of these records, that are either historical or have nothing to do with their current condition would be deemed at best as unnecessary and intrusive and at worst as a breach of the Data Protection Act 1998.

14.23 The decision for accessing the patient's notes should be recorded on the journey notes. This can be done be contacting your contact / despatch centre.

14.24 Any breach or loss of a patient's medical records must be reported as an information security incident by calling the CCO on [redacted] and following the guidance of **BMS/5.01 – Incident Reporting and Investigation**.

14.25 The use of personal or company mobile communications devices to take photographs of patients is **NOT** permitted as this would create a patient record and therefore subject to strict 'Information Governance' Controls. Clinical Memo IM 123 (27/03/17) provides more details of the specific arrangements and provisions for the use of mobile communications devices.

When an Incident or Near Miss Occurs

14.26 There is legal, regulatory and morale responsibility for ambulance crews to report incidents and near misses that occur whilst employed on duties for or on behalf of ERS Medical.

14.27 If an incident or near miss happens whilst they are still at base or on an ERS Medical facility they should report the incident to the site management, who in turn will ask them to complete an incident report form and a statement detailing what happened.

14.28 The local site management will then raise the incident for them via the on-line incident report system. Initially this will be investigated by the site management team and then passed to a technical manager, such as Health and Safety or Care Quality for their part of the investigation and closing of the incident.

14.29 If the incident happens away from base, then they should call the CCO as soon as safe to do so on [redacted] and report the incident to the call handler. The CCO will then raise the incident on their behalf and it will follow the processes described in **BMS/5.01 – Incident Reporting and Investigation**.

14.30 The types of incidents that ambulance crews are likely to need to report are:

- A member of staff has been injured;
- A contractor or visitor has been injured;
- A patient, patient's relative or carer has been injured, put at risk or otherwise come to harm;
- Identified a safeguarding concern regarding a patient, or patients relative or carer;
- Failure to act with respect, dignity or compassion to any person in contact with ERS Medical;
- There has been a breach of security or theft (excluding information security / data loss);
- A vehicle has been or caused damage;
- A member of the public has been injured in an RTA;
- A vehicle (or part thereof) has been stolen;
- Fire, explosion, another serious environmental event;
- Breach of confidential information / loss of company equipment;
- Police, coroner's enquiry about the death of a person;
- Near miss.

14.31 It is important when reporting an incident is to do so as soon after the event as possible, so that the details are fresh in your mind?

14.32 Write down and record the facts as soon as you can. Draw or sketch the scene if this helps detail what happened.

14.33 It may be useful to take photographs or video of the scene, but crews should ensure that any photographs or video taken **MUST NOT** include the patient, as this would then become a patient record and be subject to the Data Protection Act 1998.

14.34 It is important to remember that in some circumstances it is a legal requirement to cooperate with the investigation process. Remember that we hope to learn valuable lessons from these incidents and their investigations so that the patient care and safety is improved and ERS Medical can provide a safe place for staff to work.

14.35 More details on incident reporting and investigation can be found in **BMS/5.01**.

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ERS Medical

BMS/6.13 Mental Health Services

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2. Related Documents

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
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Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Serious Untoward Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Safeguarding Vulnerable Adults and Children	BMS/6.05
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safer Person Manual Handling	BMS/6.07
Non-Emergency Patient Transport Service (NEPTS)	BMS/6.10
Renal Patient (NEPTS)	BMS/6.11
High Dependency (HDU)(NEPTS)	BMS/6.12
Health and Safety Management	BMS/9.01
Uniform and PPE Issue and Use	BMS/9.03
Receiving, Transportation & Handover MH Patients	WI/6.13.01
Conflict Resolution & Physical Restraint	WI/6.13.02
Use and Application of Handcuffs	WI/6.13.03
Use and Application of Spit hoods	WI/6.13.04
Mental Health Booking Risk Matrix	F6.13.01
Booking Reference Form	F6.13.02
Patient Transfer Record	F6.13.03
Contractors Timesheet	F6.13.04
Section Papers Check Sheet	F6.13.05
Handcuff Authority and Report Form	F6.13.06
Record of Injuries	F6.13.07
Daily Issue Log	F6.13.08
Police Notice	F6.13.09
Vehicle Loading List (Specialist Services)	F6.13.10

NG10 – Violence and Aggression: Short-term management in mental health, health and community settings.

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3. Purpose of Procedure

3.1 To ensure a single procedure is defined and utilised at all locations within ERS Medical and provide instruction and guidance for all Mental Health Services personnel on activities and operations.

3.2 To define the responsibilities of personnel in relation to Mental Health Services activities and operations, ensuring consistency is achieved throughout ERS Medical.

3.3 To recognise and document where regional variances, due to contractual requirements, occur within the Mental Health Service procedure.

4. Scope and Application

4.1 This procedure applies to all ERS Medical Mental Health Service facilities and personnel carrying out specific requirements in line with regional or contractual policy.

4.2 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with ERS Medical's Capability and Disciplinary procedures.

Duty of Candour

4.3 ERS Medical acknowledges it responsibilities and duties under the provisions detailed within Regulation 20 of the Health and Social Care Act 2008 relating to a 'Duty of Candour'.

4.4 ERS Medical is committed to ensuring that it is open and honest with service users and other relevant persons (people acting lawfully on the behalf of service users) when things go wrong with care and treatment, and that they provide them with reasonable support, truthful information and a written apology where necessary.

5. Policy Statement

5.1 Please refer to ERS Medical's Quality, Environmental, Safety and Health Policy.

5.2 Please refer to ERS Medical's Business Continuity Policy.

5.3 Please refer to ERS Medical's Information Security Policy.

5.4 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for the strategic guidance and decision-making processes for the operational delivery of all Mental Health Services provided by ERS Medical.
6.2	**Senior Leadership Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director**	Has the strategic responsibility for setting, directing and monitoring clinical standards, scope of practice and ensuring that patient safety remains the primary focus of all patient facing services within ERS Medical.
6.4	**Regional & Operations Managers**	Are responsible for the implementation and management of ERS Medical policy and procedures, ensuring that suitable and sufficient training is provided and that all system records, demonstrating conformity are maintained.
6.5	**Team Leaders**	Have responsibility for ensuring that ERS Medical policy and procedures are communicated to personnel and adhered to at all time.
6.6	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Abuse** – is defined as any action that intentionally harms or injures another person. Abuse also encompasses the inappropriate use of any substance, especially those that can affect or alter consciousness e.g. alcohol & drugs.

7.2 **Assault** – is an act or threat of bodily harm, coupled with apparent ability to cause harm. It is both a crime and a Tort and therefore can result in either criminal or civil liability.

7.3 **At Work** – Includes all operational areas of Company sites and all activities undertaken off-site by Company employees.

7.4 **Capacity** – Under the Mental Health Act, a person is presumed to have the capacity to make their own decisions and choices. A lack of Capacity is where every practical and reasonable step to help the individual to make the decision has been taken without success.

7.5 **CCT** – Communications and Control Team.

7.6 **Consent** – The permission given and received from a patient or individual to fulfil a request.

7.7 **Handcuffs** – Handcuffs are considered a temporary restraining measure to prevent harm to self or others or to prevent the escape of a lawfully detained person.

7.8 **Hazard** – Source, situation or act with a potential for harm in terms of human injury or ill health or a combination of these.

7.9 **Medical Records** – A chronological written account of a patient's examinations and treatments that include the patient's history and complaints, the physician's physical findings, the results of diagnostic tests and procedures, and medications and therapeutic procedures. Medical records can cover a wide range of materials including:

- Handwritten notes;
- Computerised records;
- Correspondence between health professionals;
- Laboratory reports;
- Imaging records, including x-rays;
- Photographs;
- Video and other recordings;
- Printouts from monitoring equipment;
- Patient Report Forms (PRF's) and associated documents.

7.10 **RMHN** – Registered Mental Health Nurse.

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7.11 **Mental Illness** – There are many types of mental illness which depending on the illness described can affect 10 to 25% of the UK population at some point during their lives. Severe mental illness, which is a mental condition that is long-lasting, affects about 1% of the population at some point in their lives. These conditions can be divided into Neurotic or Psychotic conditions.

Neurotic conditions relate to normal emotions and are the most common form of mental illness. They can result in people feeling depressed and unable to cope with the normal routine of life such as working and relationships with family and friends.

Psychotic conditions are different from neuroses and being unrelated to normal emotions. Psychosis describes symptoms or experiences that happen together and alter the way in which patients perceive reality. For example, they may:

- Hear, smell, feel or see things which other do not;
- Have strange thoughts or beliefs that can make them feel persecuted or controlled;
- Have muddled or blocked thought processes;
- Appear unusually withdrawn and avoid contact with people or over or easily excited;
- They can lack the self-awareness to recognise that they are unwell.

7.12 **Personal Protective Equipment (PPE)** – Specialised clothing or equipment worn by employees for protection against health and safety hazards.

7.13 **Physical Intervention** – A physical move or hold used by staff to either directly or indirectly restrict a person's movement and ability to harm others or themselves.

7.14 **Reasonable Force** – The amount of force necessary to protect yourself, others and property.

7.15 **Restraint** – A measure, condition or piece of equipment designed and intended to keep an individual under control.

7.16 **Risk** – Combination of the likelihood of an occurrence of a hazardous event or exposure and the severity of injury or ill health that can be caused by the event or exposure.

7.17 **Risk Assessment** – The process of evaluating risks, arising from a hazard, taking into account the adequacy of any existing controls and deciding whether or not the risks are acceptable.

7.18 **Spit Hood** – is a small disposable hood that can be worn by mental health patients, in order to protect staff from the risks associated with spitting and the transfer of bodily fluids and therefore possible transfer of pathogens that could cause ill health.

7.19 **Safeguarding** – Is the multi-disciplinary work we do to minimise and manage risk to adults and children who may be vulnerable. It employs a framework which brings together all aspects of an investigation into an allegation of abuse against a vulnerable adult or child.

7.20 **Vulnerable Adult** (Department of Health 2000) – is someone who aged 18 or over:

- Who is, or may be, in need of community services due to age, illness or a mental or physical disability;
- Who is, or may be, unable to take care of himself / herself, or unable to protect himself / herself against significant harm or exploitation.

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8. Capacity and Consent

Capacity

8.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

8.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

8.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

8.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

8.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

8.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

8.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

8.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

8.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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8.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act 2005, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

8.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

8.12 This is typically a 2-stage process which requires being able to prove:

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

8.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

8.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

8.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

8.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

8.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

8.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

8.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

8.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

8.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

8.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

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8.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

9. Introduction

9.1 Mental Health Services provides a specialist service for the safe and secure transportation of patients with a diagnosed or suspected Mental Health Illness, requiring admission to and from Hospital settings.

9.2 Mental Health Services provides a specialist service for the safe and secure transportation of patients who require assessment and diagnoses for a Mental Health Illness, requiring admission to and from Hospital settings.

9.3 The core mental health service activity is the safe and secures collection and transportation of patients with, or suspected to have, mental health illness, from various locations across the UK and overseas, to secure facilities specialising in this type of care.

9.4 All patients will be transported with the appropriate number of qualified escorts and with a Mental Health Nurse (RMHN) if required. ERS Medical uses non caged vehicles for their conveyance.

9.5 All transfers are Risk Assessed (RA) to determine the number and type of escorts required and if a RMHN is required.

9.6 ERS Medical provides a national service, which runs 24 hours a day, 365 days a year, for the safe and secure conveyance of patients detained or likely to be detained under the Mental Health Act.

9.7 The core ethos of ERS Medical is that every patient, irrespective of their illness and presentation, is entitled to the highest standards of care at all times and that this service is delivered in such a way as to minimise the stress placed upon patients and maintain their dignity and safety at all times.

10. Safe Working Practices

10.1 Staff must adhere to the requirements of this procedure and any special or specific instructions given, to ensure the integrity of the service, the health, safety and wellbeing of the patient, driver, escorts and others affected by our activities.

10.2 ERS Medical has made a commitment to ensure that it delivers a service to its patients and customers in a timely and safe manner. It also recognises the importance of patients attending their appointments and admissions on time and the consequences to both the individual and their healthcare provided when this is not realised.

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Health and Safety

10.3 Crews must ensure that all passengers wear seatbelts or other safety restraints/devices appropriate to their mobility/medical classification. Patient who are exempt from wearing such devices should be able to produce valid documentation, on request by ERS Medical employees as proof. Failure to comply may result in transportation being refused.

10.4 Crew must ensure that the correct, issued PPE is worn at all times when required (as per **BMS/9.03 - Uniform and PPE issue and Use**) any defects with PPE must be reported to Line Manager or Team Leader immediately.

10.5 Crew must ensure they are familiar with the risk assessments for all work undertaken and have access to and utilise the driver Hazard Identification process as defined in **BMS/1.07 - Risk Management**.

10.6 Wherever possible drivers must select the most appropriate equipment and mobility aids, based upon the patients' functional mobility, capacity and their own dynamic scene risk assessment, in order to reduce the amount of manual handing, when assisting a patient.

10.7 When Safer Person Manual Handling cannot be avoided they must refer to and follow their training, which is based on best practice as defined within' The Guide to the Handling of People, Edition 6' (HOP6), and the procedures and risk assessments that are defined within **BMS/6.07 – Safer Person Manual Handling**.

10.8 Crew rest periods will be determined locally at the discretion of Operations Managers and in accordance with any TUPE terms and conditions for staff. ERS Medical will endeavour to allocate a 30-minute rest period during any given shift period.

10.9 Control room staff will try and schedule crew rest periods at the midpoint in their shift, but the needs of the patient will be given priority and rest periods, may on occasion be allocated early or late.

10.10 Under **NO** circumstance will crews be permitted to hold their rest period to the end of their shift and leave early.

Clinical

10.11 ERS Medical employees must adhere to Mental Health procedures and any other procedural or clinical instructions given to avoid any possible injury or harm and ensure the health and safety and the security of the patient.

10.12 Patients should be closely monitored during all journeys in order for the crew members to be aware in the first instance that the service user's clinical or mental presentation has declined or changed.

10.13 In the event of cardiac arrest, a minimum of full BLS will take place (unless a valid DNAR order is in place). Some mental health contracts stipulate a requirement for the provision of ILS trained staff. In these circumstances ERS Medical will provide staff trained to the appropriate contractual clinical level.

10.14 Patient care, safety, dignity and comfort should be paramount at all times.

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10.15 All Mental Health Vehicles are provided with a folder containing driver information sheets, clinical information sheets and other information that is deemed useful or required as part of a contractual obligation.

10.16 All issues that could affect and do affect the quality of the service provided by ERS Medical should be recorded and summated to the crews Line Manager or Team Leader on the drivers daily vehicle reports. This booklet does not negate the drivers from their responsibilities for report immediately as required by individual work instructions associated with this procedure.

10.17 All issues that could and do affect the quality of the service provided by ERS Medical should be recorded and submitted to the drivers' line manager/team leader on **F6.13.08** - **Daily Issue Log**. The use of this form does not negate the drivers from their responsibilities for reporting immediately as required by individual work instructions associated with this procedure. This does not class as incident reporting and the procedures detailed at **BMS/5.01 – Incident Reporting and Investigation** should be adhered to and followed for all such events.

10.18 The ERS Medical Clinical Team will publish 'Clinical Memo's' and Toolbox Talks, twice annually (May and November), for guidance and advice for Line Managers and Clinical Staff on the dangers of high and cold temperatures, for patients who find it difficult to regulate their internal body temperature, such as the young, elderly and those who have medical conditions that are exacerbated by extremes of temperature.

11. Scheduling and Crewing

11.1 ERS Medical has 3 separate types of staff who work and provide services on behalf of ERS Medical:

- **Full Time Employees** – Contracted staff that work to a set rota and hours (i.e. 37.5hrs per week);
- **Part Time Employees (Relief) –** Contracted staff that work on a relief / part-time basis and are assigned shifts in priority over zero hours staff;
- **Zero Hour Employees** – Contracted staff who do not work to a set rota or number of hours, but who summit their availability and receive shifts based on this declaration.

11.2 ERS Medical will schedule and roster Mental Health employees at a local level, to ensure that appropriate staffing levels are maintained to satisfy the operational and contractual requirements of ERS Medical.

11.3 ERS Medical will, wherever and whenever possible, strive to ensure that the crewing of differing clinical grades is appropriate to the requirements of the operational need, contractual requirements and the experience levels of the individual crew members:

- Mental Health Escorts;
- Healthcare Assistants;
- Registered Mental Health Nurse.

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Staffing

11.4 ERS Medical employees a mix of male and female staff for the provision of its Mental Health Services with varying clinical grades and experience and expertise in mental health illness. This is to enable ERS Medical to tailor its service to the needs of the patient, taking into account their age, gender, culture and mental capacity.

11.5 ERS Medical will whenever possible, try and provide female member(s) of staff when identified and requested as part of the booking and risk assessment process as a potential trigger. When this is not possible, we should contact the requesting NHS Trust or other healthcare provider and inform them of the situation and seek their agreement to provide a male only crew for this booking only.

11.6 Site managers can publish the staff rotas on site using an **F6.10.04 – Staff Rota** available on the ERS Medical BMS.



12. Booking of Mental Health Journeys

12.1 For all Company mental health services booking please refer to CCT **WI/6.08.06 – Mental Health – Quotes, Bookings and Journeys**.

12.2 Once the booking is confirmed and the staffing ratio and collection times have been agreed, the nearest available vehicle and crew are deployed ensuring the quickest response time and the most appropriate, efficient and economic resources are utilised.

12.3 ERS Medical Booking Management System used by the staff within the CCT, has a built-in risk matrix, provided by the ERS Medical Mental Health Service (**F6.13.01**) to help identify the correct staffing requirements in accordance with each patient's level of need.

12.4 ERS Medical acknowledges that accurate risk assessment is paramount to the safe, timely and secure transfer of patients. The provision and collation of information, in relation to the overall health and behavior of the patient, both historical and current, is paramount and ERS Medical will work with customers to ensure that this information is relevant, securely and sensitively handled and updated as required as a result of any change in the risk assessment.

12.5 Key risks that the booking matrix uses to identify and pre-populate staffing requirements are:

- Knowledge of Transfer;
- Racial, Gender or Cultural Issues;
- Absconder Risk;
- Self Harm;
- Mechanical Restraint Requirement i.e. Court appearance;

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- Physical or Verbal Aggression;
- Current Behaviour;
- Historical Behaviour;
- Recent Restraint;
- Trigger Behaviour;
- Current Presentation;
- Medication.

12.6 The risk matrix score and banding table (see below) is then utilised by the CCO, within the framework of **WI.6.08.06 - Mental Health Quotes, Bookings and Journeys** to assign the most suitable resource to the requested journey.

Score	Transfer Risk Level	Staffing Requirements
0 –4	Risk Level 1	NEPTS Double Crew Ambulance
5 - 8	Risk Level 2	NEPTS unless journey is over 4 Hrs duration then 1 x Driver plus 1 or 2 Mental Health Care Assistants.
9 – 14*	Risk Level 3	1 x Driver plus 2 MHCA, or 1MHCA & 1 Registered Mental Health Nurse (Medication dependant). Unless celled vehicle is used.
15 – 20**	Risk Level 4	1 x Driver plus 1 x RMHN & 2 x MHCA or x3 MHCA. Unless celled vehicle is used.
20+	Risk Level 5	1 x Driver plus 1 x RMHN & 3 x MHCA. Unless celled vehicle is used.

13. Receiving, Transporting and Handover MH Patients (Process)

13.1 For specific information in relation to the process of receiving, transporting and handing over patients transferred by ERS Medicals Mental Health Service please refer to **WI/6.13.01 – Receiving, Transportation & Handover MH Patients.**

14. Vehicles

14.1 ERS Medical has a specialist fleet of mainly 'VW Caravelle', which have been procured because of the specific seating configuration which has been assessed as the most suitable platform from which to deliver our Mental Health Services.

14.2 The rear compartment bench seat is fixed, and the 2 additional rear compartment seats have the capability to rotate 180° so that they are facing the rear bench seat. Thus, provided ideal escort / RMHN seating.



A typical ERS Medical VW Caravelle Vehicle

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14.3 ERS Medical uses both celled and non-celled vehicles for the transportation of mentally ill patients. The decision to use a caged vehicle is driven both from contractual arrangements and the application of our mental health risk assessment at the point of booking.

14.4 Vehicles should be checked daily by the driver and mental health escort staff, which should be recorded in accordance with **BMS/8.01 – Transport Common Tasks for Line Managers, F8.01.07b – Drivers / Managers Walk-around Check-sheet (Mental Health).**

14.5 **F6.13.10 – Vehicle Loading List (Specialist Services)** should be used to confirm that prior to starting a working shift each vehicle has the required levels of equipment on board. The completed forms should be handed into site prior to departure.

15. Conflict Resolution and Physical Restraint

15.1 ERS Medical acknowledges that although most mental health journeys will be completed without incidents involving verbal or physical abuse, there is potential, due to unpredictable nature of some of the patients being transported, for behaviour to may make staff feel uncomfortable or personally threatened.

15.2 All ERS Medical mental health staff receive training in both conflict resolution and physical restraint and breakaway techniques but can for further guidance and advice consult the procedural guidelines detailed within **WI/6.13.02 – Conflict Resolution.**

15.3 ERS Medical staff should report all incidents of verbal and physical abuse immediately to the line mangers or the CCT and complete and incident report at the earliest opportunity using the procedures within **BMS/5.01 – Incident Reporting and Investigation**.

16. Use of Mechanical Restraints (Handcuffs)

16.1 ERS Medical believes that patients should only ever be handcuffed as a last resort and for the minimum period of time for the protection of their own health and safety or for the protection of those workers escorting them.

16.2 When tasked called upon to use handcuffs staff must ensure that are fully familiar with the procedural guidelines detailed within **WI/6.13.03 – Use and Application of Handcuffs** and have completed the competency matrix within the work instruction prior to undertaking this work activity.

17. Use of Spit Hoods

17.1 ERS Medical has a legal obligation and duty to protect its employees from risks associated with violence and aggression. As part of its Policy & Procedure, as well as its Health & Safety obligation, a risk has been identified associated to patient spitting at staff.

17.2 When tasked to use a spit Hood staff should ensure they are familiar with the procedural guidelines detailed in **WI/6.13.04 – Use and Application of Spit Hoods** and that they have completed the competency matrix within the work instruction prior to undertaking this work activity.

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18. Medicines Management

18.1 For detailed guidance on the storage, use and disposal of medicines please refer to **BMS/6.04 – Medicines Management**.

19. Transportation of Personal Property

19.1 All personal property and possessions must be signed and accounted for at the time of collecting the patient, using **F6.13.02 – Mental Health Services Booking Reference Form**.

19.2 The receiving medical facility must then counter sign the **F6.13.02 – Mental Health Services Booking Reference Form**, acknowledging receipt of the patient's personal property and possessions. This instruction does not just apply for patients transferred from police stations or hospitals / units but also private addresses as well.

19.3 If in the process of the transfer any damage is caused to the patients' personal property and possessions a record must be made of this on the **F6.13.02 – Mental Health Services Booking Reference Form**.

19.4 It is possible that at some point after handing the patient over to the receiving unit, ERS Medical will receive a report stating that an item or items are missing from the patient's personal property and possessions.

19.5 Therefore, to mitigate this risk an inventory should be made or requested from the collection facility, for all items being transported by ERS Medical.

19.6 Sometimes, due to the nature of the transfer it is both impracticable and impossible to obtain a complete inventory of every item, but every effort should be made to identify what is being transferred with the patient.

19.7 This may mean that the inventory may be:

- X1 Black bin liner containing personal possessions (clothes);
- X1 Black shoulder bag (empty);
- X1 Casio 'G' Shock digital watch (broken);
- Yellow and White metal jewellery;
- Clear and coloured stone jewellery.

20. Safeguarding Vulnerable Adults and Children

20.1 For guidance and advice on dealing with safeguarding issues staff should consult the procedural guidelines detailed within **BMS/6.05 – The Safeguarding of Vulnerable Adults and Children** and its associated work instruction and forms.

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21. Infection Prevention & Control

21.1 For guidance and advice on Infection Prevention and Control (IPC), including post exposure procedures and vehicle and equipment 'Deep Clean' protocols and schedules, staff should consult the procedural guidelines detailed within **BMS/6.03 – Infection Prevention and Control** and its associated work instruction and forms.

22. Patient Incident and Near Misses

22.1 For guidance and advice on dealing with any incidents that have or had the potential to cause harm, injury or ill health to our patients, service users or members of the public, staff should consult the procedural guidelines detailed within **BMS/5.01 – Incident Reporting and Investigation**.

22.2 It is imperative that all near misses and incidents that either did or had the potential to cause a patient injury are reported. Proactive reporting allows ERS Medical to identify trends for near misses and put measures in place to either reduce eliminate the risk.

23. The Carriage of Additional Passengers

23.1 Wherever possible, requests for a relative or guardian to travel with the patient should be made in advance, through the CCO at the time of booking, providing full details of who any additional passenger will be.

23.2 Permission will only be granted for one relative or guardian to travel with the patient.

23.3 In every event where such a request is made, the decision will be taken by a member of the Management Team, after consultation with the dispatching unit/location, ensuring that a full risk assessment has been carried out prior to permission being granted.

23.4 Under **NO** circumstances should this decision be made by the team collecting the patient.

23.5 Several factors are taken into account when moving through the decision-making process, such as:

- The additional passengers' relationship with the patient;
- The risk of a physical intervention taken place during the transfer;
- The patient's absconder risk and previous history;
- The rapport, any additional passenger has with the patient.

23.6 When transferring anybody under the age of 18, ERS Medical will normally grant permission for a relative or guardian to travel with the young person, if this is going to make the journey less traumatic and daunting for them, unless there is any obvious factor, which suggests that it is not in the young person's best interest.

23.7 In any situation where permission is granted, it is understood that the relative or guardian will be travelling from the collection location to the delivery location only. ERS Medical will not routinely provide return transport for additional passengers.

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23.8 Any booked return journey, must be by prior arrangement and will be subject to the Trust or organisation, financing the transport and agreeing to any additional costs associated with a return journey.

24. Mental Health Act: Section Paperwork

24.1 The Mental Health Act has numerous Sections within it to categorise the status in relation to the treatment of patients will a diagnosed or suspected mental health illness.

Code	Section	Status
A1	Section 2	Application by the nearest relative for admission for assessment
A2	Section 2	Application by an AMHP for admission for assessment
A3	Section 2	Joint medical recommendation for admission assessment for assessment
A4	Section 2	Medical recommendation for admission assessment
A5	Section 3	Application by the nearest relative for admission for treatment
A6	Section 3	Application by an AMHP for admission of treatment
A7	Section 3	Joint medical recommendation for admission for treatment
A8	Section 3	Medical recommendation for admission for treatment
A9	Section 4	Emergency application by the nearest relative for assessment
A10	Section 4	Emergency application by an AMHP for admission for assessment
A11	Section 4	Medical recommendation for emergency admission for assessment
H1	Section 5(2)	Report on hospital in-patient
H2	Section 5(4)	Record of hospital in patient
H3	Sections 2, 3 & 4	Record of detention in hospital
H4	Section 19	Authority for transfer from one hospital to another under different managers
H5	Section 20	Renewal of authority for detention
H6	Section 21B	Authority for detention after absence without leave for more than 28 days
G1	Section 7	Guardianship application by nearest relative
G2	Section 7	Guardianship application by an AMHP
G3	Section 7	Joint medical recommendation for reception into guardianship

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Code	Section	Status
G4	Section 7	Medical recommendation for reception into guardianship
G5	Section 7	Record of acceptance of guardianship application
G6	Section 19	Authority for transfer from hospital to guardianship
G7	Section 19	Authority for transfer from the guardianship of one guardian to another
G8	Section 19	Authority for transfer from guardianship to hospital
G9	Section 20	Renewal of authority for guardianship
G10	Section 21B	Authority for guardianship after absence without leave for more than 28 days
M1	Part 6	Date of reception of a patient in England
M2	Section 25	Report barring discharge by nearest relative
T1	Section 57	Certificate of consent to treatment and second opinion
T2	Section 58(3)(A)	Certificate of consent to treatment
T3	Section 58(3)(B)	Certificate of second opinion
T4	Section 58A (3)	Certificate of consent to treatment (patients at least 18 years old)
T5	Section 58A (4)	Certificate of consent to treatment and second opinion (patients under 18)
T6	Section 58A (5)	Certificate of second opinion (patients who are not capable of understanding the nature, purpose and likely effects of the treatment)
CT01	Section 17A	Community treatment order
CT02	Section 17B	Variation of conditions of a community treatment order
CT03	Section 17E	Notice of recall to hospital
CT04	Section 17E	Community treatment order: record of patients' detention in hospital after recall
CT05	Section 17F(4)	Revocation of community treatment order
CT06	Section 17F (2)	Authority for transfer of recalled community patient to a hospital under different managers
-	Section 18	Absence without leave.
CT07	Section 20A	Community treatment order: report extending the community treatment period
CT08	Section 21B	Authority for extension of community treatment period after absence without leave for more than 28 days
CT09	Part 6	Community patients transferred to England
CT010	Section 19A	Authority for assignment of responsibility for community patient to hospital under different managers
CT011	Section 64C (4)	Certificate of appropriateness of treatment to be given to community patient (Part 4A certificate)

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25. Statutory Mental Health Paperwork (by Section)

25.1 When a patient is being either referred, treated or admitted for assessment and or treatment, various statutory forms must be used, valid and in place for this to occur legally.

25.2 The below table is an illustration of the forms required for the varying types of a patient status within the framework of the Mental Health Act.

Form Code	Status
Section 2: Admission for Assessment; Allows a compulsory admission and detention for assessment, followed by treatment for a mental disorder for up to 28 days.	
Form A1	Application by the nearest relative
	or;
Form A2	Application by a AMHP
	and;
Form A3	Joint medial recommendation
	or;
Form A4(x2)	Medical recommendation
	and;
Form H3	Record of detention in hospital
Section 3: Admission for Treatment; Allows compulsory detention for treatment for up to six months, is renewable in the first instance for six months and then for periods of 12 months.	
Form A5	Application by nearest relative
	or;
Form A6	Application by AMHP
	and;
Form A7	Joint medical recommendation
	or;
Form A8(x2)	Medical recommendation
	and;
Form H3	Record of detention in hospital
Section 4: Emergency Admission for Assessment; Allows compulsory admission and detention for assessment in an emergency for up to 72 hours.	
A9 Form	Emergency application by nearest relative
	or;
Form A10	Emergency application by AMHP
	and;
Form A11	Medical recommendation
	and;
Form H3	Record of detention in hospital

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Form Code	Status
Section 5(2): Report on hospital inpatient; Allows detention of an informal patient for up to 72 hours.	
Form H1	Report of hospital in patient. (received on behalf of the Hospital Manager in Part 2 Form H1)
Section 5(4): Record of hospital in patient; Allows a registered nurse to detain an inpatient who is already being treated for a mental disorder for up to 6 hours.	
Form H2	Record of hospital inpatient.
Section 17A: Community treatment order; Allows a patient to be moved to the community, subject to recall and certain conditions.	
Form CT01	Community treatment order.
Section 17E: Community treatment order recall; Allows a patient subject to a CTO to be recalled to hospital for up to 72 hours.	
Form CT03 Form CT04	Notice to recall to hospital. **and;** Record of patient's detention in hospital after recall.
Section 17F(4): Revocation of community treatment order; Allows a patient CTO to be revoked and provides for their original detaining section 3/37 to be reinstated (but to start again i.e. 6 months)	
Form CT05	Revocation of community treatment order
Section 18(1): Return and Readmission of patients absent without leave	
	Detained patients who are AWOL may be taken into custody and returned by an approved mental health professional (AMHP), any member of the hospital staff, any police officer, or anyone authorised in writing by the hospital managers. A patient who has been required to reside in another hospital as a condition of leave of absence can also be taken into custody by any member of that hospital's staff or by any person authorised by that hospital's managers. Otherwise, responsibility for the safe return of patients rests with the detaining hospital. If the absconding patient is initially taken to another hospital, that hospital may, with the written authorisation of the managers of the detaining hospital, detain the patient while arrangements are made for their return. In these (and similar) cases people may take a faxed or scanned copy of a written authorisation as evidence that they have the necessary authority without waiting for the original.
Section 35: Remand to hospital for report on mental condition; Allows detention for a maximum of 28 days with further periods not exceeding 12 weeks in all.	
	Court order **and;** Medical recommendation (one)
Section 36: Remand to hospital for treatment; Allows the detention for a maximum of 28 days with further periods not exceeding 12 weeks in all.	
	Court order **and;** Medical recommendation (one)

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Section 37: Hospital order; Directs the admission of an offender to a named hospital for an initial period of up to 6 months, is renewable in the first instance for six months and then for periods of 12 months.	
	Court order **and;** Medical recommendation (two)
Section **38: Interim Hospital Order;** Allows detention for an initial period of 12 weeks with further periods of 28 days at a time but no more than 12 months in total.	
	Court order **and;** Medical recommendation (two)

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Form Code	Status
Section 41: Order Restricting Discharge; When a hospital order (section 37) is made, an order restricting discharge may be made (section 37/41)	
	Court order **and;** Letter from the Ministry of Justice to Hospital Managers and responsible clinicians outlining restrictions imposed by the Court.
Section 47: Transfer to Hospital of Prisoners; Directs the transfer of a prisoner to a named hospital. Special restrictions are normally applied (section 47/49) admission of an offender to a named hospital for an initial period of up to 6 months, is renewable in the first instance for six months and then for periods of 12 months.	
	Warrant **and;** Medical recommendation (two)
Section 48: Removal to Hospital of Other Prisoners; Directs the transfer of an un-sentenced prisoner to a named hospital as per section 47, however need for transfer is urgent.	
	Warrant **and;** Medical recommendation (two)
Section 49: Hospital Order: See 47 above. If patient is subject to a fixed term sentence and they are still in hospital at this date, the order changes to a notional 37 hrs and then for periods of 12 months.	

26. Norfolk – Mental Health Journeys – Contractual Requirements

26.1 Norfolk Patients (excluding Great Yarmouth & Waveney area) including Unregistered Patients (e.g. homeless, travellers)

Within Norfolk Boundary

- Planned Outpatient or discharge – **ERS:**
  - Unless from ED then **EEAST.** (ERS Medical can convey when EEAST have been contacted and do not have capacity to complete the discharge.

- Admission from community / residential address:
  - **If non-specialist mental health crew required – EEAST;**
  - **If specialist mental health crew required – ERS.**

- Transfers:
  - ED – **EEAST;**
  - Non-ED including community hospitals – **ERS.**

- Non-registered Patient (e.g. homeless, travellers):
  - ED – EEAST;
  - Non-ED including community hospitals – ERS.

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- Patient Registered with a Non-Norfolk CCG – **Own CCG responsibility to agree and authorise transport**

Crossing Norfolk Border

- Norfolk Patient crossing Norfolk Border – ERS;
- Non-registered Patient (e.g. homeless, travellers) – ERS;
- Patient Registered with a Non-Norfolk CCG – Own CCG responsibility to agree and authorise transport.

26.2 Persons detained under the Mental Health Act 1983: Every effort should be made to determine GP practice registration or establish an address where they are usually resident, but if this fails and the patient refuses to assist, then as a last resort the responsible commissioner should be determined by the location of the unit providing treatment.

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Question 1.10.10

Mental Health Capacity Act 2005

Please provide evidence of how your organisation fulfils the Mental Health Capacity Act 2005 requirement and manage issues of consent. Please also include details of the training mechanism that will be in place to ensure all staff are adequately trained according to their roles and responsibilities in Safeguarding Adults, Children and Mental Capacity Act (MCA) and Prevent Training. Please attach evidence of the typical safeguarding training staff have undertaken to a level commensurate with the relevant staff members role.

The Bidder has evidenced they have appropriate processes in place to meet the obligations of the Mental Health Capacity Act 2005 – Pass

The Bidder does not have appropriate processes in place to meet the obligations of the Mental Health Capacity Act 2005 - Fail

We have attached our Prevent Policy, Mental Health Service Policy and our Care to Care policy which addresses how our staff manage consent.

To ensure we deliver a safe, caring and compliant service we have embedded the Mental Health Capacity Act 2019 (amended) throughout our Business Management System and operational policies.

We have attached our training prospectus outlining what training each staffing level receives in regard to roles and responsibilities in Safeguarding Adults, Children, Mental Capacity Act (MCA) and Prevent Training.

Consent

Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

In order for consent to be given and deemed valid it must have some specific criteria met:-

- **The patient must be competent** - that is they must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.
- **The patient must have sufficient information to make a choice** - without adequate information patients are unable to make a decision about their treatment or care.

Any information provided to a patient will contain an explanation of any investigation, diagnosis, treatment and care. It will also contain an explanation of the possibilities for success, any associated risks and complications/side effects that may result from any medical treatment or care.

Staff who give this type of information verbally ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes/PRF.

- **Patients must be able to give their consent freely** - pressuring patients into consenting to any treatment of care plan invalidates any consent given.

To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

All staff are trained to be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a subtle but often powerful influence.

In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment
- Prior to any medical observations being taken
- Prior to any patient manual handling that is required in assisting the patient
- Prior to entering a patient's home address

Safeguarding Training

Below we have outlined the key areas that are covered in our Safeguarding level 3 training, which all of our clinical staff are required to complete prior to starting work with us:-

- An introduction into Safeguarding Children
- Roles and responsibilities
- Duty of care
- Local authority
- Response to referral
- Immediate protection
- Assessment of a child
- Action following a strategy meeting
- Child protection conference
- Child protection plan
- The review
- Information sharing protocols
- Learning and improving framework
- Child death reviews
- Review programme

On completion of the Safeguarding Level 3 training course, our employees will be able to:

- provide an understanding of the key legislation regarding Safeguarding Children Level 3
- provide essential Safeguarding Children Level 3 training resources in an engaging and meaningful way

Prevent Training

Our Prevent and awareness training is delivered to all employees during their induction and refreshed annually. The key outcomes from our prevent training are;

- Understanding the objectives of the Prevent Strategy and how this links to our sector
- Understanding for our staff of what their professional responsibilities are in relation to the safeguarding of adults, children and young people at risk
- Understanding the vulnerability factors that can make individuals susceptible to radicalisation or a risk to others
- Who to contact and where to seek advice, if they have any concerns

Mental Health Act Training

The Mental Health Act forms part of our employees' induction training and is covered through our ELearning as part of the ACA new starter Futurequals requirement. Its is also part of our annual refresher training. The training covers;

- Introduction into the Mental Health Act
- The key aspects of the Mental Health Act
- The four step compulsion pathway
- The Mental Health Act code of practice
- Broadening professional roles under the Mental Health Act
- Mental health tribunals
- The five Mental Health Act guiding principles

The aims and objectives of this online Mental Health Act training course are to:

- provide the learner with a clear understanding of the legislation and guidelines related to the Mental Health Act
- provide an awareness of the four steps compulsion pathway and the code of practice
- improve the learner's awareness of how mental health tribunals work and the guiding principles for health and social care professionals
- provide essential learning resources relating to the Mental Health Act in an engaging and meaningful way

WI/6.05.03 Prevent

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2.0	10	All	11	30.11.18	[redacted]	Addition of Capacity & Consent Section
3.0	All	All	All	25.04.19	[redacted]	Annual Review
4.0	All	All	All	28.05.20	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Care to Care	BMS/6.01
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Risk Assessments	BMS/6.07
Patient Communications and Control (CCO)	BMS/6.08
Non-Emergency Patient Transport (NEPTS)	BMS/6.10
Renal Patient (NEPTS)	BMS/6.11
High Dependency (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Safeguarding Vulnerable Adults and Children	WI/6.05.01
DoLS	WI/6.05.02
Safeguarding Referral Form (Road Staff)	F6.05.01
Safeguarding Referral Form (CCO)	F6.05.02
Prevent Referral Form	F6.05.03
Prevent Referral Road Staff	Annex A
Prevent Referral CCO	Annex B

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3. Introduction

What is Prevent

3.1 Prevent forms one part of the Government's overall counter terrorism strategy 'CONTEST' which is led by the Home Office.

3.2 CONTEST is primarily organised around four key principles or work streams, each with a specific objective:

PREVENT - To stop individuals becoming terrorists or supporting terrorism;

PURSUE - To disrupt or stop terrorist attacks occurring;

PROTECT - To strengthen our borders, infrastructure, buildings and public spaces from a terrorist attack;

PREPARE - To reduce the impact of an attack if an act of terrorism occurs.

3.3 Prevent is aimed at front line staff and is designed to help make staff aware of their role in preventing vulnerable people being exploited for terrorist purposes.

3.4 The Counter Terrorism and Security Act (2015) places a duty on a range of organisations to have due regard to the need to prevent people being drawn into terrorism.

3.5 Prevent has three National objectives:

Objective 1 – Respond to the ideological challenge of terrorism and the threat we face from those who promote it.

Objective 2 – Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support. Channel is a key part of the Government's work to prevent terrorism and is a multiagency approach to identifying and supporting vulnerable individuals.

Objective 3 – Work with sectors and institutions where there are risks of radicalisation which need to be addressed.

3.6 The Health sector contribution to Prevent focusses primarily on objectives 2 and 3.

Why Healthcare Staff?

3.7 ERS Medical aims to improve the health and wellbeing of service users through the delivery of healthcare services whilst safeguarding those individuals who may be vulnerable to any form of exploitation. Prevent is also concerned with protecting individuals.

3.8 Healthcare staff are well placed to recognise individuals, whether patients or staff, who may be vulnerable and therefore may be more susceptible to radicalisation. Staff must have an awareness of the risk of radicalisation, no matter how remote the risk appears, and the Prevent agenda which falls within ERS Medicals duty of care and safeguarding responsibilities to our patients.

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3.9 Radicalisation is usually a process, not a one-off event, and during that process it is possible to intervene to safeguard the vulnerable individual and prevent them from supporting terrorism or becoming terrorists themselves before any harm has occurred or crime has been committed.

3.10 There is no expectation for ERS Medical staff to take on an enforcement or surveillance role as a means of implementing the Prevent agenda. In contrast, ERS Medical must work in partnership with organisations and agencies to contribute to the prevention of terrorism by protecting and effectively safeguarding vulnerable individuals who may be at risk of exploitation.

3.11 This is a shared endeavour and every member of staff has a role to play in protecting and supporting vulnerable individuals and colleagues who may be at risk of radicalisation.

4. Purpose

4.1 This work instruction describes how ERS Medical implements the Prevent agenda.

4.2 The NHS Health Care Organisation Prevent Strategy and Policy (2014) outlines that the Prevent agenda ensures that:

4.3 NHS staff know how to safeguard and support vulnerable individuals, whether service users or staff, who they feel may be at risk of being radicalised by extremists.

4.4 Appropriate systems are in place within NHS organisation for staff to raise concerns if they think this form of exploitation may be taking place.

4.5 NHS organisations promote and operate safe environments where extremists are unable to operate.

4.6 Safeguarding and incident reporting policies are integrated with the Prevent strategy.

5. Policy Statements

5.1 ERS Medical is accountable for ensuring that there are “reliable systems, processes and practices in place to keep people safe and to safeguard them from abuse and neglect” (CQC, 2015).

5.2 This policy applies to all members of staff, whether paid or unpaid, student or volunteer.

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5.3 ERS Medicals Prevent policy is designed to complement the Multi- Agency Policies and Procedures of Local Safeguarding Children Boards and Local Safeguarding Adults Boards. This policy also links closely to other Trust policies including:

- Safeguarding Adults Policy;
- Safeguarding Children Policy;
- Confidentiality and Information Sharing;
- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS);
- Personal and Professional Boundaries;
- Disclosure and Barring Service;
- Speak Up (Whistleblowing).

6. Monitoring

6.1 The policy will be monitored for its effectiveness by the Medical Director and Head of Care, through the following:

- Liaison with the Care Quality Manager and nominated Safeguarding Lead within the Care Quality Team;
- Production of reports showing trend analysis of reporting, broken down into the following:
- Type of incident reported;
- Grade of staff reporting;
- Feedback gained from social services department;
- Feedback from other relevant external agencies;
- Lessons learnt from any adverse incidents.

6.2 These will be monitored on a monthly basis and reports provided back to the Governance and Performance Review Committee (GaPR).

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7. Responsibilities

7.1	**Managing Director**	Has overall responsibility for setting and directing quality, health & safety and environmental policy.
7.2	**Medical Director /Safeguarding Lead**	Is Responsible for safeguarding is responsible for reporting to the Board and providing executive leadership. He/she is accountable for the governance of safeguarding to the service, partners and regulators and ensuring effective implementation of the Prevent strategy across ERS Medical. Support members of staff, and the organisation to fulfil its obligations to service users and their carers to work effectively to prevent harm, abuse, and neglect, and to act positively to protect adults and children where there are concerns that the person may have been, or is at risk of radicalisation. Provide advice and support to all ERS Medical on all matters relating to Prevent. The Safeguarding Team must also assist staff members and managers to share concerns relating to Prevent with the appropriate agencies/authorities and maintain oversight of Prevent referral forms and outcomes. The Safeguarding Adults Team will keep a record of all Prevent related concerns as well as the outcome.
7.3	**Senior Operations Managers / CQC Registered Managers**	Are responsible for leading improvements, innovations and best practice; for providing support, responsive supervision, clinical leadership and practice advice. They also provide a link between directorates and ERS Medical and provide information in respect of compliance and performance updates. Are responsible for notifying all Safeguarding referrals to the Care Quality Commission and ensuring all reporting procedures for the Commission adhered to.
7.4	**Operations Managers**	Are responsible for ensuring that staff are aware of ERS Medical policy and offer support to those reporting abuse. Managers should also ensure that the level of responsibility for each staff member is explicit as a statement in all job descriptions to meet the expectations of each individual role. Good clinical leadership and high professional standards are paramount in the provision of care and the prevention of abuse. Managers must support staff members to escalate concerns relating to Prevent to ERS Medical 's Corporate Safeguarding Team and liaise with ERS Medical Human Resources (HR) Department if the concern raised relates to a member of ERS Medical

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7.5 **Care Quality Team**

ERS Medical Care Quality team has a responsibility to set safeguarding adults and children within their strategic objectives, ensure there is Board level leadership, an overall policy in place which incorporates the Prevent strategy and an organisational culture which places service users and their wellbeing at the centre of safeguarding, and endeavours to prevent harm, abuse, and neglect from occurring.

7.6 **ERS Medical**

NHS Clinical Commissioning Groups are a statutory member of the Local Safeguarding Adults and Local Safeguarding Children Boards. Health Services have a vital role to play in preventing harm, abuse, or neglect from occurring, identifying the signs of abuse or exploitation and reporting concerns to Local Authorities.

7.7 **All Personnel**

All employees (including bank and agency staff), volunteers and contractors are required to adhere to the policies, procedure and guidelines of ERS Medical, including their roles and responsibilities under this policy.

All members of staff are responsible for attending the relevant Prevent training for their role.

Staff must report all Prevent related concerns to their line Manager and ERS Medical 's Safeguarding Team to ensure a timely and proportionate response to concerns.

All staff should make sure that they have familiarised themselves with their PREVENT and safeguarding policy.

Staff must also work at all times within the guidelines of their professional codes of conduct and the policies of ERS Medical to prevent abuse through an act or omission to act. Omissions to act and poor professional practice can amount to neglect even if the abuse was unintentional.

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8. Definitions

8.1 **Radicalisation -** The Prevent Strategy (Home Office, 2011) defines the term 'radicalisation' as "the process by which a person comes to support terrorism and forms of extremism, leading to terrorism".

8.2 **Terrorism** - The current UK definition of terrorism is given in the Terrorism Act 2000 (TACT 2000). This legislation defines terrorism as "an action that endangers or causes serious violence to a person/people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause".

8.3 **Extremism** - The Home Office (2011) defines this term as "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs".

8.4 **Ideology** - An ideology is a set of beliefs. In the context of Prevent, there are a wide range of organisations and groups who may share a common ideology which motivates people associated with the group to become involved in or support terrorist related activity. Ideologies may be underpinned by beliefs about animal rights, environmentalist issues, politics, religion or conceptions of power and status, which are all relevant to the Prevent agenda.

8.5 **WRAP3 - Workshop to Raise Awareness of Prevent, Third Version** - WRAP3 is the national training programme currently provided for health staff which has been designed by the Home Office.

8.6 **Vulnerability** - Within Prevent, this term describes factors and characteristics which may make an individual more susceptible to radicalisation (Home Office, 2011).

8.7 **Safeguarding** - The process of protecting vulnerable people of all ages from crime, other forms of abuse or (in the context of this policy) from the risk of being drawn in or supporting terrorism.

9. Identifying an Adult or Child at Risk of Radicalisation

9.1 There is no single profile or indication of a person who is likely to become involved in or support terrorist related activity. To date, there is no universally accepted view or theory to help explain why vulnerable individuals can become involved.

9.2 The factors associated with exploitation are vast and unique to each individual person. "The increasing body of information indicates that factors thought to relate to personal experiences of vulnerable individuals affect the way in which they relate to their external environment" (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

9.3 Vulnerable children and adults can be exploited by radicalisers in variety of ways who seek to target these individuals on the basis of their vulnerability. Contact with radicalisers is also very variable and can range from taking a direct approach i.e. face to face, or can happen indirectly through virtual forums such as the internet, social networking or other forms of media. More commonly, contact appears to occur through a combination of the above (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

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9.4 It is generally more common for vulnerable people to become involved in terrorist related activity through the influence of others (NHS Health Care Organisation Prevent Strategy and Policy, 2014). Initial contact may be via siblings, peers, other family members or acquaintances, with the process of radicalisation often being a social process. This social interaction can take place in a range of unsupervised environments such as cafes, gyms, in private homes and via the internet. As such, staff need to be mindful of booking seminar rooms, meeting rooms/public areas etc. which may be potentially be used for terrorist purposes.

9.5 Access to extremist materials can often be through the use of leaflets and local contacts. However, the internet, and in particular social media, also plays a really important role in the communication of extremist views and is often used as a tool by radicalisers. The internet provides a platform for extremists to promote their cause widely and encourage debate through websites whilst disseminating propaganda material (NHS Health Care Organisation Prevent Strategy and Policy, 2014). ERS Medical must therefore be aware and have strategies in place to identify anyone making frequent visits to websites containing extremist material. This may include images such as armed conflict around the world and providing speeches and access to material from those involved in the radicalising process (NHS Health Care Organisation Prevent Strategy and Policy, 2014). Staff must also be aware of any inappropriate leafleting/canvassing which may be linked to the Prevent agenda.

9.6 Radicalisers usually try to attract people to their cause through a persuasive and convincing rationale which is contained within a narrative or storyline. This narrative then has the potential to influence others, their views and as a consequence, their actions or behaviour. “Inspiring new recruits, embedding the beliefs of those with established extreme views and/or persuading others of the legitimacy of their cause is the primary objective of those who seek to radicalise vulnerable individuals” (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

10. Capacity and Consent

Capacity

10.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

10.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

10.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

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10.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

10.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

10.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

10.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

10.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

10.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

10.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

10.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2008.

10.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

10.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

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Consent

10.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

10.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

10.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

10.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

10.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

10.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

10.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

10.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

10.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

10.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

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11. Factors that Make Someone Vulnerable

11.1 A wide range of personal and social factors could make individuals more susceptible or vulnerable to exploitation. None of the following factors are conclusive in themselves and, therefore, should not be considered in isolation but in conjunction with the person's wider circumstances and needs as well as any other signs or possible indicators of radicalisation.

Identity Crisis

11.2 Children, adolescents and adults who are exploring issues of identity can feel both distant from their parents, family or peers, their cultural or religious heritage and uncomfortable with their place in society around them (NHS Health Care Organisation Prevent Strategy and Policy, 2014). A perceived lack of belonging or identify can be exploited by radicalisers who seek to provide the person with a sense of purpose or meaning. As a result, changes may be noticed in the person's behaviour, their circle of friends, the way in which they interact with others, alter their appearance and spend their time.

Personal Crisis

11.3 This may, for example, include "significant tensions within the family that produce a sense of isolation of the vulnerable individual from the traditional certainties of family life" (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

Personal Circumstances

11.4 The experience of migration, events affecting families who remain in countries of origin or local tensions may all contribute to a sense of alienation or detachment from UK norms and values. This may in turn lead individuals to support terrorist groups or actively seek to cause harm to symbols of the community or state (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

Unemployment or under employment

11.5 Individuals may perceive their career and lifestyle aspirations to be undermined or restricted in some way by limited achievements or employment prospects. This can in turn translate to a generalised rejection of civic life and possibly an adoption of violence as a symbolic act (NHS Health Care Organisation Prevent Strategy and Policy, 2014).

Criminality

11.6 In some cases, a vulnerable individual may have been involved in a group that engages in some form of criminal activity or, on occasion, a group that has links to organised crime. As a result, the individual may be further drawn into engagement with terrorist-related activity

Grievances

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11.7 The NHS Health Care Organisation Prevent Strategy and Policy (2014) provides the following examples of grievances and other factors which may play an important part in the early indoctrination of vulnerable individuals into the acceptance of a radical view or extremist ideology:

- A misconception and/or rejection of UK foreign policy;
- A distrust of Western media reporting;
- Perceptions that UK government policy is discriminatory (e.g. counter-terrorist legislation).

Other Factors

11.8 The following have also been found to contribute to vulnerable people joining certain groups supporting terrorist-related activity:

- Ideology and politics.
- Provocation and anger (grievance).
- Need for protection.
- Seeking excitement and action.
- Fascination with violence, weapons and uniforms.
- Youth rebellion.
- Seeking family and father substitutes.
- Seeking friends and community.
- Seeking status and identity.

12. Immediate Risks

12.1 If a staff member has concerns that an individual is presenting an immediate terrorist related risk to themselves, others or property they must contact:

- The National Counter Terrorism Hotline on **0800 789 321**

OR

- The Police on 999

13. Guidance for Raising a Concern

13.1 Prevent operates in the 'pre-criminal space'. It is about supporting individuals who are at risk of radicalisation *before* they commit acts of terrorism, or a terrorist-related criminal offence. Raising concerns that an individual may be vulnerable to radicalisation does not automatically mean that you think the person is a terrorist but rather that you are concerned that the individual may be prone to being exploited by others, is at risk of or potentially has been radicalised and as such, the concern is a safeguarding concern.

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13.2 The Prevent referral process can be described in three stages; notice, check and share.

Notice

13.3 Be aware of an individual's vulnerability to radicalisation, changes in behaviour, ideology and other forms of extremism:

Check

13.4 Check out your concerns with the individual where possible, and where safe, with your line manager, colleagues and Multi-Disciplinary Clinical meetings. Checking out your concerns with the ERS Medical Safeguarding Team will help to ensure a proportionate response to the concerns.

Share

13.5 Share your concerns with partner agencies, and as far as possible be open and honest with the individual about the duty to share your concerns.

13.6 Through the Prevent referral, information is shared to the Multi-Agency Safeguarding Hub (MASH) where it is screened for acceptance into the Channel process.

14. Channel

14.1 Channel is a multi-agency process, much like safeguarding adults, where partner agencies share expertise and resources to create a bespoke support package for vulnerable individuals.

14.2 If a service user is accepted into the Channel process, involved staff can be expected to be asked to become involved in the process, share relevant information and attend the multi-agency Channel panel if appropriate.

14.3 Staff must cooperate fully with the Channel panel, continue to support the service user to manage identified risks and to engage with the Channel process. Channel is a consensual process whereby agreement from the service user is fundamental to the provision of interventions. The service user is therefore a key partner in the process and staff must seek to empower the individual to play an active role in support planning processes.

14.4 Staff must escalate all concerns relating to Prevent to the ERS Medical Safeguarding Team.

14.5 As with any other Safeguarding incident, a RADAR incident report **must be** completed under the cause group 'Prevent'.

14.6 If the concern relates to a member of ERS Medical, ERS Medical 's Human Resources (HR) Department must be contacted for advice and support following a discussion between the relevant Senior Manager and Safeguarding Professional. Any internal processes or forms of investigation will be deferred if a Police investigation is in progress to ensure there is no risk of compromising criminal proceedings.

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15. Information Sharing

15.1 ERS Medical 's Confidentiality and Information Sharing, Safeguarding Children and Safeguarding Adults Policies support ERS Medical to share information relating to children and adults where there are safeguarding concerns.

16. Training Requirements

16.1 Prevent awareness training is mandatory for all staff, at a basic awareness level for all non- clinical staff and a face-to-face WRAP3 course for all clinical staff. All staff must also undertake an annual Prevent refresher.

16.2 Please refer to the Training Prospectus for details on all Prevent training requirements.

17. Supporting References

CQC (2015) Statement on CQC's roles and responsibilities for safeguarding children and adults, London: Care Quality Commission.

- Home Office (2015) Counter Terrorism and Security Act 2015, London: TSO;
- Home Office (2011) Prevent Strategy, London: TSO;
- Home Office (2000) Terrorism Act 2000, London: TSO;
- NHS Health Care Organisation (2014) Prevent Strategy and Policy.

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Question 1.10.8

Patient protection

Please describe how the service will ensure patients are protected from abuse and avoidable harm.

The Bidder has clearly demonstrated they have systems in place to ensure patients are protected from abuse or avoidable harm – Pass

The Bidder has failed to demonstrate they have appropriate systems in place to ensure patients are protected from abuse and / or avoidable harm - Fail

All ERS Medical staff (patient facing and support staff) are required to have a DBS prior to employment. This DBS is then renewed every 3 years. Patient facing staff receive the enhanced DBS check.

All staff who show a DBS with a marker on it are then risk assessed and if required boarded for further risk management, before they are either allowed to become patient facing or return to patient facing duties.

All staff receive either level 2 or level 3 safeguarding training in compliance with both ERS Medical training policy and the safeguarding intercollegiate documents. This training is provided as part of their initial training and annually as part of their face to face update CPD.

ERS Medical continually monitors its compliance systems for safeguarding incidents, whistleblowing from staff, complaints and patient surveys to ensure that we maintain the highest standards possible.

All staff have an annual appraisal, which is also linked to a formal review of our compliance systems to make sure that there are no trends of poor behaviour and or performance with staff. If this is identified additional actions can then be put in place dependent on if the identified issues is one of conduct or capability.

All new staff must complete a minimum 6-month probation period, in which time they are supported and mentored and if required provided with additional support and training. Probation periods can be extended if required and if no significant improvements are made, staff can and have been manged out of the service.

Safeguarding

Safeguarding concerns relate to potentially abusive situations where others, who are providing care (paid, or unpaid) may be neglecting a patient, or causing physical harm, through their actions, or through their failure to act to keep a patient safe.

Observations about the condition of adults or children in the household might suggest risk (e.g. living in an environment where domestic violence has taken place or carers suffering from a mental health crisis or substance misuse). Staff may observe hazards in the home or find signs of distress shown by others in the home. These may alert ERS Medical staff to potential abuse or patient's in need of safeguarding to avoid suffering harm.

Ambulance staff may often be the first or only professionals on scene and the actions taken and accurate recording of information may be crucial to subsequent enquiries.

Forms of abuse can include but not be limited to:-

- Physical Abuse
- Domestic Abuse
- Sexual Abuse
- Psychological Abuse
- Financial or Material Abuse
- Modern Slavery and Human Trafficking
- Discriminatory Abuse
- Organisational Abuse
- Neglect and Acts of Omissions
- Self Neglect
- Mental Health
- Forced Marriages (Honour Abuse)
- Female Genital Mutilation (FGM)

All staff receive either level 2 or level 3 safeguarding training in compliance with both ERS Medical training policy and the safeguarding intercollegiate documents to ensure they can recognise what abuse may look like. This training is provided as part of their initial training and annually as part of their face to face Continuous Professional Development (CPD).

All staff are trained to have a heightened index of suspicion if they encounter the following patterns of injuries, although they are also trained to note that the presence of these types of injuries does not confirm that there is a safeguarding issue:-

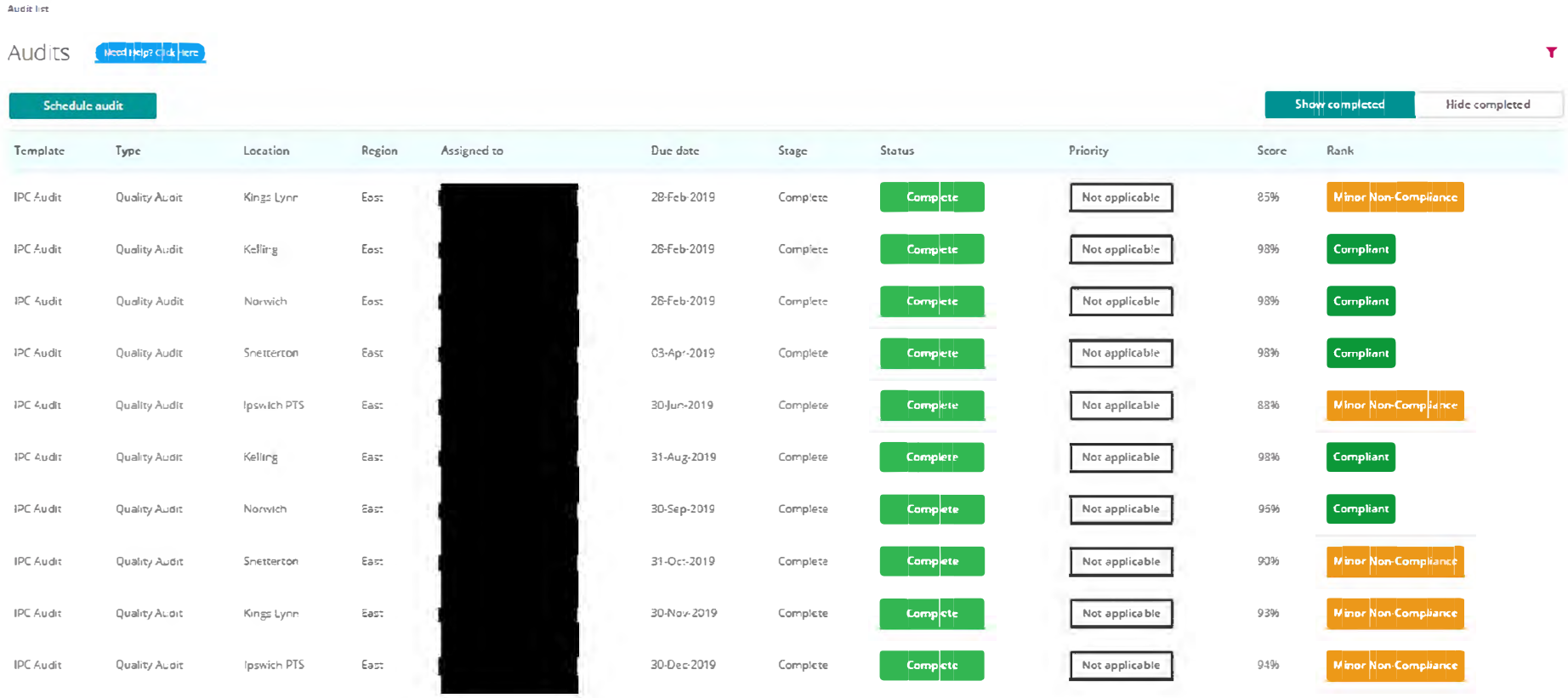
- Abnormal Bruising/Injuries
- Any Groin, Anal or Genital Injury
- Bite Patterns
- Black Eye
- Bruises
- Burn Marks
- Cigarette Burns
- Delayed Admission to Hospital
- Different Stages of Bruising
- Scalds with Inconsistent History
- Suspicious Patterns of Bruising
- Torn Frenulum
- Uncharacteristic Parental Response

If the vulnerable person is deemed at immediate risk, then the Police will be contacted without delay and it may be necessary to transport the vulnerable person to the nearest A&E department. If Police assistance is required then crews will either stay on the scene or near the scene, until the Police arrive without putting themselves or others at risk.

Whether at immediate risk or not, a safeguarding referral will be made through our 24/7 Call Centre, and all referral forms completed accordingly. The Call Centre will action the referral immediately by phone, using the ERS Medical Safeguarding Social Services Index to identify which Social Services Team (SST) needs to be contacted.

The CCO call handler will then raise a safeguarding incident on the our compliance system, [redacted] incident log, detailing all the information they have captured on the Call Centre Safeguarding Referral Form and this is investigated by our Care Standards Team.

1.10.11


Audit list
Audits
Need Help? Click Here
Schedule audit
Show completed
Hide completed
Template Type Location Region Assigned to Due date Stage Status Priority Score Rank
IPC Audit Quality Audit Kings Lynn East [redacted] 28-Feb-2019 Complete Complete Not applicable 85% Minor Non-Compliance
IPC Audit Quality Audit Kelling East 28-Feb-2019 Complete Complete Not applicable 98% Compliant
IPC Audit Quality Audit Norwich East 28-Feb-2019 Complete Complete Not applicable 98% Compliant
IPC Audit Quality Audit Snetterton East 03-Apr-2019 Complete Complete Not applicable 98% Compliant
IPC Audit Quality Audit Ipswich PTS East 30-Jun-2019 Complete Complete Not applicable 88% Minor Non-Compliance
IPC Audit Quality Audit Kelling East 31-Aug-2019 Complete Complete Not applicable 98% Compliant
IPC Audit Quality Audit Norwich East 30-Sep-2019 Complete Complete Not applicable 95% Compliant
IPC Audit Quality Audit Snetterton East 31-Oct-2019 Complete Complete Not applicable 90% Minor Non-Compliance
IPC Audit Quality Audit Kings Lynn East 30-Nov-2019 Complete Complete Not applicable 93% Minor Non-Compliance
IPC Audit Quality Audit Ipswich PTS East 30-Dec-2019 Complete Complete Not applicable 94% Minor Non-Compliance

BMS/6.03 Infection Prevention and Control (IPC)

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1.1	All	All	All	13.04.18	*** REDACTED ***	Addition of review date
2.0	All	All	All	19.11.18	*** REDACTED ***	Annual Review and Addition of Capacity & Consent Section
3.0	All	All	All	14.11.19	*** REDACTED ***	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
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3. External Guidance Publications

- Health and Social Care Act 2015;
- The Mental Health Act 2005;
- The Mental Capacity Act 2019;
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12;
- Health and Safety at Work Act 1974;
- Control of Substances Hazardous to Health 2002 Regulations;
- NICE Guidelines;
- Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.

4. Introduction

4.1 This procedure has been written to protect ERS Medical staff, sub-contractors providing services on behalf of ERS Medical, patients and visitors by minimising the risks and likelihood of the transmission of infectious pathogens and micro-organisms.

4.2 The National Institute for Health and Care Excellence (NICE) quality standards are central to supporting the Government's vision for an NHS and social care system that is focused on delivering the best possible outcomes for people who use services, as detailed in The Health and Social Care Act; code of practice on the prevention and control of infections and related guidance in 2008.This Act relates to all health care providers and is used by the Care Quality Commission to assess compliance with the registration requirements on “cleanliness and infection prevention and control”.

4.3 The Code of Practice and related guidance sets out how the Care Quality Commission (CQC) will assess compliance with the registration requirement. This procedure provides the best evidence-based practice and available legislation to enable the delivery of safe practices within ERS Medical.

4.4 Infection prevention and control is based on the use of practices and procedures which prevent or reduce the risk of infection from being transmitted from a source of infection.

4.5 These sources can include a person, contaminated body fluids, equipment, the environment, other patients, staff members, healthcare workers or members of the public.

4.6 The information and practices outlined in this procedure are evidence-based or in line with current national guidelines, legislation or regulations. Where evidence is not available, consensus opinion from specialist professionals is used.

4.7 ERS Medical recognises that good infection prevention and control measures are essential to ensure that people who use health care services receive safe and effective care.

4.8 Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of infection prevention and control are developed and maintained.

4.9 ERS Medical will monitor the effectiveness of the policy and procedures via audit and reporting to the Governance and Patient Safety Committees (GaPS) including the UK Leadership Team.

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4.10 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.11 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to ERS Medical's Care and Treatment Policy.

5.2 Please refer to ERS Medical's Quality, Environmental, Safety and Health Policy.

5.3 Please refer to ERS Medical's Information Security Policy.

5.4 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director (IPC Lead) & Head of Care Standards**	Have responsibility to ensure that the appropriate Infection Prevention and control policy is used in everyday practice, to reduce infection risk and promote patient and staff safety. Ensure compliance with the Health and Social Care Act 2008, Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. Cooperate and assist with the implementation of this policy. Bring to the notice of management, at all levels problems and failings associated with the application of this procedure. Has the responsibility of chairing the PSC committee meetings and ensuring that IPC is an agenda item and that all IPC incidents and trends are monitored, reviewed and recommendations made.
6.4	**Regional and Operations Managers**	Are responsible for the implementation and co-ordination of Infection control process at a site level.
6.5	**Care Standards Team**	Are responsible for providing advice and support to all operational sites on matters relating to IPC. Additionally, they are responsible for conducting internal IPC audits and inspections and for the forward reporting of these to the Head of Care Standards.
6.6	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

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7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address

8. Definitions

8.1 **Contagious Period** – Is the period of time during which a contracted disease can be spread, either through direct or indirect contact from one person to another.

8.2 **Communicable Diseases** – Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms **infectious** and contagious are also used to describe communicable disease.

8.3 **Formite(s)** – Any object or substance that is capable of carrying and infectious organism, such as germs or parasites and transferring them from one individual to another. This could include, but not be limited to:

- Clothing;
- Watches;
- Bedding;
- Hair;
- Medical equipment.

8.4 **Hepatitis B Core Antibody (HBcAb)** – The HbcAb is an antibody that is part of the virus – it does not provide protection. A "positive" or "reactive" HBcAb (or anti-HBc) test result indicates a past or present infection, but it could also be a false positive. The interpretation of this test result depends on the results of the other two tests. Its appearance with the protective surface antibody (positive HBsAb or anti-HBs) indicates prior infection and recovery. For chronically infected persons, it will usually appear with the virus (positive HBsAg).

8.5 **Hepatitis B Surface Antibody (HBsAb)** – A "positive" or "reactive" HBsAb (or anti-HBs) test result indicates that a person has successfully responded to the hepatitis B vaccine or has recovered from an acute hepatitis B infection. This result means that you are immune to future hepatitis B infection and you are not contagious. This test is not routinely included in blood bank screenings.

8.6 **Incubation Period** – The period of time that passes between the initial exposure to a disease or infection and the appearance of the signs and symptoms of the disease.

8.7 **Outbreak** – An outbreak is said to have occurred where the number of cases of an infectious or communicable disease is greater than the number expected over a given period or two or more cases are linked by epidemiological, clinical or microbiological features.

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8.8 **Reservoir** – Any person, animal, plant, soil or substance in which an infectious agent normally multiplies.

8.9 **SHARPS** – A medical sharp is defined as being an object or instrument necessary for the exercise of specific health care activities which is able to cut, prick or cause injury. This would include equipment such as needles, scalpels and other articles found in a healthcare setting capable of breaking the skin barrier.

8.10 **Vector(s)** – A carrier of diseases such flying and biting insects and animals, such as a mosquito, which is a vector for malaria

9. Occupational Health Services

9.1 Wherever and whenever there is deemed a requirement, which could include a staff referral to occupational health services or the provision of advice from occupational health services, all such contact should be made, through and in consultation with ERS Medical's HR Department.

9.2 Details on all Occupational Health provisions can be found at **BMS/2.03** – **Employee Health and Wellbeing**.

10. Training and Supervision

10.1 All staff involved in the delivery of health care will have sufficient and appropriate infection prevention and control training.

10.2 All staff will undertake infection prevention and control training on induction and on an annual basis.

10.3 All training will be recorded in accordance with the requirements of **BMS/2.02** – **Personal Development and Training**.

11. The Spread of Infection

11.1 One feature that distinguishes infections is that they can be transmitted and spread. There are various means by which micro-organisms can be transferred or transmitted. The means of spreading infections are classified as:

- **Direct Contact** – Direct spread of infection occurs when one person infects the next by direct person-to-person contact (e.g. chickenpox, tuberculosis, sexually transmitted infections). Hands of healthcare workers are probably the most important vehicles of cross-infection. The hands of residents can also carry microbes to other body sites, equipment and staff;
- **Indirect Contact** – Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogens e.g. fomite or vector.

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11.2 A fomite is defined as an object, which becomes contaminated with infected organisms and which subsequently transmits those organisms to another person. Examples of potential fomites are:

- Vomit Bowls;
- Steering wheels & door handles;
- Gear sticks & handbrakes;
- Trolleys;
- Carrychairs;
- Wheelchairs
- Or any inanimate object that may incur either direct or indirect patient contact.

11.3 A vector can be a crawling or flying insects which transmits or transfers an infection. Insect bites may cause infections such as malaria in areas where malaria carrying mosquitoes live.

Routes of Infection

11.4 There are numerous methods of infections entering the human body such as:

- **Inhalation** – Inhalation spread occurs when pathogens are exhaled or discharged into the atmosphere by an infected person. These are then inhaled by another person and potentially cause an infection. The common cold and influenza are examples, but it is likely that hands and fomites (inanimate objects) are also important in the spread of respiratory viruses;
- **Ingestion** – Infection can occur when organisms capable of infecting the gastro-intestinal tract are ingested. When these organisms are excreted faecally by an infected person, faecal/oral spread is said to occur. Organisms may be carried on fomites, hands or in food and drink e.g. Hepatitis A, Salmonella, Campylobacter;
- **Inoculation** – Inoculation infection can occur following an injury with a sharp instrument when a micro-organism for example, Hepatitis B virus, can be directly inoculated into the blood stream of the person receiving the injury. Human, animal and insect bites can also spread infection by the inoculation mode;
- **Absorption –** Infections can enter into the bloodstream by absorption through the skin. This can occur in locations where there are mucus membranes, such as the mouth and gums and where there is a break in the integrity of the skin due to open wounds such as cuts and abrasions.

The Chain of Infection

11.5 The chain of infection provides an overview of the process by which an infection can be acquired. The characteristics of each link show how organisms are transferred.

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11.6 Breaking the link or cycle is necessary to prevent the spread of any infection.

The chain of infection can be broken by either:

- Eradicating the source of infection through appropriate antimicrobial therapy;
- Preventing the method of spread through hand washing, hygiene, disposal of waste, decontamination of equipment;
- Protecting the individual at risk by immunisation;
- Preventing microbes from entering the body by wearing protective clothing;
- Using an aseptic technique when handling invasive devices, covering wounds and insertion sites with sterile dressings.

11.7 Some diseases are infectious before any signs or symptoms develop, such as chickenpox. Some infections may not show any signs or symptoms for long periods after the initial exposure, such as hepatitis B or HIV.

11.8 Some people may be carriers without developing the infection themselves, e.g. salmonella or MRSA. For this reason, it is important that everyone carries out standard precautions at all times, regardless of whether staff are aware that infection is present or suspected

12. Healthcare Associated Infections (HCAI)

12.1 Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a health/social care setting. The term HCAI covers a wide range of infections. The most well-known include those caused by:

- Methicillin-Resistant Staphylococcus Aureus (MRSA);
- Methicillin -Sensitive Staphylococcus aureus (MSSA);
- Clostridium Difficile (C. Difficile);
- Escherichia coli (E. coli).

12.2 HCAI's cover any infection contracted:

- As a direct result of treatment in, or contact with, a health or social care setting;
- As a result of healthcare delivered in the community;
- Outside a healthcare setting (for example, in the community) and brought in by patients, staff or visitors and transmitted to others (for example, Norovirus).

12.3 HCAI's pose a serious risk to patients, staff and visitors, they can incur significant costs for health and social care provision, causing significant morbidity to those infected. As a result, infection prevention and control protocols are a key priority for the all healthcare providers.

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13. IPC Structure

13.1 ERS Medical has established a structure to define, support and review all matters relating to IPC. This structure is defined on the organisational chart on page 12 of this procedure.

13.2 Regional PSC's will monitor IPC incidents and near misses, through the IPC structure and make recommendations, back through the IPC structure and up to Senior Management as required.

13.3 Care Standards Team will be responsible for providing guidance and advice to ERS Medical Operations on all matters relating to infection prevention and control, this will also include the identification, or any remedial actions required.

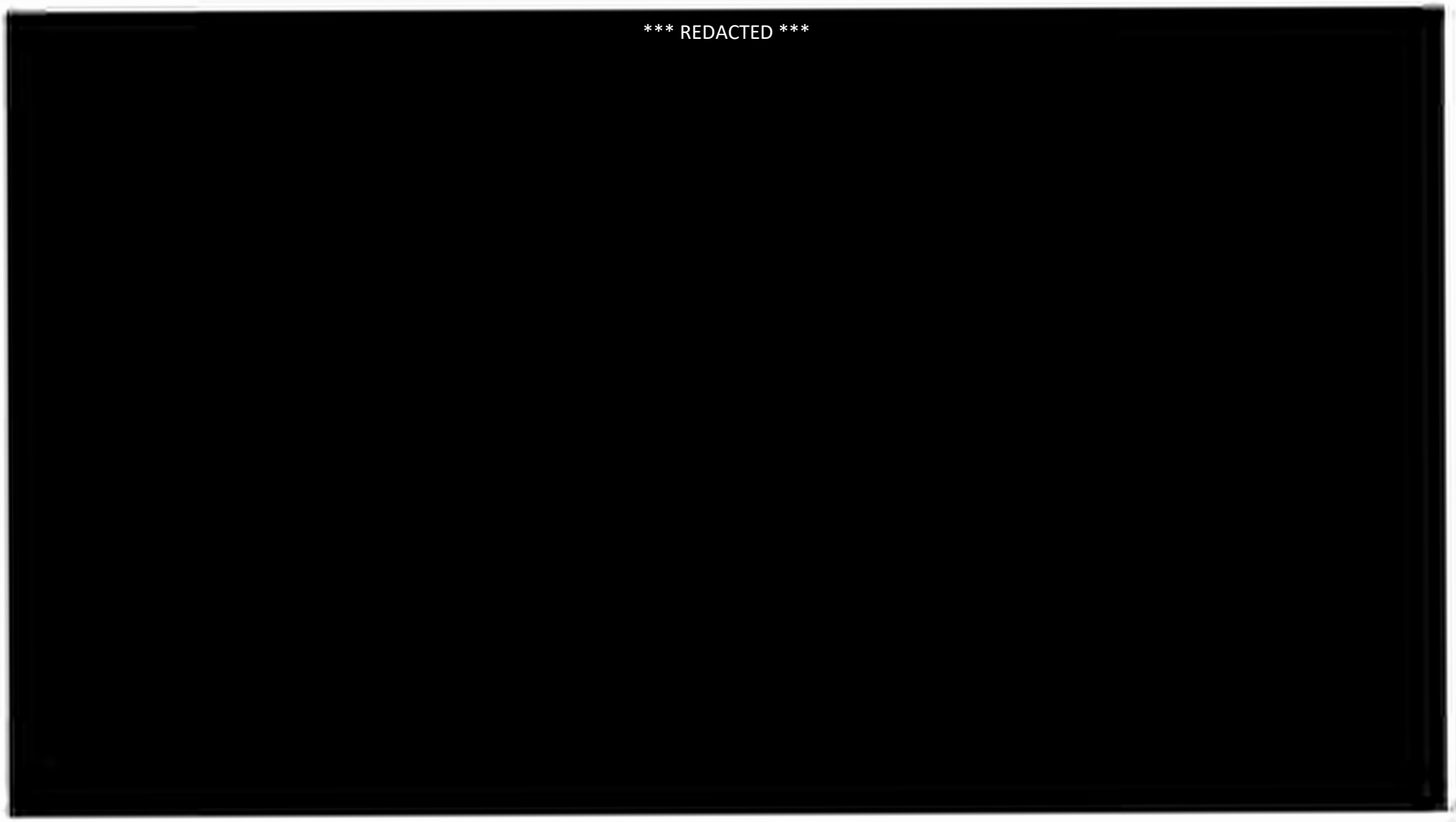
13.4 In addition to this they will be responsible for both auditing and inspecting site facilities, ambulances, specialist services (Mental Health) secure vehicles and crews for compliance with the requirements of this procedure and its associated work instructions and forms.

13.5 On completion of any inspection or audit they will forward the report details to the Care Quality Manager. They will be responsible for compiling the information, identifying trends and forward reporting their findings to senior managers, through the Head of Care and Medical Director.

13.6 All site managers must ensure that a copy of the IPC structure is displayed prominently at their site.

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ERS Medical IPC Structure



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14. Standard Precautions

14.1 Standard IPC precautions will be formally detailed within the three work instructions related to this procedure. These precautions will include, but not be limited to:

- Hand Hygiene (See ERS Medical A Hand-washing technique with soap and water);
- Personal Protective Equipment (PPE) - (gloves, aprons, facemasks, goggles);
- Safe handling of waste;
- Safe handling of soiled linen;
- Bare below the elbow uniform policy;
- Environmental management.

14.2 The main purpose of IPC standard precautions is to minimise contact with blood and bodily fluids by ensuring safe working practices, protective barriers and a safe working environment.

14.3 The National Institute of Health and Care Excellence (NICE), 2012 guidance for clinical workers details standard precautions as follows (epic3: Guidelines):

- Apply good basic hygiene practices with regular hand decontamination;
- The safeguard the health and safety of all patients it is essential that good working practices are adopted at all times. This involves careful handling of all blood and body fluids from all patients, regardless of whether a risk of infection has been identified or not;
- Cover existing wounds or skin lesions with waterproof dressings;
- Appropriate personal protective clothing, e.g. disposable gloves and plastic aprons must be available and worn when in contact with blood and body fluids. Eye protection and or face protection must also be worn if splashing is anticipated;
- Protect the mucous membranes of eyes, nose and mouth from blood splashes;
- Health care workers should treat all blood/body fluids as potentially infectious;
- Hand washing and or alcohol hand gel should take place before and after all patient contacts;
- SHARPS MUST NOT be re-sheathed or recapped, but must be placed directly into an approved SHARPS container **BY THE USER**;
- Infectious/ offensive waste must be transported and disposed of appropriately;
- All blood spillage must be disinfected immediately with hypo-chlorite granules or solution (spill packs), (ERS Medical has made the decision to use high level disinfectants for this purpose).

14.4 Additional precautions may be necessary for specific infections, and guidance will be provided by the Infection Prevention and Control Lead or Public Health England (PHE).

14.5 Guidance at a glance for standard precautions are available at Annex B to this procedure

15. SHARPS Safety

15.1 SHARPS injuries can occur when anyone comes into contact with a sharp instrument previously used on a patient.

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15.2 ERS Medical has a responsibility to suitably manage and control the risk, through risk assessments, training and the application of industry standard SHARPS safety protocols, with the aim of reducing the risks of a SHARPS injury to its employees, patient's, other health care professionals and escorts.

15.3 Due to the high degree of risk of a sharp's injury ERS Medical has made the decision to use safety cannulas and needles.

15.4 SHARPS injuries are more likely to occur:

- During use;
- After use, prior to disposal;
- Between steps in procedures;
- During disposal;
- While re-sheathing or recapping needles.

15.5 Some clinical procedures have a higher risk of SHARPS injury, such as:

- IV Cannulation;
- Intramuscular hypodermic needle and syringe usage;
- Phlebotomy.

15.6 In addition to these higher risk medical procedures, SHARPS injuries can also occur when using or being exposed to:

- Lancets;
- Scalpels;
- Razors;
- Scissors;
- Fragments of bone;
- Teeth.

SHARPS Standard Safety Precautions (Do's and Don'ts)

15.7 When handling or dealing with SHARPS **DO**:

- Dispose of SHARPS in an approved SHARPS container (see figure 1);
- Keep an approved SHARPS container to hand when carrying out procedures that involve SHARPS;
- Dispose of SHARPS as soon as reasonably practicable;
- Always plan a means of disposal prior to any procedure that involves SHARPS;
- Always bring the SHARPS container to the sharp;
- Final Close all SHARPS containers when ¾ full;
- Complete the final closure label on the SHARPS container (see figure 2);
- Wear appropriate PPE as required;
- Record and report all SHARPS injuries and near misses.

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15.8 When handling or dealing with SHARPS **DO NOT**:

- Recap or re-sheath needles;
- Bend or manipulate needles;
- Leave SHARPS unattended;
- Dispose of SHARPS in any location other than an approved SHARPS container;
- Bring SHARPS to the container when ready for disposal;
- Use a sharp for any purpose other than what is has been designed to do.



Figure 1: Typical Approved SHARPS Containers

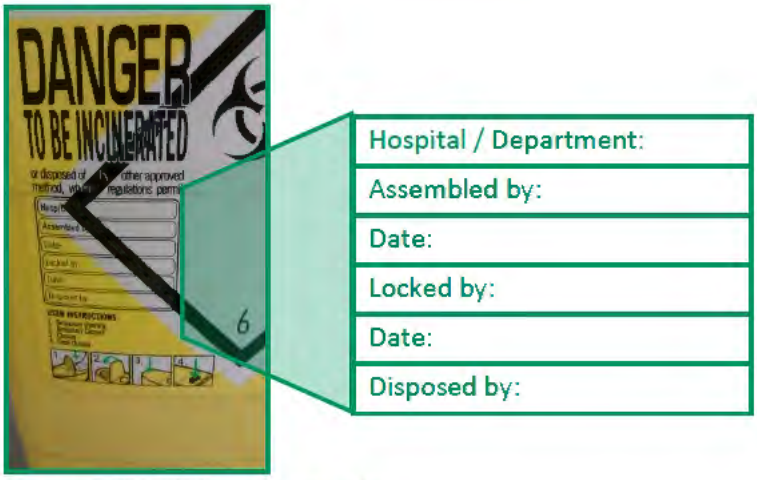


Figure 2: SHARPS container label

16. SHARPS Storage and Disposal

16.1 All used SHARPS are classified as clinical waste and therefore should be treated as such. In addition to this, due to their potential to cause injury and serious ill health, they are afforded a higher level of protection (SHARPS containers) in their waste management.

16.2 It is the responsibility of all clinicians who use SHARPS to ensure that they are used, are disposed of in the appropriate and authorised SHARPS container.

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16.3 All SHARPS containers will have its storage and usage information entered on the exterior label along with the date that it was first placed in their housing.

16.4 All SHARPS containers should be disposed of, as clinical waste, either when the contents reach the fill level indicator (3/4 full) of after 3 months if this level is not reached.

16.5 Under **NO** circumstances should items be removed or attempted to be removed once placed inside a SHARPS container.

16.6 Once either the ¾ level or the 3-month period has been reached the SHARPS container should be:

- Removed from the housing;
- Closed and secured;
- The closing details on the exterior label completed (see figure 2);
- The SHARPS container is then to be placed inside a large clinical waste bin at an ERS Medical site (see figure 3);
- Under **NO** circumstances should a SHARPS container be left at the side or on top of a clinical waste bin.



Figure 3: Typical Clinical Waste Bins

16.7 Guidance at a glance for the safe handling and disposal of SHARPS are available at Annex B to this procedure.

17. Managing Exposure

17.1 In the event of a SHARPS exposure incident, where exposure of blood or other bodily fluids has occurred immediate action must be taken. It will include:

- Immediate first aid;
- Reporting the exposure incident;
- Information about the source patient;
- Information about the exposed person;
- Supporting Staff;
- The prevention of further incidents.

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Immediate First Aid

- If the mouth or eyes are involved, they should be washed thoroughly with water;
- If the skin is punctured, free bleeding should be gentle encouraged and the wound washed with soap and water, **but not scrubbed or sucked**.
- If there is a possibility of HIV exposure, urgent advice should be sought about the relative indications for anti-retroviral post-exposure prophylaxis.

Reporting Exposure Incidents

17.2 After completing the initial first aid for an exposure incident, it should immediately be reported to the staff member's line manager or control room/helpdesk.

17.3 Staff will be required to proceed to their nearest Accident and Emergency (A&E) Department for initial health screening. They will be required to provide:

- The date and time of incident;
- The procedure that was being performed, if any, at the time of the incident;
- What immediate actions they took directly after the exposure incident;
- A blood sample to be sent to virology or microbiology lab for storage. (There may be no need to analyse the serum immediately unless there is reason to believe the exposed person may already be infected).

17.4 All exposure incidents, including near misses should be reported in accordance with the requirements of **BMS/5.01 – Incident Reporting and Investigation**.

Source Patient information

17.5 When a SHARPS exposure incident does occur, the crew should (were possible), ensure that they have the details of the source patient when reporting to their nearest A&E department.

17.6 This information will include but not be limited to:

- Patient Name;
- Patient's infectious status (if known);
- Patient's location (ward, department and or present location).

Staff Information

17.7 In addition to providing information about the source patient, the A&E department will require information relating to the exposed member of staff, such as their Hepatitis B immune status:

- Unvaccinated;
- One, two or three or more doses of hepatitis B vaccine;
- Most recent HBsAb result and date;
- HBcAb positive (natural immunity).

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Supporting Staff – Employee Assistance Programme

17.8 Once the initial management of an exposure incident has been completed, the exposed person may require additional support. This support can come from various departments and agencies both from within and outside of the Company, such as, but not limited to:

- **Immediate Line Managers**: Provide time and understanding to the exposed person to allow them to come to terms with the emotional shock and stress, that can often follow these types of incidents;
- **Human Resources**: The facilitation on Occupational Health Services in support of post exposure protocols, such as on-going health screening and counselling and support services;
- **Health and Safety Team and Care Quality Team**: Additional training may be required to help ensure that such an incident does not occur again.

17.9 Staff will also be required to observe their wound for signs of infection and inflammation and either consult their GP or request a referral back through Occupational Health.

Prevention of Further Incidents

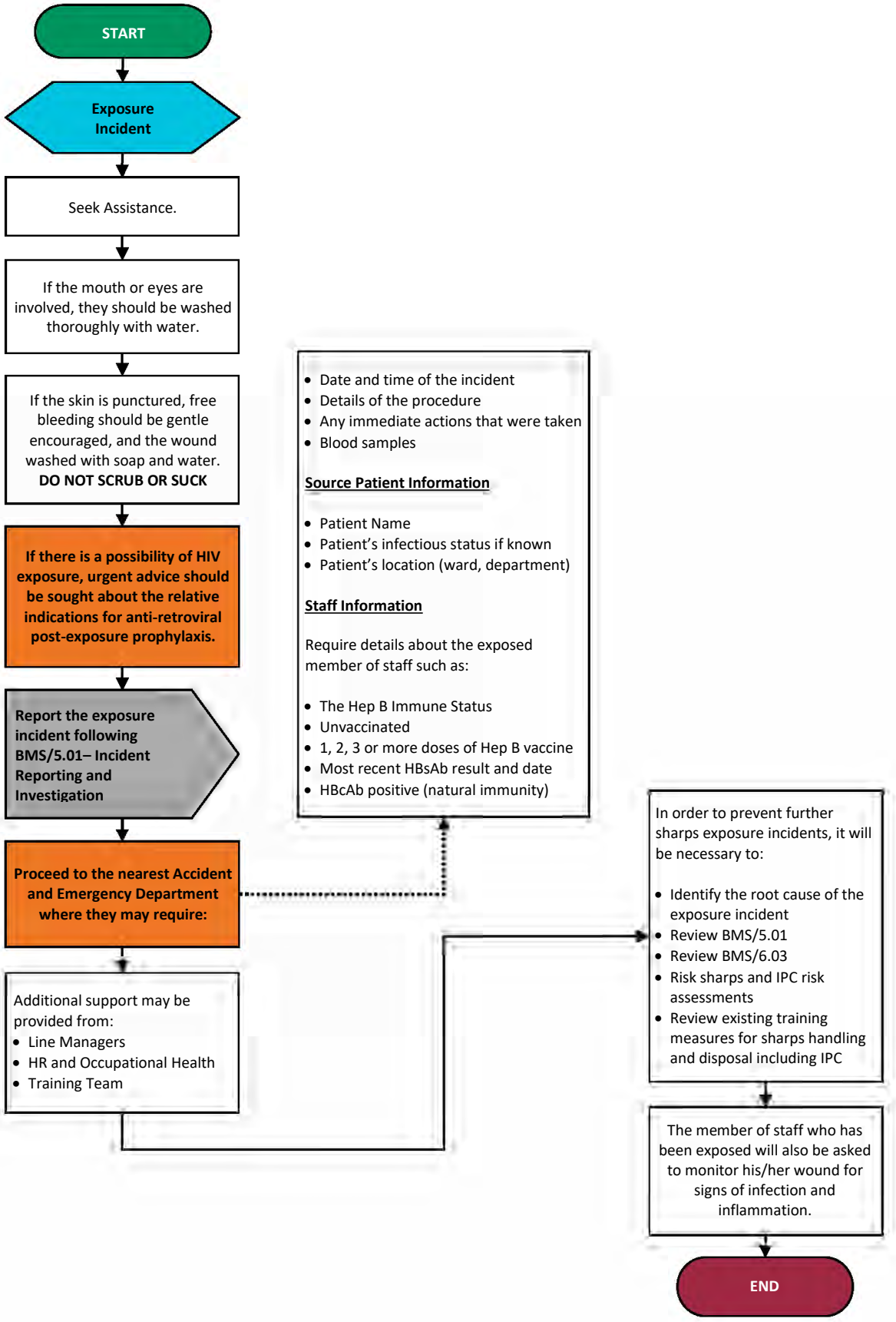
17.10 As a result of any exposure incident and its subsequent investigation, which will be required to determine the root cause, it may be necessary to review all Company SHARPS procedures, with the view to drive improvement and prevent further incidents.

17.11 This review will include, but not be limited to:

- A procedural review of **BMS/6.03** – **Infection Prevention and Control (IPC)** and its related documents;
- Review risk assessments for SHARPS;
- Review of existing training to determine if additional emphasis, resources are resources are required or to train out newly identified SHARPS procedures.

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18. Key Steps



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19. Communicable and Infectious Diseases

19.1 Outbreaks of communicable diseases can develop over the period of days or weeks, whilst other types of outbreaks can develop within hours.

19.2 The differing nature of these outbreaks will significantly dictate the response from ERS Medical and the health service as a whole. It may lead to a significant increase in the number of patient's being admitted into hospital, which in turn could also see an increase in either discharges or inter hospital/healthcare facility transfers.

19.3 It will remain the primary responsibility of the commissioner of patient transport, in the case of non-emergency and or high dependency, for the notification and initial management protocols for patients diagnosed or suspected of having a communicable or infectious disease.

19.4 ERS Medical will adhere to all established protocols, where practicable to do so in the pre-hospital environment. However, it will remain the responsibility to the commissioner for the original transport request to ensure that:

- The receiving facility has received a full handover of the patient's infectious status;
- The receiving facility is ready and prepared for the arrival of the patient at the time of collection;
- To fully brief ERS Medical crews of any changes to the patient's condition or infectious status since the time of booking;
- To determine the suitability of the patient to travel either alone or with other patient's, based on their current infectious status and or the medical conditions of other patients travelling.

Staff Illness

19.5 When and where ERS Medical staff become ill with a diagnosed or suspected communicable & infectious disease they must inform their line managers immediately and be withdrawn from all duties until such time as there is no risk of transferring the infection to others.

19.6 This could include, but not be limited to diseases such as:

- Skin infections or exposed areas of infestation;
- Severe respiratory diseases such as influenza, viral pneumonia and TB, but excluding self-limiting viral infections such as the common cold;
- Diarrhoea;
- Vomiting;
- Jaundice;
- Hepatitis;
- Chicken Pox;
- Measles;
- Meningitis;
- Mumps;
- Rubella;
- Scarlet Fever.

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19.7 Line Managers should immediately seek specialist clinical advice from the Company's Occupational Health provider if a member of staff notifies them of any infectious disease listed or not listed at point 17.6 for clarification of contagious periods.

19.8 The table below has been created to provide an initial guide to Managers for the management of the more common infections and diseases that ambulance crews will be exposed to.

Disease / Condition	Comments
Chicken Pox:	Incubation period: 1–3 Weeks Contagious Period: 1-2 days before the rash appears, until all the blisters have crusted over, this can take from 5-6 days from the start of the rash.
Clostridium Difficile (*c-diff*):	Incubation Period: Unknown, although it could be as short as 7 days. Staff should be symptom free for a minimum period of 48 hours before returning to work.
Diarrhoea:	Incubation period depends on the type of illness. Staff should be symptom free for a minimum period of 48 Hours before returning to work.
Influenza:	Incubation period: 1-3 Days. Contagious Period: 1 day prior to the onset of symptoms and on average for a further 5-7 days after the illness onset.
Measles:	Incubation Period: 10-12 Days with a further 2-4 days before the rash appears. Contagious Period: 4 Days prior to the rash appearing and another 4 days after the rash has appeared.
Meningitis:	Incubation Period: 2-10 Days with an average of 4 Days.
Mumps:	Incubation Period: 12-25 Days with an average of 17 Days. Contagious Period: Approximately 7 days before the onset of symptoms and a further 8 days after symptoms start.
Norovirus:	Incubation Period: 1-3 Days. Contagious Period: You can be contagious during the same 1-3 days as the incubation period. You should be symptom clear for a minimum period of 48 hours prior to returning to work.
Rubella (German Measles):	Incubation Period: 14-21 Days. Contagious Period: From 1 week until 4 days before the rash appears.
Shingles:	As shingles is very closely related to the chicken pox virus (herpes-zoster virus) its incubation and contagious periods are also very similar.
Vomiting:	Incubation period depends on the type of illness. Staff should be symptom free for a minimum period of 48 Hours before returning to work.

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20. Notifiable Infectious Diseases

20.1 ERS Medical does not assume any responsibility for the notification of infectious diseases in relation to the patients that it provides care, treatment and transportation. This responsibility rests with other healthcare providers such as: acute hospitals, GP's etc.

20.2 It will remain the responsibility of the individual patients attending medical practitioner to notify these agencies of any notifiable disease, in line with their responsibilities laid out in the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010.

20.3 If a member of staff either suspects or has been diagnosed as contracting a notifiable disease, they should always follow the guidance provided by their medical practitioner and notify their line manager as soon as practicable to do so.

20.4 Line managers should immediately make contact, through Human Resource, with the Company's Occupational Health Provider for specialist advice for any further actions or reporting that may be required.

20.5 For information purposes only a list of notifiable diseases is available at Annex A of this procedure.

21. Infection Prevention and Control - People

21.1 All IPC processes, not covered in this procedure, relating to individuals be they staff, patient, carers, other healthcare professional or members of the public will be detailed within **WI/6.03.01** – **Infection Prevention and Control – People**.

21.2 This work instruction will include the processes for managing, but not be limited to:

- Hand Hygiene;
- Personal Protective Equipment (PPE);
- Aseptic Techniques;
- Uniform and Dress Code;
- Bare Below the Elbow Policy;
- Uniform Compliance Inspections.

22. Infection Prevention and Control – Ambulances and Medical Equipment

22.1 All IPC processes, not covered in this procedure, relating to ambulances, medical equipment and medical devices will be detailed within **WI/6.03.02** – **Infection Prevention and Control – Ambulances, Medical Equipment & Devices**.

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22.2 This work instruction will include the processes for managing, but not be limited to:

- Single Use Items & Aseptic Techniques;
- Routine Cleaning of Ambulances, Medical Equipment & Devices;
- Decontamination of Ambulances, Medical Equipment & Devices (Deep Clean);
- Use of Disinfectants – The ERS Medical Choice (ChemEx).

23. Infection Prevention and Control – Environmental Management

23.1 All IPC processes, not covered in this procedure, relating to management of any environmental IPC processes will be detailed within **WI/6.03.03** – **Infection Prevention and Control – Environmental Management**.

23.2 This work instruction will include the processes for managing, but not be limited to:

- Clinical Waste;
- Site IPC Stations and MOP Management;
- Site Housekeeping;
- House Keeping Inspections and Audits.

24. IPC Patient Booking Information

24.1 CCO / Helpdesk / Despatch Teams will enquire at the time of initial booking, from the booking facility, the infectious status of any patient where transport is requested.

24.2 They will also gain information on, but not limited to:

- The type of infection present;
- Special provisions in place at the requesting facility such as isolation nursing or care;
- Specific IPC PPE required by the attending crew;
- Is the patient still infectious;
- Do they need to travel alone?

24.3 This information will be passed to the assigned crew in preparation of their arrival at the patient's collection location.

24.4 The attending crew must make contact with the patient's attending healthcare professional and receive and update on the patient's infectious status, prior to any patient contact, to insure that the information is still correct from the time of initial booking.

24.5 They will then take all reasonable actions to maintain the integrity of any IPC measures put in place for the safety of the patient and others.

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24.6 If the Patients IPC status has significantly changed, they should at their earliest opportunity make their despatcher aware of this change, so that CAD can be updated and suitably provisions be made for:

- Informing the receiving facility;
- Their next allocated tasking (this may have to be re-assigned if a deep clean is required).

24.7 For more information about the process please refer to **WI/6.08.07 - CAD Bookings**

25. IPC Risk Assessment

25.1 Infection prevention and control risks will be assessed by the Care Quality Team and recorded on **F1.07.05 – Health and Safety Risk Assessment**.

25.2 This risk assessment will be authorised by the Head of Care Standards and published to the Care Quality Teams SharePoint area.

25.3 The risk assessment will be reviewed annually or as below, but not limited by:

- As a result of an incident investigation;
- Changes to industry standard IPC processes;
- As a result of an internal audit;
- As a result of an external audit;
- As a result of inspection from the CQC;
- As a result, in changes to ERS Medical procedures.

26. IPC Annual Statement

26.1 ERS Medical will publish an annual IPC statement every January detailing its commitment to maintaining IPC standards across the business.

26.2 This IPC statement will be written and signed off by the Company IPC Lead, distributed to all ERS Medical sites and published to the Care Teams SteriPoint point page for access by all staff.

26.3 The statement will also be available to customers and potential customers on request. All received request will be staffed through the Care Quality Manager.

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27. IPC Annex's

27.1 For more detailed information on certain specific IPC requirements or just for general information please refer to the appropriate IPC Annex at the end of this procedure.

27.2 This information will include guidance at a glance and information on the more common types of patient infectious pathogens for:

- **Annex A** – Notifiable Disease;
- **Annex B** – Standard Precautions;
- **Annex C** – Chain of Infection
- **Annex D** – Aseptic Techniques
- **Annex E** – Safe Handling and Disposal of SHARPS;
- **Annex F** – Clostridium Difficile (c-Diff);
- **Annex G** – MRSA;
- **Annex H** – Norovirus.

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Annex A – Notifiable Diseases

Notifiable Disease	England	Northern Ireland	Scotland	Wales
Anthrax	✓	✓	✓	✓
Botulism	✓		✓	✓
Brucellosis	✓		✓	✓
Chicken Pox		✓		
Cholera	✓	✓	✓	✓
Clinical Syndrome due to *Escherichia Coli* 0157 Infection			✓	
Diphtheria	✓	✓	✓	✓
Encephalitis and Meningitis	✓	✓		✓
Enteric Fever (Typhoid or Paratyphoid Fever)	✓	✓	✓	✓
Food Poisoning	✓	✓		✓
Gastroenteritis (<2 years)		✓		
Haemolytic Uraemic Syndrome	✓		✓	✓
Haemophilus Influenza Type B			✓	
Hepatitis A, B & unspecified		✓		
Hepatitis (infectious)	✓			✓
Infectious Bloody Diarrhoea	✓			✓
Invasive Group A Streptococcal Disease	✓			✓
Legionnaires Disease	✓	✓		✓
Leprosy	✓			✓
Leptospirosis		✓		
Malaria	✓			✓
Measles	✓		✓	✓
Meningococcal Disease			✓	
Meningococcal Septicaemia	✓	✓		✓
Mumps	✓	✓	✓	✓
Necrotising Fasciitis			✓	
Plague	✓	✓	✓	✓
Poliomyelitis	✓	✓	✓	✓
Rabies	✓	✓	✓	✓
Relapsing Fever		✓		
Rubella	✓	✓	✓	✓
Scarlet Fever	✓	✓		✓
Severe Acute Respiratory Syndrome (SARS)	✓		✓	✓
Smallpox	✓	✓	✓	✓
Tetanus	✓	✓	✓	✓
Tuberculosis (any site)	✓			✓
Tularaemia			✓	
Typhus	✓			✓
Viral Haemorrhagic Fever	✓	✓	✓	✓

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Annex B – Guidance at a Glance - Standard Precautions

GUIDANCE AT A GLANCE – STANDARD PRECAUTIONS

These guidelines support the prevention and control of infection in the pre-hospital environments such as whilst being treated, cared for and transported within an ambulance. The principles reflect national guidelines and industry best practice.

KEY POINTS

Standard precautions are a range of measures that reduce the risk of transmission of infection from known and unknown sources. They are basic IPC precautions and should be used on all patients.

Your 5 moments for hand hygiene at the point of care*



Hand Hygiene

Effective hand cleaning significantly reduces infection rates. See the WHO 'Five Moments for Hand Hygiene'. Technique is vital – this should cover all areas of the hands including wrists.



Alcohol hand rubs should not be used if the patient has diarrhoea and/or vomiting as they do not work.

Other standards include: keep nails short; no nail varnish / gel / false nails; no stoned rings, no watches / bracelets. Hand washing facilities should be dedicated, of adequate size and supplied with liquid soap and paper towels.

Personal Protective Equipment (PPE)

Consists of gloves, disposable aprons, face and eye protection. What is worn is dependent on the risk assessment to be performed to establish if there is to be contact with blood or other bodily fluids.

No contact with bodily fluids	Contact with uniform or clothing with patient or contaminated equipment.	Contact with bodily fluids + low risk of splashing.	Contact with bodily fluids + high risk of splashing.
↓	↓	↓	↓
No PPE required.	Disposable gloves and disposable apron	Disposable gloves and plastic apron	Disposable gloves and plastic apron plus eye/face protection

PPE must be changed between procedures and patients

Sharps Safety

The following procedures will reduce the risk of injury:

- **YOUR sharps are YOUR responsibility. YOU dispose of them at the point of care;**
- **Never re-sheath or bend razors and other sharp needles prior to disposal;**
- **Use sharps safety devices (EU directive 2013) where available, ensuring staff are suitably trained.**

The BIN

- **Use the temporary closure mechanism between uses to reduce the risk of accidental spillage;**
- **Sign and date the bin on assembly + close when the fill line or 3 month point is reached;**
- **Store the bin out of the reach of children and NOT in direct contact with a heat source;**
- **Take the bin to the sharp, NEVER the sharp to the bin.**

Blood and Bodily Fluids Spillage

'Spill Kit' should be used for a blood or bodily fluid spillage. If you have one wear PPE, mop up excess spill with paper towels, ventilate the area and disinfect with ChemEx products, following the manufacturers guidance on the product label or at the ChemEx station on your ERS Medical site.

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Annex C – Guidance at a Glance – Chain of Infection

GUIDANCE AT A GLANCE – Chain of Infection – Break the Chain!



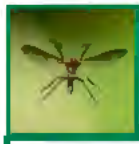
Virus, Bacteria & Fungus

- MRSA
- C-Diff
- Norovirus
- Influenza



Person at Risk

- Susceptible People
- Elderly
- Immuno-Compromised



Examples of Reservoirs/hosts

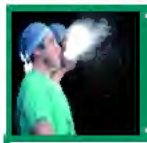
- Humans
- Animals
- Environmental surfaces
- Food / Water





Way into the body

- Break in skin (wound)
- Needle stick injury
- Mucous membranes (mouth, eyes)
- Inhalation (breathing)



Ways out of the body

- Faeces
- Urine
- Wound drainage
- Blood and other bodily fluids



Method of spread

- Contact - Hands
- Contact - Equipment
- Droplet – Influenza
- Airborne - TB

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Annex D – Asepsis and Aseptic Techniques

GUIDANCE AT A GLANCE - ASEPTIC TECHNIQUE

The principles of asepsis play a vital role in the prevention of infection in all environments and it is the responsibility of all health and care staff to understand these and incorporate them into their everyday working practices, where relevant.

The principles of asepsis/aseptic technique require that:



Exposure

- Exposure of any susceptible areas is kept to a minimum.



Hand Hygiene

- Correct hand decontamination should be carried out.



Gloves

- Correct types of gloves are used as appropriate.



Clothing

- Uniform and clothing is protected with a plastic disposable apron.



Materials

- All fluids and materials used are sterile.



Sterile

- Sterile packs are checked for damage, expiry date and moisture penetration.



Non-Sterile

- Contaminated non-sterile items are not placed in the sterile area.



Single Use

- Single use items are never reused.

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Annex E – Guidance at a Glance - Safe Handling and Disposal of SHARPS

GUIDANCE AT A GLANCE - Safe Handling and Disposal of Sharps



RISK

Inoculations, cuts and other injuries.

Transmission and exposure of blood borne viruses (BBVs).

Bacterial infections.



INJURY

If an injury occurs then bleed wash it and report it..

Use a waterproof dressing.

Complete an incident report.



DISPOSAL

Never overfill a sharps bin.

Correct disposal should be immediate.

Ensure proper closure and complete labels of containers.





SAFETY

Sharps must not be passed from hand to hand.

Never re-sheath or re-cap needles.

Sharps safety begins with **YOU!**



POSITION

Ensure correct container is available at point of use.

Located at correct height and safe position.

Available at point of use.



CONTAINER

Always assemble and label containers correctly.

Available at point of use.

Ensure appropriate size is used for activity.

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Annex F – Clostridium Difficile (C-Diff)

GUIDANCE AT A GLANCE – *CLOSTRIDIUM DIFFICILE (c-diff)*

The guidelines support the control and prevention of *C-Difficile* in the community and for the patients cared for by ERS Medical. Key Ref: PHE (2013)

KEY POINTS

- C-Diff is an anaerobic bacterium meaning it does not need oxygen to survive and multiply;
- It does not usually affect healthy children and adults;
- Some antibiotics can upset the balance of bacteria in the bowel, which can then lead to *C-Diff*;
- Early diagnosis prevents complications and saves lives;
- Prudent prescribing of antibiotics may prevent infection;
- Alcohol hand rubs are **ineffective** at killing *C-Difficile* spores;
- Over 65's with recent hospitalisation, recent antibiotic treatment, GI procedures and gastric ulcer medications all increase the risk of *C-Diff*.

C-DIFF Symptoms

- **Watery diarrhoea with or without blood;**
- **Abdominal pain;**
- **Loss of appetite;**
- **Fever.**

My Patient has Diarrhoea

A useful mnemonic protocol for infective diarrhoea is **S.I.G.H.:**

Suspect all cases of patients experiencing diarrhoea as being infectious, unless there is a clear alternative cause.
Isolate patients as appropriate and if admitting to hospital immediately inform the hospital staff or pre-alert so appropriate isolation nursing can be instigated and prepared;
Gloves and other forms of PPE such as aprons should be worn to reduce the risk of contamination;
Hand washing with soap and water before and after each patient contact and with their environment.

My Patient has confirmed *C-Diff*

Communicating Infection Risk:

- If the patient is symptomatic with diarrhoea, the patients should be transported individually;
- PPE **MUST** be worn;
- If admitting a patient with symptoms, notify the receiving facility so that appropriate isolation protocols can be put in place;
- Record the infection risk of the PRF;
- Severe C-Diff is associated with a temperature >38.5ºC, evidence of Colitis;
- Life threatening C-Diff includes the same as severe C-Diff and Hypotension;
- Ambulances and equipment will require decontamination immediately after handover of the patient with Bacticlean solution if no bodily fluid exposure (**no requirement to return to base**) and Bacticlean and Antibak if there has been bodily fluid exposure (**this will require a return to base for a full decontamination**).
- The Deep Clean **MUST** be recorded on both the BMS Deep Clean form and the Fleet Database.

***C-Diff* can lead to:**

- **Dehydration;**
- **Electrolyte imbalance;**
- **Low blood albumin;**
- **Pseudomembranous colitis;**
- **Toxic megacolon;**
- **SPESIS;**
- **DEATH.**

Complication

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Annex G – MRSA

GUIDANCE AT A GLANCE – *Methicillin-Resistant Staphylococcus Aureus (MRSA)*

These guidelines support the control and prevention of *MRSA* in the community and for the patients cared for by ERS Medical. They reflect best practice/national guidelines of the DH.

KEY POINTS

- Methicillin Resistant Staphylococcus (MRSA) refers to the resistance of a strain of the Staphylococcus aureus, to the Beta lactam class of antibiotics;
- MRSA can colonise or cause infections in patients;
- MRSA can colonise or cause infections;
- It survives well in the environment, on skin, dust and can be transiently carried on hands;
- The main route of transmission is through direct contact, mainly by hands;
- If a patient has had a positive MRSA result in the last 3 years, then it is good practice to consider them as positive and take standard precautions for IPC.

Your Patient is colonised with MRSA

- Colonisation with MRSA may be identified when patients have been screened in hospital and discharged prior to the result being known;
- Sometimes it may be appropriate for the patient to have a course of colonisation suppression treatment;
- Some patients may have an MRSA alert card that they can present during healthcare interventions;
- Consideration must be taking when transporting MRSA positive patients in an ambulance, including the risk to other patients sharing the ambulance, especially if they are already immuno-compromised.

MRSA Suspected

A useful mnemonic protocol for suspected MRSA is **S.I.G.H.:**

Suspect all cases of patients with a query of MRSA as being infectious.
Isolate patients as appropriate and if admitting to hospital immediately inform the hospital staff or pre-alert so appropriate isolation nursing can be instigated and prepared;
Gloves and other forms of PPE such as aprons should be worn to reduce the risk of contamination;
Hand washing with soap and water before and after each patient contact and with their environment.

Your patient has MRSA

- Clinical infection with MRSA requires systematic treatment when symptoms of infection are present;
- Consideration must be taking when transporting MRSA positive patients in an ambulance, including the risk to other patients sharing the ambulance, especially if they are already immuno-compromised.

Your patient has recurrent abscesses

- Panton Valentine Leukocidin (PVL) can be a cause of recurrent skin abscesses or boils.
- PVL can be MRSA or MSSA (Meticillin-Susceptible Staphylococcus Aureus), standard precautions should be applied.

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Annex H – Norovirus

GUIDANCE AT A GLANCE – *Norovirus*

These guidelines support the control and prevention of *Norovirus* in the community and for the patients cared for by ERS Medical. They reflect best practice/national guidelines of the DH.

KEY POINTS

- Norovirus is a virus that causes diarrhoea and /or vomiting and spreads very much like a cold or flu (gastric flu).
- It is more common in the colder winter months;
- It is sometimes referred to as Gastric-Flu or Winter Vomiting;
- Outbreaks are common in the UK, including hospitals, care homes, nursing homes and schools;
- It only takes a small amount of Norovirus to make you ill;
- People with the Norovirus are contagious from the moment they begin to feel sick and for the first few days after they recover. The standard rule of thumb is 48 hours clear or D&V;
- The Norovirus can survive outside of the body on objects and surfaces for days or weeks;
- Norovirus is resistant to some disinfectants, making it difficult to get rid of;
- ERS Medical's decision to use ChemEx products is backed up by the kill data for its use on Norovirus.

Symptoms of Norovirus

- Norovirus can make patients feel extremely sick with diarrhoea and vomiting many times a day;
- It can cause dehydration, especially in young children and the elderly and with people with other illnesses;
- It is a major cause of hospital admissions, during the winter periods, especially for the elderly in the UK;
- It is one of the main contributors to what if often called 'Winter Pressures'.

Preventing Spread

Key actions to take:

- ***Follow the guidance provided by the WHO 5 Moments of Hond Hygiene;***
- ***Before patient contact;***
- ***Before aseptic technique;***
- ***After exposure to bodily fluids;***
- ***After patient contact;***
- ***After contact with patient surroundings including any equipment used;***
- ***PPE to be worn during potient contact;***
- ***Decontaminate all re-usable equipment and patient contact areas with Bacticlean after each use;***
- ***Decontaminate the ambulance (Deep Cleon), only if there hos been exposure to bodily fluids with the correct ChemEx solutions and IPC equipment.***

Treatment for Norovirus

- There is no vaccine against Norovirus;
- Antibiotics will not work for the treatment of Norovirus; they do not work on viruses and their use could complicate the patient's conditions (see C-Diff guidance at a glance);
- Encourage patients to drink plenty of fluids to keep hydrated.

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Question 1.10.11

Health and Social Care Act 2008

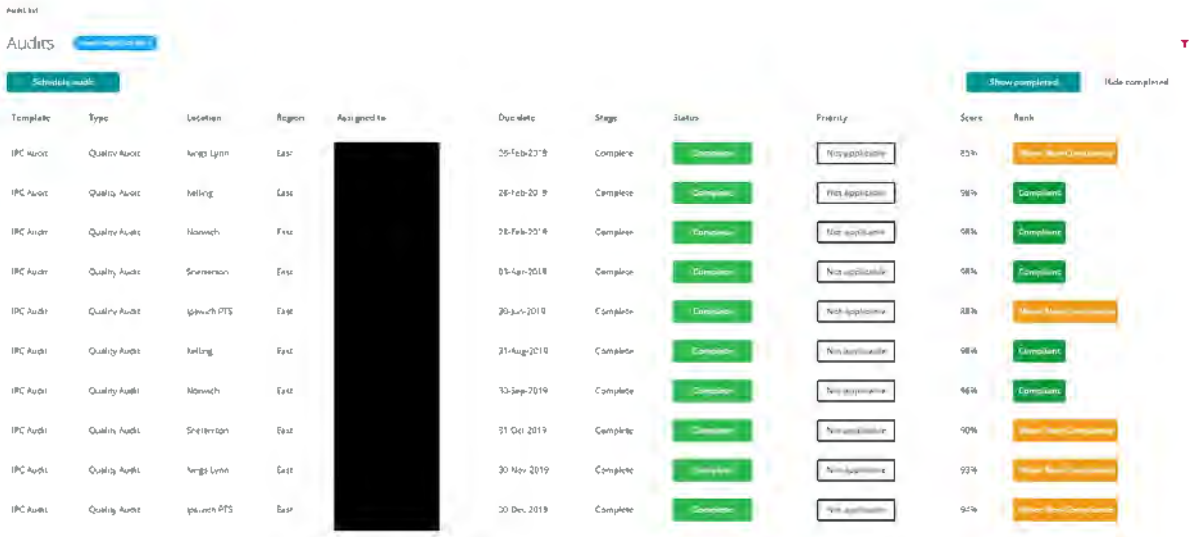
Please provide details of your compliance with the Health and Social Care Act 2008 and code of practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

Attachments permitted

The Bidder has evidenced they have appropriate policies in place– Pass

The Bidder does not have appropriate polices in place – Fail

Below we have provided our redacted IPC audit schedule. We have also attached our IPC policies.



Immunisation

We recognise our responsibility as an employer to ensure the health, safety and welfare of our team members and the requirement for us to have in place measures to mitigate as far as practically possible factors that might harm them.

A robust immunisation programme will support the protection of patient and the hospital environment.

As part of our employee induction all employees are required to complete our Health Questionnaire, which as well as asking for general health information also asks what immunisations they have received and when. This allows us to document and record the immunisations all of our employees have received prior to commencing work and any booster they may require in the future.

We operate a tiered level of immunisation requirements for each level of staff which reflect the role that they will be carrying out on behalf of the business. The below table outlines this requirement

Job Role	Diphtheria, Tetanus & Polio	MMR	Varicella	Tuberculosis	Hepatitis B	Flu
Mental Health Care Assistant	No	Yes	Yes	Check only	Yes	Optional
Ambulance Care Assistant	No	Yes	Yes	Check Only	Yes	Optional
Hospital Care Driver Volunteers	No	Yes	Yes	Check Only	Yes	Optional
Hospital Care Assistant	No	Yes	Yes	Check Only	Yes	Optional

Should it be identified within the Health Questionnaire that an employee has not received an immunisation that is outlined within their job role we offer the inoculation as part of their induction. Should an employee wish not to receive the inoculation they are required to fill out and sign an 'immunisation opt out' form which is kept on their file for the term of their employment. This form outlines that the staff member acknowledges and understands the increased risk they are exposing themselves to during their routine daily work. Should an employee who has previously opted out wish to receive the immunisation it will be arranged for them as soon as practicably possible.

We recognise the benefit of offering our employees the Flu vaccination. We organise annual immunisation days at each of our sites to allow our employees to receive the Flu vaccination free of charge. While we actively encourage staff to receive the inoculation it is not a mandatory requirement.

WI/6.03.01 Infection Prevention and Control - People

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
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2.1	All	All	All	19.09.19	[redacted]	Addition of Neilsen Chemicals to IPC Procedures
3.0	All	All	All	14.11.2019	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
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3. External Guidance Publications

- Health and Social Care Act 2015;
- The Mental Health Act 2005;
- The Mental Capacity Act 2019;
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12;
- Health and Safety at Work Act 1974;
- Control of Substances Hazardous to Health 2002 Regulations;
- NICE Guidelines;
- Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.

4. Introduction

4.1 This work instruction has been written to protect ERS Medical staff, sub-contractors providing services on behalf of ERS Medical, patients, other healthcare professionals and visitors by minimising the risks and likelihood of the transmission of infectious pathogens and micro-organisms.

4.2 It will deal specifically with the infection prevention and control measures and protocols established for the protection of, or directly affected by the actions of a person or group of people.

4.3 Infection prevention and control is based on the use of practices and procedures which prevent or reduce the risk of infection from being transmitted from a source of infection.

4.4 These sources can include a person, contaminated body fluids, equipment, the environment, other patients, staff members, healthcare workers or members of the public.

4.5 The information and practices outlined in this work instruction are evidence-based or in line with current national guidelines, legislation or regulations. Where evidence is not available, consensus opinion from specialist professionals is used.

4.6 To ensure a single infection prevention and control process is in place, for all people related infection prevention and control (IPC) activities and risks, which is both defined and utilised at all locations within ERS Medical, where CQC regulated activity is undertaken.

4.7 To recognise and document any regional or contractual differences and obligations that may be in place across different CCG or NHS Trust areas in relation to all CQC regulated activity.

4.8 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.9 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

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5. Policy Statements

5.1 Please refer to the Company's Care and Treatment Policy.

5.2 Please refer to the Company's Quality, Environmental, Safety and Health Policy.

5.3 Please refer to the Company's Business Continuity Policy.

5.4 Please refer to the Company's Information Security Policy.

5.5 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

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6. Responsibilities

6.1	Managing **Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director (IPC Lead) & Head of Care Standards**	Have responsibility to ensure that the appropriate Infection Prevention and control policy is used in everyday practice, to reduce infection risk and promote patient and staff safety. Ensure compliance with the Health and Social Care Act 2008, Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. Cooperate and assist with the implementation of this policy. Bring to the notice of management, at all levels problems and failings associated with the application of this procedure.
6.4	**Regional Managers**	Have the responsibility of chairing the regional PSC committee meetings and ensuring that IPC is an agenda item and that all IPC incidents and trends are monitored, reviewed and recommendations made.
6.5	**Operations Managers**	Are responsible for the implementation and co-ordination of Infection control process at a site level.
6.6	**Care Standards Team**	Are responsible for providing advice and support to all operational sites on matters relating to IPC. Additionally, they are responsible for conducting internal IPC audits and inspections and for the on the Radar Healthcare compliance system. They also hold the responsibility to raise, assign and track all Action Plans, resulting from identified non-conformities to this work instruction on the Radar Healthcare compliance system.
6.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address

8. Definitions

8.1 Aseptic – Without micro-organisms.

8.2 **Contagious Period** – Is the period of time during which a contracted disease can be spread, either through direct or indirect contact from one person to another.

8.3 **Communicable Diseases** – Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms **infectious** and contagious are also used to describe communicable disease.

8.4 **Formite(s)** – Any object or substance that is capable of carrying and infectious organism, such as germs or parasites and transferring them from one individual to another. This could include, but not be limited to:

- Clothing;
- Watches,
- Bedding,
- Hair;
- Medical equipment.

8.5 **Hepatitis B Core Antibody (HBcAb)** – The HBcAb is an antibody that is part of the virus – it does not provide protection. A "positive" or "reactive" HBcAb (or anti-HBc) test result indicates a past or present infection but could also be a false positive. The interpretation of this test result depends on the results of the other two tests. Its appearance with the protective surface antibody (positive HBsAb or anti-HBs) indicates prior infection and recovery. For chronically infected persons, it will usually appear with the virus (positive HBsAg).

8.6 **Hepatitis B Surface Antibody (HBsAb)** – A "positive" or reactive HBsAb (or anti-HBs) –test result indicates that a person has successfully responded to the hepatitis B vaccine or has recovered from an acute hepatitis B infection. This result means you are immune to future hepatitis b infection and you are not contagious. This test is not routinely included in blood bank screening.

8.7 **Incubation Period** – The period of time that passes between the initial exposure to a disease or infection and the appearance of the signs and symptoms of the disease.

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8.8 **Outbreak** – An outbreak is said to have occurred where the number of cases of an infectious or communicable disease is greater than the number expected over a given period or two or more cases are linked by epidemiological, clinical or microbiological features.

8.9 **Reservoir** – Any person, animal, plant, soil or substance in which an infectious agent normally multiplies.

8.10 **Sharps** – A medical sharp is defined as being an object or instrument necessary for the exercise of specific health care activities which is able to cut, prick or cause injury. This would include equipment such as needles, scalpels and other articles found in a healthcare setting capable of breaking the skin barrier.

8.11 **Vector** – A carrier of diseases such flying and biting insects and animals, such as a mosquito, which is a vector for malaria.

9. Standard Precautions

9.1 Infection prevention and control is based on the use of safe, sensible practices and procedures irrespective of what is known about an individual's infectious status. These are referred to as standard precautions and aim to prevent, or reduce, the risk of infection being transmitted from a source of infection (e.g. a person, contaminated body fluids, equipment, or the environment) to patients and others.

9.2 Detailed and comprehensive information for standard precautions can be found within the sections of this work instruction from Sections 8 to Section 15 inclusive.

10. Occupational Health and Wellbeing

10.1 Where there is either a confirmed or suspected exposure to infection i.e. a needle stick injury. A referral to ERS Medical's Occupational Health services should be made.

10.2 Any referral should be made through and in consultation with the Head of HR and Training.

10.3 Details on all Occupational Health provisions can be found at **BMS/2.03** – **Employee Health and Wellbeing**.

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11. Hand and Personal Hygiene

11.1 Cleanliness and high standards of personal hygiene are essential in minimising the risks of cross infection and can include specific instructions and/or restrictions on, but not be limited to, the following points:

- Clean uniform;
- Dental hygiene;
- Daily washing and bathing;
- Covering cuts and abrasions with a waterproof dressing;
- Bear below the elbow;
- Not wearing watches of bracelets;
- Nail clear of varnish and no extensions;
- Hair clean and off the collar;
- Stud earrings;
- Single band rings.

11.2 Specific details on the requirements or any restrictions for some these items will be provided within this work instruction and at Annex A.

11.3 The highest levels of personal hygiene are required by all staff. They should keep themselves clean and presentable at all times.

Hand Hygiene & Care

11.4 Ambulance and Specialist Service (Mental Health) crews with dermatitis may be at an increased risk of exposure to blood-borne viruses during any skin to skin contact or with exposure to bodily fluids, due to their reduced skin integrity. Any member of staff with excessive skin problems must seek advice through the Company's Occupational Health service or through their GP.

11.5 Good and efficient hand hygiene is the single most important personal method of reducing the risk of either contracting or infection or passing it onto others.

11.6 Hand washing with liquid soap and water must be utilised wherever possible. Liquid soap must be available in all staff toilets and washrooms. When liquid soap is not available hand santisers must be used. These are available on all ambulances and at all sites.

11.7 Hand hygiene must be carried out on all of the following occasions following the World Health Organisations (WHO) 5 moments of hand hygiene and care approach. This approach also forms parts of the National Patient Safety Agency's (NPSA) campaign to promote effective hand hygiene.

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11.8 The 5 moments of hand hygiene are:

- **Before Patient Contact** – When: Clean your hands before touching a patient when approaching him / her. Why: To protect the patient against harmful germs carried on your hands;
- **Before any Aseptic Task** – When: Clean your hands immediately before any aseptic task. Why: To protect the patient against any harmful germs, including the patient's own from entering his / her body;
- **After Bodily Fluid Exposure Risk** – When: Clean your hands immediately after an exposure risk to bodily fluids (and after glove removal). Why: To protect yourself and the healthcare environment from harmful patient infectious substances;
- **After Patient Contact** – When: Clean your hands after touching a patient and his/her immediate surroundings when leaving the patient's side or immediate proximity. Why: To protect yourself and the healthcare environment from harmful patient infectious substances;
- **After Contact with Patient Surroundings** – When: Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving, even if the patient hasn't been touched. Why: To protect yourself and the healthcare environment from harmful patient infectious substances.



Fig 1: Company Poster for 5 Moments for Hand Hygiene.

11.9 The Company poster for the 5 moments of hand hygiene must be prominently displayed at all Company sites on notice boards and hand washing stations.

11.10 Hand sanitisers should only be used for the decontamination of visible clean hands, as they are ineffective if hands are visible soiled and dirty.

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11.11 The use of hand santisers should be encouraged between different care activities, which are available on all vehicles.

11.12 ERS Medical ambulances and specialist services secure vehicles are not equipped with hand washing facilities. The use of hand sanitising products therefore proves the next best option for crews to use when required to decontaminate their hands.

11.13 Hand washing should also be carried out:

- At the start and finish of each shift;
- Prior to eating, drinking and smoking;
- After carrying out any cleaning procedure or protocol;
- After using the toilet;
- When hands are visible dirty;
- Before and after each patient contact activity such as handling, changing linen, handling personal effects and or equipment;
- Before and after preforming any invasive procedure;
- After the removal of any items of PPE such as gloves and aprons;
- After handling contaminated laundry;
- After handling any clinical waste, including waste bin receptacles such as sharps boxes.

Hand Washing Technique

11.14 When hand washing technique is more important than just the solution used. When hands are washed in a hasty manner certain areas tend to be commonly missed.

11.15 The below diagram illustrates the areas of the hands that are commonly missed with the use of poor hand washing technique.

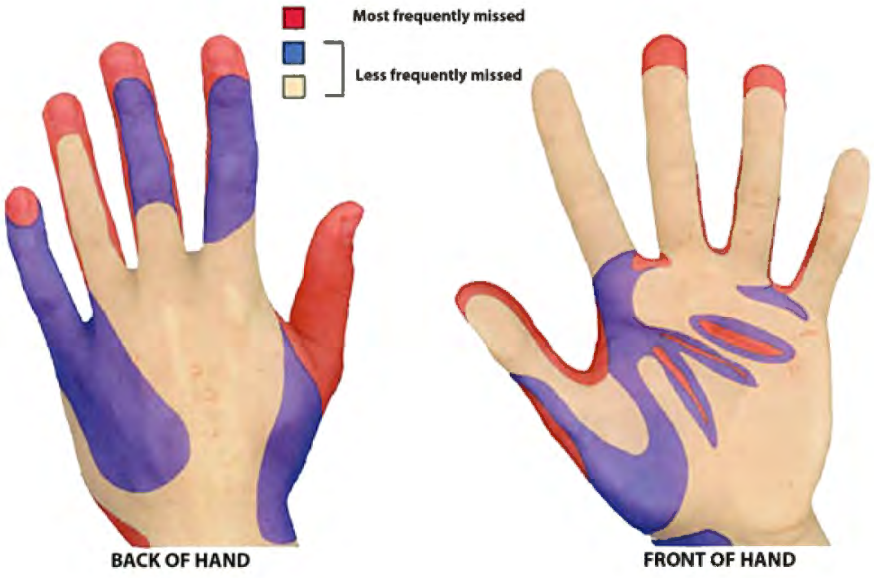


Fig 2: Common areas of the hands missed when using poor hand washing technique.

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11.16 When washing hands:

- Apply liquid soap and water;
- Vigorously rub hands together for a minimum of 10 t 15 seconds, whilst paying particular attention to the fingertips, thumbs and between the fingers;
- Rinse thoroughly and dry using paper towels (if available);
- Do **NOT** dry hands on shared linen towels as these can act as a reservoir for infections.



Fig 3: Good hand washing technique.

12. Hand Hygiene Training

12.1 The Care Standards Team will conduct hand hygiene training at sites periodically on an Adhoc basis and as part of a sites scheduled internal IPC audit.

12.2 The team will utilise portable hand hygiene training kits manufactured by 'Glowtec' to highlight the common areas typically missed by healthcare workers when washing their hands.

12.3 Additional guidance and advice, in the form of providing them hand washing guidance as per figure 3, will be provided to team members who require additional support.

12.4 All hand hygiene training will be recorded on **F6.03.07 – IPC – Hand Hygiene Training Record**. The Care Standards Team will retain the original for centralised retention and a copy will be scanned and emailed to the relevant sites Operations Manager for retention for the purposes of audit and inspection.





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13. IPC Personal Protective Equipment (PPE)

13.1 Personal protective equipment (PPE) is primarily used to protect users, patients, other staff and members of the public from the transfer of germs and pathogens from one person to another or from one environment to another.

13.2 PPE also serves to protect uniforms from contaminants and serves to reinforce local IPC protocols such as isolation nursing.

13.3 The overuse of PPE can, on occasions be considered poor practice, because it may demonstrate a lack of clinical understanding in regard to the risks present and in many cases, it can increase patient anxiety and concerns unnecessarily.

13.4 Many clinical procedures, such as taking a pulse, blood pressure or temperature may involve no direct contact with bodily fluids and so therefore the use of PPE is questionable, unless a specific concern is present.

13.5 In these cases, following the WHO 5 moments of hand hygiene and standard precautions would be deemed sufficient.

13.6 It is the responsibility of the attending clinician, based upon all information available, including their index of suspicion, any differential diagnoses of the patient's current presentation and information relayed to them as part of a handover, to determine whether the use of PPE is appropriate or not.

13.7 For guidance ERS Medical provides the advice contained within the table below:

Circumstance and or Care / Clinical Activity	Appropriate PPE
No exposure to blood / bodily fluids anticipated.	Good hand hygiene (5 moments of hand hygiene)
Exposure to blood / bodily fluids anticipated, but low risk of splashing assessed.	Wear gloves, sleeve protectors and plastic apron.
Exposure to blood / bodily fluids anticipated and high risk of splashing.	Wear gloves, sleeve protectors, plastic aprons and eye / mouth / nose protection.

13.8 ERS Medical makes available for staff some standard items of PPE for the purposes of IPC. These will include, but not be limited to:

- Nitrile Gloves (all sizes) (Standard Precaution);
- Disposable Aprons (Standard Precaution);
- FFP3 Respirator Masks (where appropriate).
- Face Masks (where appropriate);
- Disposable Suits (where appropriate);
- Visor and Eye Protection (where appropriate).

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Nitrile Gloves

13.9 The wearing of gloves plays a dual role in that they create a barrier for the protection and prevention for the transmission of infection and secondly as a method of hand hygiene.

13.10 Gloves **MUST** be worn for:

- Any aseptic procedure;
- Any invasive procedure;
- Contact with sterile sites and non-intact skin and mucous membranes;
- All activities that have been assessed as carrying a risk of exposure to blood and bodily fluids, secretions and excretions;
- When cleaning equipment for disinfection;
- hen handling chemical disinfectants;
- When cleaning up spillages.

13.11 All gloves must be worn as a single use item and disposed as clinical waste immediately after use. They should under **NO CIRCUMSTANCES** be discarded as general waste or in sharps receptacles or containers.

13.12 Gloves must be changed when handling different patients, or between different care and treatment activities for the same patient and hand hygiene must be performed between each task.

13.13 Gloves **MUST NOT** be worn:

- Whilst driving;
- Normal patient care activities, where there is no risk of contamination.

Sizes of Gloves

13.14 All sizes of gloves must be available to staff at the point of care and treatment.

13.15 When choosing an appropriate size of glove, the following should be considered:

- Gloves that are too large may compromise in grip;
- They may increase the risk of a glove failure such as a split or puncture;
- Gloves that are too small may become restrictive in their use.



Fig 4: Typical Nitrile Gloves.

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Disposable Aprons

13.16 Disposable plastic aprons must always be worn whenever contamination of uniform and clothing, with blood and or bodily fluids is anticipated and or when instructed to do so by the specific IPC Exposure Guidance which is available from the Care Standards Teams SharePoint area.

IPC Exposure Guidance Link to SharePoint

13.17 Disposable aprons should also be worn when undertaking cleaning procedures, or on any occasion where uniform and clothing is at risk of being soiled.

13.18 After use all disposable aprons must be treated as clinical waste and disposed of accordingly. Hand hygiene should be completed when disposed of.



Fig 6: Typical Disposable Apron

Face Masks – Respirators (FFP3)

13.19 Respirators are designed to reduce the wearer's exposure to certain airborne particles when dealing with infectious diseases. Their effectiveness depends on the use and design parameters such as the FFP3 face masks/respirators which comply with EN149 FFP3.

13.20 FFP3 facemasks / respirators are designed, when worn correctly by trained staff; reduce the wearer's exposure to airborne particles by a factor of least 20.

13.21 They should be worn is the same circumstances as the surgical face mask (FFP2) but be worn in preference to these if available.



Fig 7: Typical FFP3 Surgical Face Mask

Disposable Suits (Tyvex Suits)

13.22 Tyvex suits are waterproof, disposable and impervious to micro-organisms. They offer protection to staff from contamination and significantly reduce the risk of cross contamination.

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13.23 They should be worn:

- When caring for patients heavily contaminated with excreta, lice, blood and or bodily fluids;
- When dealing with highly infectious diseases (see **BMS/6.03(ERS)** Annex A).



Fig 8: Typical Disposable Suit

Eye Protection

13.24 Protective eye wear is provided on a personal issue basis, normally for front line crews only, where the risk of exposure is greater.

13.25 Eye protection or face wear, such as a face shield, goggles or spectacles, must be worn whenever there is a risk of:

- Blood or bodily fluid contamination to the face;
- Splashes to the face with fine particles;
- Splashing to the face from activities such as vehicle or equipment cleaning.



Fig 9: Typical Eye Safety Spectacles

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14. Aseptic Techniques

14.1 Aseptic technique is a method of working that has been designed to prevent contamination from microorganisms during a clinical procedure. It involves the application of strict clinical and IPC processes.

Principles of Aseptic Technique

14.2 All staff undertaking aseptic procedures must adhere to the 'WHO 5 Moments of hand hygiene' and the uniform and dress code policy of the Company detailed within Section 14 and Annex A of this work instruction and be bare below the elbows.

14.3 If practicable the environment should be prepared, including decontamination, using ChemEx / Neilsen Chemicals 'Bacticlean / Bactericidal All-Purpose Cleaner' on any working surfaces or trays to be used, allowing them to dry before use.

14.4 Hand hygiene should be performed again.

14.5 The wearing of Company provided IPC PPE gloves is mandatory and other items of IPC PPE, such as aprons, eye protection and FFP3 respirator, should be considered depending on the infection risk of the patient and whether bodily fluid splashes are anticipated.

14.6 All packaged 'sterile' items that will be used for the procedure should be assembled prior to starting. Staff should check that the packaging is intact and that expiry dates have not been exceeded.

14.7 All 'sterile' packaged items such as needles, cannulas and syringes should be opened carefully by peeling back the packaging and not by pushing the equipment through the packaging.

14.8 Any soiled dressings should be removed carefully, as a large number of microorganisms can be shed into the air when removed, using an inverted yellow clinical waste bag to protect the already gloved hands of the clinician. This waste should be disposed of immediately.

14.9 Wounds should only be exposed for the minimum time possible to avoid contamination and maintain temperature.

14.10 Gloves should be changed, and hands decontaminated at any stage when contamination has occurred or is suspected of occurring. Staff should **NEVER** apply decontamination products directly to gloves.

15. Aseptic Non-Touch Technique (ANTT)

15.1 An Aseptic Non-Touch Technique (ANTT) is a modified aseptic process where clean nonsterile gloves are worn or cleaned un-gloved hands and touching either the patient and keys parts of 'sterile' equipment is avoided.

15.2 Aseptic Non-Touch Technique is more suited to the pre-hospital environment.

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15.3 In general, this means avoiding direct contact with, but not limited to:

- Sterile equipment that will be used for an invasive procedure, such as needles and cannulas;
- Sterile products used for preparing solutions for injections such as the hub of a syringe (see figure 10 for the anatomy of a syringe);
- The surface of sterile dressings that will be in contact with a wound;
- Seals of IV connectors that have been disinfected prior to the administration of medication;
- Skin after it has been disinfected prior to cannulation or phlebotomy, open wounds and invasive device sites such as chest drains or central lines.

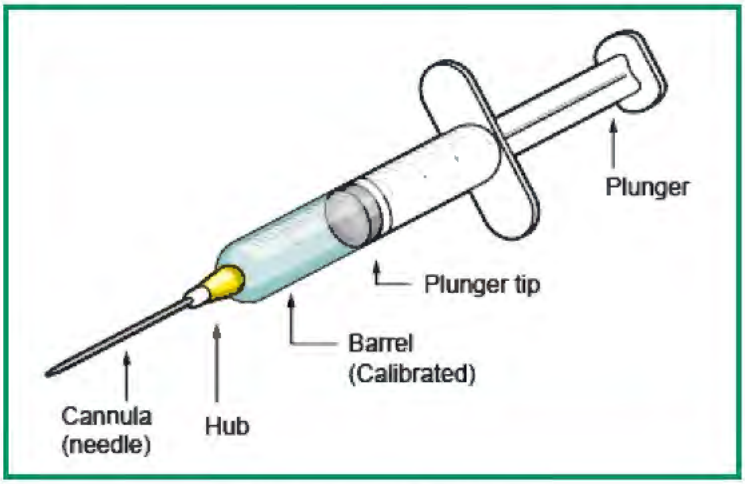
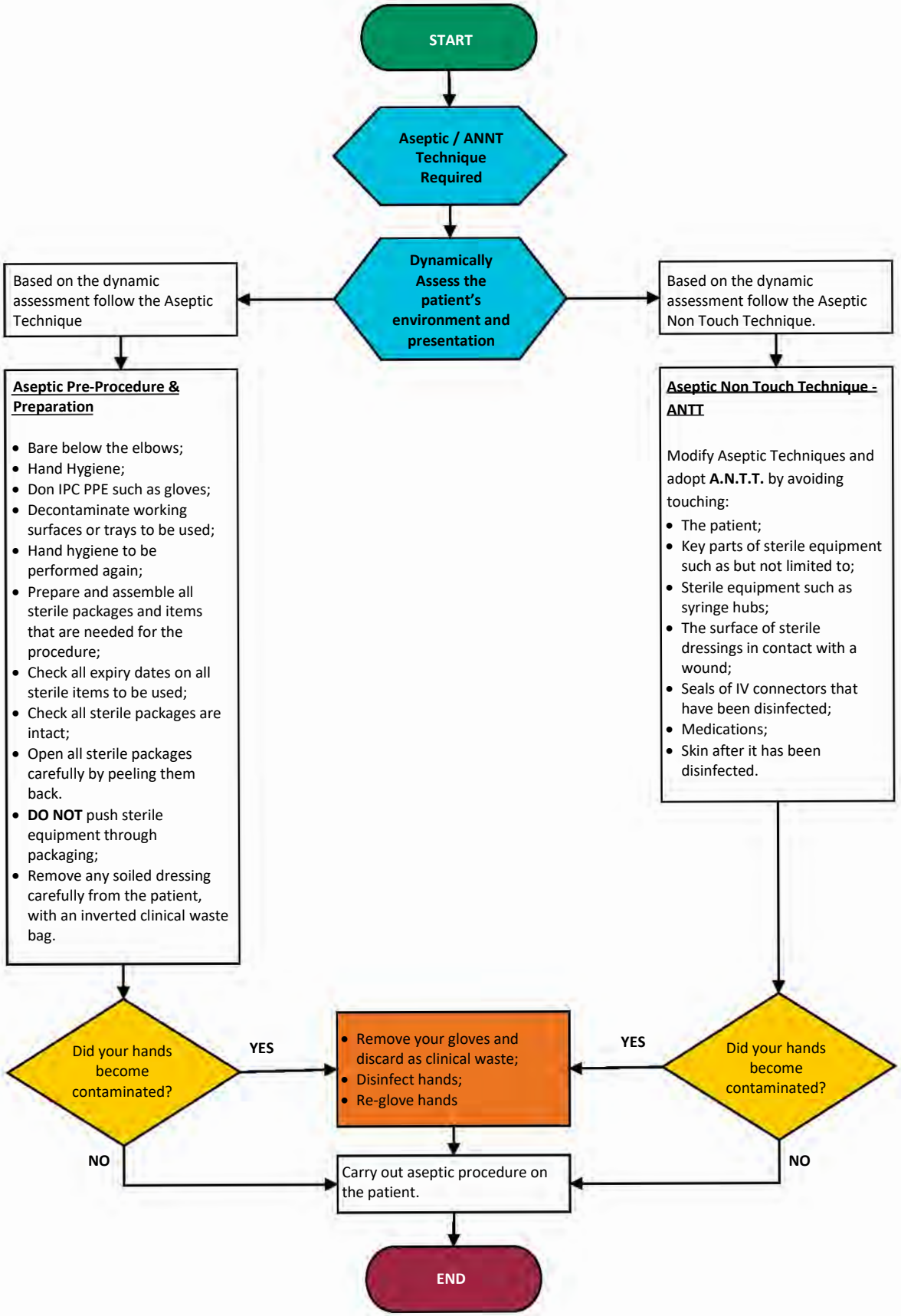


Fig 10: Anatomy of a Syringe

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16. Key Steps – Aseptic and ANTT

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17. Uniform and Dress Code

17.1 All staff working within a clinical environment must comply with the uniform and dress standards detailed within this work instruction.

17.2 These procedures have been set for the safeguarding of patients, staff, other healthcare professionals and members of the public from the transference of infectious micro-organisms.

17.3 Only ERS Medical issued and approved items are to be worn, these will include:

- ERS Medical shirts green / or Specialist Services (Mental Health) polo shirts;
- ERS Medical trousers green / or Specialist Services (Mental Health) black trousers;
- Black belt;
- Black Company issued or approved boots with black laces (clean and with good tread on the sole);
- White T-Shirts (non-issued);
- ERS Medical soft-shell jacket;
- ERS Medical high visibility jacket;
- Any other Company issued PPE.

17.4 In addition to this staff must also wear and adhere to the following requirements:

- Wear and Display their ERS Medical Identification Card;
- Wear and Display their appropriate clinical grade epaulettes;
- All uniform items should be clean, ironed if applicable and in good condition;
- Hair should be clean and not loose (off the shoulder) (tied up or back);
- Be bear below the elbows;
- Wear of carry issued hand sanitiser;
- No Watches due to both IPC and tissue viability issues they cause;
- No stoned or raised rings due to both IPC and tissue viability issues they cause;
- No Bracelets due to both IPC and tissue viability issues they cause;
- No nail varnish, gels or acrylic extensions due to both IPC and tissue viability issues they cause;
- Only stud earring may be worn as they can pose a tear threat to the wearer;
- No non ERS Medical issued or authorised headwear.

17.5 All uniform and authorised items should be laundered in accordance with the manufacturer's instructions to ensure that all infectious micro-organisms are killed during the wash cycle. It is recommended that uniform items are washed at 60° with normal laundry detergent.

17.6 All employees and sub-contractors working for and on behalf of ERS Medical should ensure that when reporting for duty they do so in a clean and presentable manner and in compliance with the requirements. Failure to do so may result in disciplinary action being taken against them.

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17.7 All Operational sites are to display, for staff information purposes Annex A- ERS Medical Uniform standards Poster, in a prominent location.

17.8 It is the responsibility of all ERS Medical Managers and Supervisors to challenge any employees or sub-contractors who fail to comply with these requirements.

17.9 The wearing of ERS Medical uniform for any other purpose than Company work activity is expressly forbidden.

17.10 Any member of staff wishing to wear ERS Medical uniform for any other reason must seek the authority of the Company to do so; prior to the time they are intend to wear it.

17.11 Staff members who do wear ERS Medical uniform and act in manner that does not meet the standards of behaviour expected and required by the Company may have disciplinary action taken against them. Examples of this type of infringement may include; Facebook, Twitter and other social media platforms.

18. Monitoring

18.1 In addition to the responsibilities that are detailed within Section 6 of this work instructions, ERS Medical Operations Managers, Care Standards Team member and where practicable Health and Safety Advisors will have responsibilities to insure that:

- Site Hand Hygiene inspections are conducted and recorded;
- Site Hand Hygiene audits are conducted and recorded;
- Uniform compliance inspections are conducted and recorded;
- Uniform compliance audits are conducted and recorded.

Site Hand Hygiene Inspections

18.2 Regional and Operations Managers will hold the responsibility to ensure that monthly random site hand hygiene inspections are conducted.

18.3 ERS Medical recognises that these types of inspections are problematic at best to conduct in the pre-hospital environment as not all ‘WHO 5 Moments of Hand Hygiene’ can be inspected.

18.4 Therefore Operations Managers, through their Team Leader should make provisions for random inspections for hand hygiene to be conducted wherever it is possible. This can include, but not be limited to:

- ERS Medical premises;
- Hospital Wards for discharge patients (permission must be gained from the ward manager);
- Hospital Departments for outpatient appointments (permission must be granted from the Dept Manager);
- Accident and Emergency Departments for admissions and discharges (permission must be gained from the A&E Manager).

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18.5 The Care Standards Team will at random intervals conduct educational and training workshops for hand hygiene using 'GloTech Checkpoint 2' portable hand hygiene testing and training stations.

18.6 All random inspections and training must be recorded on **F6.03.01** – **Hand Hygiene Inspection Form**. These forms must be retained and be readily available on site for the purpose of audit and inspections by, but not limited to:

- Care Standards Team;
- Regulatory Compliance Team;
- Contracted NHS Customers as part of any service provision review or monitoring exercise;
- Healthcare Regulator – Care Quality Commission;
- External ISO certification body.

18.7 Any breaches or non-compliance with hand hygiene should be immediately addressed with the staff members in question. This should be conducted as further education and support to IPC and Company procedure, rather than a direct confrontation.

18.8 It will remain the responsibility of the staff member's line manager to record all breaches of compliance with hand hygiene on **F2.01.08 – Record of Discussion**, to provide supporting evidence and documentation for repeat offenders who may require further action taken IAW the Company's disciplinary procedure.

18.9 It may be necessary, depending on the nature and severity of the breach to bypass the process defined at Section 17.7 and instigates immediate disciplinary proceedings, through HR.

Uniform Compliance Inspections

18.10 General and Operations Managers will hold the responsibility to ensure that monthly random site uniform inspections are conducted.

18.11 The Operations Managers, through their Team Leader will make provisions for random inspections for uniform compliance to be conducted wherever it is possible. This can include, but not be limited to:

- ERS Medical premises;
- Any location where staff members carryout work activity on behalf of the Company.

18.12 All random inspections must be recorded on **F6.03.02 – Uniform Inspection Form**. These forms must be retained and be readily available on site for the purpose of audit and inspections by, but not limited to:

- Care Standards Team;
- Contracted NHS Customers as part of any service provision review or monitoring exercise;
- Healthcare Regulator – Care Quality Commission;
- External ISO certification body.

18.13 Any breaches or non-compliance with uniform compliance should be immediately addressed with the staff members in question. This should be conducted as further education and support to IPC and Company procedure, rather than a direct confrontation.

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18.14 It will remain the responsibility of the staff member's line manager to record all failing of compliance with hand hygiene on **F2.01.08 – Record of Discussion**, to provide supporting evidence and documentation for repeat breaches that may require further action taken IAW the Company's disciplinary procedure.

Hand Hygiene and Uniform Inspections Standards

18.15 Hand hygiene and uniform inspections will have a pass / fail standard. This standard will be derived from a points scoring matrix as detailed on the table below.

Category	Description	Weighting
Observation	Observation made about hand hygiene technique or general appearance.	No limit to observations
Minor	Minor infringement to either hand washing moments or uniform compliance.	2 Minors or less = Pass
Major	Major breach of either hand washing moments or uniform compliance.	1 Major = Fail

Hand Hygiene, Uniform & IPC Compliance Audits

18.16 It will be the responsibility of the Care Standards Team, to conduct both hand hygiene and uniform compliance audits for each ERS Medical location within their area of responsibility at least once per quarter as part of the care quality audit schedule.

18.17 All will be detailed within the internal audit schedule of the Regulatory Compliance Team's SteriPoint page in accordance with **BMS/1.03 – Audit**.

18.18 All audits should be recorded on the **F1.03.01(CQC) – Clinical Quality and Governance Site Compliance Audit** which is available from the Business Management System (BMS).

18.19 It will be the responsibility of the Head of Care Standards and the Care Standards Team to:

- Coordinate all IPC audits;
- Publish completed audits to Radar;
- Ensure that Action Plans are raised and recorded IAW with **BMS/1.04 – Corrective / Preventive Actions.**

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Annex A – Guidance at a Glance – Uniform Standards

GUIDANCE AT A GLANCE – UNIFORM STANDARDS

All staff and sub-contractors working and providing services for and on behalf of ERS Medical must comply with the uniform and dress standards detailed below and contained with WI/6.03.01 – Infection Prevention and Control – People, which is available on the BMS or on request from your line manager or supervisor.

Key

Compulsory

Optional

Uniform Standards

ERS Medical

PLEASE NOTE: whilst in uniform you are required to maintain a smart appearance and be naked below the elbow.



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GUIDANCE AT A GLANCE – UNIFORM STANDARDS

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Key

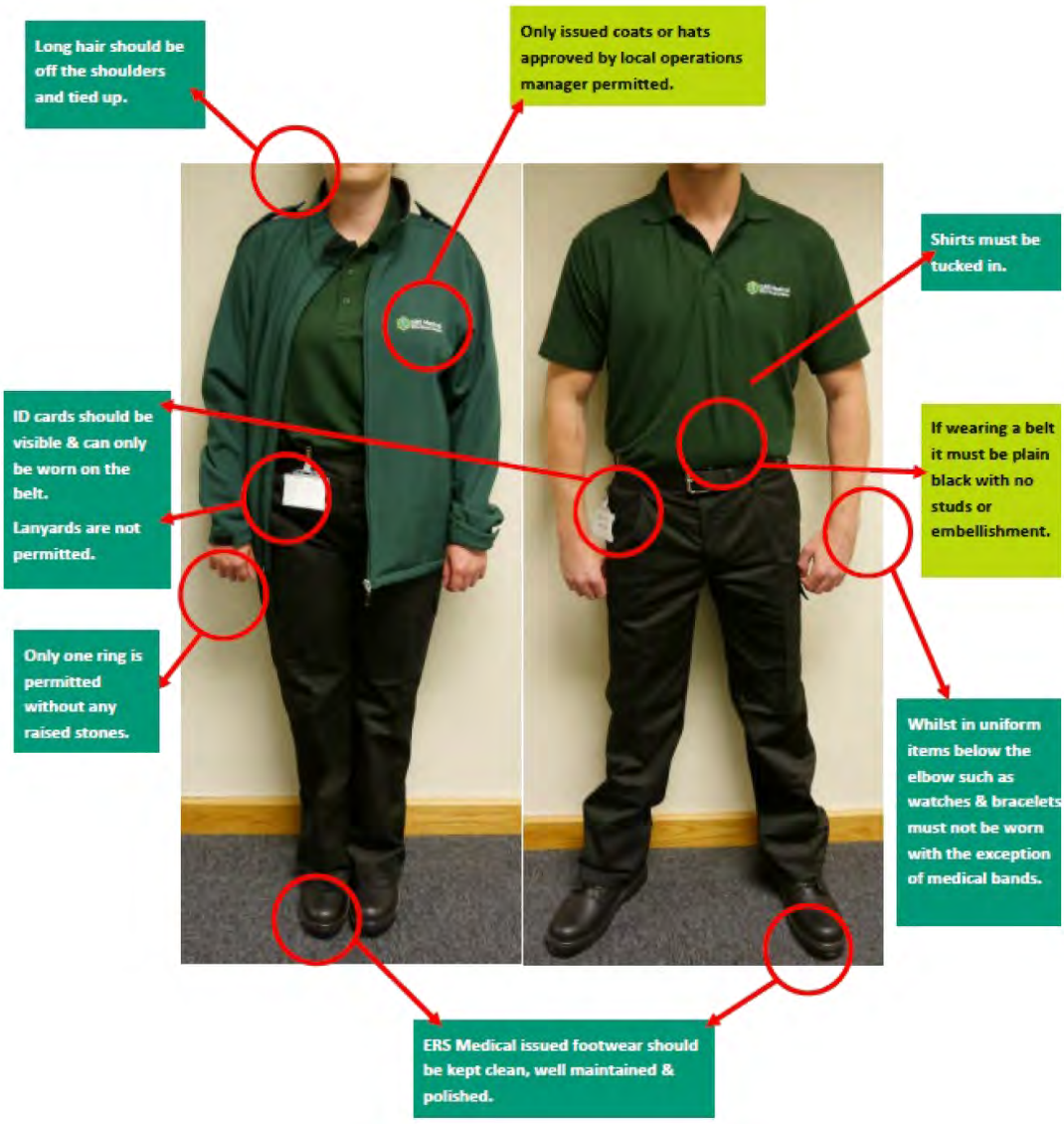
Compulsory

Optional

ERS Medical

Mental Health Uniform Standards

PLEASE NOTE: whilst in uniform you are required to maintain a smart appearance and be naked below the elbow.



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WI/6.03.02 Infection Prevention and Control – Ambulances, Medical Equipment & Devices

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Document Owner:	[redacted]		Managing Director		
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2.1	All	All	All	19.09.19	[redacted]	Addition of Neilsen Chemicals to IPC Procedures
3.0	All	All	All	15.11.19	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Information Governance	BMS/1.09
GDPR	BMS/1.10
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Personal Development and Training	BMS/2.02
Employee Health and Wellbeing	BMS/2.03
Whistleblowing (Raising Concerns at Work)	BMS/2.05
Procurement and Supply Chain Management	BMS/4.01
Incident Reporting and Management	BMS/5.01
Serious Untoward Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding Vulnerable Adults and Children	BMS/6.05
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Assessments	BMS/6.07
Patient Communications and Control (CCO)	BMS/6.08
Non-Emergency Patient Transport Services	BMS/6.10
Renal Patient Services	BMS/6.11
High Dependency Unit (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Service Operations – Common Tasks for Line Managers	BMS/8.01
Infection Prevention and Control – People	WI/6.03.01
Infection Prevention and Control – Environmental Management	WI/6.03.03
Deep Clean Records	F6.03.03
IPC Inspection and Testing Form	F6.03.04

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3. External Guidance Publications

- Health and Social Care Act 2015;
- The Mental Health Act 2005;
- The Mental Capacity Act 2019;
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12;
- Health and Safety at Work Act 1974;
- Control of Substances Hazardous to Health 2002 Regulations;
- NICE Guidelines;
- Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.

4. Introduction

4.1 This work instruction has been written to protect ERS Medical staff, sub-contractors providing services on behalf of ERS Medical, patients, other healthcare professionals and visitors by minimising the risks and likelihood of the transmission of infectious pathogens and micro-organisms.

4.2 It will deal specifically with the infection prevention and control measures and protocols established for the routine and scheduled deep cleaning and decontaminations of medical devices, equipment and ambulances.

4.3 Infection prevention and control is based on the use of practices and procedures which prevent or reduce the risk of infection from being transmitted from a source of infection.

4.4 These sources can include a person, contaminated body fluids, equipment, the environment, other patients, staff members, healthcare workers or members of the public.

4.5 The information and practices outlined in this work instruction are evidence-based or in line with current national guidelines, legislation or regulations. Where evidence is not available, consensus opinion from specialist professionals is used.

4.6 To ensure a single infection prevention and control process is in place, for all ambulance, medical equipment and device related infection prevention and control (IPC) activities and risks, which is both defined and utilised at all locations within ERS Medical, where CQC regulated activity is undertaken.

4.7 To recognise and document any regional or contractual differences and obligations that may be in place across different CCG or NHS Trust areas in relation to all CQC regulated activity.

4.8 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.9 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

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5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting Company objectives and allocating adequate resources to meet those objectives.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director (IPC Lead) & Head of Care Standards**	Have responsibility to ensure that the appropriate Infection Prevention and control policy is used in everyday practice, to reduce infection risk and promote patient and staff safety. Ensure compliance with the Health and Social Care Act 2008, Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. Cooperate and assist with the implementation of this policy. Bring to the notice of management, at all levels problems and failings associated with the application of this policy. Has responsibility for the coordination, implementation and reporting of all IPC audits and inspections.
6.4	**Regional & Operations Managers**	Have the responsibility of chairing the regional GaPR committee meetings and ensuring that IPC is an agenda item and that all IPC incidents and trends are monitored, reviewed and recommendations made. Are responsible for the implementation and co-ordination of Infection control process at a site level.
6.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Everyday decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address

8. Definitions

8.1 **Aseptic** – Without micro-organisms.

8.2 **Contagious Period** – Is the period of time during which a contracted disease can be spread, either through direct or indirect contact from one person to another.

8.3 **Communicable Diseases** – Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms **infectious** and contagious are also used to describe communicable disease.

8.4 **Decontamination** – Is the process of cleaning items of equipment or parts of the body, to remove microorganisms or hazardous materials such as chemical and infectious diseases for the purposes of infection prevention and control.

8.5 **Deep Clean** – For the purposes of this work instruction the term 'Deep Clean', will be used for the scheduled and reactive decontamination of ALL ambulance born equipment, medical devices and ambulance surfaces.

8.6 **Formite** – Any object or substance that is capable of carrying and infectious organism, such as `germs or parasites and transferring them from one individual to another. This could include, but not be limited to:

- Clothing;
- Watches,
- Bedding,
- Hair;
- Medical equipment.

8.7 **Hepatitis B Core Antibody (HBcAb)** – The HBcAb is an antibody that is part of the virus – it does not provide protection. A "positive" or "reactive" HBcAb (or anti-HBc) test result indicates a past or present infection but could also be a false positive. The interpretation of this test result depends on the results of the other two tests. Its appearance with the protective surface antibody (positive HBsAb or anti-HBs) indicates prior infection and recovery. For chronically infected persons, it will usually appear with the virus (positive HBsAg).

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8.8 **Hepatitis B Surface Antibody (HBsAb)** – A "positive" or reactive HBsAb (or anti-HBs) –test result indicates that a person has successfully responded to the hepatitis B vaccine or has recovered from an acute hepatitis B infection. This result means you are immune to future hepatitis b infection and you are not contagious. This test is not routinely included in blood bank screening.

8.9 **Incubation Period** – The period of time that passes between the initial exposure to a disease or infection and the appearance of the signs and symptoms of the disease.

8.10 **Isolation Nursing** – The term isolation is the use of IPC aimed at controlling and preventing the spread of an infection. There are 2 types of isolation:

- **Source Isolation (Barrier Nursing)** – Where the patient is the confirmed or potential source of infection and an individual or group of patients are isolated from mixing with other patients. Additional IPC measures may be brought in to control these environments;
- **Protective Isolation (Reverse Barrier Nursing)** – Where a patient requires protection from either contact with other patient's, staff members, visitors and even their environment as they may well be immunocompromised.

8.11 **Outbreak** – An outbreak is said to have occurred where the number of cases of an infectious or communicable disease is greater than the number expected over a given period or two or more cases are linked by epidemiological, clinical or microbiological features.

8.12 **Reservoir** – Any person, animal, plant, soil or substance in which an infectious agent normally multiplies.

8.13 **Routine Clean** – For the purposes of this work instruction the term 'Routine Clean' will used for the decontamination of medical equipment, devices and ambulance surfaces for any purpose other than a 'Deep Clean'.

8.14 **Sharps** – A medical sharp is defined as being an object or instrument necessary for the exercise of specific health care activities which is able to cut, prick or cause injury. This would include equipment such as needles, scalpels and other articles found in a healthcare setting capable of breaking the skin barrier.

8.15 **Vector** – A carrier of diseases such flying and biting insects and animals, such as a mosquito, which is a vector for malaria.

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9. ChemEx / Neilsen Chemicals Dosing Station and Products

9.1 ERS Medical provides a designated IPC resource cleaning solution station at each of its operational sites. These dosing stations are provided by and fitted by ChemEx / Neilsen Chemicals.

9.2 ChemEx / Neilsen Chemicals delivers to site, a hygiene control programme which not only provides a simplified process for cleaning in the number of differing products used, but also by providing:

- Defined hygiene protocols for the use of their products;
- Installation and product use training.

9.3 All of this information can be accessed by staff within the ChemEx / Neilsen Chemicals white information folder that is located at each ChemEx / Neilsen Chemicals station.



Figure 1: ChemEx / Neilsen Chemicals IPC Protocol & Information Folder

9.4 Each ChemEx / Neilsen Chemicals information folder is sectionalised and contains additional guidance and product specific information for:

- **Section 1** - A guide to CQC IPC compliance;
- **Section 2** - Chemical Health and Safety and First Aid;
- **Section 3** - Risk Assessment Guidelines;
- **Section 4** - Product and COSHH Data;
- **Section 5** - Hygiene Policies and Cleaning Procedures;
- **Section 6** - Protocols for Body Fluid Spills. SRVs and Spores;
- **Section 7** – Product information for Ambulance Crews;
- **Section 8** - Staff Training Records (this section is not applicable see BMS/2.02);
- **Section 9** – Hygiene Control Programme Wall Charts;
- **Section 10** – Supplementary MSDSs.

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ChemEx / Neilsen Chemicals Products

9.5 ChemEx / Neilsen Chemicals provides ERS Medical with a number of biocidal products for use within our IPC protocols. All products carry independent test certificates to international standards proving their biocidal efficacy which are available on request from ChemEx / Neilsen Chemicals.



Figure 2: A Typical ERS Medical ChemEx / Neilsen Chemicals Dosing Station (Trafford Park)

9.6 The standard products supplied by ChemEx / Neilsen Chemicals are:

- **Antibak Powder / Terminix** – concentrated broad-spectrum steriliser; This has been proven by independent test to be effective against viruses such as; polio, HIV, SARS & Avian Flu (H5N1) and bacteria including Clostridium including C-Difficile, Pseudomonas and Staphylococcus, fungi such as Aspergillus;
- **Bacticlean / Bactericidal All-Purpose Cleaner** – Hard surface cleaner and disinfectant; This has been proven by independent test kill; Listeria, Staphylococcus aureus (incl MRSA), Escherichia Coli (E-Coli), Pseudomonas aeruginosa, Klebsiella Pnemoniae, Aspergillus Niger and more;
- **Citrus Toilet Fresh** – Toilet cleaner and descaler;
- **Dash It** – Silicone free dressing for vehicle cabs;
- **Enduro Hand Sanitiser** – Alcohol-free sporicidal hand foam;
- **Hazeaway / Blue Window Cleaner** – Combination alcohol & glycols windscreen and window cleaner;
- **Powerforce Original / Cyclone**– Concentrated grime remover for floors and vehicle exteriors;
- **RTY-240 / Terminix** – Emergency clean up powder / spray for accidents involving bodily fluids;
- **Safehands** – Biological liquid hand soap;
- **Sprite** – General purpose UPVC cleaner.

9.7 Details on how and when to use these products in contained within the information available in the ChemEx folder and as part of IPC staff training.

9.8 Dosing station will provide and dispense a pre-defined amount of product concentrate to maximise the efficiency of the cleaning product while minimising the cost of products used.

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9.9 Staff must **NOT** exceed the pre-measured and dispensed amount of product as this may cause health problems and damage to equipment and surfaces.

10. Vehicle and Equipment Cleaning / Decontamination - General

10.1 All staff have a general responsibility to keep ambulances and specialist vehicles (Mental Health) clean and reduce the risks of cross infection to themselves, patients, colleagues, other healthcare professionals and members of the public.

10.2 This is best achieved by all crews participating in frequent IPC cleaning activities at defined times such as, but not limited to:

- Before commencing their first job if required;
- After every patient contact;
- 5 Moments of hand hygiene;
- On exposure to confirmed or suspected infectious patients or materials;
- On accidental exposure to bodily fluids;
- At the end of every duty shift.

10.3 These cleaning activities must be undertaken with the appropriate cleaning materials provided by ERS Medical (see Section 15) whether equipment or surfaces appear contaminated or not.

Mops and Buckets

10.4 **ERS Medical has adopted the national colour coding standard for the management of mops and buckets.**

10.5 **This management protocol requires that specific colour coded mops and buckets are provided and used for specific areas such as:**

- **RED:** Toilets and Shower areas;
- **Yellow:** Ambulance interiors;
- **Green:** Kitchen and Dining Areas;
- **Blue**: General Areas.

10.6 For the specific management of mops and buckets, please refer to **WI/6.03.03 – IPC Environmental Management.**

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11. Cleaning / Decontamination Levels

11.1 Cleaning and decontamination has been broken down into 5 distinct levels for ease of understanding and measurement. These cleaning and decontamination levels are:

- **Level 1:** Pre-Shift if required**;**
- **Level 2:** Patient Handover – After every patient**;**
- **Level 3:** Risk of contamination i.e. where there has been an exposure to bodily fluids**;**
- **level 4:** Post shift;
- **level 5:** Scheduled deep cleans.

12. Level 1 – Pre-Shift

12.1 In order to ensure that all practicable measures are taken for the safeguarding and wellbeing patient's, carers, other healthcare professional, staff and sub-contractors certain IPC actions will need to be undertaken by crews, prior to departing their sites at the start of their duty shift.

12.2 These actions will include but not be limited to:

- The ambulance is clean and presentable (inside and exterior);
- Sufficient IPC materials are available for the duration of shift;
- Vehicle is clear from clinical waste & dirty laundry;
- Sharps boxes are present and in compliance with BMS/6.03;
- All staff are bare below the elbow and in compliance with WI/6.03.01(;
- All 'sterile' single use medical devices are in sealed wrapping and in date;
- All equipment is clean, present and ready for use (see vehicle loading list).

12.3 Level 1 cleaning and decontamination crew actions will be recorded within each specific vehicle Daily Vehicle Inspections (DVI) by the crew by both ticking the appropriate boxes and annotating the vehicle 'Left clean' box with their response and signature.

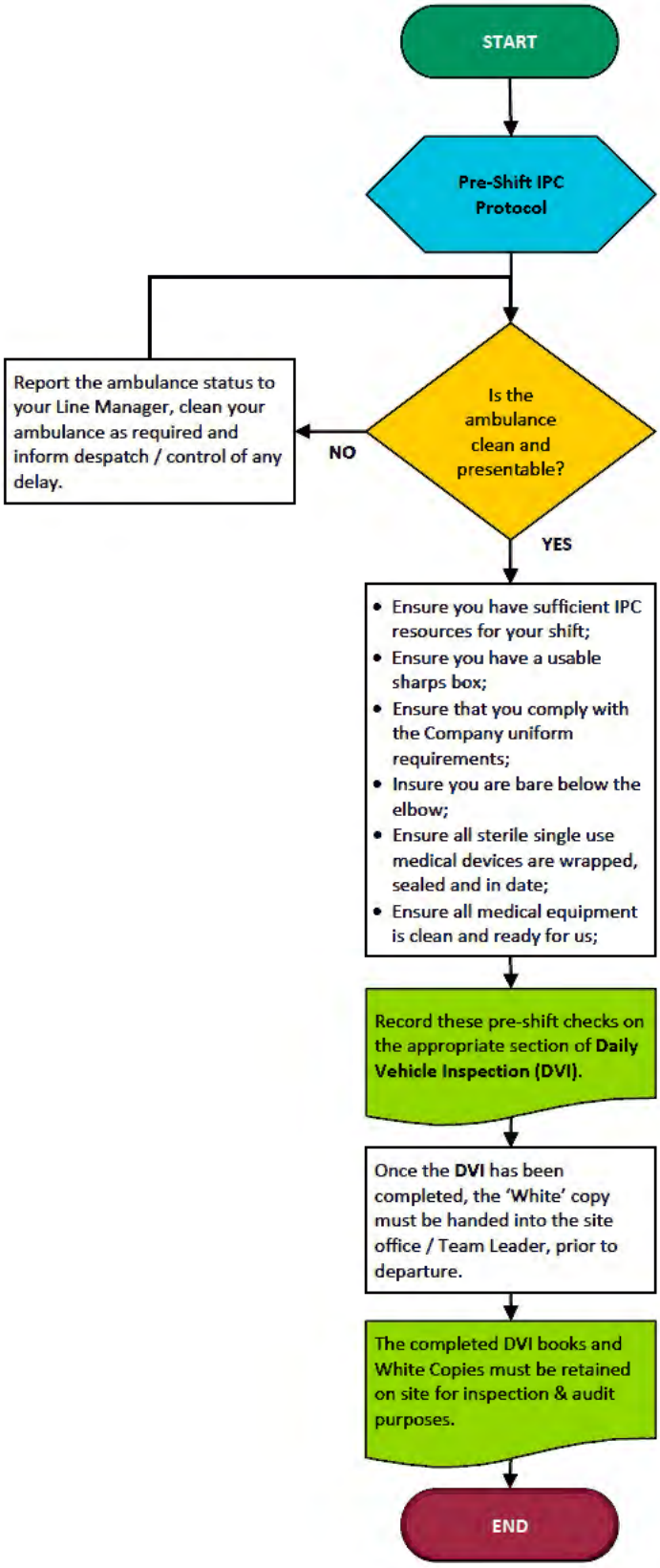
12.4 Once filled in and completed the 'White' copy of the DVI book should be removed from the book and handed into the site office / Team Leader. The DVI book should then remain on the vehicle until needed again.

12.5 Operations Managers and Team Leaders are to ensure that all manned resources submit their 'White' page of the DVI book before the commencement of their shift and prior to departing site for their first task.

12.6 The completed DVI books and 'White' copies of the DVI book will be retained at site for the purposes of inspection and audit.

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13. Level 1 – Key Steps – Start of Shift



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14. Level 2 – After Every Patient

14.1 In order to safeguard the health and wellbeing of patients, carers, other healthcare professionals, staff and sub-contractors, good IPC protocols require that cleaning takes place after each and every patient contact. Specific guidance on known infections can be found on the Care Quality Teams intranet site page named 'Specific IPC Exposure Guidance'.

14.2 These cleaning protocols are established to minimise the risk of either direct or indirect transfer of infectious substances and to maintain the high standards of cleanliness required by the Company, our customer and patients and the Care Quality Commission.

14.3 After every patient contact staff are required to:

- Wash/Clean their hands (WHO 5 Moments of Hand Hygiene);
- Don appropriate IPC PPE if required (gloves & aprons etc);
- Remove all linen and bag as required (white – non-soiled – red (double bagged) –soiled linen);
- Clean all medical re-usable medical equipment (monitors, sphygmomanometers, stethoscopes);
- Dispose of any discarded single use medical devices used appropriately (clinical waste or sharps bins);
- Clean all surfaces that the patient has had contact with (trolley, seats, grab rails etc);
- Decontaminate floor surfaces using the appropriate ChemEx / Neilsen Chemicals product and colour coded mop and bucket (if available and if required);
- Dispose of any used cleaning materials, i.e. wipes or roll as clinical waste;
- Remove any IPC PPE that was worn and dispose of as clinical waste;
- Wash/Clean their hands (WHO 5 Moments of Hand Hygiene).

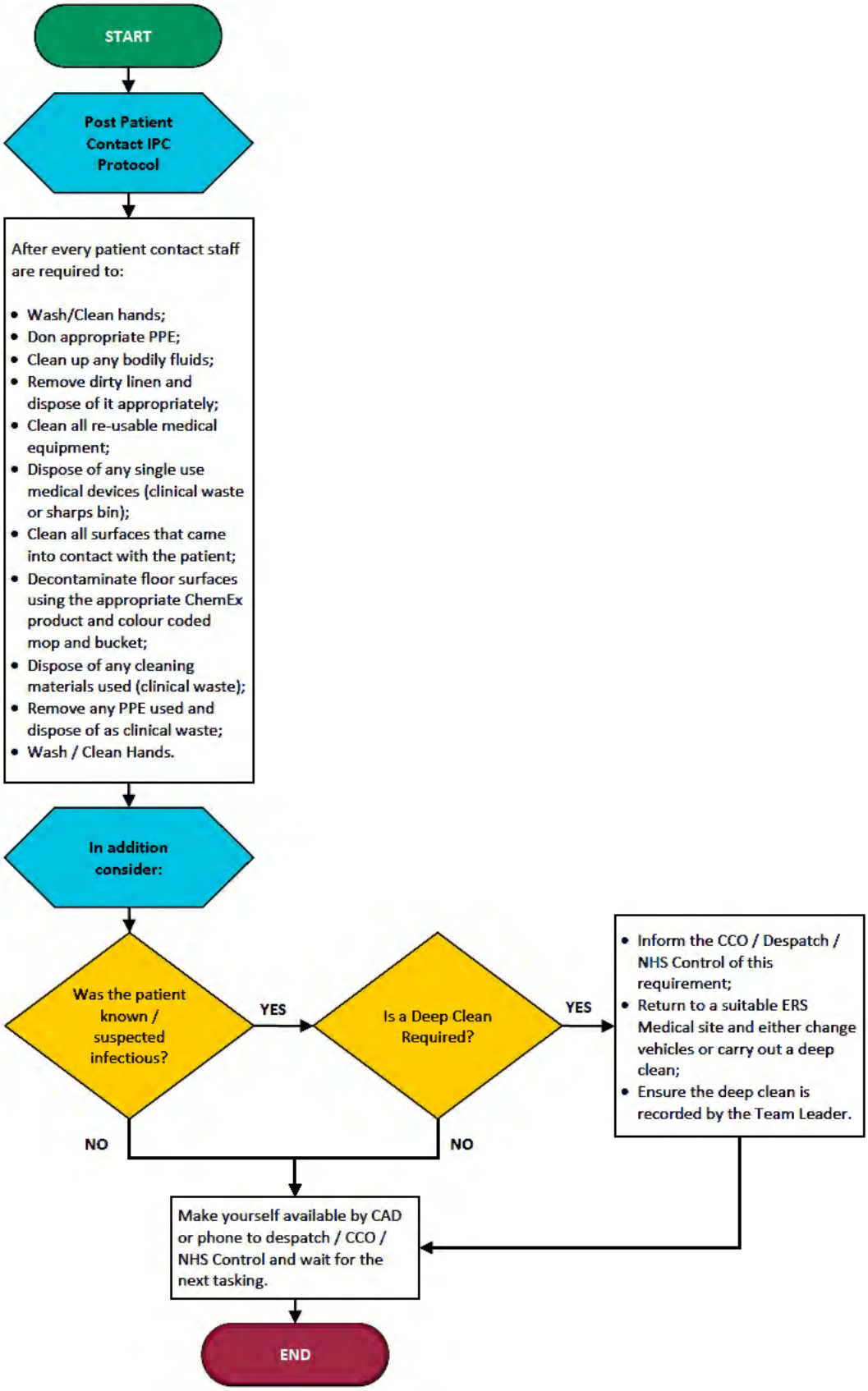
14.4 In addition to these standard cleaning protocols crews should consider the following:

- Was the patient known to be or suspected of being infectious;
- In the case of patients with either confirmed or suspected MRSA or C-Difficile, diluted (via the pre-metered ChemEx / Neilsen Chemicals dosing station) Bacticlean / Bactercidal All-Purpose Cleaner is sufficient to manage the IPC risks. There should be no requirement to return to base, so long as there has been no exposure of bodily fluids (see Level 3);
- Does any known or suspected infectious status require a Deep Clean;
- Do I need to inform the CCO / Despatch or NHS Ambulance control.

14.5 Guidance on when a Deep Clean is triggered can be found at Section 20 of this work instruction.

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15. Level 2 – Key Steps – After Every Patient



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16. Level 3 – Risk of Contamination (Exposure to Blood and Bodily Fluids)

16.1 The effective management of all exposures to blood and bodily fluids, either by design during a procedure or accidentally as a result of s spillage is a crucial factor in IPC management and the controlling the spread of infection.

16.2 All spillages must be dealt with promptly with the materials provided by the Company (Antibak / Terminex Powder / spray).

16.3 In the event of a spillage of blood or bodily fluids the following methods should be used.

16.4 If a patient has confirmed MRSA or C-Difficile and there has been exposure to bodily fluids additional decontamination, above and beyond those already conducted as part of level 2 cleaning will be required.

16.5 This will require the crew and vehicle to proceed to the nearest Company facility with ChemEx / Neilsen Chemicals resources and in particular Antibak / Terminex. This is a requirement as once diluted Antibak / Terminex is only effective for 8 hours and it must be used in a diluted form (detailed instruction on the use of Antibak / Terminex can be found within the ChemEx / Neilsen Chemicals folder.

Low Risk Body Fluids (Non-Blood)

16.6 Don any appropriate PPE required (disposable gloves, aprons etc).

16.7 Soak up as much of the spill as possible using paper towels or blue roll, until it is convenient and safe to deal with it fully.

16.8 All soiled paper towels and blue roll should be treated as clinical waste and placed in a clinical waste bag. Any soiled linen should be disposed of in the same manner (disposable single use linen only).

16.9 Once these initial actions have been completed the following should be adhered to:

- Mop up any remaining excess organic matter with paper towels and blue roll and dispose of previously used;
- Clean surface thoroughly with Bacticlean / Bactercidal All-Purpose Cleaner spray and paper towels and blue roll. Detergent wipes can be used as an alternative to this if available;
- Return to base to use main ChemEx / Neilsen Chemicals dosing station IPC resources and diluted Antibak / Terminex;
- Decontaminate floor and all contact surfaces using the appropriate ChemEx / Neilsen Chemicals product (diluted Antibak / Terminex) and colour coded mop and bucket, following the ChemEx / Neilsen Chemicals use guidance instructions;
- Dispose of any cleaning materials used as clinical waste;
- Dispose of PPE as clinical waste;
- Wash hands thoroughly.

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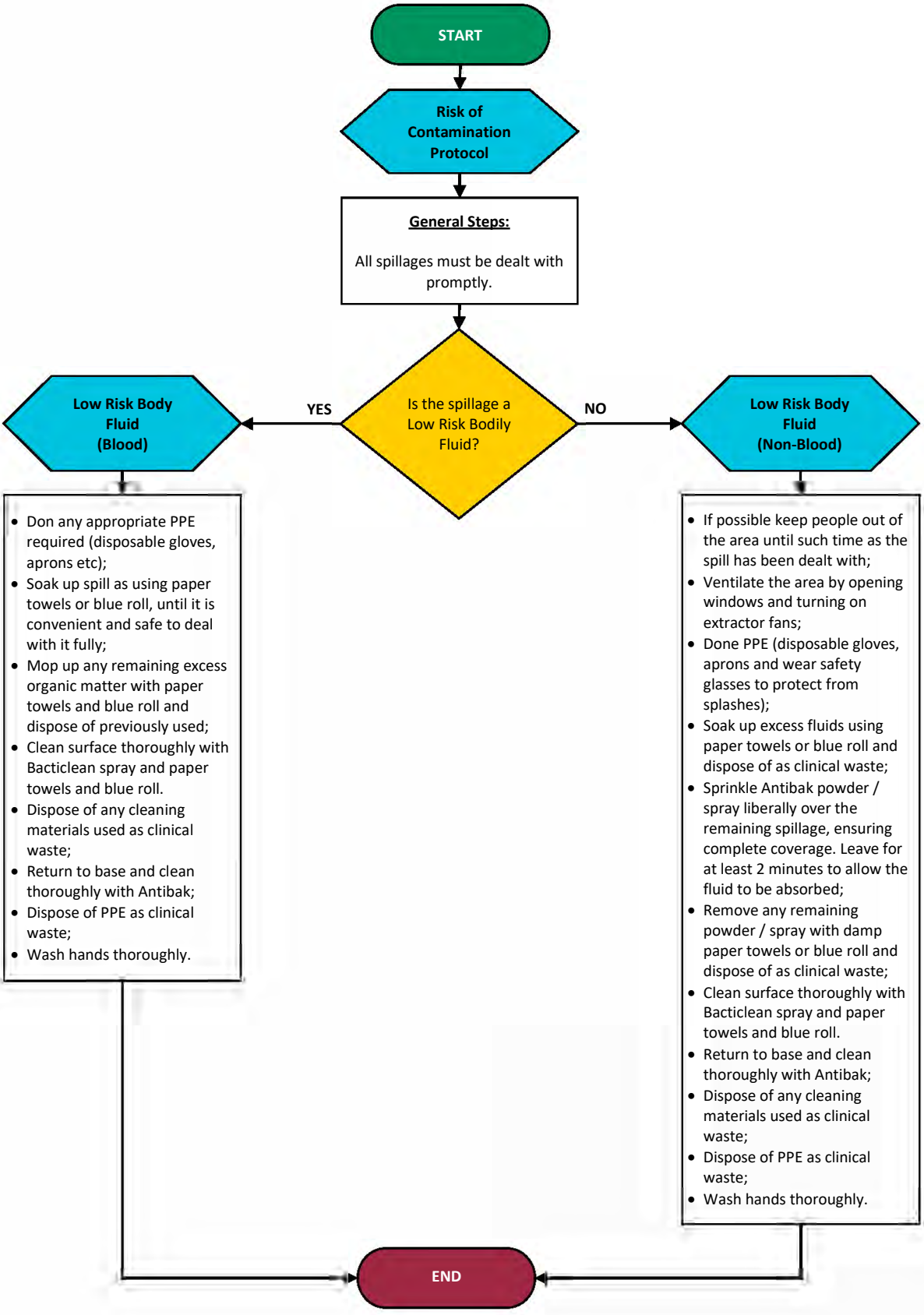
High Risk Body Fluids (Blood)

16.10 Follow the initial steps as per Low Risk Body Fluids (Non-Blood) and then:

- If possible, keep people out of the area until such time as the spill has been dealt with;
- Ventilate the area by opening windows and turning on extractor fans;
- Done PPE (disposable gloves, aprons and wear safety glasses to protect from splashes);
- Soak up excess fluids using paper towels or blue roll and dispose of as clinical waste;
- Sprinkle the contents of the spill kit powder / spray liberally over the remaining spillage, ensuring complete coverage. Leave for at least 2 minutes to allow the fluid to be absorbed;
- Remove any remaining powder / spray with damp paper towels or blue roll and dispose of as clinical waste;
- Clean surface thoroughly with Bacticlean / Bactercidal All-Purpose Cleaner spray and paper towels and blue roll. Detergent wipes can be used as an alternative to this if available;
- Return to base to use main ChemEx / Neilsen Chemicals dosing station IPC resources and diluted Antibak / Terminex;
- Dispose of any cleaning materials used as clinical waste;
- Dispose of PPE as clinical waste;
- Wash hands thoroughly.

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17. Level 3 – Key Steps - Exposure to Blood and Bodily Fluids



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18. Level 4 – Post Shift

18.1 At the end of each shift, irrespective of whether the ambulance / specialist vehicle (Mental Health) is being handed over to another crew a standardised post shift routine will be undertaken and recorded on the yellow page of the DVI book.

18.2 The yellow copy should then be handed into the site Operations team.

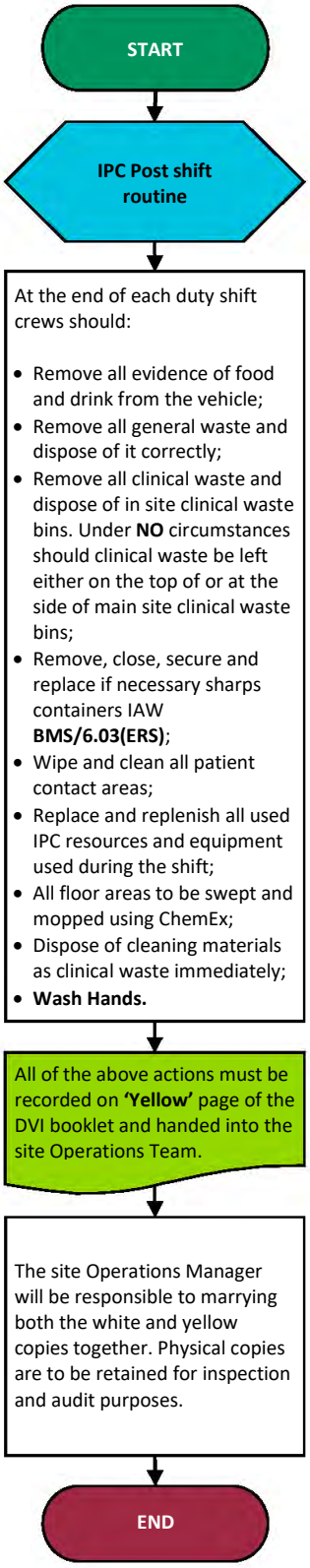
18.3 The Operations Manager is to then marry the 'White' and 'Yellow' copies of the DVI book together. All physical copies will be retained on site for inspection and audit purposes. Pink copies of the DVI book will remain in the book and on the vehicle.

18.4 This routine will include all items listed on the DVI 'Yellow' copy and but not be limited to:

- All evidence of food and drink removed from the vehicle;
- All general waste removed from the vehicle and disposed of within the correct waste stream;
- All clinical waste removed from the vehicle and deposited in the main site clinical waste bin. Under NO circumstances should clinical waste bags be left at the side or on top of clinical waste bins;
- If full or out of date sharps containers should be closed and secured and if necessary removed and replaced (see BMS/6.03(ERS) for more details);
- All patient contact areas wiped down and cleaned;
- All IPC resources and equipment used during the shift are replaced and replenished;
- All floor areas are swept and mopped using the appropriate ChemEx / Neilsen Chemicals products and colour coded mop and bucket;
- Dispose of any used cleaning materials as clinical waste immediately;
- Wash hands.

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19. Level 4 – Key Steps – Post Shift



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20. Level 5 – Deep Clean

20.1 Deep cleans form an essential part of ERS Medical's IPC strategy for safeguarding the health and welfare of our patients, staff and others who use our services or come into contact with out vehicles and crews.

20.2 Robust deep clean protocols and schedules will help reduce the risk and likelihood of any cross infections to staff, patients, other service users and others.

20.3 Deep cleans require the complete and systematic decontamination of the ambulance and all of its associated medical equipment and devices including patient handling equipment and aids, in a suitable and defined deep clean area at site.

20.4 This dedicated deep clean area should not be used for,:

- The storage of other medical supplies and equipment;
- The storage of vehicle parts and consumables;
- Any vehicle maintenance activities;
- Any work activities that are not conducive with Deep Clean protocols.

Deep Clean and Required Resources

20.5 Ideal resources required to complete a vehicle and equipment deep clean are (these may not all be available at every location):

- Access to a ChemEx / Neilsen Chemicals dosing station;
- Access to bulk IPC stores to replenish IPC materials for the ambulance (hand santisers);
- Access to ChemEx / Neilsen Chemicals products no dispensed by the dosing station (blue roll, Antibak / Terminex powder / spray);
- Access to hot and cold running water;
- Appropriate colour coded mob and bucket;
- Clinical waste facilities for the disposal of all cleaning materials;
- Control of access and egress to the deep clean area.
- Designated deep clean area with pre-identified dirty and clean equipment areas;
- Electricity supply for any powered items of cleaning equipment (vacuum cleaner);
- F6.03.04(ERS) – Deep Clean Record;
- Residual Current Detector (RCD) to protect staff from the electrical hazard;
- Suitable and sufficient IPC PPE (disposable gloves, aprons, spectacles, facemasks);
- Suitable lighting and heating to complete the activity.

20.6 All ambulances should receive an external clean prior to the commencement of a deep clean, if local weather conditions permit.

20.7 Ensure you have a copy of the **F6.03.04 – Deep Clean Record** to aid as guidance and record the areas decontaminated.

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20.8 All equipment removed from ambulances for the purposes of a deep clean are to be considered dirty and as such deep cleaners should don appropriate IPC PPE (disposable gloves and aprons).

20.9 Remove all medical equipment & medical devices, including all items stored in lockers and cupboards and any manual handling equipment and place in the designated dirty equipment area.

20.10 Decontaminate all medical equipment & medical devices using the appropriate ChemEx / Neilsen Chemicals products and materials, following the instructions detailed within the ChemEx / Neilsen Chemicals information folder.

20.11 As each individual item of medical equipment & medical device is decontaminated it should immediately be moved from the dirty equipment are to the clean equipment area.

20.12 Ensure that each decontaminated item is dried prior to moving to the clean equipment area.

20.13 Under NO circumstances is dirty equipment and clean equipment to be placed in the same area. Any breach of this protocol would mean that the equipment would need to be decontaminated again.

20.14 All used cleaning materials (blue roll / paper towels) should immediately dispose of as clinical waste.

20.15 All floor areas of the vehicle should be swept to remove obvious debris.

20.16 All lockers, cupboards and vehicle cab surfaces should be decontaminated and either dried or allowed to dry.

20.17 All ceiling, wall, flat surfaces and glasses areas should be decontaminated. Care should be taken in any area where there are electrical switches or sockets. All areas should be dried or allowed to dry.

20.18 All vehicle tracking or solo studs should be cleaned out and obvious debris and grime removed.

20.19 All used cleaning materials (blue roll / paper towels) should immediately dispose of as clinical waste.

20.20 All floors should be decontaminated using the appropriate ChemEx / Neilsen Chemicals products and colour coded mop and bucket.

20.21 Ventilate the vehicle for at least 15 minutes to allow any cleaning fumes and vapours to clear and the floor surfaces to dry.

20.22 Remove any used PPE, discard as clinical waste immediately and wash your hands.

20.23 Don disposable gloves prior to replacing decontaminated medical equipment and devices back onto the vehicle in the same positions as they came off.

20.24 Replenish any on board cleaning fluids and resources that were used during the deep clean.

20.25 Record the deep clean / decontamination on **F6.03.04 – Deep Clean Record** and sign. Hand this form to the site Operations Manager.

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20.26 The site Operations Manager will be responsible to updating the Fleet Database record for the deep clean and scanning the completed **F6.03.04 - Deep Clean Record** and uploading this, as evidence to the Fleet Database.

20.27 The original copy of the **F6.03.04 - Deep Clean Record** must be retained at site for the purpose of audit and inspection.

Deep Cleaning Staff Resource

20.28 In order to provide ERS Medical Operations Managers with differing models to best manage their responsibilities for deep cleaning vehicles that fall within their remit, the Company has provided them with 4 options, which are:

1. Locally employed staff;
2. Locally externally contracted services, in accordance with BMS/4.01 – Procurement and Supply Chain Management and the Approved Suppliers List);
3. Nationally / regionally externally contracted services BMS/4.01 – Procurement and Supply Chain Management and the Approved Suppliers List);
4. Operational ERS Medical crews for deep clean triggered for a cause other than a scheduled clean and when other options are not available.

Deep Clean Ambulance Schedule

20.29 To recognise the differing levels of risk within the services provided by ERS Medical and to adhere to industry standard cleaning timeframes, ERS Medical with adhere to the below detailed deep clean schedule.

Ambulance Type	Deep Clean Schedule
NEPTS Ambulances (all variants)	Every 90 Days
HDU & Frontline Ambulances	Every 45 Days
RRV's, GP Transport & Specialist Services (Mental Health) Vehicles	Every 90 Days

20.30 Deep clean schedules will initially be set and distributed to site by Fleet Team, within the Fleet Database. These dates will also be promulgated to site on the 3rd parties' fleet management annual fleet maintenance planner.

20.31 It will be the responsibility of the site Operations Manager to ensure that the vehicle deep clean schedule is adhered to and that any vehicles that go over this planned schedule have mitigation for this failure recorded at site and through the Fleet Team.

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Deep Clean Triggers

20.32 There will be occasions where a vehicle deep clean will have to be conducted before the scheduled date within either the Fleet Database or in the annual fleet maintenance planner issued by the 3rd party vehicle servicing and scheduling provider. These occasions will include, but not be limited to:

- Scheduled deep clean date has been reached;
- After transporting any patient that has been under source isolation protocols;
- Heavily soiled or visible contaminated vehicles (trauma patient).

20.33 Additional advice on deep clean triggers can be sought by contacting your site Care Quality Advisor.

20.34 Once a trigger has enacted a deep clean at site which falls outside of the scheduled deep clean regime for that vehicle the 45 day or 90-day schedule will be recalculated from the date of that deep clean.

20.35 The site Operations Manager will hold the responsibility to ensure that the Fleet database is updated with the revised schedule and that the Fleet Compliance Administrator is notified by email to ensure that central records match those at site.

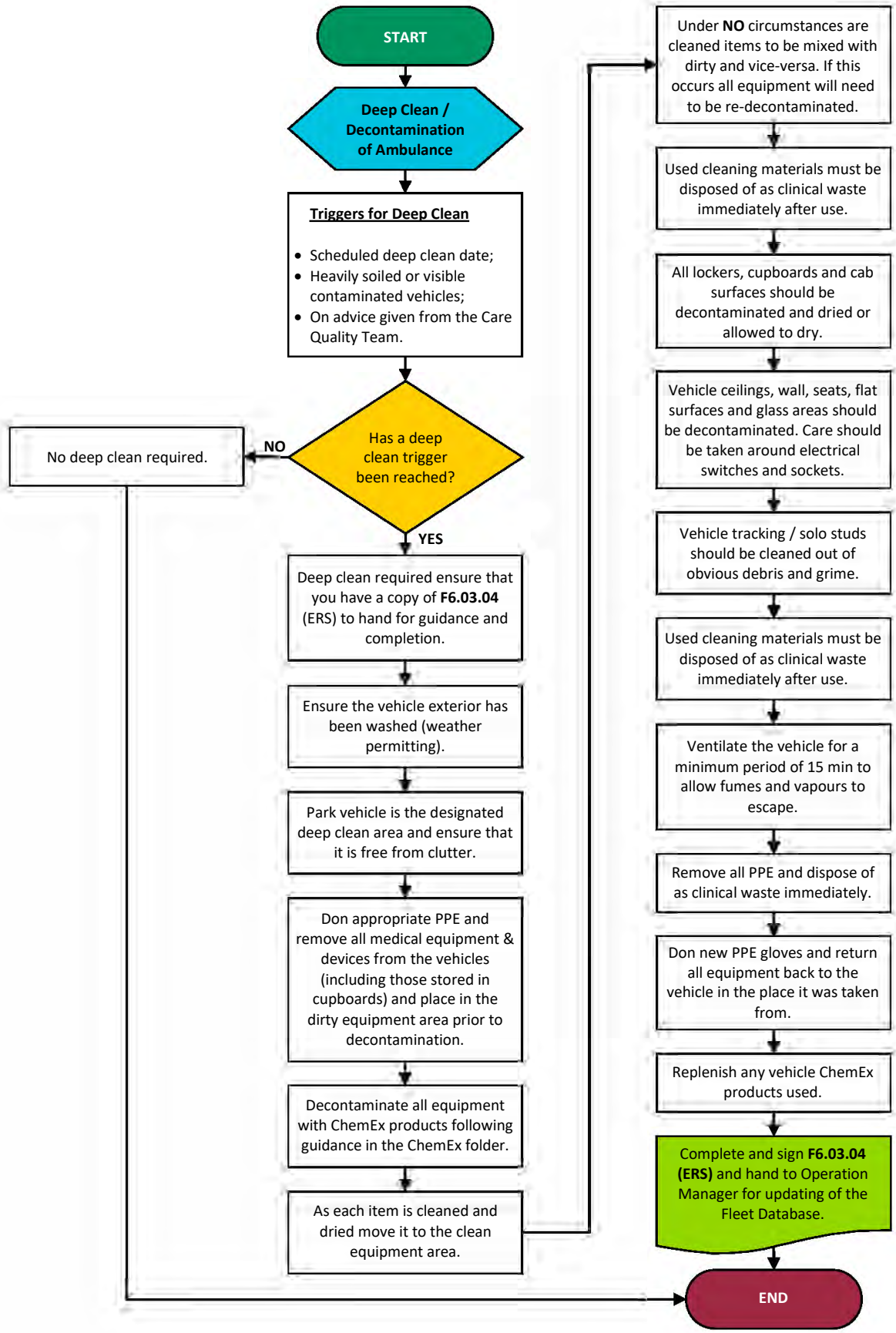
Vehicle Maintenance (planned and unplanned)

20.36 Where a vehicle is scheduled for a planned vehicle maintenance or has an unplanned vehicle maintenance requirement, it will be the responsibility of the site Operations Manager to ensure that the vehicle in question has undergone either a Level 1 – Pre-Shift Cleaning or Level 4 –Post Shift Cleaning regime, completed and recorded for its last operational duty shift, prior to being released for maintenance.

20.37 On return to operational availability crews should ensure that if required IAW with this work instruction a Level 1 – Pre-Shift clean is completed and recorded on DVI book.

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21. Level 5 – Deep Clean



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22. Central Fleet Resource

22.1 It will remain the responsibility of site Operations Manager to ensure that all vehicles that are currently allocated as a central fleet resource, but which are parked at their sites, are available to adhere to their specified deep clean schedule.

22.2 Additionally, they will hold the responsibility to ensure that all record keeping and reporting for these vehicles is done so in compliance with this work instruction.

22.3 It is imperative for the maximisation of fleet resource availability that these resources remain at a state of readiness so they can be brought on-line and into service with minimal delays.

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23. Decontamination of Medical Equipment and Medical Devices

23.1 Apart from when cleaning is required as part of a vehicles deep clean scheduled, either planned or unplanned medical devices and equipment will require decontamination as detailed in the table below.

Equipment & Medical Device	Method
Airways Body bags Catheters Entonox mouthpieces E.T. tubes & catheter mounts Facemasks Forceps (*Magills, Spencer Wells*) In line filters Intravenous cannulas Lancet devices Laryngoscope blades Nebulisers and tubing Oxygen masks and tubing Resuscitator bag and mask Umbilical scissors/clamps Vomit bowls Peak flow mouth pieces Linen (ERS Issued change after every patient)	Single Use Items – Disposable.
Blood glucose monitor Sphygmomanometer cuffs Pulse Oximetry Units Carry Chair Defibrillator and ECG monitor Laryngoscope Handles Pillows (plastic cover) Patient handling equipment (Mangar Elk, patient hoist, banana board etc) Scoop Stretcher Splints Spinal Board (including head blocks and straps) Stethoscopes Stretcher mattress and frame	After every patient use: clean the item with a detergent wipes or blue roll and Bacticlean / Bactercidal All-Purpose Cleaner. (If excessively contaminated with blood/body fluids please use Antibak / Terminex made up in trigger spray). See Section 4 of the ChemEx / Neilsen Chemicals Information Folder for Details.
Linen	Change after every patient
Bedpans / urinals	Single Use Items – Disposable.
Sphygmomanometer cuffs	Contamination with bodily fluids necessitates disposal and replacement.
Suction equipment	Suction jar liner: Single patient use only – dispose of as clinical waste. Casing: Detergent wipe then disinfect as above.
Tympanic thermometers	Earpiece: single use. Equipment casing: After every patient use: Detergent wipe then disinfects as above.
Wheelchair (handles, arm rests, seat and back rest)	After every patient use: Detergent wipe then disinfect as above.

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24. Inspection and Monitoring

24.1 In addition to the responsibilities that are detailed within Section 6 of this work instruction, ERS Medical Operations Managers, Care Quality Advisors, Fleet Compliance Managers, Fleet Compliance Administrators and where practicable Health and Safety Advisors will have responsibilities to ensure that site IPC inspections and records are maintained for:

- **Daily Vehicle Inspection Books – x1 per vehicle on site (White, Yellow & Pink copies);**
- **F6.03.03 - Deep Clean Records;**
- **F6.03.04 - IPC Inspection and Testing Form.**

Daily Vehicle Inspection Book (DVI)

24.2 It is the responsibility of the site Operations Manager through their Team Leaders to ensure that crewed ambulances have a completed white page from the VDI book completed and handed into site office or Team Leader prior to the crew departing site on their first tasking.

24.3 Yellow copies are completed at the end of every shift, irrespective if the vehicle is being handed over to another crew. Both the 'White' and 'Yellow' copies should then be married together for scanning and uploading to the Fleet Database. Physical copies are to be retained at site for inspection and audit purpose.

F6.03.03 - Deep Clean Record

24.4 It is the responsibility of the site Operations Manager through their Team Leaders to ensure that all ambulances undergo a full Deep Clean within the specified schedule for that particular vehicle type and IAW the requirements of this work instruction.

24.5 In all cases where a scheduled Deep Clean cannot be completed they must record at both site and on the Fleet Database any mitigating factors and circumstances for this failure and ensure that its scheduled deep clean is completed as soon as reasonable practicable.

24.6 Further to this they must also ensure that the vehicle record is updated on the 'Fleet Database and the original copy of the **F6.03.03(ERS)** - **Deep Clean Records** is retained at site and is freely available for the purposes of audit and inspections.

F6.03.04 – IPC Inspection and Testing Form

24.7 Operations Managers, Care Quality Advisors, Fleet Compliance Administrators and Health and Safety Advisors will retain the responsibility for completing site IPC inspections and testing. These should be conducted in accordance with the table below and recorded on **F6.03.04(ERS)** - **IPC Inspection and Testing Form**.

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24.8 Inspections schedules will be dependent upon the type of ambulance to be inspected (see table below).

Ambulance Type	Inspection Period
NEPTS Ambulances	Monthly
HDU & Frontline Ambulances	Monthly
RRV's & Specialist Services (Mental Health) Vehicles	Monthly

24.9 A copy of any completed **F6.03.04 – IPC Inspection and Testing Form** will be retained on site for the purposes of audit and inspection.

24.10 Care Quality Advisors should use the information captured within these forms to identify any immediate concerns that require attention and trends that show any degrading of the standards required by the Company.

24.11 Any degrading of the required standards or identified trend musts be acted upon by notifying the responsible site Operations Manager, providing advice and agreeing a remedial action plan with time frames for these actions to be completed.

24.12 All agreed timeframes should be in accordance with the severity of the identified issues and IAW with the guidance provided within **BMS/1.04 – Action Plans.**

24.13 RAPS will be discussed in detail at area Patient Safety Committee meetings.

Swabbing

24.14 Swabbing of ERS Medical ambulances will only be undertaken by and at the discretion of Care Quality Advisors. Swabbing results will be recorded on **F6.03.04 – IPC Inspection and Testing Form.**

24.15 A suggested methodology and regime for ambulances and premises swabbing can be, but not be limited to:

Location	Number of Swab Area	Examples of Swab Areas
Ambulance Cab	2	Steering Wheel Handbrake Door Handles Window winders or buttons Masternaut system
Ambulance Clinical Area	3	Trolley Side Rails Trolley handles (front & rear) Trolley mattress Grab Bags Locker doors Carrychairs Seats & Seat Belts

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Location	Number of Swab Area	Specific Swab Areas
ERS Medical Premises	3	Shower areas Kitchen areas Clinical waste bin handles ChemEx / Neilsen Chemicals Dosing Station Buckets Tablet charging / storage area
CCO / Helpdesks / Despatch / Offices	2	Telephone receivers Telephone keys Computer keyboards Computer mice Photocopier machines Fax machines

24.16 ERS Medical premises should be inspected and swabbed in accordance with the requirements of **WI/6.03.03 – IPC Environmental Management**. Please refer to this WI for more detail.

24.17 All remedial action plans must be formally recorded on **F1.04.01 – Remedial Action Plan** and sent to the Care Quality Manager for recording on SteriPoint.

IPC Audits

24.18 It will be the responsibility of the Care Quality Team, to conduct all IPC compliance audits for each ERS Medical location within their area of responsibility at least once per quarter as part of the care quality audit schedule.

24.19 All will be detailed within the internal audit schedule of the Regulatory Compliance Team's SteriPoint page in accordance with **BMS/1.03 - Audit**.

24.20 Where sites have demonstrated sustained compliance with the requirements of **BMS/6.03 – Infection Prevention and Control (IPC)** and its associated WI's and forms this audit scheduled can be relaxed to a 6 monthly audit regime.

24.21 The decision to relax any site audit schedule must be made from a recommendation of the relevant Care Quality Advisor to the Head of Care Quality.

24.22 All audits should be recorded on the **F1.03.01(IPC) - Clinical Quality and Governance Site Compliance Audit** which is available from the Business Management System (BMS).

24.23 It will be the responsibility of the Care Quality Manager to:

- Coordinate all Care Quality Team audits with the Group BMS Manager;
- Publish completed audits to SteriPoint;
- Ensure that RAP's are raised and recorded IAW with **BMS/1.04 – Action Plans**;
- Report to the Head of Care Quality any significant findings and or trends identified as a result of audit.

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25. Annex A – Guidance and Glance – Which ChemEx / Neilsen Chemicals Product Where

GUIDANCE AT A GLANCE – WHICH CHEMEX PRODUCTS WHERE?

Information to staff on where specific ChemEx products should be used.

BACTICLEAN



Bactericidal cleaner and degreaser. Use on all surfaces.
Spray on using trigger spray. Wipe off with blue roll.
Kills bacteria and viruses on contact.
Dispose of all cleaning materials used as clinical waste

POWERFORCE



Heavy duty grime remover. Use on floors and vehicle exteriors.
Dispense no more than ¼ of a bucketful.
Mop on or apply with brush. Agitate and leave to dwell briefly. Wash off.
This is a caustic product. Do not allow to dry. Wear gloves and goggles.





HAZEAWAY



Concentrated Screen Wash
Only to be dispensed from the dosing station.
DO NOT USE NEAT.



ANTIBAK



FOR EMERGENCY DECONTAMINTAIONS AND DEEP CLEANS ONLY
High-level sporicidal and virucidal disinfectant for emergency decontaminations where Norovirus and C-Difficile is suspected.



CITRUS TOILET FRESH



Heavy duty toilet cleaner and descaler. Use in toilet bowl **only**.
Squirt around the inside of the toilet bowl. Agitate with a toilet brush if necessary, to remove heavy soiling. Leave to dwell.



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Site:	All locations where patient care and treatment is provided for or on behalf of ERS Medical.
Area, Process or Task:	All operational locations where care and treatment is provided
Assessment Ref:	ERS/IPC/01/2017
Assessment Date:	03/07/17
Next Review Date:	03/07/18
Description of Task:	Risk Assessment for Infection Prevention and Control (IPC) and the Prevention and Control of Healthcare Associated Infections (HCIA's) In compliance with The Health and Social Care Act: Code of Practice on the prevention and control of infections and related guidance (2008 and drafted guidance 2014).

Table 3 – Impact / Severity							
	Catastrophic	5	5	10	15	20	25
	Major	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5
Risk = Table 2 - Likelihood x Table 3 - Impact			1	2	3	4	5
			Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain
			Table 2 – Likelihood / Probability				

Action Guide					
Risk Rating		Action Level	Action time scale	Remedial Action Owner	Decision to Accept Risk
Green	Low	Observations	12 months or more	Health and Safety Advisor. .	Site Operations Manger
Yellow	Low to Medium	Recommendations / Continuous Improvement	6 to 12 months	Health and Safety Advisor.	Site Operations Manager
Orange	Medium	Further Additional Controls	3 to 5 months	Health and Safety Advisor and Health and Safety Manager.	Regional General Manager and Site Operations Manager.
Red	Medium to High	Further Additional Controls / Process, Task, Activity Review / Escalation	2 weeks to 2 Months	Health and Safety Advisor and Health and Safety Manager	General Manager / Senior Management.

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Staff exposure to an infectious disease or an infection	Potential transmission of an infectious diseases and or an infection by direct or indirect contact	All patients and staff with contact to patients and others.	(4 x 3) = 12	Staff with patient contact to undertake IPC induction and mandatory training, to improve knowledge and understanding of IPC. All staff to access and adhere to the IPC procedures and work instructions (BMS/6.03). Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional PSC and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6
Occupational exposure to a needle sticks or bites injury.	Potential transmission of an infectious diseases and or an infection by direct or indirect contact. v	All staff with patient contact, patients and others.	(4 x 3) = 12	Staff with patient contact to undertake IPC Induction and mandatory IPC training, to improve knowledge and understanding of IPC. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). Provision of appropriate sharps bins, training and information on the correct protocols for invasive procedures. Robust, clear and appropriate immediate actions and Occupational Health support services. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6
Incorrect disposal of infectious or clinical Waste / Linen	Potential transmission of an infectious disease and or an infection by direct or indirect contact	All staff with patient contact, patients and others	(3 x 3) = 9	All staff with patient contact to undertake IPC induction and mandatory IPC training, to improve knowledge and understanding of IPC. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). Provision of sharps bins / receptacles, clinical waste bins and bags. Robust procedures for dealing with dirty and soiled. The use of disposable linen. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Low staff compliance with the company uniform policy, Including bare below the elbows (BBE) and Personal Protective Equipment (PPE) i.e. Long sleeves, wearing jewellery, false nails, nail polish or watches	Potential transmission of an infectious disease and or an infection by direct or indirect contact.	All staff with patient contact, patients and others	(3 x 3) = 9	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of BBE and PPE. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). Provision of suitable and sufficient qualities of approved Company uniform and the use and enforcement of the staff policy. To introduces auditing and monitoring of all clinical staff. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6
Poor hand hygiene compliance. Limited provision and access to hand washing facilities.	Poor hand hygiene compliance can directly result in the transmission of harmful micro-organisms and HCAI's to patients and staff.	All staff with patient contact, patients and others.	(4 x 3) = 12	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the importance of Hand hygiene. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). The provision of suitable quantities of all hand hygiene products and materials. To conduct hand hygiene audits and data systems to monitor compliance. The use of IPC posters, electronic systems and staff notices to high light good practice. To conduct internal and external IPC audits and inspections. To promote the use of alcohol hand gel to unsoiled hands. The provision of suitable and sufficient waste receptacles for used and or discarded of PPE and clinical waste materials. Auditing and monitoring of compliance for hand hygiene. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Hand decontamination not performed before and after each patient contact or activity.	Poor hand hygiene compliance can directly results in the transmission of harmful micro-organisms and HCAI's to patients and staff.	The patient, staff and others	(3 x 3) = 9	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the importance of Hand hygiene All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). The use of IPC posters, electronic systems and staff notices to re-enforce good practice. To monitor hand hygiene compliance via a robust audit process. The provision & access to hand sanitisers for all clinical staff, which may not have direct access to hand washing facilities Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6
Clinical staff not applying PPE (gloves & aprons etc) appropriately.	Staff not applying PPE appropriately can lead to the transmission of harmful micro-organisms and HCAI's to patients and staff. Hands and uniforms could become contaminate either by direct or indirect contact with infected patients.	The patient, staff and others	(4 x 3) = 12	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the use of PPE. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). To ensure that there is accessibility and sufficient amounts of PPE. The use of IPC posters, electronic systems and staff notices to re-enforce good practice. To conduct internal and external audits and collect audit data. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Poor aseptic techniques and not adhering to best practice or protocols.	Poor aseptic technique and poor clinical practice can directly lead to the transmission of harmful micro-organisms and HCAI's which could result in a patient(s) developing a blood stream infection and patient death.	The patient, staff and others	(4 x 3) = 12	Only suitably qualified and trained staff to carry out aseptic techniques. Robust aseptic and IPC training for all suitable qualified staff on induction and during CPD. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). The use of IPC posters and staff notices to re-enforce good practice. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6
Sharp(s) items not disposed of immediately after use and in the correct sharps container.	The inappropriate use and disposal of sharps can lead to occupational exposure resulting in sharps injury to patients, staff or others. The incorrect disposal of sharps disposal may result in a fine to the organisation.	The patient, staff and others	(4 x 3) = 12	Only suitably qualified and trained staff to carry out aseptic techniques. Robust aseptic and IPC training for all suitable qualified staff on induction and during CPD. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). The use of IPC posters and staff notices to re-enforce good practice. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(2 x 3) = 6
Potential Sterile single use equipment being reused.	Poor compliance and practice can directly results in the transmission of harmful micro-organisms and HCAI's to patients and staff	Patients and others.	(2 x 3) = 6	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the use of single use medical devices. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). To ensure that there is accessibility and sufficient amounts of PPE. The use of IPC posters, electronic systems and staff notices to re-enforce good practice. To conduct internal and external audits and collect audit data. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards. External support from Occupational Health support services if required.	(1 x 3) = 3

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Damaged packaging or Out of date and or sealed sterile clinical equipment being used.	Degrading of the clinical equipment due to exceeding its shelf life and the possibility of contamination to the equipment through the damaged exterior packaging.	Patients and others.	(4 x 3) = 12	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the use of sterile equipment. All clinical staff should adhere to best practice .All ambulance equipment should be checked for its condition and expiry date on a daily basis. All damaged and life exceeded equipment should be removed, discarded and replaced immediately. Equipment should be subject to audit and inspection to ensure that only in date and serviceable equipment is deployed.	(2 x 3) = 6
Equipment / Medical devices not being decontaminated between patients.	Poor compliance and practice can directly results in the transmission of harmful micro-organisms and HCAI's to patients, staff and others. which could result in a patient(s) developing a blood stream infection and patient death	Patients and others, staff.	(4 x 3) = 12	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the decontamination of equipment. The provision of suitable and sufficient quantities of cleaning resources (products and equipment). Training to staff on the correct use of these resources and the required frequency of the cleaning and decontamination regimes. The use of IPC posters and staff notices to re-enforce good practice. Monitoring by IPC audits and environmental inspections including data collection. To document and report data findings to the PSA. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Occupational Health support services.	(2x 3) = 6
Equipment / Medical devices not being decontaminated as part of a routine and or deep clean regime.	Poor compliance and practice can directly results in the transmission of harmful micro-organisms and HCAI's to patients, staff and others.	Patients, others and staff.	(3 x 3) = 9	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the decontamination of equipment. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). The provision of suitable and sufficient quantities of cleaning resources (products and equipment) Training to staff on the correct use of these resources and the required frequency of the cleaning and decontamination regimes. The use of IPC posters and staff notices to re-enforce good practice. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards.	(2 x 3) = 6

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Interior ambulance surfaces not being decontaminated between patients.	Poor compliance and practice can directly results in the transmission of harmful micro-organisms and HCAI's to patients, staff and others .which could result in a patient(s) developing a blood stream infection and patient death. Cross infection from poor or incorrect cleaning and decontamination techniques and protocols being followed.	Patients, others and staff	(3 x 3) = 9	All staff with patient contact to undertake IPC induction and mandatory IPC training to improve knowledge and understanding of the decontamination of ambulance surfaces. The provision of suitable and sufficient quantities of cleaning resources (products and equipment). All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). Training to staff on the correct use of these resources and the required frequency of the cleaning and decontamination regimes. The use of IPC posters and staff notices to re-enforce good practice. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards.	(2 x 3) = 6
Ambulance site facilities not being cleaned and decontaminated as part of a routine and or deep clean regime.	Cross infection from poor or incorrect cleaning and decontamination techniques and protocols being followed.	All staff, patients and others.	(3 x 3) = 9	The provision of suitable and sufficient quantities of cleaning resources (products and equipment). Training to staff on the correct use of these resources and the required frequency of the cleaning and decontamination regimes. All staff to access and adhere to the IPC procedures & work instructions (BMS/6.03). The use of IPC posters and staff notices to re-enforce good practice. Monitoring by IPC audits and environmental inspections including data collection. The provision of suitable and sufficient waste receptacles for used and or discarded clinical waste materials. Monitoring by IPC audits and inspections including data collection. To document and report findings and trends to the regional GaPS and Head of Care Standards.	(2 x 3) = 6

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Assessment – Identify the hazard(s) present, the people who are or may be affected and the current control measures in place.					
Hazard	**Risk**	**Persons Potentially Affected**	**Initial Risk Rating (SXLP = IRR)**	**Current Controls**	**Residual Risk Rating (SXLP) = RRR)**
Illness through exposure to known pathogens as detailed within BMS/2.03 - Team Member Health and Wellbeing	Risk of infection, through exposure, to ERS Medical Team Members from either direct or in-direct exposure to known pathogens	Tier 1 Team Members: Make Ready Operatives (Deep Clean) and Mental Heath Staff.	(2 x 3) = 6	Compliance with the 'Green Book - Chapter 12 Compliance with BMS/2.03 - Team Member Health & Wellbeing Compliance with BMS/2.01 - Human Resources Compliance withBMS/6.03 - IPC Compliance with BMS/5.02 - Incident Reporting & Investigation Training, Information and Signage Support from the Care Quality Team and its resources Provision of PPE for the purposes of IPC Provision of ChemEx decontamination products Waste Management Provision of Occupational Health Services	(1 x 3) = 3
		Tier 2 Team Members: ACA's, UCA's, ECA's, Technician, Paramedic in non frontline roles i.e. PTS / HDU	(3 x 3) = 9		(1 x 3) = 3
		Tier 3 Team Members: ECA's, Technician, Paramedic employed on front line duties	(4 x 3) = 12		(1 x 3) = 3

REQUIRED IMPROVEMENTS – For any of the hazards with a score of 6 and higher in the table above identify the required improvements (if any) to reduce the risk to ALARP						
Hazard (from table above)	**Additional Control(s) Required**	**Who Will Carry Out Action / RAP No.**	**Date Action to be Completed by**	**Re-score once action complete**		
				"P"	**"PS"**	**Risk Rating (numerical value and description)**

Comments:	All assessments must be added to the ERS Business Management system for management review.			
	Prepared and published by:	Simon Smith – Head of Care Standards	03/07/17	03/07/18

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ERS Medical

Hand Hygiene Inspection Form

Date:	
Time:	
Location:	
Inspectors Name:	
Staff Members Name:	
Clinical Grade:	
Home Site Location:	

Standards: Observation (no limit); Minor (up to 2 minor = Pass); Major (1 major = Fail)

5 Moments of Hand Hygiene: *Where they Observed or able to be observed?*		
Hand Hygiene Moments	**Standard**	**Observations and Comments**
Before patient contact:		
Before aseptic task:		
After exposure to bodily fluids:		
After patient contact:		
After contact with patient surroundings:		

Additional Hand Hygiene Observations	**Standard**	**Observations and Comments**
At the start of shift:		
Prior to and after eating or drinking:		
After carrying out a cleaning process:		
Between Patients:		
After using the toilet:		
After removing IPC PPE such as gloves and aprons:		
After changing or handling laundry:		
After handling waste: clinical or general:		

Overall Rating & Comments	**PASS** ☐	**FAIL** ☐
Comments:		

All inspections failing must be immediately addressed and reported to the staff members Line Manager for action in accordance with WI/6.03.01 – Infection Prevention and Control – People.

Inspectors Signature:	
Staff Members Signature:	

This form must be retained at site for audit and inspection purposes.

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Uniform Inspection Form

Date:	
Time:	
Location:	
Inspectors Name:	
Staff Members Name:	
Clinical Grade:	
Home Site Location:	

Standards: Observation (no limit); Minor (up to 2 minor = Pass); Major (1 major = Fail)

Uniform Compliance	Standard	Observations and Comments
Hair clean, neat and tidy and not loose & off the shoulder:		
Correct clinical grade epaulettes worn:		
ID card carried and displayed:		
Issued green shirt worn, clean & tidy:		
White T-Shirt (optional), clean & tidy:		
Issued trousers worn, clean & tidy:		
Black Boots (clean, polished with good grip):		
Plain Black Belt (No studs, Logos etc):		
Bare below the elbows (no watches or bracelets):		
Hand Sanitiser (worn or carried):		
Nails clean & tidy (no varnish, gels or extensions):		
Non-Uniform Items (details of any non-issued items worn):		

Overall Rating & Comments	PASS ☐	FAIL ☐
Comments:		

All inspections failing must be immediately addressed and reported to the staff members Line Manager for action in accordance with WI/6.03.01 – Infection Prevention and Control – People.

Inspectors Signature:	
Staff Members Signature:	

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ERS Medical

Vehicle Deep Clean Record

Vehicle Registration:		**Vehicle Type: (Please Select)**	A&E ☐	HDU ☐
Date:			NEPTS ☐	RRV ☐
Site:		**Mileage:**		
Call Sign:		**Deep Cleaners Name:**		

Planned Deep Clean:	☐	**Unplanned Deep Clean:**	☐

Check	Clean / Clean & Disinfect	Completed	Comments / Actions (e.g. Damaged or Missing)
Cleaning Process: Exterior			
1. All Panels	C	Yes ☐ / No ☐ / N/A ☐	
2. All Glass	C	Yes ☐ / No ☐ / N/A ☐	
3. Wheels & Arches	C	Yes ☐ / No ☐ / N/A ☐	
4. Mirrors	C	Yes ☐ / No ☐ / N/A ☐	
5. Lights	C	Yes ☐ / No ☐ / N/A ☐	
6. Number Plates	C	Yes ☐ / No ☐ / N/A ☐	
7. Door Handles	C	Yes ☐ / No ☐ / N/A ☐	
Cleaning Process: Cab Interior			
8. Vacuum Cab	C	Yes ☐ / No ☐ / N/A ☐	
9. Headlining	C&D	Yes ☐ / No ☐ / N/A ☐	
10. Doors / Bulkheads	C&D	Yes ☐ / No ☐ / N/A ☐	
11. Dashboard	C&D	Yes ☐ / No ☐ / N/A ☐	
12. All Seats (incl under seats)	C&D	Yes ☐ / No ☐ / N/A ☐	
13. Seat Belts	C&D	Yes ☐ / No ☐ / N/A ☐	
14. Steering Wheel	C&D	Yes ☐ / No ☐ / N/A ☐	
15. Footwells	C&D	Yes ☐ / No ☐ / N/A ☐	
16. Floor	C&D	Yes ☐ / No ☐ / N/A ☐	
Cleaning Process: Cab Area – Equipment (Caution with electrical devices)			
17. Masternaut Terminal	C&D	Yes ☐ / No ☐ / N/A ☐	
18. CAD Tablet Dock	C&D	Yes ☐ / No ☐ / N/A ☐	
19. Hands Free Kit	C&D	Yes ☐ / No ☐ / N/A ☐	
Cleaning Process: Cab Area – Saloon Area (Caution with electrical switches and devices)			
20. Empty Vehicle	C&D	Yes ☐ / No ☐ / N/A ☐	
21. Ceiling	C&D	Yes ☐ / No ☐ / N/A ☐	
22. Walls	C&D	Yes ☐ / No ☐ / N/A ☐	
23. All Cupboard Facias	C&D	Yes ☐ / No ☐ / N/A ☐	
24. All Cupboard Interiors	C&D	Yes ☐ / No ☐ / N/A ☐	
25. Storage Trays / Drawers	C&D	Yes ☐ / No ☐ / N/A ☐	
26. Work Surfaces	C&D	Yes ☐ / No ☐ / N/A ☐	

This form is to be scanned and uploaded to the Fleet Database. The original must be kept at site for audit and inspection purposes.

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Check	Clean / Clean & Disinfect	Completed	Comments / Actions (e.g. Damaged or Missing)
Cleaning Process: Cab Area – Saloon Area (Caution with electrical switches and devices)			
27. All Seats (incl under seats)	C&D	Yes ☐ / No ☐ / N/A ☐	
28. Seat Belts (all)	C&D	Yes ☐ / No ☐ / N/A ☐	
29. Windows	C&D	Yes ☐ / No ☐ / N/A ☐	
30. Floor	C&D	Yes ☐ / No ☐ / N/A ☐	
31. Tail Lift / Ramp	C&D	Yes ☐ / No ☐ / N/A ☐	
32. Switches Sockets	C&D	Yes ☐ / No ☐ / N/A ☐	
33. Equipment Brackets	C&D	Yes ☐ / No ☐ / N/A ☐	
34. Cleaner Dispensers	C&D	Yes ☐ / No ☐ / N/A ☐	
35. Fire Extinguisher	C&D	Yes ☐ / No ☐ / N/A ☐	
36. Stretcher & Housings	C&D	Yes ☐ / No ☐ / N/A ☐	
37. Hand / Grab Rails	C&D	Yes ☐ / No ☐ / N/A ☐	
38. Vents / Speakers / Grills	C&D	Yes ☐ / No ☐ / N/A ☐	
39. Skylights	C&D	Yes ☐ / No ☐ / N/A ☐	
40. Waste Receptacle	C&D	Yes ☐ / No ☐ / N/A ☐	
41. Doors Inside	C&D	Yes ☐ / No ☐ / N/A ☐	
42. Oxygen Housing / Flow Meters	C&D	Yes ☐ / No ☐ / N/A ☐	
43. Carrychair	C&D	Yes ☐ / No ☐ / N/A ☐	
44. Wheelchair	C&D	Yes ☐ / No ☐ / N/A ☐	
45. PAT Slide / MH Equipment	C&D	Yes ☐ / No ☐ / N/A ☐	
46. Baby Seat	C&D	Yes ☐ / No ☐ / N/A ☐	
47. Baby Pod	C&D	Yes ☐ / No ☐ / N/A ☐	
48. Child Booster Seat	C&D	Yes ☐ / No ☐ / N/A ☐	
49. Pedi-Mate	C&D	Yes ☐ / No ☐ / N/A ☐	

Start Time:		**Finish Time:**	
Total Cleaning Time:		**Date Scanned and Emailed to Fleet:**	
Comments:			
Deep Cleaners Name:		**Deep Cleaner Signature:**	

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IPC Inspection and Testing Form

Date:	
Time:	
ERS Site:	
Other Location:	
Type of Inspection:	A&E ☐ / HDU ☐ / NEPTS ☐ / RRV ☐
Inspector Name:	
Inspector Job Title:	
Date of Last Inspection:	
Last Inspection Result:	PASS ☐ / FAIL ☐
Vehicle Registration Mark:	
Vehicle Resource / CAD Number:	

Process:	Visual inspections and swab testing of specified areas and environments.
Standard:	To provide and maintain a clean and safe environment for patient's, staff, carers and other healthcare professionals in the provision of healthcare regulated activity. This will be recorded as a Pass or Fail.
Outcome:	Site premises, vehicles, medical equipment and devices ready for the provision of healthcare.

Vehicle Exterior Checks	Pass	Fail	Not Applicable	Comments
Vehicle Exterior:				
Tail Lift & Rails:				
Vehicle Steps:				
Vehicle Ramp:				
Windows:				
Vehicle Markings:				

Vehicle Cab Interior Checks	Pass	Fail	Not Applicable	Swabbed	Comments
Door pockets & storage:					
Vehicle controls:					
Communications and tracking systems:					

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Saloon Interior Checks	Pass	Fail	Not Applicable	Swabbed	Comments
Door handles and hand rails:					
Work surfaces:					
All walls and doors:					
Ceiling:					
Windows and blinds:					
Floor:					
Clamp tracking:					
Cupboard & draw exteriors:					
Cupboard & draw interiors:					
All seats and seat belts:					
Heating and ventilation ducks:					
All equipment brackets and mounts:					
All Seats & Mattress free from Rips & Tears:					

Medical Equipment & Devices	Pass	Fail	Not Applicable	Swabbed	Comments
Defib / Monitor Bracket:					
Response bag:					
Medical gases:					
Long boards / scoop / head blocks & straps:					
Trolley and mountings:					
Trolley accessories:					
Carry chair & mount:					

This form must be retained at site for inspection and audit purposes.
A copy must be scanned and emailed to the Care Quality Manager for central retention and reporting.

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Medical Equipment & Devices (continued)	Pass	Fail	Not Applicable	Swabbed	Comments
Clinical waste bin:					
Hand sanitiser and IPC materials:					
ePCR unit:					
All patient handling equipment:					
Fire extinguishers:					
WTOR's:					
Wheelchair (if fitted)					
Linen:					
Portable AED:					
Oxygen flow meters:					
Ventilator:					
Drugs Safe:					
Sharps receptacles and labelling:					
Manger Elk:					

Swab Results: (Care Quality Team Only) Post inspection action required	Pass	Fail	Comments

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Are all on board consumables in date?	YES / NO	**If out of date remove and replace**
Are all seats and the mattress free from tears and holes?	YES / NO	**If torn arrange repair and remove from service**

Overall Rating:	**PASS** ☐	**FAIL** ☐
Any fail requires a remedial action plan (F1.04.01) to be written and submitted to the Head of Care Standards in accordance with BMS/1.04 – Corrective and Preventive Actions (RAPs).		
RAP No.:	/ / /	

General Comments:	
Name of Inspector:	
Signature of Inspector:	

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Weekly Mop Management Record

This form is be completed on a weekly basis by site Operations Managers or their nominated Team Leader to the record the management and disposal of all mop heads IAW the requirements of **WI/6.03.03 – Infection Prevention and Control – Environmental Management.**

Enter the mop number(s), print your name and initial each section to record the disposal of each mop.

Site:		Date Started:		Date Ended:	

Enter Week Commencing:												
RED Mop(s) Toilets / Showers:	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(S):	Mop No(s):	Mop No(s):	Mop No(s):	M Mop No(s):	Mop No(s):
Blue Mop(s) General Areas:	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):
Green Mop(s) Kitchen / Dining Areas:	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):
Yellow Mop(s) Ambulance Interiors:	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):	Mop No(s):

By signing this form you are making a declaration that all mops have been managed in accordance with the requirements of WI/6.03.03.			
Site Managers Name:		Signature:	

This form must be retained at site for the purposes of audit and inspection.

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Daily Housekeeping Record

This form is be completed on a weekly basis by site Operations Managers or their nominated Team Leader to the record site housekeeping management IAW the requirements of **WI/6.03.03 – Infection Prevention and Control – Environmental Management.**

Enter the time and initial the relevant box to record that actions have been completed.

Site:		**Date Started:**		**Date Ended:**	

Enter Week Commencing:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Antibacterial Soap Dispensers:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Hand Sanitiser Dispensers:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Blue Roll / Paper Towels:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Crockery and Cutlery:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Kitchen Areas:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Fridge:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Freezer:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:

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Enter Week Commencing:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Floors:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Vacuum Cleaners:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Showers:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Hand Basins:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Toilets:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:
Waste Streams:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:	Initials & Time:

By signing this form you are making a declaration that all daily housekeeping actions have been managed in accordance with the requirements of BMS/6.03 and WI/6.03.03.			
Site Managers Name:		**Signature:**	

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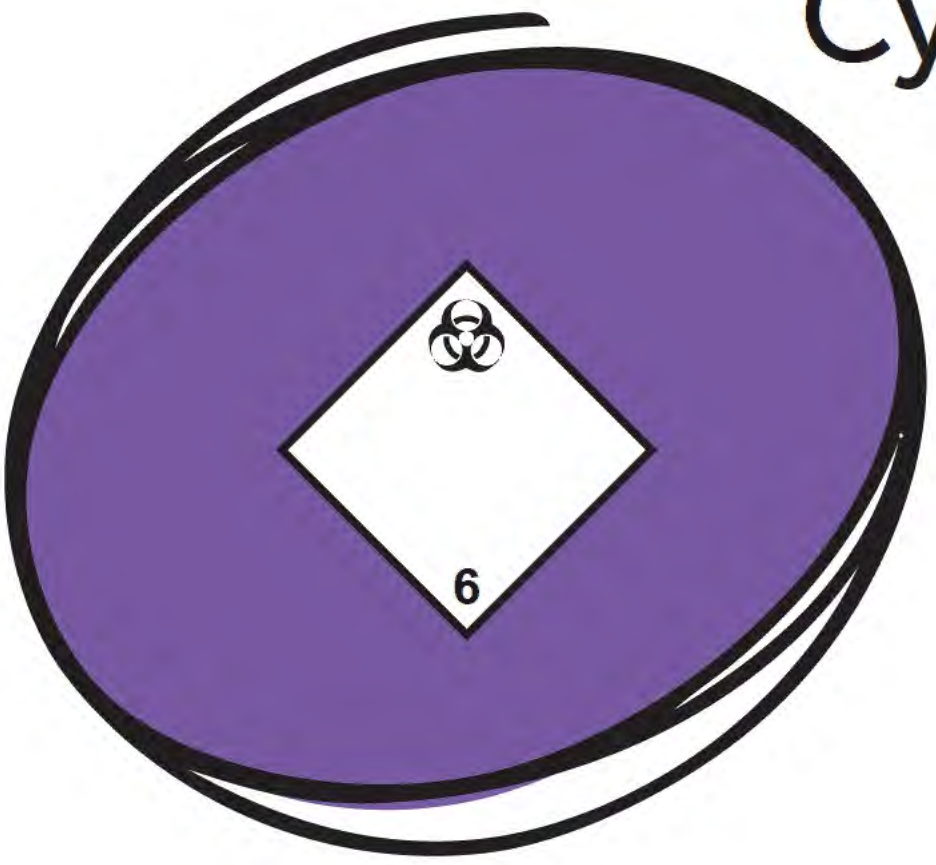
IPC – Hand Hygiene Training Record

Date:	
Time:	
ERS Site:	
Trainers Name:	
Job Title:	

Name (Print)	Clinical Grade or Job Titles	Signature	Trainers Comments

This original record of IPC Hand Hygiene Training is to be kept by the Care Quality Team. A copy is to be sent to the sites Operations Manager for retention for the purposes of audit and inspection.

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Cytotoxic / Cytostatic Waste Only

HAZARDOUS

Waste consisting of, or contaminated with, cytotoxic and/or cytostatic products which requires disposal by incineration.

CLINICAL RIGID CONTAINERS



Blister packs



Unopened medicine vials



Patches



Disposable garments
contaminated with cytotoxic and/or cytostatic medicines



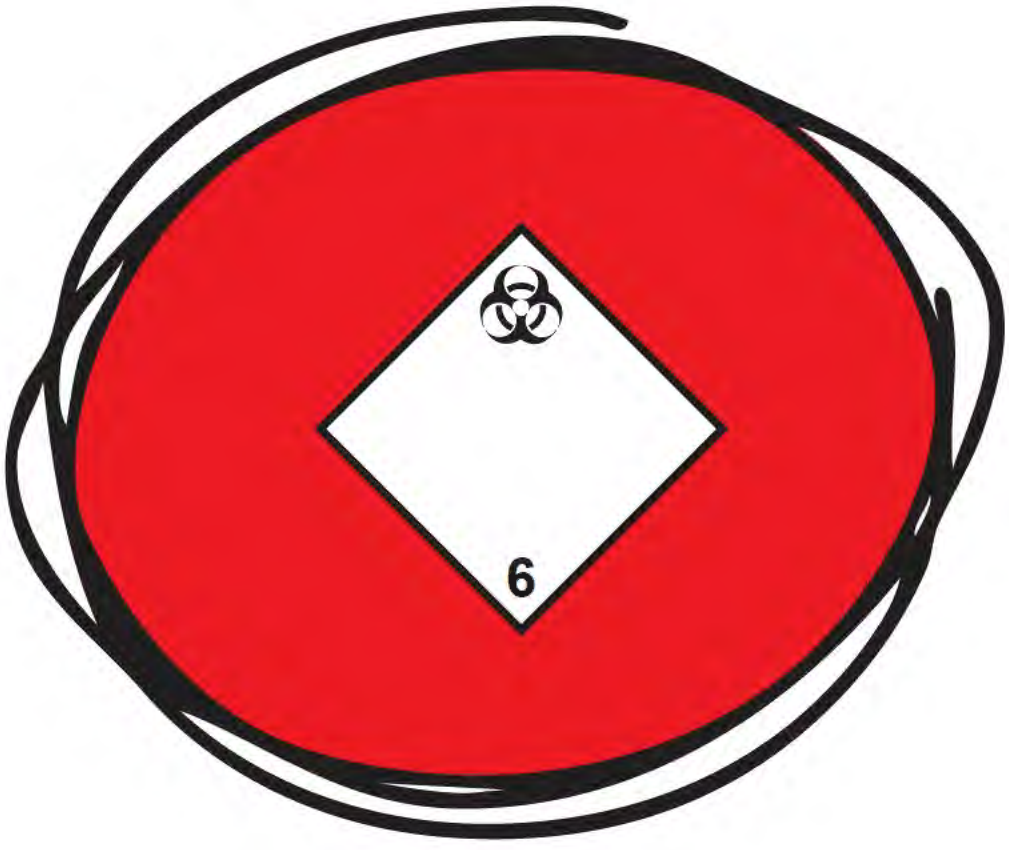
Gloves & wipes
contaminated with cytotoxic and/or cytostatic medicines

Initial
The Experts in Healthcare Waste Management

0800 731 0802
followthecolourcode.co.uk

FOLLOW THE COLOUR CODE



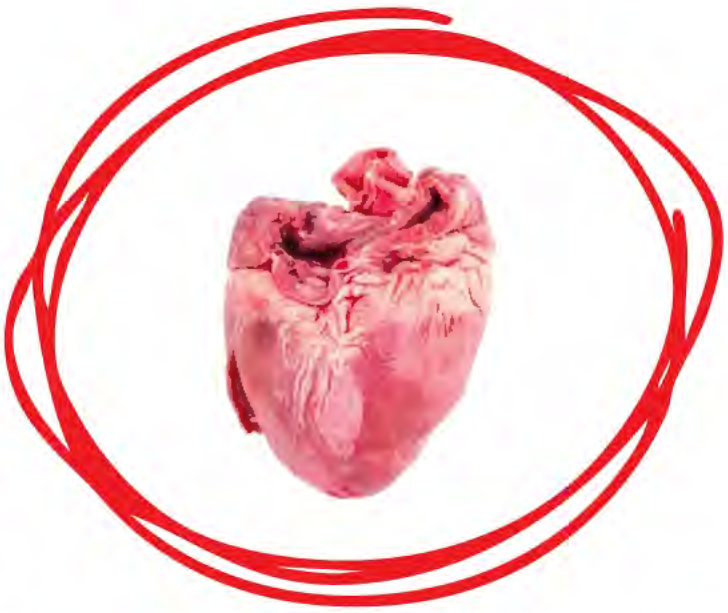


Anatomical Waste Only

HAZARDOUS

Anatomical waste which requires disposal by incineration.

CLINICAL RIGID CONTAINERS



Organs



Body parts



Blood bags

Initial

The Experts in Healthcare Waste Management

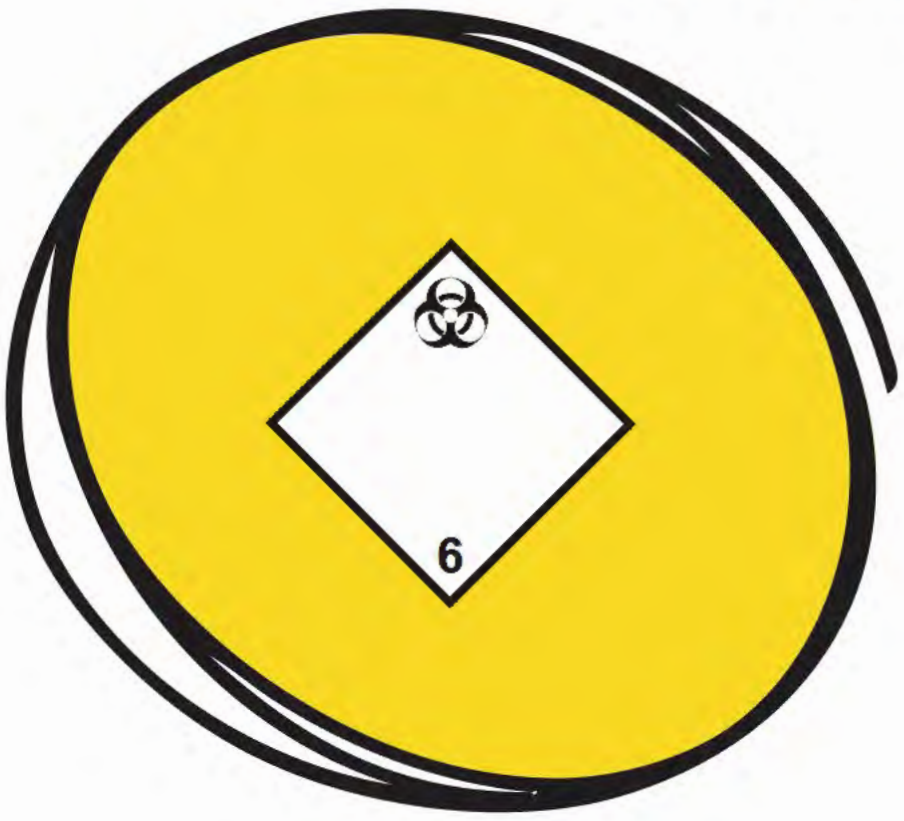
0800 731 0802

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FOLLOW THE COLOUR CODE



Clinical / Highly Infectious Waste Only



HAZARDOUS

Highly infectious waste which requires disposal by incineration.

SOFT WASTE BAGS



Dressings & wipes



Bandages



Gloves



Couch roll



Disposable garments

contaminated with infectious body fluids

- Liquids
- Food
- Glass
- Sharps
- Uncontaminated packaging

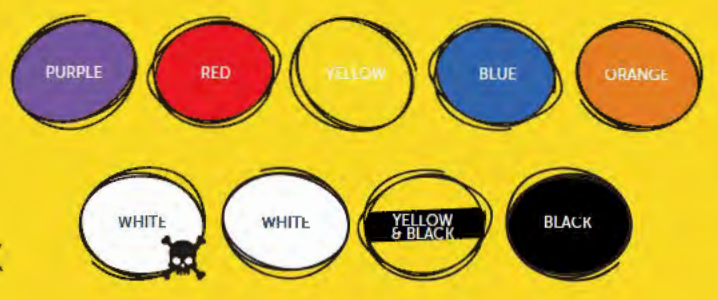
Initial

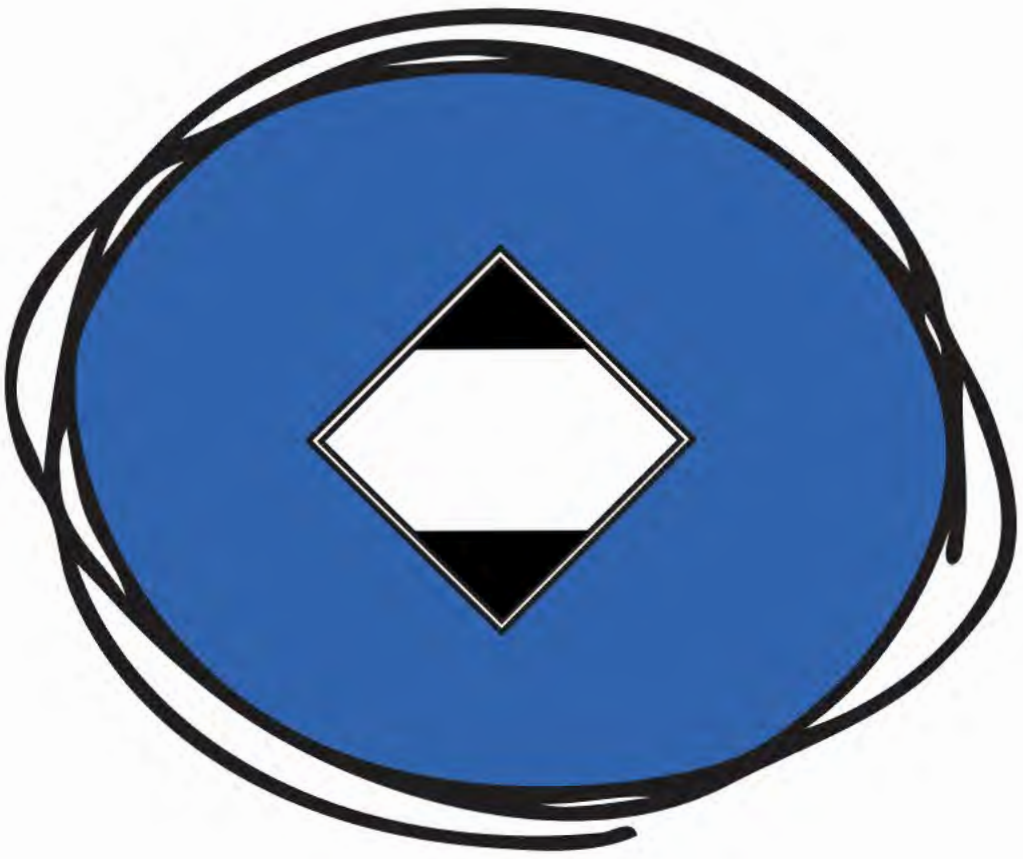
The Experts in Healthcare Waste Management

0800 731 0802

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FOLLOW THE COLOUR CODE





Medicinal Waste Only

NON-HAZARDOUS

Waste medicines, out of date medicines, denatured drugs, which requires disposal by incineration.

CLINICAL RIGID CONTAINERS



Tablets in containers



Blister packs



Unopened medicine vials



Inhaler cartridges



Droplet bottles

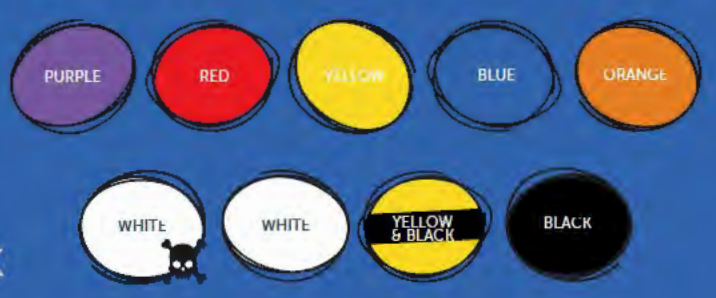
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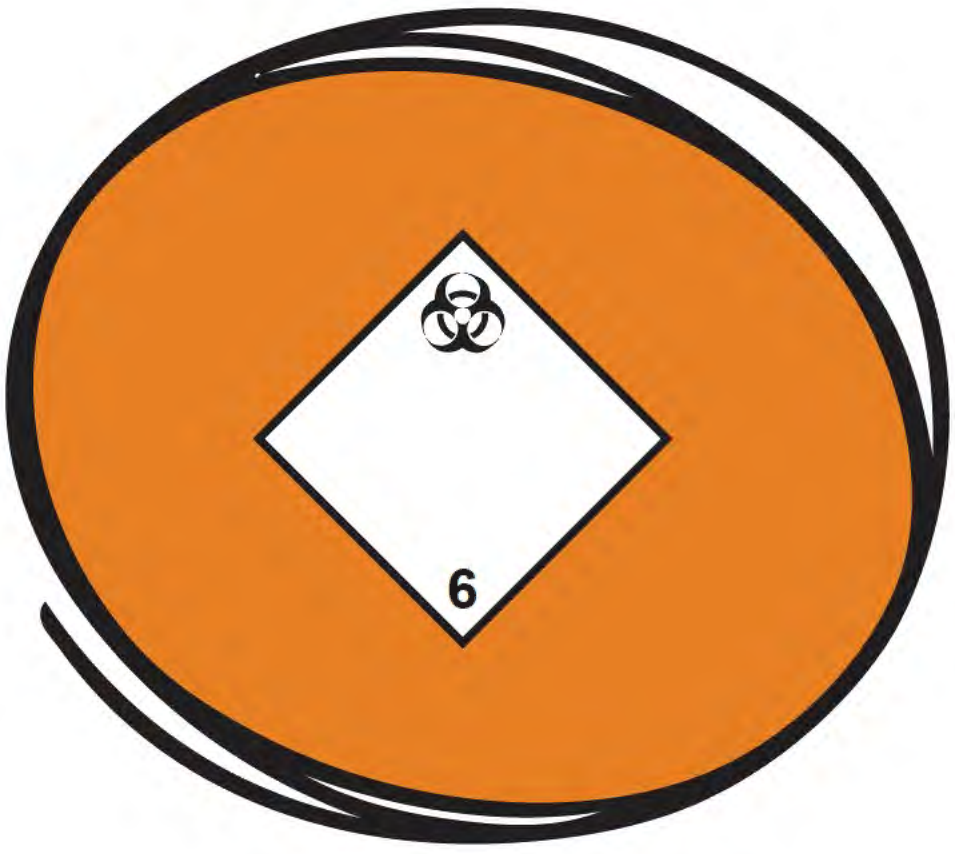
The Experts in Healthcare Waste Management

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FOLLOW THE COLOUR CODE





Clinical Infectious Waste Only

HAZARDOUS

Infectious waste which may be treated to render safe prior to disposal or alternatively it can be incinerated.

SOFT WASTE BAGS



Bandages



Masks



Dressings & Wipes



Gloves



Aprons

- Liquids
- Food
- Glass
- Sharps
- Uncontaminated packaging

Initial

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Dental (Amalgam) Waste Only

TOXIC

Dental amalgam & mercury including contents of amalgam separators which requires disposal by recovery or recycling.

CLINICAL RIGID CONTAINERS



Unwanted amalgam



Teeth with fillings



Capsules containing residues

Initial

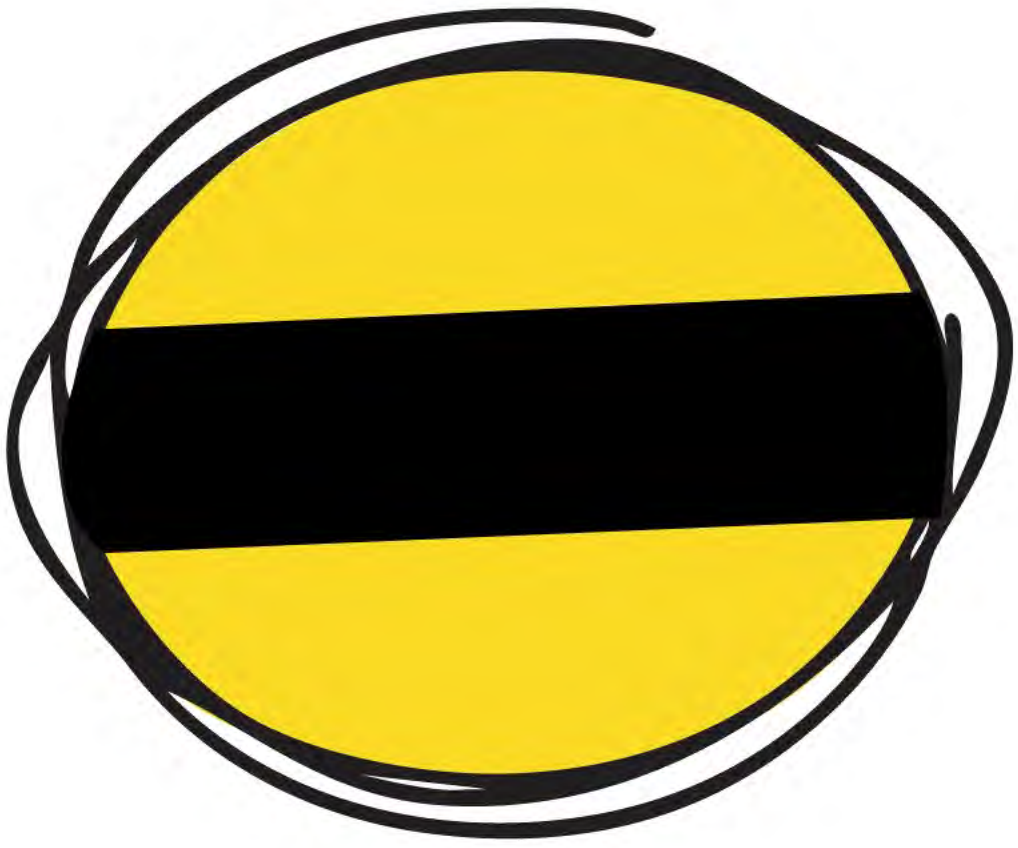
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Offensive Waste Only

NON-HAZARDOUS

Non-infectious, offensive/hygiene waste which may be recycled, incinerated (waste for energy) or deep landfilled.

SOFT WASTE BAGS



Empty colostomy bags



Incontinence pads



Nappies & wipes



Gloves

contaminated with non-infectious body fluids



Disposable garments

contaminated with non-infectious body fluids

- Liquids
- Food
- Glass
- Sharps
- Uncontaminated packaging

FOLLOW THE COLOUR CODE

PURPLE RED YELLOW BLUE ORANGE

Initial

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WHITE WHITE YELLOW & BLACK BLACK

Mixed Municipal Waste

Black or other colour supplied from local councils e.g. green

UNCONTAMINATED / VARIOUS

Municipal wastes and similar commercial, industrial and institutional wastes including separately collected fractions. Requires disposal by landfill.



Non-recyclable packaging



Disposable cups



Food wrappers



Tissues



Flowers

Initial

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ERS Medical

Training Prospectus

Jan-Dec 2020

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Introduction

Our staff are at the forefront of our business, particularly those that interact with patients and the public. Clinical training must continue to be relevant, comprehensive and credible in order for us to be a safe, caring, responsive, well-led and effective service.

This has often been a challenge for the patient transport industry as historically there have been no qualifications designed specifically for NEPTS. This has resulted in many NHS organisations providing non-accredited in-house training and private organisations using accredited qualifications designed for first responders to give their training credibility.

From now onwards ERS Medical will train its ambulance staff to be ambulance staff, using accredited courses that are designed by and for the Ambulance Trusts. We will also continue to offer staff routes for progression and personal development. ERS Medical will also be expanding into another avenue of business and offsetting the cost of internal training by giving the training department its own commercial revenue stream.

Andrew Pooley, Managing Director

Internal Staff Training

The training delivered to ERS Medical clinical staff directly correlates to the scope of practice for that clinical grade. It is the expectation that once a clinical member of staff has learnt a skill or technique though their training that they will safely be able to deliver that skill if required for best patient care. This does require that as part of continuing professional development (CPD) that clinical staff are aware of their limitations but also approach the education and training team for support to maintain the required skillsets if they are unable to do so themselves through personal study and CPD.

FutureQuals™
APPROVED CENTRE

Training Hubs

ERS has five Education and Training hubs at:

- Leeds (North Region)
- Mansfield (Midlands Region)
- Norwich (East Region)
- Durham (North East Region)
- Eastleigh (South Region)

Each supported by a Clinical Trainer and Associate Trainers. The hubs all have a good selection of equipment for the courses they deliver.

Clinical Trainers

Each Region within ERS Medical has a dedicated Clinical Trainer who will provide a clinical focal point within the region. However fundamentally they will with the assistance of Associate Trainers oversee and manage training within that region under the direction of the Regional Manager.

Continuing Professional Development

Continuing professional development (CPD) is the way in which staff continue to learn and develop throughout their career so they keep their skills and knowledge up to date and are able to practise safely and effectively.

CPD is not just formal courses. A CPD activity is any activity from which you learn and develop. This might include the following.

- **Work-based learning**. For example, reflecting on experiences at work, considering feedback from service users or being a member of a committee.
- **Professional activity**. For example, being involved in a professional body or giving a presentation at a conference.
- **Formal education**. For example, going on formal courses or carrying out research.
- **Self-directed learning**. For example, reading articles or books.

Paramedics, Technicians and Nurses maintain individual CPD as it is a requirement of their professional competency. However, ERS Medical has an expectation that **all** staff will consider their ongoing professional development throughout their career.

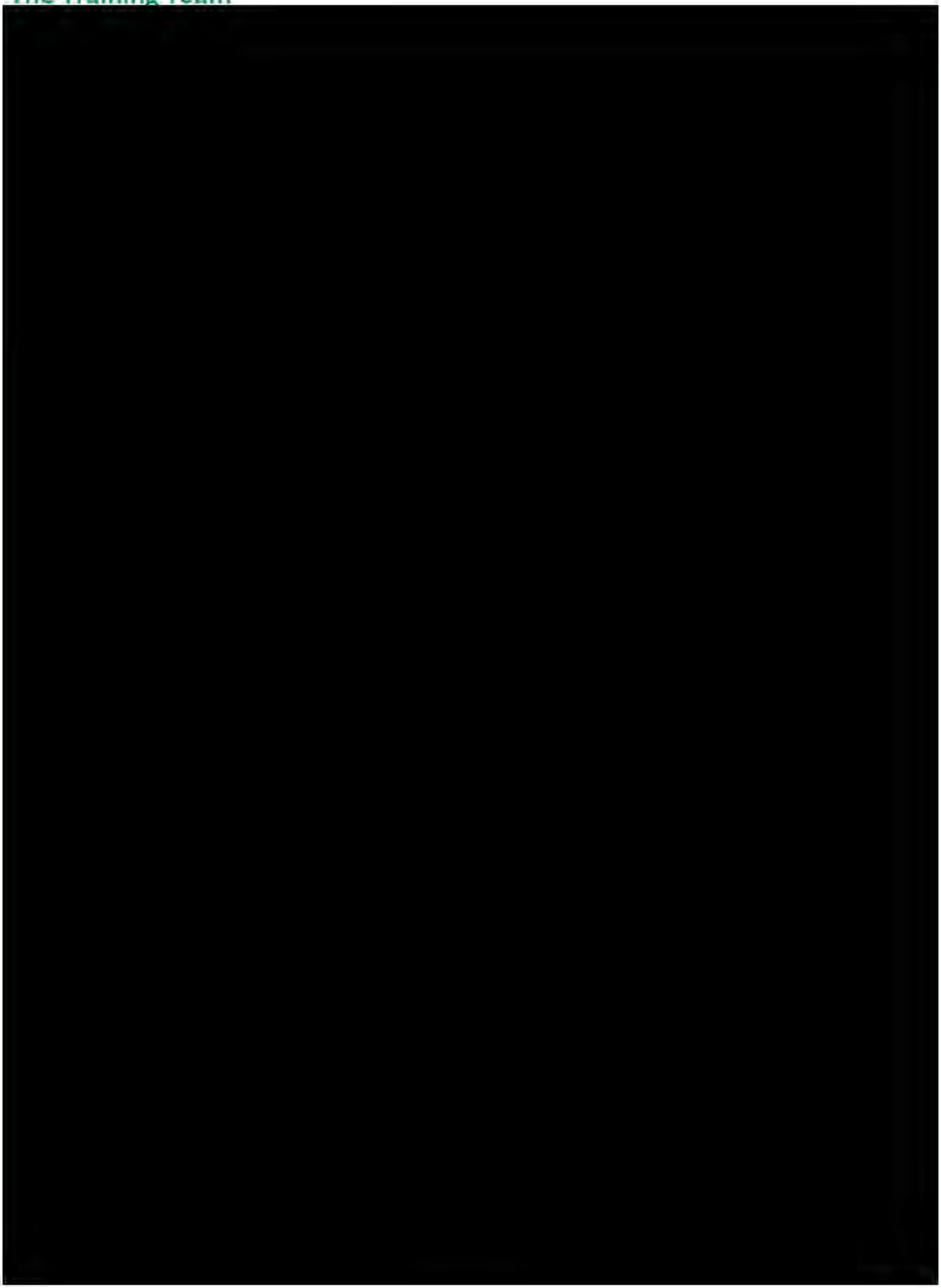
Portfolios

Staff may wish to keep portfolios of all CPD and for some staff such as Technicians and Registered Healthcare Professionals it may be a requirement. Non-registered staff can look to their regional clinical trainers for portfolio guidance and registrants should look towards their respective councils for their requirements.

Administration

Courses are administered regionally by the Regional Clinical Trainer and Administrative staff with oversight by the Head of HR and Training. The exception is any courses not listed in this prospectus.

The Training Team



Patient Facing Staff Development Pathway

This document aims to provide a clear, robust pathway for the educational development of all clinical roles within ERS Medical. It should be understood by all users that training offered will be subject to operational and business requirements. The pathway takes the standard point of entry to ERS Medical as being Ambulance Care Assistant, with other roles then being developed from this foundation.

The pathway will provide a robust and (where appropriate) nationally accredited educational basis for our patient facing staff. It will equip them with the skills and knowledge they need to provide high quality care for our patients and reflect ERS Medical's mission to put people at the heart of everything we do.

Recruitment

Selection for employment will take the following format:

- Functional Skills Test – English
- Functional Skills Test – Maths
- Driving Assessment – Theory
- Driving Assessment – Practical
- Physical Capability Assessment – Manual Handling
- Structured, competency-based interview (to include values and behaviours)

This approach will ensure that candidates who progress to training are capable of performing the role of operational ambulance crew. The functional skills tests will ensure a basic level of numeracy and literacy to ensure the candidates are then able to successfully complete the accredited training.

Ambulance Care Assistant

Once the candidate has been selected, and subject to their pre-employment checks, they will complete the following program:

- 1-week classroom foundation course
- 2 days professional driver improvement program
- 2 days observing on an operational vehicle
- 1-day classroom for practical and theory assessments.

This will be supported by a comprehensive workbook for the student to complete in their own time within 4 weeks of course completion. Successful completion will lead to a Level 3 Award – Non-Urgent Care Services. The qualification has no expiry date, however, to be considered valid, the individual must maintain their continuing professional development. ERS Medical will support this requirement via annual mandatory training, both classroom based and blended learning.

Mental Health Escort:

ERS Medical recognise that patients with mental health problems may require additional care and support during transport yet are still patients. To best meet the needs of this group of patients, we have set the standard for training as follows:

- Qualified ACA (min 12 months experience)
- Legal Considerations – MHA / MCA / DoLS (LPS) / PACE (delivered by blended learning)
- Physical Intervention and Mechanical Restraint

Urgent Care Assistant

UCA crews deal with patients who are unwell, but not currently in a life-threatening condition. They may deal with interfacility transfers where patients require formal monitoring, HCP admissions etc. They will be able to perform a greater range of monitoring, including Pulse Oximetry, Non-Invasive Blood Pressures, ECG Rhythms. They will have additional training to manage deteriorating patients.

- Qualified ACA (6 months min.)
- Level 3 Certificate – Urgent Care Services

If required by the contract, UCA's may be trained in emergency driving. They will be expected to maintain their CPD to a level commensurate with their grade.

Emergency Care Assistant

Similar to the role of a UCA, the ECA will provide transport to patients who are more acutely unwell and typically work alongside a qualified clinician (EMT / Paramedic). This may include providing emergency transfers, responding to 999 calls to back up a solo clinician, or dealing with HCP admissions.

- Qualified UCA (6 months min.)
- Qualified ACA (12 months min.)
- Level 3 Certificate – Emergency Care Services
- Emergency Driving Qualification
- CPD Portfolio

UCA / ECA update CPD training provided annually

- Up to an additional 3 days (including: 1 day immediate life support, 1 day clinical update and CPD day with specific areas depending on contractual requirements).

Further Steps:

The FutureQuals suite allows progression directly on to the next stage, which would be Associate Ambulance Practitioner (previously Technician), and then in turn to undergraduate Paramedic Programs. ERS Medical do not currently offer these as internal courses, however the availability of all training is subject to the needs of the business and is under constant review. We recognise that customers may need support at short notice and as such we need to be responsive to their needs.

For further information, please speak to your Regional Trainer or Operations Manager.

Clinical Training

Annual Patient Facing - Staff Core Update Day

This update day must be completed by all ambulance crews, hospital liaison, ambulance team leaders and operations managers at bases where ambulances are based. It provides a conduit to ensure all changes with ERS can be disseminated through all patient facing staff and ensures continued competency in core areas.

It can be delivered by the Regional Clinical Trainer / Associate Trainer. This will consist of face to face guided learning and assessment. These are run and managed at regional level, records are kept at regional level but are still subject to Internal Quality Assurance checks at request of the Lead Internal Quality Assurer (IQA). No modifications can be made without prior approval from the Care Standards team.

	0830-0915	0915-1000	1000-1015	1015-1100	1100-1145	1145-1230	1230-1315	1315-1400	1400-1445	1445-1500	1500-1545	1545-1630
Subject	Introduction paperwork, Company News, Staff welfare resources, CPD	Safeguarding Refresher – including MCA.	**Break**	DNACPR, TEP, ADRT, LPOA	First Aid Basics, the Deteriorating Patient – including IPC & DoLs		**Lunch**	Adult and Paediatric Basic Life Support with AED Incl. Adult BLS Competency Assessment		**Break**	Safe Moving & Handling Update & Assessment	Information governance Local TBT/ Clinical Updates
Reference Materials		BMS 6.05 - Safeguarding of Vulnerable Adults and Children		BMS 6.06 End of Life Care	Ambulance Care Essentials & BMS 6.02 Patients Who Deteriorate in Transit			UK Resuscitation Council 2015 Guidelines				Provided on consultation with Care Quality Manager

Non-Clinical Staff Training

Courier Initial Training Course

The ERS Courier initial training course is delivered over 2 days:

Classroom induction followed by “on the job” training to learn routes etc.
Extended driving assessment (includes highway code test) – 2 hours

Annual update classroom session.

GP Out of Hours Service Driver Initial Training Course

The ERS GP Out of Hours Service Driver initial training course is delivered over 3 days:

1-day induction – 8 hours
Extended driving assessment (includes highway code test) – 2 hours
1-day Level 3 Award in Emergency First Aid at Work – 8 hours (subject to contractual need)

Annual update classroom day.

Control and Communications Operator Initial Training Course

The ERS Control and Communications Operator initial training course is delivered using a blended approach:

Approximately 16 hours of e-learning
1-day induction – 8 hours
1-day role specific training – 8 hours
2-days practice placement – 16 hours

Non-patient contact staff Initial Training Course

ERS has various non-patient contact roles which are too numerous and varied to state specific training packages, however the core minimum induction package includes a mix of e-learning and face to face induction training.

Approximately 6 hours of e-learning
1-day induction – 8 hours

Driver Training and Assessments

All new staff who have had an initial driving assessment (PDIP or Extended) will be re-assessed within 12 months of the date of their initial assessment. If they passed with an Amber (Medium Risk) this will be within 6 months.

All ECA's, Technicians & Paramedics who hold a current Emergency Response qualification which is relevant to their role will be assessed every 6 months (This period is at the discretion of the Fleet Compliance Manager and is subject to change). This assessment will be carried out under 'Emergency Response' conditions.

All staff from the above groups (except Non-Patient facing staff and Control & Communications staff) will have a driving assessment at a period which is dictated by the result of their previous driving assessment. Green (Low risk) is within 3 years and Amber (Medium Risk) is within 1 year.

If any time staff feel they need further driving training and support the they can contact Steve Dixon (Fleet Compliance & Standards Manager) directly or through their Operations Manager or Team Leaders.

Education and Training Staff Courses

Associate Trainer

ERS Associate Trainers are not clinical grades in their own right although are often also employed additionally in-patient facing roles. ERS Associate Trainers are used primarily to support the commercial external training wing of the education and training team, although may occasionally assist internal training and should be seen as an entry level position for those wishing to progress into the education and training team. Applicants will normally come pre-qualified in some areas however an initial training course for fully unqualified staff can be arranged if required.

The below is a list of minimum requirements required for this role.

- Level 3 Award in First Aid at Work (AET)
- Level 3 – Non-Emergency Care (Future Quals)
- Level 3 Award in Education & Training (CAVA)
- Level 3 Manual Handling Award (ROSPA)

Associate Driver Assessor

ERS Associate Driver Assessors are used primarily to support the internal driver training and assess drivers to meet our compliance standards.

Our Assessors must have at least one of the below requirements to fulfil this role.

- Approved Driving Instructor (ADI)
- Level 3 Award in Education & Training (CAVA)
- Certified Assessment Qualification or Award

Clinical Trainer

ERS Clinical Trainers are the local members of the education and training team, they will be responsible for delivering the ACA, ECA and UCA initial training courses and local CPD day packages as well as be a local point of contact regarding education and training enquiries. They will also be responsible for assessing qualification portfolios prior to being quality assured.

Clinical Trainer must have the following qualifications to be accepted into role:

- Technician/AAP (FREC 5) - Grade or Registered Healthcare Professional (Paramedic or Nurse – AD or MH)
- Level 3 Award in Education & Training
- Level 3 Certificate in Assessing Vocational Achievement

And will be given priority and funding to complete the following:

- Level 3 Manual Handling Award (ROSPA)
- Level 3 Award in Safeguarding
- Level 4 Certificate in Education and Training
- Level 4 Certificate in Assessing Vocational Achievement

Fleet Driver Trainer

ERS Fleet Driver Trainer provides driver training in line with company requirements and compliance standards.

Driver Trainer must have the following qualifications to be accepted into role:

- Approved Driving Instructor (ADI)
- Level 3 Award in Education & Training (CAVA) or Assessor's Award
- Level 3 Award in AET - Optional
- Level 3 Manual Handling Award (ROSPA) - Optional

Management Staff Training

Operations Support (Managers/Team Leaders/Site Administration)

April 2020

	9.00-10.00	1000-1015	1015 - 1145	1145-1230	1230-1300	1300 - 1400	1400 -1430	1430-1445	1445-1600
Subject	Introduction to Culture, Business, Vision and Values	Break	Back to Basics Disciplinary & Grievance Policy & Process		Lunch	Conducting Investigations		Break	Performance Management & Sickness Management Policy & Process
Reference Materials			Disciplinary Policy Grievance Policy Guidance document			Guidance and Templates			Staff Handbook

Oct 2020

	0830-10.00	**1000-1015**	**1015 - 1145**	**1145-1230**	**1230-1315**	**1315-1400**	**1400-1430**	**1430-1445**	**1445-1600**
Subject	Legal Update for 2020 Case Reviews and feedback from HR Matters in 2020	**Break**	'Good Work Plan' update		**Lunch**	MH & Wellbeing Plan update		**Break**	HR GAPS Recruitment, Onboarding & Offboarding
Reference Materials	Guidance & Templates		Guidance and Templates			Guidance and Templates			Bamboo Guidance

Training day 1. (April 2020)

The day will start with an introduction to our business, culture, vision and values.

Our Management Training will then focus on a back to basic session by looking at the following areas:

- Disciplinary Process and Procedures
- Grievance Process and Procedures
- Conducting Investigations
- Sickness process and Procedures
- Capability Process and Procedures

Training day 2. (October 2020)

Our Management Training will look at the year that has past – highlighting trends across the business on HR matters and cases and also look at the legal updates for 2020 and the implementation of the MH Strategy and the 'Good Work Plan'.

- Legal Update - 2020
- HR Case Work Update – 2020
- Good Work Plan
- MH & Wellbeing Plan
- Recruitment, Onboarding & Offboarding
- HR GAPS

Training Webinars *(Webinars are offered fortnightly and managers should attend all webinars that are provided by ERS and if they are unable to attend, the webinars are held on SharePoint to view).*

Both Peninsula and Health Assured also offer training webinars that look at different management topics both practical and interactive webinar training courses, which provide a foundation in basic elements of employment law and mental health and support to support staff within the workplace. The webinars are designed to enable managers to handle common employment issues that may arise, in a professional and positive manner.

Commercial Training

ERS Medical will deliver popular First Aid at Pre-Hospital Emergency Care training commercially to the Public, other businesses and at a discounted rate to staff and business partners. This creates an opportunity for the training department to generate its own revenue which can be used to better staff development.

Qualsafe Awards will be the awarding organisation for ERS Medicals commercial training stream in 2020 and each Region will deliver the following:

- Level 3 Award Emergency First Aid at Work.
- Level 3 Award Emergency Paediatric First Aid.
- Level 3 Award First Aid at Work.
- Level 3 Award Paediatric First Aid.
- Level 3 Certificate First Response Emergency Care.

Internal training sold commercially

Courses run for internal staff with spaces should also be marketed commercially in order to minimise cost of internal training. Care should be taken not to accept commercial customers onto courses until it is certain now more space will be required for ERS staff.

Discounted rates for staff

ERS staff who wish to pay for training that they are not required to attend will be given a 20% discount. For example, an ACA who wishes to pay to complete the Level 3 Certificate in First Response Emergency Care for their own CPD may do so at a 20% discounted rate, but ordinarily this will have to be taken during time off or using their leave allocation.

Training Equipment List

Equipment required to run the suite of Qualsafe First Aid courses and the FutureQuals Level 3 ACA Award and Level 3 UCA Certificate.

Item	Comments	Qty
Adult Full body Manikin	Able to accept Airway adjuncts	1
CPR Adult manikins	With sufficient consumables	4
CPR Child manikins	With sufficient consumables	4
CPR Infant manikins	With sufficient consumables	4
Choking trainer		4
Bariatric Manikin or suit		1
Airway manikin Advanced manikin	Adult Adult	2 1
AED trainers	Should be training model of AED most common in ERS region.	4
Manual Suction devices		1
Electronic Suction	Leardal suction unit	2
Patient Monitor	Lifepak 12/15	2
Dressings/bandages	Sufficient trauma bandages: various sizes and types. A variety of tourniquets and haemostatic agents for management of catastrophic bleeding.	
Oxygen Cylinder		2
N2O2 Cylinder	With demand valve + hose, ***Only Hubs delivering UCA.***	1
Bag-Valve-Mask	Adult	2
Bag-Valve-Mask	Paediatric	2
Bag-Valve-Mask	Neonate	1
Pocket Mask		4
Oxygen Masks	100% NRB mask • Multi flow rate masks (Ventura type or similar) • Simple face mask • Nasal cannulas	As Req.
Response Bag (training)	As carried on HDU with training stock. ***Only Hubs delivering UCA.***	2
OP/ NP Airways	OPA (sizes 2 to 4). NPA (sizes 6 to 7).	2 sets
Burn dressings		As Req
Projector		1
Laptop		1
speakers		1
Book	Concise First Aid Made Easy by Nigel Barraclough	for all students attending first aid courses
Book	Ambulance Care Essentials by Richard Pilbery and Kris Lethbridge	12 not to be issued without return
Book	Ross and Wilson's Anatomy and physiology	12 not to be issued without return
Book	JRCALC 2019 A4	12 not to be issued without return

Student Feedback from Courses

"Professional, enjoyable experience, friendly instructors along with a relaxed training environment made it easier to learn."

[redacted]

"Instructors were fantastic, made the course worthwhile and made me personally feel more at ease entering into the prehospital emergency care setting. Thanks, ERS training team"
Rebecca Nithsdale, Technician - Southampton

"The instructor was good to work with; he explained everything before starting the driving course, was always helpful and whilst assessing my driving made me feel relaxed and never nervous"

[redacted]

"The instructor had incredible presence, he was relaxed, thorough and approachable for any questions or help needed. Great mentor!"

[redacted]

"Choosing an apprenticeship with ERS medical was one of the best things I could have done. I hated classroom-based learning, but with ERS you are constantly learning new skills and qualities every day, in a relaxed/professional environment. The Training team made me feel so welcome and accepted, and I can't wait for my future with ERS"
Jennifer Hitchen, Apprentice – Hetton Court

SHOULD YOU HAVE ANY QUERIES IN RELATION TO ANY OF THE CONTENT WITHIN THIS PROSPECTUS PLEASE CONTACT YOU REGIONAL TRAINING TEAM

Appendix 1. Core Competency Matrix – Operational Staff

Role	Required Training	When	Renewal	Method	Delivered By
ACA	Foundation Course	Recruitment	None (subject to CPD)	Face to Face	Clinical Trainers
	Level 3 Award in Non-Urgent Care Services	Recruitment	None (subject to CPD)	Blended Learning	Clinical Trainers
	Care Certificate	Within 4 Weeks of start	None (subject to CPD)	E-Learning	Self-Study
	Professional Driver	Recruitment	3 years	Face to Face	Driver Trainer
	Annual Mandatory Training	Annual	1 year	Face to Face	Regional Trainer
	Quality Audit	Annual	1 year	Face to Face	Team Leader
	Toolbox Talks / Clinical Updates	As Required (Min 3 monthly)	As Required	Face to Face	Team Leader
Mental Health Escort (Secure Patients)	All ACA package				
	Physical Intervention	At Start of Role	1 year	Face to Face	Dynamis
	Mental Health Act	At Start of Role	1 year	Blended Learning	Clinical Trainers
UCA	All ACA package				
	Level 3 Certificate in Urgent Care Services	At start of role	None (subject to CPD)	Blended Learning	Clinical Trainers
	Emergency Driving (Subject to contract)	At start of role	3 Years	Face to Face	Driver Trainer
ECA	As per UCA				
	Level 3 Diploma in Emergency Support	At start of role	None (subject to CPD)	Blended Learning	Clinical Trainers
	Emergency Driving	At start of role	3 Years	Face to Face	Driver Trainer
Courier	Role Specific Induction	Recruitment	Once Only	Face to Face	Clinical Trainers
	Annual Mandatory Training	Annual	1 year	Face to Face	Regional Trainer
GP OOH Driver	Role Specific Induction	Recruitment	Once Only	Face to Face	Clinical Trainers
	Annual Mandatory Training	Annual	1 year	Face to Face	Regional Trainer
Call Handler / Admin	Role Specific Induction	Recruitment	Once Only	Face to Face	Line Manager
	Annual Mandatory Training	Annual	1 year	E-Learning	Self-Study

Appendix 2. Mandatory E-learning

How to register:

[redacted]

Click the **REGISTER** tab on the right of the page

Select from the left-hand list - "**I work within the Social Care Sector in England and have a NMDS-SC registration code"**

[redacted]

Click "Register"

Complete the fields in the Your Details box entering **England** as the Country

In the *Your Current Role* box type in Ambulance and select the **Ambulance Worker (Health)** option

Grade then becomes N/A

Primary Speciality select **Othe**r at the bottom of the drop-down list

Place of Work type **Unknown –** it will display **"Unknown Location"** below – click on it to select.

Then click **REGISTER**

On the next screen, you will be presented with a number of tabs for different courses, separated by workforce groups. Scroll down the screen until you reach the **"workforce wide or generic"** section.

Here you will find the relevant e-learning package for you:

Ambulance Crew / Mental Health Staff / Other patient facing role: Please select **"Care Certificate (CCT)"**

Office Staff – Please Select **"Statutory and Mandatory Training (SMT)"**

Scroll to the bottom and click "Save Changes"

Now check your email!

Activation:

Once you have been signed up to the E-Learning Portal you will received an Email that contains your Username and an Account Activation Link

The link will lead you to a page that prompts you to create a password and confirm your email address.

When you first sign into your new account you will be asked to agree to some Terms and Conditions and enter some password retrieval data. Follow the instructions on the screen.

Eventually, you will arrive at the dashboard screen.

Once you have done this please go to the **My Account** tab, and select **Reporting Permissions,** in the



The courses that you have chosen when registering will appear in the top part of the screen where it says "My e-learning". Click on the image for your chosen course.

Courses are split into several different modules which will appear in list form. Each module is broken down into sections which all need completing. You can begin the tasks by clicking the 'Play' button.

When you click 'Play' to begin a task another window will pop up with instructions for how to complete that module. Follow the instructions for all tasks within a module to completion.

PATIENT FACING STAFF: All modules in the care certificate to be completed.

OFFICE STAFF: After clicking on the SMT link at the top of the page, scroll to the bottom of the module list. Click the link for "Health Education England Learning Path". Here you will find the mandatory modules for completion.

Certificates:

When you have completed all tasks within a module you will then need to print off your certificate and pass it on to your manager. Return to the Modules Page to do so.

Upon completion of all tasks the Certificate button that is found back on the Modules page (Circled in Red above) will change (as displayed below) to indicate that the course has been passed and a certificate available for print.

Click on this button and the Certificate will be downloaded in PDF Format for you to print. Please save the PDF file and attach it as an email to your team leader – they will then be able to upload it to Bamboo as evidence of completion of your training.

We encourage all team members try the other courses available.

WI/6.03.03 Infection Prevention and Control – Environmental Management

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.0	**Date Active:**	15.11.2019	**Review Date:**	30.11.2020

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	17.04.18	[redacted]	Addition of review date
2.1	18	.5	16	25.06.18	[redacted]	Addition of recording postcodes
2.2	18	.6	16	18.09.18	[redacted]	Clarification on clinical waste bags
3.0	All	All	All	19.11.18	[redacted]	Annual Review
3.1	All	All	All	19.09.19	[redacted]	Addition of Neilsen Chemicals to IPC Procedures
4.0	All	All	All	15.11.19	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Employee Health and Wellbeing	BMS/2.03
Whistleblowing (Raising Concerns at Work)	BMS/2.05
Procurement and Supply Chain Management	BMS/4.01
Incident Reporting and Management	BMS/5.01
Serious Untoward Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Care to Care	BMS/6.01
Patients Who Deteriorate in Transit	BMS/6.02
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding Vulnerable Adults and Children	BMS/6.05
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Assessments	BMS/6.07
Patient Communications and Control (CCO)	BMS/6.08
Non-Emergency Patient Transport Services	BMS/6.10
Renal Patient Services	BMS/6.11
High Dependency Unit (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Infection Prevention and Control – People	WI/6.03.01
Infection Prevention and Control – Ambulances, Medical Equipment & Devices	WI/6.03.02
IPC Inspection and Testing Form	F6.03.04
Monthly Mop Management Record	F6.03.05
Site Housekeeping Inspection Form	F6.03.06
Daily Housekeeping Record	F6.03.07
Waste Guidance	F6.03.09

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3. External Guidance Publications

- Health and Social Care Act 2015;
- The Mental Health Act 2005;
- The Mental Capacity Act 2019;
- Health and Social Care Act 2008: Code of practice on the prevention and control of infections;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12;
- Health and Safety at Work Act 1974;
- Control of Substances Hazardous to Health 2002 Regulations;
- NICE Guidelines;
- Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England.

4. Introduction

4.1 This work instruction has been written to protect ERS Medical staff, sub-contractors providing services on behalf of ERS Medical, patients, other healthcare professionals and visitors by minimising the risks and likelihood of the transmission of infectious pathogens and micro-organisms.

4.2 It will deal specifically with the environmental management of infection protection and control at ERS Medical premises and cover our potential impacts on external environments to the Company such as but not limited to:

- NHS Trust Wards and Departments;
- Patient home addresses;
- Care and Nursing homes;
- GP surgeries & NHS Walk-in Centres;
- Commercial premises (primarily our A&E services)
- Public places (primarily for our A&E services).

4.3 Infection prevention and control is based on the use of practices and procedures which prevent or reduce the risk of infection from being transmitted from a source of infection.

4.4 Time, dust (organic matter), dirt and moisture are the main contributing factors that allow the survival and growth or micro-organisms. To ensure that any microbes die rapidly areas must be kept clean and dry.

4.5 Good housekeeping at site and respecting and complying with other organisations IPC protocols are essential tools in maintaining a safe environment for patient's, staff and all others.

4.6 The information and practices outlined in this work instruction are evidence-based or in line with current national guidelines, legislation or regulations. Where evidence is not available, consensus opinion from specialist professionals is used.

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4.7 Whilst undertaking site housekeeping duties, consideration must be given to using appropriate PPE, ensuring adequate protection. Providing no contact has been made with blood or bodily fluids, disposable cleaning materials can be discarded as domestic and general waste.

4.8 If however, there has been contact with blood or bodily fluids all disposable cleaning materials should be treated as clinical waste and be placed within a yellow / orange clinical waste bag, sealed and then placed into a suitable clinical waste bin immediately.

4.9 To ensure a single infection prevention and control process is in place, for all ERS Medical site management and environmental management that is related to infection prevention and control (IPC) activities and risks.

4.10 To detail all processes utilised at all locations within ERS Medical, where CQC regulated activity is undertaken.

4.11 To recognise and document any regional or contractual differences and obligations that may be in place across different CCG or NHS Trust areas in relation to all CQC regulated activity.

5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

5.4 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director (IPC Lead) & Head of Care Standards**	Have responsibility to ensure that the appropriate Infection Prevention and control policy is used in every day practice, to reduce infection risk and promote patient and staff safety. Ensure compliance with the Health and Social Care Act 2008, Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. Cooperate and assist with the implementation of this policy. Bring to the notice of management, at all levels problems and failings associated with the application of this procedure.
6.4	**Regional Managers**	Have the responsibility of chairing the regional GaPR committee meetings and ensuring that IPC is an agenda item and that all IPC incidents and trends are monitored, reviewed and recommendations made.
6.5	**Care Quality Managers**	Has responsibility for the coordination, implementation and reporting of all IPC audits and inspections. Are responsible for providing advice and support to all operational sites on matters relating to IPC. Additionally, they are responsible for conducting internal IPC audits and inspections and for the forward reporting of these to the Care Quality Manager.
6.6	**Senior Operations Managers and Operations Managers**	Are responsible for the implementation and co-ordination of Infection control process at a site level.
6.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Aseptic** – Without micro-organisms.

7.2 **Contagious Period** – Is the period of time during which a contracted disease can be spread, either through direct or indirect contact from one person to another.

7.3 **Communicable Diseases** – Communicable diseases spread from one person to another or from an animal to a person. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluid. The terms **infectious** and contagious are also used to describe communicable disease.

7.4 **Decontamination** – Is the process of cleaning items of equipment or parts of the body, to remove microorganisms or hazardous materials such as chemical and infectious diseases for the purposes of infection prevention and control.

7.5 **Deep Clean** – For the purposes of this work instruction the term 'Deep Clean', will be used for the scheduled and reactive decontamination of ALL ambulance born equipment, medical devices and ambulance surfaces.

7.6 **Formite** – Any object or substance that is capable of carrying and infectious organism, such as `germs or parasites and transferring them from one individual to another. This could include, but not be limited to:

- Clothing;
- Watches,
- Bedding,
- Hair;
- Medical equipment.

7.7 **Hepatitis B Core Antibody (HBcAb)** – The HBcAb is an antibody that is part of the virus – it does not provide protection. A "positive" or "reactive" HBcAb (or anti-HBc) test result indicates a past or present infection, but could also be a false positive. The interpretation of this test result depends on the results of the other two tests. Its appearance with the protective surface antibody (positive HBsAb or anti-HBs) indicates prior infection and recovery. For chronically infected persons, it will usually appear with the virus (positive HBsAg).

7.8 **Hepatitis B Surface Antibody (HBsAb)** – A "positive" or reactive HBsAb (or anti-HBs) –test result indicates that a person has successfully responded to the hepatitis B vaccine or has recovered from an acute hepatitis B infection. This result means you are immune to future hepatitis b infection and you are not contagious. This test is not routinely included in blood bank screening.

7.9 **Incubation Period** – The period of time that passes between the initial exposure to a disease or infection and the appearance of the signs and symptoms of the disease.

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7.10 **Isolation / Barrier Nursing** – The term isolation is the use of IPC aimed at controlling and preventing the spread of an infection. There are 2 types of isolation:

- **Source Isolation (Barrier Nursing)** – Where the patient is the confirmed or potential source of infection and an individual or group of patients are isolated from mixing with other patients. Additional IPC measures may be brought in to control these environments;
- **Protective Isolation (Reverse Barrier Nursing)** – Where a patient requires protection from either contact with other patient's, staff members, visitors and even their environment as they may well be immunocompromised.

7.11 **Outbreak** – An outbreak is said to have occurred where the number of cases of an infectious or communicable disease is greater than the number expected over a given period or two or more cases are linked by epidemiological, clinical or microbiological features.

7.12 **Reservoir** – Any person, animal, plant, soil or substance in which an infectious agent normally multiplies.

7.13 **Routine Clean** – For the purposes of this work instruction the term 'Routine Clean' will used for the decontamination of medical equipment, devices and ambulance surfaces for any purpose other than a 'Deep Clean'.

7.14 **Sharps** – A medical sharp is defined as being an object or instrument necessary for the exercise of specific health care activities which is able to cut, prick or cause injury. This would include equipment such as needles, scalpels and other articles found in a healthcare setting capable of breaking the skin barrier.

7.15 **Site Housekeeping** – The systematic cleaning and decontamination of ERS Medical premises and resources for the purposes of infection prevention and control.

7.16 **Vector** – A carrier of diseases such flying and biting insects and animals, such as a mosquito, which is a vector for malaria.

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8. Capacity and Consent

Capacity

8.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

8.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

8.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

8.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

8.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

8.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

8.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

8.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

8.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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8.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

8.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

8.12 This is typically a 2 stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

8.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

8.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

8.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

8.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

8.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

8.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

8.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

8.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

8.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

8.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

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8.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address

9. Mops and Bucket Management

9.1 ERS Medical has in conjunction with ChemEx / Neilsen Chemicals has adopted the National Colour Coding Scheme, which is advocated by the National Patient Safety Agency (NPSA) for the management of mops and buckets in the healthcare sector.

9.2 In accordance with this scheme only the correct colour mop and bucket can be used in designated areas – see table below. All sites will display the appropriate ChemEx / Neilsen Chemicals colour coding poster for staff information.



9.3 Mops and their corresponding colour coded buckets must not be interchanged. A fresh water and ChemEx / Neilsen Chemicals solution should be prepared each time the mop is used.

9.4 All mops once used should be wrung out as dry as possible before being stored clipped against a wall with the mop head facing down to allow run off and facilitate further drying.

9.5 Below each mop station there should be a drip tray to collect any run off from the mops. Trays should be emptied and dried daily.

9.6 Where multiple same colour mop heads are used, all mop handles should be numbered with a permanent marker to allow the tracking and management of their respective mop heads.

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9.7 All mop heads should be changed at least once per week, unless obviously soiled or contaminated, in which case they should be changed immediately. This change should be recorded on **F6.03.05 (ERS) – Weekly Mop Management Record**, making note of the corresponding mop handle number.

9.8 All yellow mop heads will be treated as clinical waste and placed inside a yellow/orange clinical waste bag, sealed and placed inside a clinical waste bin for disposal purposes.



Mop heads stored with their heads facing down to facilitate run off and drying

9.9 All used buckets will have their contents disposed of into waste water, be physically dried by using paper towels or blue roll and then stored in the inverted position.

9.10 All staff should wear appropriate PPE (minimum of gloves) when drying buckets. On completion all materials used for drying buckets, gloves, paper towels and or blue roll should be treated as clinical waste and dispose of accordingly as detailed in Section 7.4.

10. Antibacterial Soap

10.1 It is the responsibility of the site Operations Manager to ensure that there are sufficient stocks of antibacterial soaps available at all hand washing stations within ERS Medical premises for which they are responsible for.

10.2 Site Operations Managers should record these levels daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

10.3 All staff should take must take an active role in IPC and should therefore report to their site management any hand washing area that does not have a supply of anti-bacterial soap or has a dispenser that is faulty.

11. Hand Sanitisers

11.1 It is the responsibility of the site Operations Manager to ensure that there are sufficient stocks of hand sanitiser product available at all ChemEx / Neilsen Chemicals hand sanitiser stations within ERS Medical premises for which they are responsible for.

11.2 Site Operations Managers should record these levels daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.



11.3 All staff should take must take an active role in IPC and should therefore report to their site management any hand sanitiser dosing stations that are either empty, near empty or not working due to mechanism failure.

12. Paper Towels and Blue Roll

12.1 It is the responsibility of the site Operations Manager to ensure that there are sufficient stocks of paper towels and or blue roll available at all hand washing stations within ERS Medical premises for which they are responsible for.

12.2 Site Operations Managers should record these levels daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.



12.3 All staff should take must take an active role in IPC and should therefore report to their site management any paper towel or blue roll dispenser stations that are either empty, near empty or not working due to mechanism failure.

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13. Crockery and Cutlery

13.1 Hot water and general-purpose detergent should be used for hand washing. All items should be dried with either blue roll or paper towels.

13.2 Where crockery and cutlery are washed by a mechanical dishwasher the machine should have dishwasher tablet and sufficient rinse aid for each wash cycle. The machines automatic drying facility should be sufficient to dry all items.

13.3 Dirty and used crockery and cutlery should not be left out overnight. All items should be cleaned at the earliest opportunity.

13.4 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

14. Kitchen Areas

14.1 All food preparation surfaces must be cleaned regularly with hot water and general-purpose detergent.

14.2 Any defects in these areas must be reported to site management to ensure they are kept in good repair.

14.3 Surfaces should not be allowed to become cluttered with non-kitchen items.

14.4 Waste bins should be cleaned inside and outside on a weekly basis. Bin liners must be used in all waste bins and when full they should be safely secured and removed for disposal in the site commercial main waste bin.

14.5 Cookers, microwaves and other kitchen appliances must be cleaned on a weekly basis and after each use.

14.6 All food and fluid spillages should immediately be cleaned.

14.7 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

15. Fridges and Freezers

15.1 These must be cleaned and defrosted on a regular basis with hot water and detergent:

- **Fridges:** Cleaned Weekly;
- **Freezers:** Defrosted and cleaned every 6 months.

15.2 Cleaning should be completed when any food item has been spilled or has become stale.

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15.3 All items stored in fridges and freezers should be labelled with the date and owner's name and fresh food should not be left in a fridge for more than 24 hours unless it has a specific sell by or best by date.

15.4 All fridges must be checked every Friday and where out of date, incorrectly labelled or non-labelled foods and food storage containers will be thrown out.

15.5 Staff members should be aware that any items left in fridges are done so at their own risk and that items will be disposed of if they do not comply with this work instruction.

15.6 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

16. Floors

16.1 Properly maintained vacuum cleaners should be used to clean all carpeted areas. Dust from non-carpeted areas should be initially removed with a vacuum cleaner, if available or a soft bristle broom.

16.2 Non-Carpeted areas should then be mopped with detergent and hot water using the appropriate colour coded mops and buckets for each specific area as detailed in Section 9 of this work instruction.

16.3 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

17. Vacuum Cleaners

17.1 Bags or chambers must be changed or emptied when necessary with general cleanliness ensured i.e. dry dusting the exterior of the appliance before putting away for storage.

17.2 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

18. Showers and Hand Basins

18.1 Shower rooms and wash basins must be cleaned regularly with a single use cloth and detergent cleaner, which is then disposed of as general waste.

18.2 Any shower curtains and anti-slip mats should be free from stains, smudges, odours and mould. Liquid antibacterial soap must be available at all sinks with hand hygiene signage present.

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18.3 Bars of soap and nail brushes **MUST NOT** be used.

18.4 Paper towels and or blue roll must be provided for hand drying.

18.5 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

19. Toilets

19.1 Toilet brushes should be cleaned in a designated cleaning area in hot water and detergent on a regular basis and then stored to dry in the brush holder.

19.2 It is the responsibility of the site Operations Manager to ensure that there are always available sufficient stocks of:

- Paper Towels or Blue Roll;
- Liquid Antibacterial Soap,
- Hand Washing Signage;
- Toilet Paper;
- Hand Sanitising Solution.

19.3 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

20. Waste Streams (General Waste & Clinical Waste)

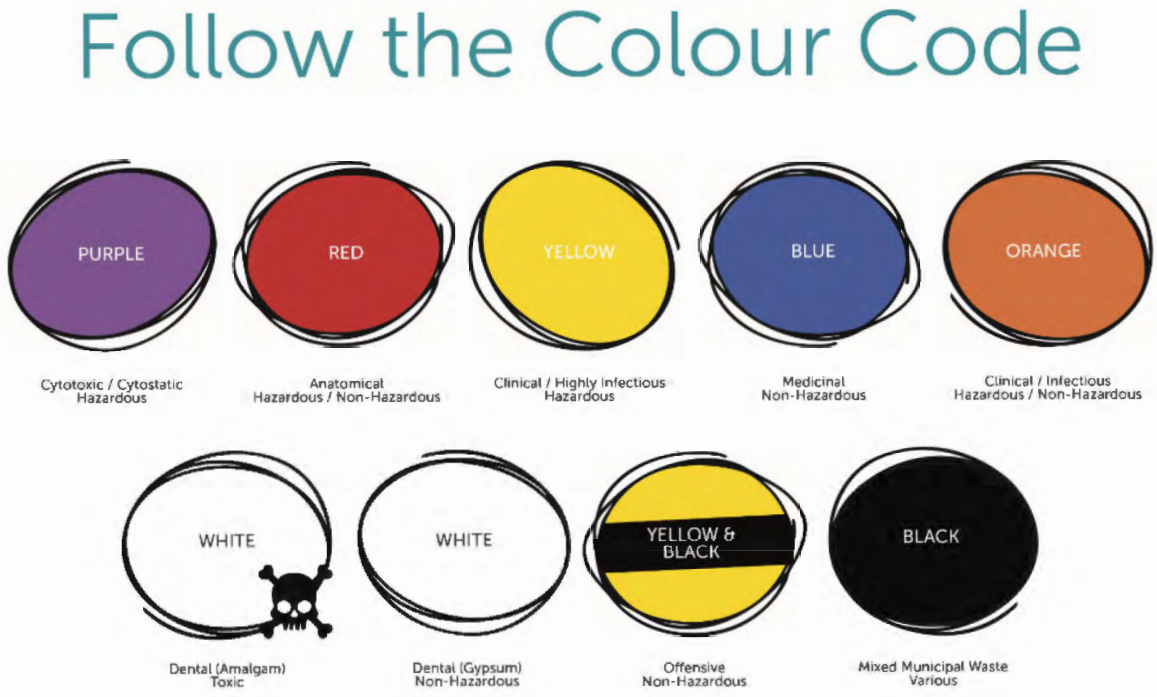
20.1 ERS Medical provides a waste management system for the following waste streams:

- **General Waste** –Commercially provided general waste bin services;
- **Clinical** – Initial provides clinical waste services at all sits;
- **Recycling Waste** - Commercially provided recycling services;
- **Secure Waste** – Shred-Station provides a secure waste service.

20.2 Site Operations Managers should record that these actions have been completed daily by completing **F6.03.07 – Daily Housekeeping Record**. This record will be retained at site for the audit and inspection purposes.

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20.3 ERS Medical will follow the below colour coding for the management of what is commonly referred to as clinical waste.



20.4 ERS Medical will typically only produce Clinical / Infectious Waste or Offensive Non-Hazardous Waste. For more specific guidance please refer to **F6.03.09 – Waste Guidance.**

20.5 All clinical waste bags, irrespective of colour and type must be marked with the sites postcode to that our waste contractor can evidence where the waste came from.

20.6 All clinical waste bags must be sealed and marked with the postcode of the site, producing the waste, at the point of collection.

21. NHS Isolation Protocols

21.1 When entering into a NHS ward or department ERS Medical staff should, prior to any patient contact, seek to identify if there are any isolation IPC protocols in place.

21.2 It is essential that they do this to maintain the integrity of these protocols, if in place and already established.

21.3 This can be achieved by speaking to the Nurse in change or observing IPC isolation signage displayed either near the entrance to the Ward / Department or the side room where individual source isolation protocols have been put in place.

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A typical Source Isolation Warning Sign

21.4 Source Isolation can be achieved by placing patients in:

- Single rooms or general wards;
- Isolation units with isolation rooms with negative pressure ventilation with an anteroom and en-suite facilities.

21.5 Some Examples of source isolation may include:

- Clostridium Difficile;
- Chicken Pox;
- H1N1 influenza;
- MRSA;
- Pulmonary TB;
- Viral Diarrhoea.

21.6 It is highly unlikely that ERS Medical staff would ever be involved in the transportation of a patient being treated under protective isolation.

21.7 If such a situation should arise guidance and advice should be sought from the despatching facility, prior to transportation for all matters relating to IPC and general patient care.

21.8 In addition to this guidance and advice can be sought from the Care Quality Team and the Regulatory Compliance Team.

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22. Inspections and Monitoring

22.1 In addition to the responsibilities that are detailed within Section 6 of this work instruction, ERS Medical Operations Managers, Care Quality Advisors and Health Safety Advisors will hold a responsibility to ensure that IPC standards are maintained, monitored, inspected and audited at regular intervals.

F6.03.06 – Monthly Site Mop Management Records

22.2 Site Operations Managers are responsible for ensuring that mops are managed in accordance with the requirements of Section of this work instruction.

22.3 In addition to this they are responsible for ensuring that all completed **F6.03.05 – Weekly Mop Management Records** are retained at site and are readily available on request by either an auditor or inspector.

22.4 Care Quality Advisors and or Health and Safety Advisors will have a responsibility for conducting site inspections and audits in accordance with the requirements of this work instruction.

F6.03.07 – Site Housekeeping Inspection

22.5 Site housekeeping inspections must be carried out at least once per month. These can be conducted by either the site Operations Manager, Care Quality Advisor or Health and Safety Advisor.

22.6 If a site fails to meet the standards required a remedial action plan must be completed and agreed upon. This plan should be recorded on **F1.04.01 – Remedial Action Plan**.

22.7 All completed **F6.03.06 – Site Housekeeping Inspection Form** and **F1.04.01 – Remedial Action Plan** should be emailed to the Care Quality Manager for recording and publishing to Radar.

Audits

22.8 It will be the responsibility of the Care Quality Team, to conduct all IPC compliance audits for each ERS Medical location within their area of responsibility at least once per quarter as part of the care quality audit schedule

22.9 All will be detailed within the internal audit schedule on the Radar compliance system in accordance with **BMS/1.03 – Audit**.

22.10 Where sites have demonstrated sustained compliance with the requirements of **BMS/6.03 – Infection Prevention and Control (IPC)** and its associated WI's and forms this audit scheduled can be relaxed to a 6-monthly audit regime.

22.11 The decision to relax any site audit schedule must be made from a recommendation of the relevant Care Quality Advisor to the Head of Care Standards.

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22.12 It will be the responsibility of the Head of Care Standards to:

- Coordinate all Care Quality Team audits;
- Monitor the compliance system for compliance with scheduled audits;
- Ensure that RAP's are raised and recorded IAW with **BMS/1.04** – **Corrective / Preventive Actions**;
- Report to the SMT any significant findings and or trends identified as a result of audits.

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ERS Medical

Question 1.10.13

Not used

NEPTS

ON BOARD AMBULANCE SURVEY

Freepost Plus RUBR-CHYX-LZTY
ERS Medical
Angels Wing 1
Whitehouse Street
Leeds
LS10 1AD

ERS Medical

HOW TO GET YOUR VIEWS HEARD!

If you want to **make a comment...**

Or, thank the staff who **cared for you...**

Or, if you are **unhappy about something...**

Or, just ask a **question...**

YOU CAN DO SO BY:

Telephone: 0333 240 4999

Email: info@ersmedical.co.uk
complaints@ersmedical.co.uk

Website: www.ersmedical.co.uk/contact

Letter: Patient and Client Experience,
ERS Medical, Angels Wing 1,
Whitehouse Street, Leeds LS10 1AD

Company Registration Number 10783395

PS-NEPTS-0217

ERS_NEPTS_Survey_4pp_A5_Amend_V3_2020_CTP_Awk.indd 1 13/10/2020 12:46

On Board Patient Experience Survey

ERS Medical

ERS Medical Site:

Date of Journey:

Our Purpose: To provide a reliable caring service that puts people at the heart of everything we do.

The Friends and Family Test

We would like you to think about your recent experience with our service – **"Overall, how was your experience of our service?"**

Very Good	Good	Neither Good	Poor	Very Poor	Don't Know
					
☐	☐	☐	☐	☐	☐

Thinking about your experience with ERS Medical and the question. Please tell us why you feel this way.

Is there anything that would have made your experience better?

Task	Date	Owner	Details	Remarks
ELI - Holidays/Sickness Records/				
Measures letter				
Consultation - Group / 1-to-1				
PI Data Collect & FALCK FAQ				
P45				
Vehicle redeployment				
Uniforms				
Mobile terminals				
IG				
HR Data				
Data transfer/bookings				
Complaints contact ERS				
Phone line				
SV				
Off load staff on Bamboo & licence check etc				

ERS Medical

WI/6.08.01 Complaints, Comments, Concerns & Compliments Management

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.0	**Date Active:**	23.06.2020	**Review Date:**	30.06.2021

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Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
1.1	All	All	All	13.04.2018	[redacted]	Addition of review date
2.0	All	All	All	01.06.2018	[redacted]	Review due to restructure and addition of the new concerns event at Section 7.
3.0	All	All	All	13.06.19	[redacted]	Annual Review
4.0	All	All	All	23.0620	[redacted]	Annual Review

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2. Related Documents & Legal References

Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Safeguarding of Vulnerable Adults and Children	BMS/6.05
Patient Communications and Control (CCO)	BMS/6.08
Mail and Courier Operations	BMS/6.09
Non-Emergency Patient Transport Service (NEPTS)	BMS/6.10
Renal Patient (NEPTS)	BMS/6.11
High Dependency (HDU)(NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
CCO Dispute Statement Form	F6.08.01A
CCO Dispute Statement Continuation Sheet	F6.08.01B
CCO Dispute Response Form	F6.08.02
Internal Complaints Registration Form	F6.08.07
Patient Consent Form	Annex A
Formal Complaint Response Letter Template	Annex B

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3. Introduction

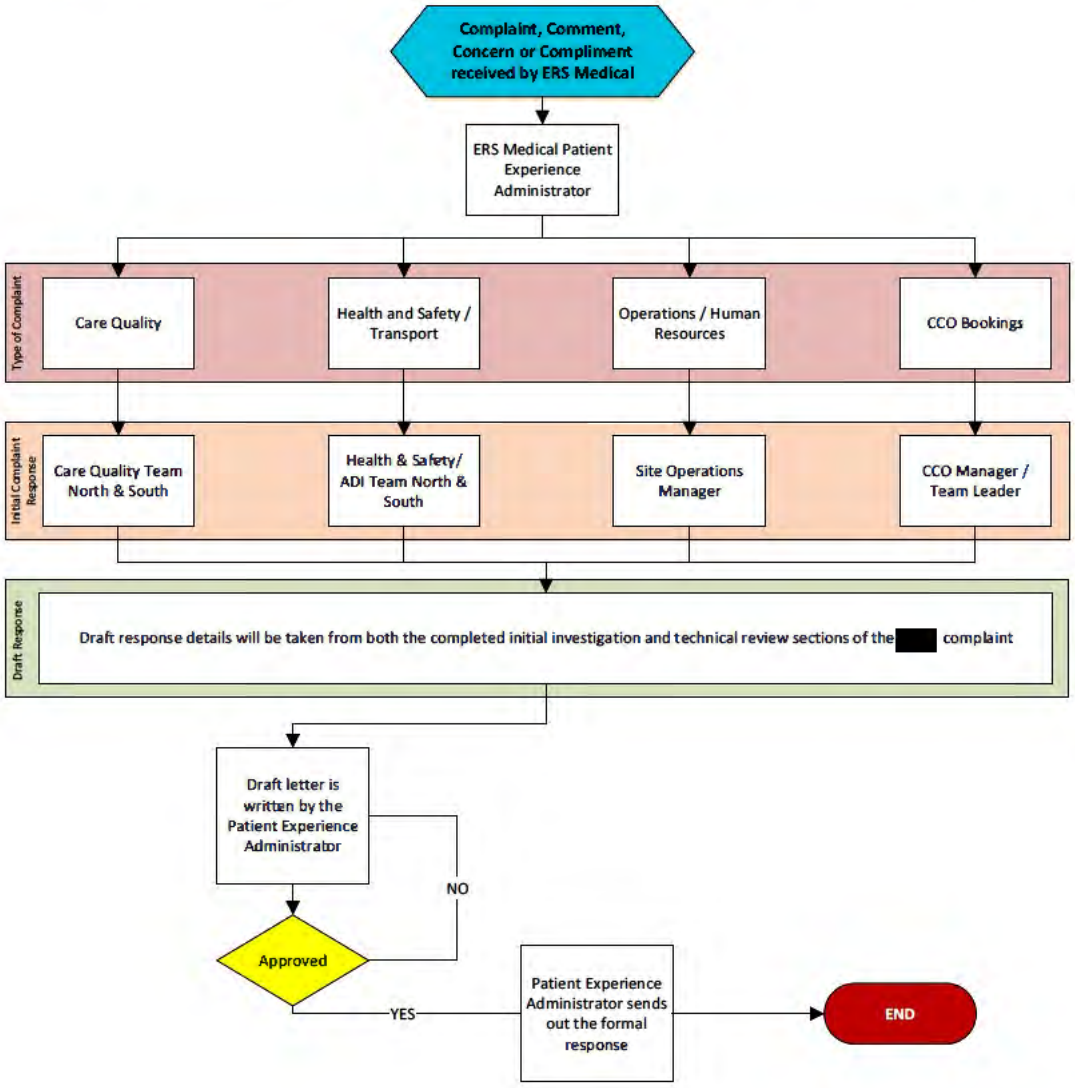
3.1 ERS Medical supports equal access for all, to all our services and does not discriminate against any group or individual, wishing to access our services.

3.2 Complaints, comments, concerns and compliments are managed in a fair and equitable way and are investigated and followed up by an independent role within the business.

3.3 ERS Medical adheres to the current NHS guidelines and best practice for responses to and the management of complaints.

3.4 Complaints, comments, concerns and compliments received by ERS Medical can come from numerous sources such as NHS Trusts, direct from patients or service users, next-of-kin of service user, concerned members of the public and other healthcare professionals.

3.5 Complaints, comments, concerns and compliments received by ERS Medical can have a clear pathway of responsibility but can on occasion take multiple paths through multiple streams of investigation before reaching a satisfactory outcome for the complainant and ERS Medical.



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3.6 To set out the process for the management of complaints about the service provided by ERS Medical to all service users.

3.7 Where possible the aim of ERS Medical is to resolve and address all queries at the initial point of contact, be that face to face, while the service is being delivered or via a telephone call, email, fax or letter.

3.8 It is recognised that an immediate resolution is not always possible, and that sometimes a query requires the intervention of others within the wider Company to ensure a resolution, which meets the needs and expectations of both the service user and ERS Medical in keeping with our customer 1st principle.

3.9 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.10 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the Company's Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the Company's Business Continuity Policy.

4.3 Please refer to the Company's Information Governance Policy.

4.4 Please refer to the Company's Care and Treatment Policy.

4.5 Please refer to the Company's Corporate Social Responsibility Policy.

4.6 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained, and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
5.3	**Head of Care Standards**	Is responsible for setting the strategic direction of Care Quality Team, Health and Safety Team for ERS Medical. Is responsible for the development, implementation, and co-ordination of consistent, quality, efficient and accountable procedures, and work instructions.
5.4	**Patient Experience Administrator**	Has the day to day responsibility, for ensuring that this procedure is put into practice for ERS Medical. For the initial recording on the [redacted] compliance systems and for ensuring that all assigned workflows are managed in a timely manner, Additionally, the Patient Experience Administrator is responsible for the final draft of all responses, prior to sending for authorisation, where required.
5.5	**Senior Operations Managers and Operations Managers**	Are responsible for ensuring they always understand ERS Medical policy and procedures and follow the processes.
5.6	**All Team Members**	Are responsible for ensuring they always understand ERS Medical policy and procedures and follow the processes. Additionally, they have a responsibility to cooperate with all investigations that result from a received complaint, comment or concern.

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6. Definitions

6.1 **BMS** – Business Management System.

6.2 **CCO** – Contact Centre Operations.

6.3 **Concern** – A complaint made by any NHS organisation or private or independent provider or responsible body. Areas of concern may include:

- Poor clinical performance;
- Service delivery issues such as perceived late supply of ambulances;
- Ill-treating patients;
- Unacceptable behaviour such as harassing or unlawfully discriminating against staff or patients;
- Breaching sexual or other boundaries with patients, colleagues or staff;
- Poor teamwork that compromises patient care;
- Personal health problems which lead to poor practice or conduct;
- Not complying with professional codes of conduct;
- Not complying with medical revalidation requirements;
- Poor management or administration which adversely affects clinical care or;
- Suspected fraud or criminal offence.

6.4 **Complaint**: A complaint or concern is an expression of dissatisfaction about an act, omission or decision of ERS Medical, either verbal or written, and whether justified or not, which requires a response. A complaint may be made by the person who is affected by the action, or it may be made by a person acting on behalf of a patient in any case where that person:

- Is a child; (an individual who has not attained the age of 18) In the case of a child, we must be satisfied that there are reasonable grounds for the complaint being made by a representative of the child, and furthermore that the representative is making the complaint in the best interests of the child;
- Has died; In the case of a person who has died, the complainant must be the personal representative of the deceased. NHS England needs to be satisfied that the complainant is the personal representative. Where appropriate we may request evidence to substantiate the complainant's claim to have a right to the information;
- Has physical or mental incapacity; In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act 2005, to make the complaint themselves, NHS England needs to be satisfied that the complaint is being made in the best interests of the person on whose behalf the complaint is made;

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- Has given consent to a third party acting on their behalf; In the case of a third party pursuing a complaint on behalf of the person affected we will request the following information: - Name and address of the person making the complaint; - Name and either date of birth or address of the affected person; and - Contact details of the affected person so that we can contact them for confirmation that they consent to the third party acting on their behalf. This will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the person affected;
- Has delegated authority to act on their behalf, for example in the form of a registered Power of Attorney which must cover health affairs.
- Is an MP, acting on behalf of and by instruction from a constituent.

6.5 **Patient Experience Administrator** – For the purpose of this Work Instruction the Hetton Court Office Manager will be referred to as the Patient Experience Administrator.

6.6 **Compliment** - A compliment is a positive comment received from someone who has come into contact with ERS Medical. It will contain sufficient detail to enable ERS Medical to understand what has been liked or valued by the person.

6.7 **C.R.M.** – Customer Relationship Management tool, used to log, manage and provide an accurate, accountable and transparent audit trail for all customer related queries.

6.8 **C.R.M. User** – An operational user of the CRM system who is not CCO based.

6.9 **Customer 1st** – A key value of ERS Medical which is used to define the way we manage, handle and respond with all service user interactions.

6.10 **Direct Complaint** – A direct complaint is one that is received by the Complaints Team direct from a patient or customer who has used or been exposed to our service.

6.11 **Dispute** – A disagreement or argument or interpretation of facts, a point of view that differs from one to another.

6.12 **Indirect Complaint** – An indirect complaint is one that has initially been received by one of our contractual partners and been passed to the Complaints Team for investigation and response within the contractual requirements. This would be any such event that falls out of the definition of a concern, as detailed at **Section 6.16** of this work instruction.

6.13 **ERD** – Estimated Resolution Date, this is the next time when an update is estimated to be received by or provided by the service user in accordance with this process.

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7. Concerns Management

7.1 When a concern is received into the NHS.Net email account, the Patient Experience Administrator will do the following initial actions:

- Check the concern details to ensure that it relates to ERS Medical activity, using the patient name, nhs number and date of the reported concern;
- Verify the ERS Medical site that the concern relates to;
- Check the concern for content to see if the concern relates to a patient missing a booked medical appointment. If the concern does the concern will receive a full investigation and response.

7.2 Once this information has been checked and verified a new 'Concern' event will be created on the [redacted] system.

7.3 At the end of the 'Concerns' event forms a selection has to be made to trigger an investigation workflow to the selected site. This decision should be based on the parameter detailed at bullet point 3 of Section 7.1. i.e. does the concern relate to a patient missing a booked medical appointment?

7.4 If an investigation is triggered the workflow will follow the standards 'Complaints' process and align to the complaints timeframes for completion.

7.5 If an investigation is not required, the new 'Concern' event, will be logged on the [redacted]

7.6 The Head of Care Standards will interrogate the [redacted] on a weekly basis and produce a communication to all Senior Operations Managers, Operations Managers and Care Standards Team members for all 'overdue' incidents currently recorded on [redacted]

7.7 In addition to the weekly communications for overdue incidents, the Head of Care Standards will produce a monthly regional ONE compliance report, which will provide details of all complaints, concerns, and compliments. A similar HEAD report will be produced for all regions for the SLT.

7.8 Where a concern relates to a delay, which resulted in a patient missing a scheduled medical appointment, details of the findings of these concerns will be recorded and provided to commissioners of the service through the monthly Governance and Performance Review (GaPR) One Report.

7.9 Feedback / Responses to concerns raised by NHS Trusts and CCG's will be provided by the local Senior Operations Manager and his / her Operations Managers during pre-arranged and scheduled contract performance and review meetings.

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8. Complaints Management

8.1 On receipt of a complaint into the ERS Medical Head Office, this should be logged by the CCO agent or the Patient Experience Administrator onto the [redacted] system.

8.2 If initially managed by the Patient Experience Administrator, they should attach any associated documentation to the [redacted] incident such as: booking details from Cleric, phones calls, emails.

8.3 On receipt of a complaint the Patient Experience Administrator will ascertain if the complaint is also an incident. They will do this be referring to the definitions of an incident contained with **BMS/5.01 – Incident Reporting and Investigation.**

8.4 This consideration is given so that the appropriate SME within the Care Standards Team can ascertain if there is a requirement for any of the following:

- Notification to the CQC or HSE or other official body;
- Notification to the ERS Medical insurers;
- Notification to commissioners of service i.e. CCG's and or NHS Trusts.

8.5 The Patient Experience Administrator should also attempt to ascertain if the complaint has already been responded to i.e. this is a continuing complaint such as 'I want an exclusive ambulance every time I travel'. If we have already responded, then we should immediately respond to the complainant and it has been answered. If you are not satisfied with the response, then the complaint should be escalated.

8.6 An acknowledgement of receipt for the dispute / complaint should be communicated by letter or email to the named contact of the complaint within **3 working days**, detailing the unique reference number assigned and any promised or inferred timeframes for a resolution date or further contact. This should be recorded within the [redacted] system.

8.7 The Template response for this should either be in the form of an email or letter:

Dear Sir/ Madam

This email/Letter is to acknowledge receipt of your complaint/Concern relating to (Nature of complaint details) on (Date Received). We would like to confirm that this is currently under investigation and aim to respond within 25 working days.

We can confirm that your ERS Medical Reference for this is CPL-****.***

In the meantime, if you have any further inquiries please do not hesitate to contact us quoting the reference above.

Yours sincerely,

8.8 Initial acknowledgement of a complaint may on occasion vary from contract to contract depending on their individual specification. The Patient Experience Administrator will ensure that he/she are aware of these contractual variations. A copy of the acknowledgement must be recorded on [redacted].

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8.9 When a complaint, either direct or indirect is received and it is deemed to also be an incident in accordance with definitions contained within **BMS/5.01 – Incident Reporting and Investigation**, the complaint must also be recorded as an incident.

8.10 The Patient Experience Administrator will investigate with current systems and available information to attempt to resolve and understand the issue, if they are unable to find this information allocate and contact the person(s) assigned as internal contact(s) for the case and advise them of any agreed timescales for any scheduled communications with named contact and any ERD.

8.11 All investigations and internal actions will be logged to the case for all authorised parties to be able to track and see the status on the account. For all other [redacted] users, only basic information will be viewable, in the interest of information governance pertaining to patient identifiable information.

8.12 The Patient Experience Administrator will delegate the need to investigate and provide statements from team members involved in the incident on **F6.08.01a** and **F6.08.01b**. These must be provided on the correct form within **5 working days** from the date of request. These types of complaints could be, but not limited to:

- **Care Quality Complaints** – Dignity, Respect and or Clinical Issues including Safeguarding and Prevent;
- **Health and Safety** – Complaints that relate to any issues where a patient has been injured due to poor manual handling, failure, misuse or lack of equipment;
- **Operational / HR** – Complaints that relate directly to service delivery and or attitude of employees through act or omission;
- **CCO** – Complaints that relate to the activity of the CCO such as bookings.

8.13 If these are not received within this timeframe the Patient Experience Administrator will make an additional contact with the concerned person(s) where they are given an additional 3 working days to complete, before the matter is escalated to their line manager.

8.14 This process will be repeated until the relevant information is received from the person in question and will be escalated to the level of Senior Operations Manager for the service area if required. If no response is received the Patient Experience Administrator will refer the case of the Head of Care Standards.

8.15 Where a complaint is received from anybody other than the patient / service user ERS Medical provided a service to a 'consent letter' will be sent to seek authority to respond from either the patient (if they have capacity and physical ability) to respond. If they are unable to do so a responsible person may sign of their behalf, such as, but not limited to:

- Legal guardian (under 16 years of age);
- Person holding Power of Attorney.

8.16 On completion of an investigation, the Patient Experience Administrator will review all the information and if any further action is required a request will be sent to the responsible Operations Manager who must provide a response within 5 working days of this request on **F6.08.02**.

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8.17 The Patient Experience Administrator will coordinate the ERS Medical response to the named contact, for the complaint, detailing all relevant information pertaining to the issue and any associated observations, actions and timelines which have generated to ensure this is successfully resolved and no re-occurrence of a similar type will occur in future. This will be recorded on the case notes held within the [redacted] system.

8.18 The Patient Experience Administrator will provide the formal written response, based on part by the content provided by the specialist team, to the named contact on the complaint within **25 working days** of the case being raised; the full details and content of this will be added to [redacted] for audit, transparency and accountability.

8.19 If it becomes evident that ERS Medical will not be able to provide a full response within the required timeframe, we will provide an update to the contact when this becomes apparent with timescales for resolution and reasons, if known, why there has been a delay in the investigation.

8.20 Should the internal owner of the dispute or complaint be unable to reach an agreed resolution with the named contact, the case will be escalated to the Senior Operations Manager (SOM) for the Operational area concerned. The SOM will make immediate contact with the Patient Experience Administrator to confirm they will be taking ownership of the complaint from this point forward.

8.21 The Patient Experience Administrator will inform the named contact of the need for an escalation and any new timeframes set for a resolution. This will be recorded in notes for the case and the ERD amended as required.

8.22 The Patient Experience Administrator will confirm the named contact for the dispute or complaint is informed of the agreed actions and timescales and then assigns a new ERD accordingly.

8.23 In the case of complaints that originate from an NHS source the Patient Experience Administrator will allow an initial period of **2 weeks** to elapse, from the notification to the named contact of any investigations outcomes for them to respond.

8.24 All disputes and complaints are routinely closed at the point where a response is issued to the client, patient, or 3rd party.

8.25 If a client, patient or 3rd party replies indicating they are unhappy or not satisfied with the response issued, the case would be re-opened, revisiting the points raised within the complaint, ensuring that all responses were looked at again.

8.26 If anything, further can be added it will be communicated back to the client, patient, or 3rd party. If, however, no further response can be identified or if the client, patient, or 3rd party is still dissatisfied, we would refer them at this point to the ombudsman (see section 9.20).

8.27 For all non- NHS complaints, we will ask the named contact to contact ERS Medical should they not be satisfied with the resolution provided. The case will then be closed and only reopened if we receive a communication from the named contact that they are not satisfied with the provided resolution.

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8.28 If at the end of the disputes and complaints procedure the named contact is still not fully satisfied with the response from ERS Medical, they can if they wish to do so, escalate their original dispute or complaint to the Parliamentary and Health Services Ombudsman by visiting their website at;

http://www.ombudsman.org.uk

8.29 The Patient Experience Administrator will have a responsibility to produce a monthly report for the regional Patient Safety Committees (PSC) and as a requirement of some contractual KPI packs. This report should detail the number, type, location and trends of disputes and complaints received within the Complaints process.

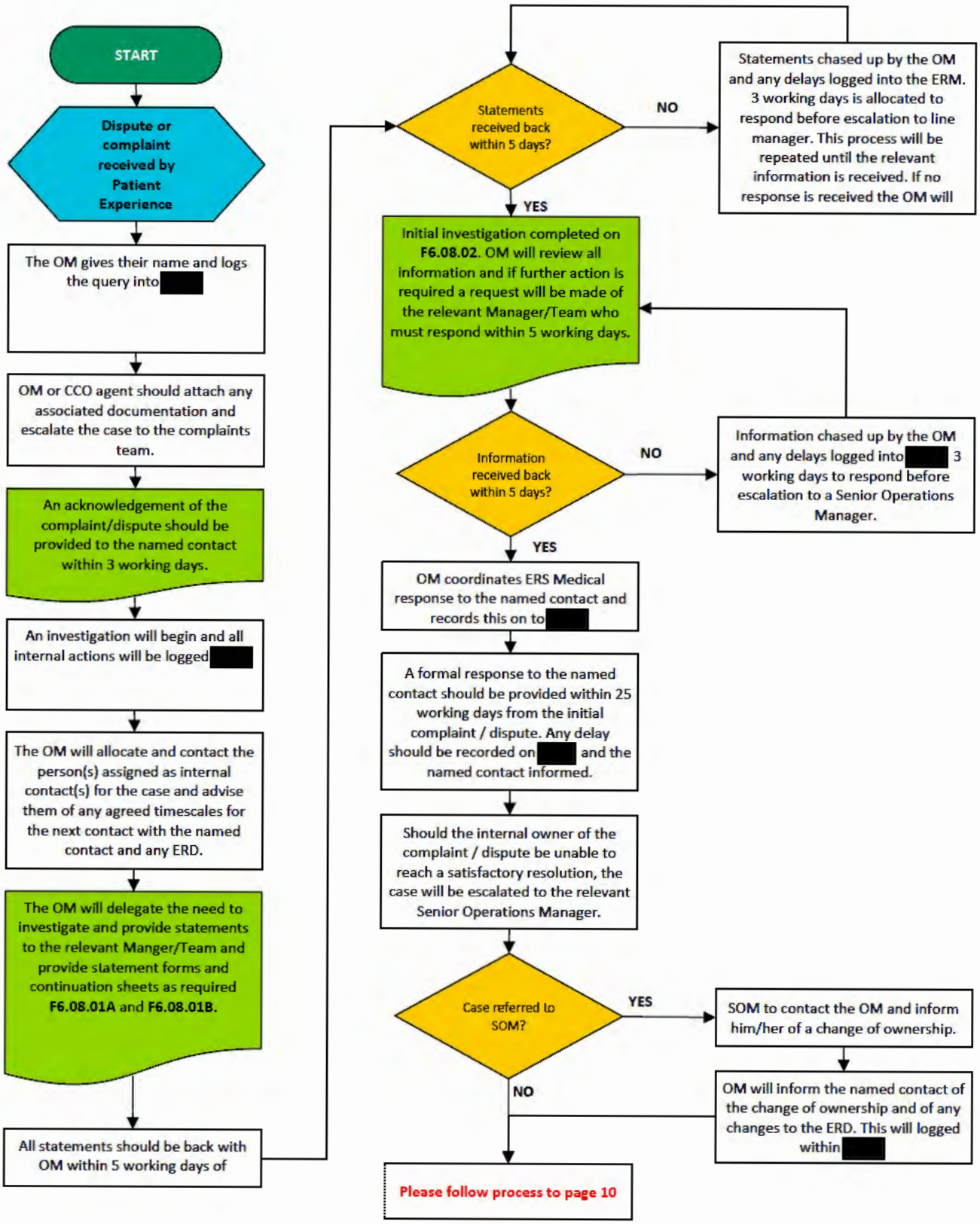
8.30 Where ERS Medical receive a complaint of concern from an individual other than the patient, we need to ensure that we have the patients consent to disclose information. In all circumstances the Patient Experience Administrator will ensure that an **Annex B – Patient Consent Form** is sent and returned side, prior to any disclosures.

8.31 Further guidance can be sought from the ERS Medical Caldicott Guardian.

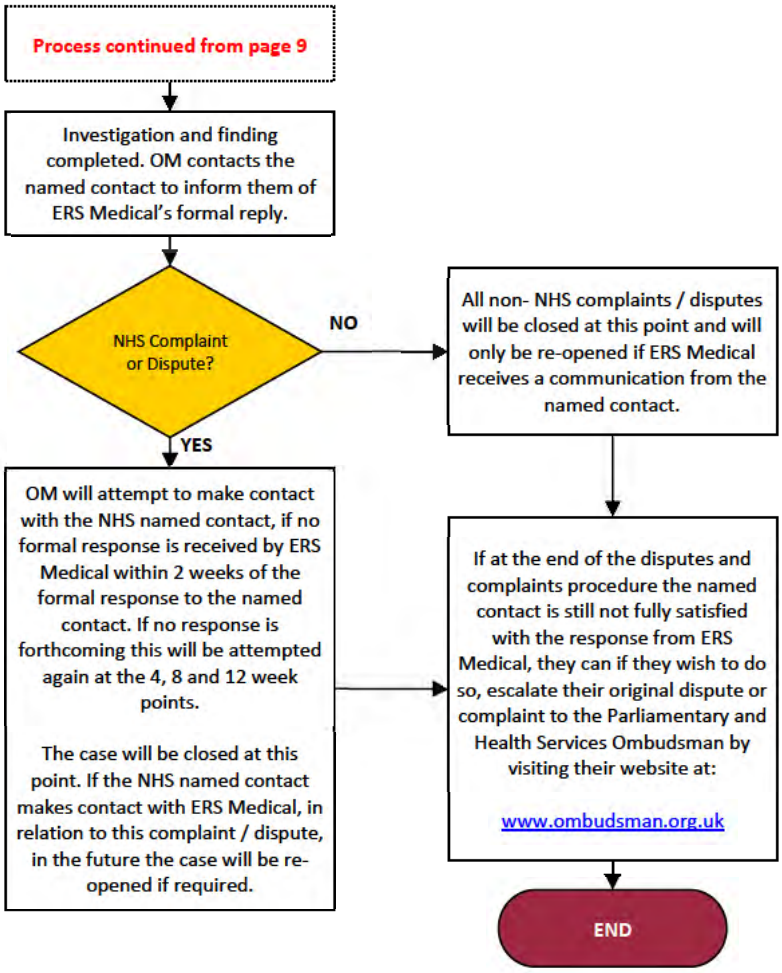
8.32 Formal complaint responses will be written on **Annex B** to this work instruction, which is available on the Bamboo HR system, in Section 8.

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9. Key Steps



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10. Complaint Referenced to an Incident

10.1 On receipt of a complaint the Patient Experience Administrator will determine if the complaint also refers to a reportable incident in accordance with the definitions of an incident as defined in Section 7 of **BMS/5.01 – Incident Reporting and Investigation**.

10.2 If the complaint is not categorised as an incident, then the complaints process will adhere to the process detailed within Section 7 of this work instruction.

10.3 If, however, the complaint is found to be a reportable incident within the requirement of **BMS/5.01 – Incident Reporting and Investigation**, the Patient Experience Administrator will conduct a check of the on-line incident log to identify if an incident has already been logged in relation to the complaint.

10.4 If an incident has already been logged then the Patient Experience Administrator will annotate the incident with the [redacted] references and tick the box in the evidence gathering section of the log, named 'Did this incident arise from a complaint'.

10.5 If the complaint has come in as an in-direct complaint from a contracted NHS Trust, then the Patient Experience Administrator will also record the Trusts Datix ref within [redacted]

10.6 If an incident has not already been raised on the online incident log, the Patient Experience Administrator will raise a new incident for the site that the complaint refers to.

10.7 Once the incident log has been updated the Patient Experience Administrator will email the relevant ERS Medical Operations or relevant Team that will be conducting or is conducting the incident investigation and make them aware that the incident is also a complaint. This email must contain the differing time requirements for the complaints Estimated Resolution Date (ERD).

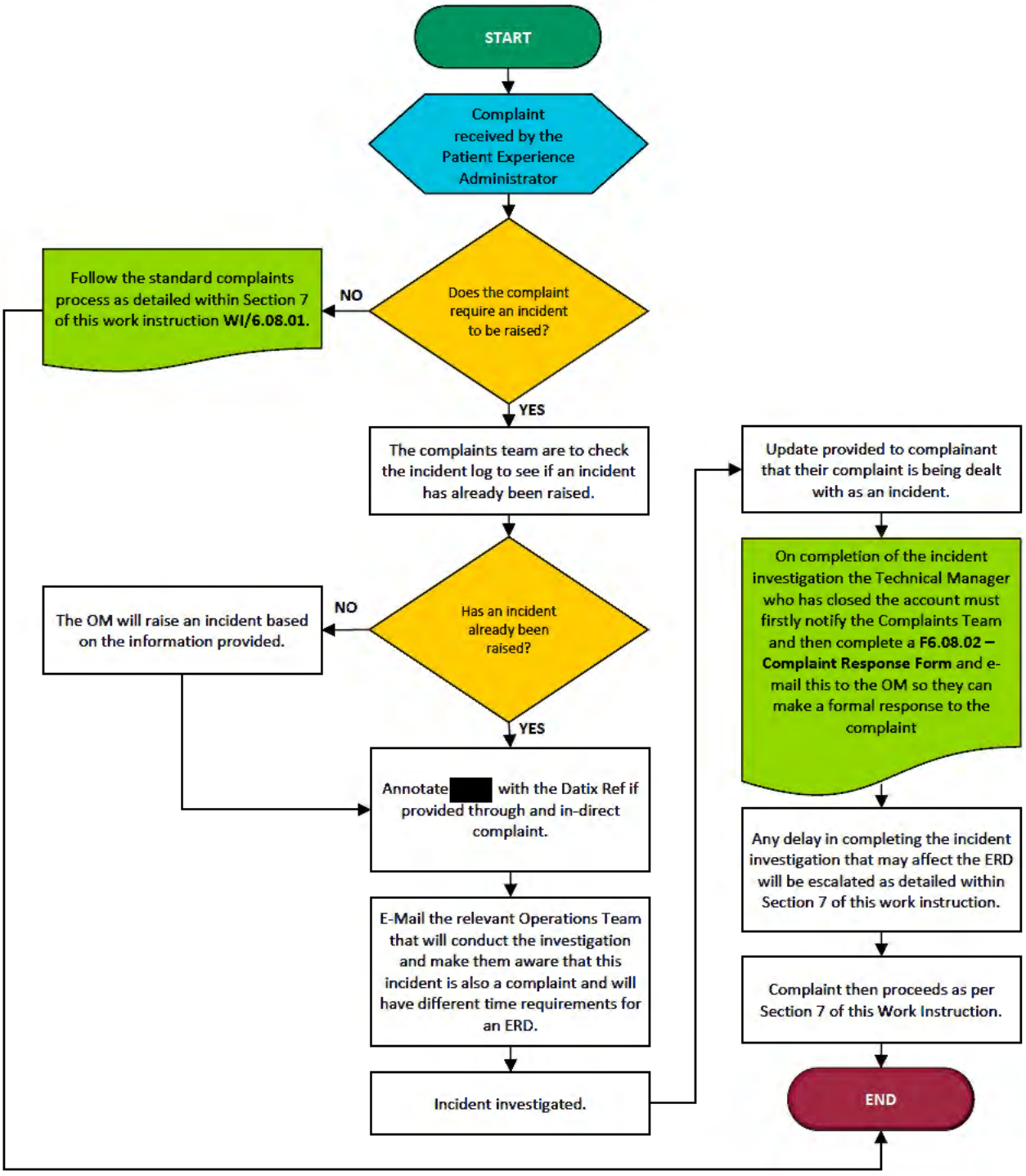
10.8 On completion and closing of the incident the technical reviewing manager / advisor will complete an **F6.08.02 – Complaint Response Form** and email the Patient Experience Administrator to notify them that the incident investigation has been completed.

10.9 On receipt of the **F6.08.02 – Complaint Response Form** the complaints team will follow the complaint formal response process as detailed at Section 7 of this work instruction.

10.10 Any delays in closing the investigation which may affect the ERD will result in the Complaints Team escalating the complaint as detailed at Section 7 of this work instruction.

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11. Key Steps



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12. Comments

12.1 Low level remarks or comments both positive and negative to the service, which may on their own not require any formal action to be taken, other than logging, will be recorded by the Patient Experience Administrator on a designated spreadsheet.

12.2 However, if multiple comments are made on the same or similar subject, they may identify a trend or pattern either in activity, location or service type. On these occasions it may be necessary to take proactive action to address the issues identified before they either result in a complaint and or incident.

12.3 The Patient Experience Administrator will report through the monthly regional Governance and Performance Review (GaPR) committee meetings on any trends and patterns and actions will be identified and allocated as part of the GaPR process and recorded as such within the official minutes.

13. Compliments

13.1 When any compliment is received into the Company either through the CCO or Patient Experience Administrator, it will be identified to the ERS Medical site that has provided services for the compliment and forwarded to the relevant Line Manager to action. The Patient Experience Administrator will log the compliment of the [redacted] system.

13.2 When a line manager receives a compliment either from the CCO or Patient Experience Administrator, he/she will identify the relevant team members that the compliment refers to and interview them on a one to one basis, thanking them for the efforts and work ethos.

13.3 A copy of the compliment will be given to the relevant team members for their personal records and a copy with be placed into their personal HR file.

13.4 It will be at the discretion of the relevant line manager if they feel that the compliment is worthy of nominating the relevant team members for a Company 'Employee Recognition Scheme' award.

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ERS Medical

BMS/2.01 Human Resources

Document Author:	[redacted]		Head of HR and Training		
Document Owner:	[redacted]		Managing Director		
Version:	3.0	**Date Active:**	10.09.2020	**Review Date:**	30.09.2021

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Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	01.08.2018	[redacted]	Annual Review
3.0	All	All	All	03.09.2020	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
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Managing Probation Periods	WI/2.01.02
Keeping in Touch Record	WI/2.01.07
Fit and Proper Persons	WI/2.06.01
Employer Handbook	

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3. Introduction

3.1 This procedure provides an overview to the Human Resources (HR) function of the business and acts as a roadmap to key HR processes.

3.2 This procedure and the subsequent work instructions provide advice and guidance to Line Managers and Supervisors on these key HR processes.

3.3 HR is committed to developing and implementing dynamic and forward-looking HR strategies to support ERS Medical's Mission, Vision and Identity.

3.4 ERS Medical believes that it can only succeed through including all staff, and by creating the right environment where every person can flourish and is supported to succeed.

3.5 HR contributes across all areas of ERS Medical's activities and works in partnership with all employees to support them in their areas of work.

3.6 HR work to high professional standards and constantly seek to improve how we can add value in what we do and how we do it, both within the HR provider, and across ERS Medical.

3.7 HR have developed a series of "Manager Guides" as work instructions that complement ERS Medical's Employee Handbook and provide comprehensive, yet easy-to-use guidelines for the personnel management decisions that are made every day.

3.8 These documents will support all company personnel in making those decisions by providing the information that Managers and Supervisors need to manage HR tasks.

3.9 The majority of the decisions made by Managers and Supervisors in personnel management fit into the category of routine decisions. That doesn't mean they are easy, but that they fall within fairly standard guidelines.

3.10 This majority can be handled without help if Managers and Supervisors are familiar with or have experience of managing people. However, Managers and Supervisors will often seek reassurances to check and balance the decisions that are made. It is the HR providers intention that these guides will assist this decision-making process.

3.11 In cases where there is a requirement to record an informal discussion that has taken place with an employee (outside of ERS Medical's Disciplinary, Absence, and Capability Procedures), F2.04.08 – Record of Discussion can be used. This document can be retained on an employee's file indefinitely.

3.12 The structure and content of the guidance documents has been developed to include the wide variety of processes related to Managers and Supervisors HR responsibilities and are organised by the employee life cycle.

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3.13 The text provides the "how-to" that flows from the guiding principles. It defines:

- The steps to follow when implementing a policy or procedure;
- The issues to consider when making a decision;
- The details to cover when you're developing a plan;
- The general know how and reassurance to confidently manage employees.

3.14 The structure and content of the guidance will be amended from time to time to reflect changes to legislation, ERS Medical practices and business requirements.

3.15 The following sections provide an outline of what is covered by each work instruction in this series.

3.16 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.17 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Quality, Environmental, Safety and Health Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing ERS Medical's Health & Safety and HR policies.
5.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
5.3	**Head of HR**	Is responsible for ensuring that the ERS Medical's HR procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to undertake their duties. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
5.4	**SOM's and Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
5.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Recruitment and Selection

6.1 **WI/2.04.01 – Recruitment and Selection** has been written to provide guidance and practical advice to Line Managers on recruitment and selection. The processes contained within this document are:

- Identifying a Vacant Post;
- Ring-fencing;
- Compiling a Job Description / Competencies;
- Advertising a Vacancy;
- Closing Dates;
- Application Process;
- Short-listing;
- Testing;
- Interviews;
- Conditional Offers of Employment (Appointment Process);
- Unconditional Offers of Employment;
- Starting Salary;
- Withdrawing an Offer of Employment;
- Making Reasonable Adjustments;
- Reserve Candidates;
- Feedback;
- Complaints;
- References;
- Qualifications;
- Checking Identity and Right to Work in the UK;
- Appointment;
- Contract of Employment.

7. Managing Probation Periods

7.1 **WI/2.04.02 – Managing Probation Periods** has been written to provide guidance and practical advice to Line Managers on managing probation periods. The processes contained within this document are:

- Aims / Objectives;
- Induction;
- Probation Review – 3 and 6 Months;
- Performance Review – 12 Months;
- Probation Period on Internal Transfer or Re-deployment;
- Probation Period on Fixed Term Contracts;
- Probation Period during Long-term Absence;
- Probation Period during Maternity Leave;

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- Managing Health Related Absence;
- How to Deal with Unsatisfactory Performance;
- Taking Formal Action during Probation;
- Roles and Responsibilities;
- Notice Period during Probation.

8. Sickness Absence

8.1 **Sickness Absence Policy (located in the employee handbook)** has been written to provide guidance and practical advice to Line Managers on managing sickness absence. The processes contained within this document are:

- Reporting Absence;
- Failure to Report Health Related Absence;
- Recording and Monitoring;
- Telephoning Staff off Sick;
- Trigger Points;
- Return to Work Interviews;
- Occupational Health Service;
- Responsibilities Regarding Referral to Occupational Health;
- The Occupational Health Report;
- Confidentiality;
- Formal Stage in Managing Sickness Absence.

9. Discipline

9.1 **Disciplinary Policy (located in the employee handbook)** has been written to provide guidance and practical advice to Line Managers on managing discipline. The processes contained within this document are:

- Discipline or Capability – Which should it be?
- How does the Procedure help me Manage?
- Timescales
- Your Responsibility as a Manager
- How can HR Support me as a Manager?
- Using the Discipline Procedure
- Informal Action
- Formal Investigation
- Formal Disciplinary Action
- Step 1 – Inform the Employee
- Step 2 – The Formal Meeting
- Step 3 – The Appeal

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10. Grievance

10.1 **Grievance Policy (located in the employee handbook)** has been written to provide guidance and practical advice to Line Managers on managing grievances. The processes contained within this document are:

- Informal Procedure;
- Formal Procedure.

11. Expectant Mothers and Maternity Leave

11.1 **The Family Friendly Policy (located in the employee handbook)** has been written to provide guidance and practical advice to Line Managers on managing expectant mothers and maternity leave. The processes contained within this document are:

- Informing the Company of Pregnancy;
- How the Staff Member Should Tell the Company She is Pregnant;
- Pregnancy Meetings;
- Contact on Leave;
- Health and Safety;
- Risk Assessment;
- Avoiding Risk;
- Suitable Alternative Work;
- Time off – Antenatal Care;
- Sick Leave before Maternity Leave;
- Staff who need to Change Hours;
- Annual Leave;
- Choosing a Date to Start Maternity Leave;
- Absence due to Childbirth before the Intended Start Date;
- Compulsory Maternity Leave;
- The Length of Maternity Leave;
- Maternity Pay;
- Keeping in Touch Days;
- Complications;
- Pay Rises;
- Return to Work Date;
- Return to Work Meeting;
- Failure to Return after Additional Maternity Leave;
- Refusal to Allow a Member of Staff to Return from Additional Maternity Leave;
- Sick when due to Return to Work;
- Resuming Work after Statutory Maternity Leave;
- Dismissal on Grounds Unrelated to Maternity Leave;
- Childcare Vouchers.

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12. Paternity Leave

12.1 **The Family Friendly Policy (located in the employee handbook)** has been written to provide guidance and practical advice to Line Managers on managing paternity leave. The processes contained within this document are:

- Ordinary Paternity Leave;
- Notification of Ordinary Paternity Leave;
- Ordinary Statutory Paternity Pay;
- Additional Paternity Leave;
- Eligibility for Additional Paternity Leave;
- Notification of Additional Paternity Leave;
- Additional Statutory Paternity Pay;
- Contact during Additional Paternity Leave;
- Keeping-in-touch Days during Additional Paternity Leave;
- Returning to Work after Additional Paternity Leave;
- Rights on and after Return to Work;
- Adoption from Overseas.

13. Managing Change

13.1 **WI/2.04.08 – Managing Change** has been written to provide guidance and practical advice to Line Managers on managing change. The processes contained within this document are:

- Managing Minor Change;
- Managing Change due to Organisational Re-structure;
- Redeployment, Suitable and Alternative Employment, Training, Trial Period and Severance;
- Frequently Asked Questions;
- Writing a Rationale / Script for Change – for Consideration by a Senior Manager;
- Consultation Processes – Advice / Guidance;
- Restructuring – Terminology and Processes;
- Practical Advice and Guidance on the Consultation Process during a Restructure;
- Redeployment - Suitable Alternative Employment;
- Minimising and Avoiding Redundancy.

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14. Adoption and Surrogacy

14.1 **The Family Friendly Policy (located in the employee handbook)** has been written to provide guidance and practical advice to Line Managers on managing adoption and surrogacy. The processes contained within this document are:

- Eligibility for Leave;
- Eligibility for Pay;
- Notification of Adoption Leave;
- Transfer of Leave (Additional Partner Leave – APL);
- Accrual and use of Annual Leave;
- Starting Adoption Leave;
- Contact during Leave;
- Keeping-In-Touch (KIT) Days;
- Contractual Entitlements;
- Continuity of Service;
- Ill Health;
- Pension;
- Returning to Work after Adoption Leave;
- Member of Staff not returning to Work.

15. Flexible Working

15.1 **WI/2.01.10 – Flexible Working** has been written to provide guidance and practical advice to Line Managers on managing flexible working. The processes contained within this document are:

- Guidance for Considering Requests;
- Considerations for Staff with Significant Caring Responsibilities;
- Guidance for the Flexible Working Request Meeting;
- Advice to help you make your Decision;
- Dealing with Multiple Requests;
- Budget Implications;
- Guidance for Managing Flexible Working;
- Time off for Dependents;
- Implementation with the Company.

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16. Managing Capability

16.1 **WI/2.04.11 – Capability Managing Under Performance** has been written to provide guidance and practical advice to Line Managers on managing capability. The processes contained within this document are:

- Personal or Domestic Problems;
- Disability or Medical Issues;
- Establishing the Facts;
- Informal Resolution;
- Notification of a Formal Capability Hearing;
- The Capability Meeting;
- Appeals.

17. Home Working

17.1 **WI/2.04.12 – Home Working** has been written to provide guidance and practical advice to Line Managers on Home Working. The processes contained within this document are:

- Minor Home Working;
- Major Home Working;
- Application Process.

18. Company Directors - Fit and Proper Persons

18.1 **WI/2.06.01 – Company Directors – Fit and Proper Persons** has been written to provide guidance on the requirements of Regulation 5 – The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to ensure:

- Directors are of good character (3a);
- Directors are qualified, competent; skilled and have the necessary experience necessary for the position they hold within the organisation (3b);
- Directors are able by reasons of health, after any reasonable adjustments have been made, of properly tasks which are intrinsic to the position they hold (3c)
- Directors have not been responsible for serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity (3d);
- Directors would deemed an 'Unfit Person' if the meet any of the criteria set out in Schedule 4, Part 2 of the regulation.

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ERS Medical



EMPLOYEE HANDBOOK

ERS Transition Limited

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Employee Handbook Issues and Updates

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1 - 51	1	July 2018
1 – 61	2	September 2018
1 – 61	3	April 2019
39	4	January 2020
6, 8, 52, 53, 54, 55	5	September 2020

Introduction

WELCOME TO ERS MEDICAL TEAM

We want to help you settle into your new job as quickly and as easily as possible. To ensure this happens, you will be given a full induction during your first few weeks/months of employment by your manager. The induction, along with the information in this handbook, is intended to give you an overview of the company and help you understand the nature and service of the business. This should help you understand how your role fits within the overall company structure, what we expect from you and what you can expect from us.

Our company purpose is to provide a reliable, caring service that puts people at the heart of everything we do. We are first and foremost a healthcare company, so it is important that we put our patients at the centre of every decision we make.

As a company we ask you to follow our core values by being patient focused, treating our patients with compassion, integrity, respect and professionalism. As a company we will strive towards innovation and working in partnership with other healthcare providers.

Within this handbook, you will find details of the main policies and procedures that relate to your employment. The details within this handbook should be read in conjunction with your offer letter, contract of employment and relevant business management policies found on our company HR system.

Please be advised that the policies in the handbook do not form part of your terms and conditions of employment.

Please read this handbook carefully and if you have any queries don't hesitate to contact a member of the management team.

Thank you and I look forward to working with you,

*** REDACTED ***

*** REDACTED *** Managing Director – ERS Medical

Joining Our Organisation

A) INDUCTION

At the start of your employment with our Company you are required to complete an induction programme, during which all our policies and procedures (including Health and Safety) will be explained to you. Information relating to these will be given to you at the induction.

B) JOB DESCRIPTION

Amendments may be made to your job description from time to time in relation to our changing needs and your own ability.

C) STAFF APPRAISAL SCHEME

We have a staff appraisal scheme in place for the purpose of monitoring staff performance levels with a view to maximising the effectiveness of individuals, details of which are available separately.

D) JOB FLEXIBILITY

It is an express condition of employment that you are prepared, whenever necessary, to transfer to alternative departments or duties within our business. During holiday periods, etc. it may be necessary for you to take over some duties normally performed by colleagues. This flexibility is essential for operational efficiency as the type and volume of work is always subject to change.

E) MOBILITY

It is a condition of your employment that you are prepared, whenever applicable, to travel to any other of our sites within reasonable travelling distance on a temporary basis. This mobility is essential to the smooth running of our business.

F) DISCLOSURE AND BARRING CERTIFICATE(S)

Your initial employment may be conditional upon the provision of a satisfactory Disclosure and Barring Certificate of a level appropriate to your post. You may be required to undertake subsequent criminal record checks from time to time during your employment as deemed appropriate by the Company. In the event that such certificate(s) are not supplied your employment with us will be terminated.

Data collected about criminal convictions will be processed in line with the Data Protection Act. You may read more about the data we hold on you, why we hold it and the lawful basis that applies in the employee privacy notice.

G) CONVICTIONS AND OFFENCES

During your employment, you are required to immediately report to the Company any convictions or offences with which you are charged, including traffic offences. Data collected about criminal convictions will be processed in line with the Data Protection Act. You may read more about the data we hold on you, why we hold it and the lawful basis that applies in the employee privacy notice.

H) POLICY STATEMENT ON THE SECURE STORAGE, HANDLING, USE, RETENTION AND DISPOSAL OF DISCLOSURES AND DISCLOSURE INFORMATION

1) As an organisation using the Disclosure and Barring Service and/or Disclosure Scotland to help assess the suitability of applicants for positions of trust, we comply fully with the Disclosure and Barring Service/Disclosure Scotland Code of Practice regarding the correct handling, use, storage, retention and disposal of disclosures and disclosure information. We also comply fully with our obligations under the Data Protection Act.

2) Disclosure information is never kept in an applicant's personnel file. It is always kept separately and securely in lockable, non-portable storage containers with access strictly controlled and limited to those who are authorised to see it as part of their duties in accordance with Section 124 of the Police Act 1997.

3) We maintain a record of all those to whom disclosures and disclosure information has been revealed and we recognise that it is a criminal offence to pass the information to anyone who is not entitled to receive it.

4) Disclosure information is only used for the specific purpose for which it was requested.

5) Once a recruitment (or other relevant) decision has been made, we do not keep disclosure information for any longer than is absolutely necessary in order to allow for the consideration and resolution of any disputes or complaints. Where appropriate, the Disclosure and Barring Service/Disclosure Scotland will be consulted, and full consideration will be given to the data protection and human rights of the individual.

6) Once the retention period has elapsed, we will ensure that any disclosure information is immediately destroyed by secure means, i.e. by shredding, pulping or burning. While awaiting destruction, disclosure information will not be kept in any insecure receptacle (e.g. a waste bin or confidential waste sack). We will not keep any photocopy or other image of the disclosure or any copy or representation of the contents of the disclosure. However, we may keep a record of the date of issue of the disclosure, the name of the subject, the type of disclosure requested, the post for which the disclosure was requested, the unique reference number of the disclosure and the details of the recruitment (or other relevant) decision taken.

I) OTHER POLICIES AND PROCEDURES

The Company has a number of other policies and procedures that will have been explained to you during your induction. Copies of these will have been provided to you separately or are available on request from your line manager on can be located on Bamboo under 'policies and procedure road map'.



Salaries and Wages, etc

A) ADMINISTRATION

1) Payment

a) For all staff the pay period is the calendar month. Basic salaries are paid by the 28th day of the current month.

b) You will receive a payslip showing how the total amount of your pay has been calculated. It will also show the deductions that have been made and the reasons for them, e.g. Income Tax, National Insurance, etc.

c) Any pay queries that you may have should be raised with your Line Manager.

2) Overpayments

If you are overpaid for any reason, the total amount of the overpayment will normally be deducted from your next payment but if this would cause hardship, arrangements may be made for the overpayment to be recovered over a longer period.

3) Income Tax and National Insurance

At the end of each tax year you will be given a form P60 showing the total pay you have received from us during that year and the amount of deductions for Income Tax and National Insurance. You may also be given a form P11D showing non-salary benefits. You should keep these documents in a safe place as you may need to produce them for tax purposes.

B) LATENESS/ABSENTEEISM

1) You must attend for work punctually at the specified time(s) and you are required to comply strictly with any time recording procedures relating to your work.

2) All absences must be notified in accordance with the sickness reporting procedures laid down in this Employee Handbook.

3) If you are hourly paid and you "clock in" more than four minutes late (e.g. at 8.05 am) you will lose 15 minutes pay. If you "clock in" more than 19 minutes late (e.g. at 8.20 am) you will lose 30 minutes pay and so on.

4) If you arrive for work more than one hour late without having previously notified us, other arrangements may have been made to cover your duties and you may be sent off the premises for the remainder of the shift without pay.

5) Lateness or absence may result in disciplinary action and/or loss of appropriate payment.

C) SHORTAGE OF WORK

In the event that the Company is faced with a shortage of work, or is unable to provide you with work for any other reason, then you agree that the Company may temporarily:

- place you on short time working, in which case you will be paid for those hours worked; or
- lay you off from work, in which case you will be paid in accordance with the statutory guarantee pay provisions in place at that time; or
- designate you as a furloughed (or similar) worker, in accordance with the terms of any Government furlough (or similar) scheme in place from time to time, in which case during such period, if required, you will cease to carry out any work for the Company. (For this purpose, you agree that the Company may adjust your salary and benefits by an appropriate amount to ensure that it receives reimbursement of such salary and benefits under the said scheme to the fullest extent possible)

The entirety of this section entitled "Shortage of work" forms part of your contractual terms and conditions.

D) PENSION SCHEME

Automatic enrolment occupational pension scheme: The Company operates an auto enrollment pension scheme and, in compliance with the employer pension duties under the Pensions Act 2008, you will be enrolled as an active member of this scheme (or such other registered pension scheme as may be established by the Company to replace the scheme) from the start of your employment. You will be subject to the trust deed and rules of the scheme as are in force from time to time and HM Revenue & Customs requirements. The Company reserves the right to vary, amend or withdraw the scheme, or any of its rules or benefits, at any time. Full details of the scheme, including the rules, conditions of eligibility and the rates of contributions and benefits, can be obtained from your line manager.

You will pay such contributions to the scheme as may be required by the rules of the scheme from time to time and the Company will also pay such contributions to the scheme as may be required by the rules of the scheme from time to time. Any Company and employee contributions paid, or the minimum rate at which benefits build up, will be sufficient to maintain the scheme's status as a qualifying scheme for the purposes of the Pensions Act 2008. Your contributions to the scheme will be deducted from your salary and paid into the scheme.

Automatic enrolment only takes place for staff who are aged 22 years or over, however as long as you are earning over £6,032 in a full tax year, ERS are happy for staff to opt into a staff pension and we will manually enrol you.

E) RETIREMENT

The Company does not operate a normal retirement age and therefore you will not be compulsorily retired on reaching a particular age. However, you can choose to voluntarily retire at any time, provided you give the Company the required period of notice of termination of your employment as set out in your terms and conditions.

Holiday Entitlement and Conditions

A) ANNUAL HOLIDAYS

1) Your annual holiday entitlement is shown in your individual Statement of Main Terms of Employment (Form SMT).

2) It is our policy to encourage you to take all of your holiday entitlement in the current holiday year. We do not permit holidays to be carried forward and no payment in lieu will be made in respect of untaken holidays other than in the event of termination of your employment.

3) We operate an online system for booking holidays via from your personal profile within Bamboo HR. You will be given the rights to request absence online and you will also be able to view your holiday entitlement online at any time. This is to give you the facility to easily plan your holidays throughout the year.

4) Once you have registered your holiday request online, you will receive an e-mail from your Line Manager authorising or declining your request. If you feel that your request has been unreasonably refused for any reason you should refer the matter to your Line Manager. They will endeavour to ensure that you have every opportunity to take your holidays at the time you request them, but they will need to balance your requests with the needs of the department.

5) You should give at least four weeks' notice of your intention to take holidays of a week or more and one week's notice is required for odd single days.

6) You may not normally take more than two working weeks consecutively (unless exceptional circumstances and agreed with your Line Manager).

7) Your holiday pay will be at your normal basic pay unless shown otherwise on your Statement of Main Terms.

8) You may be required to reserve sufficient days from your annual entitlement to cover the Christmas/New Year shut-down period. If you have not accrued sufficient holiday entitlement to cover this period, you will be given unpaid leave of absence.

9) As a business we ask that holidays can be booked as soon as possible from the start of the holiday year (January) this ensures that operationally holiday can be authorised and can be planned affectively across the site.

B) PUBLIC/BANK HOLIDAYS

Your entitlement to public/bank holidays are shown in your individual Statement of Main Terms of Employment.

Sickness/Injury Payments and Conditions

A) NOTIFICATION OF INCAPACITY FOR WORK

1) You must notify us by telephone on the first day of incapacity at the earliest possible opportunity and by no later than your scheduled start time. Text messages and e-mails are not an acceptable method of notification. Other than in exceptional circumstances notification should be made personally, to your Line Manager.

2) You should try to give some indication of your expected return date and notify us as soon as possible if this date changes. The notification procedures should be followed on each day of absence unless you are covered by a medical certificate.

3) If your incapacity extends to more than seven calendar days you are required to notify us of your continued incapacity once a week thereafter, unless otherwise agreed.

B) EVIDENCE OF INCAPACITY

1) Medical certificates are not issued for short-term incapacity. In these cases of incapacity (up to and including seven calendar days) you must sign a self-certification absence form on your return to work.

2) If your sickness has been (or you know that it will be) for longer than seven days (whether or not they are working days) you should see your doctor and make sure he/she gives you a medical certificate and forward this to us without delay. Subsequently you must supply us with consecutive medical certificates to cover the whole of your absence.

C) PAYMENTS

1) You are entitled to statutory sick pay (SSP) if you are absent for four or more consecutive days because of sickness or injury provided you meet the statutory qualifying conditions. SSP is treated like wages and is subject to normal deductions.

2) Qualifying days are the only days for which you are entitled to SSP. These days are normally your working days unless otherwise notified to you. The first three qualifying days of absence are waiting days for which SSP is not payable. Where a second or subsequent period of incapacity (of four days or more) occurs within 56 days of a previous period of incapacity, waiting days are not served again.

3) Any contractual sickness/injury payments are shown in your individual Statement of Main Terms of Employment.

4) Any days of contractual sickness/injury payments which qualify for SSP will be offset against SSP on a day-to-day basis. A deduction will be made for any other state benefits received if you are excluded or transferred from SSP.

5) If you are entitled to any payments in excess of SSP and your entitlement expires, full or part payment may be allowed at our discretion where it is considered that there are special circumstances warranting it.

6) Where the circumstances of your incapacity are such that you receive or are awarded any sum by way of compensation or damages in respect of the incapacity from a third party, then any

payments which we may have made to you because of the absence (including SSP) shall be repaid by you to us up to an amount not exceeding the amount of the compensation or damages paid by the third party and up to, but not exceeding, any amount paid by us.

To qualify for SSP workers must:

- Have an employment contract and have done some work under it
- Earn at least £113 a week
- Have been sick for at least 4 days in a row, including non-working days
- Give correct notice, as set out in this policy, by contacting your line manager on the first morning at your earliest possible opportunity and outline the required details
- Give you proof of their illness if they've been off for 7 days. This should be in the form of a fit note from their doctor.
- SSP is provided over a long-term sick period of 28 weeks only.

D) OCCUPATIONAL SICK PAY (OSP)

6) This money is payable to you under the terms of your contract and your conditions of service. Your entitlement is determined by your length of service and by any previous sickness absence during a certain period. The scale of allowances for all ERS Medical staff are set out below, unless your contract of employment states otherwise.

Probation Period	Statutory Sick Pay
During 1st year of service	Statutory Sick Pay
During 2nd year of service	Statutory Sick Pay
During 3rd year of service	1-month FP and 1-month HP
During 4th year and successive Years	2-months FP and 2-months HP

Sick leave for all staff is calculated based on a rolling year. Hence the entitlement during an absence is determined by deducting from the full entitlement all sickness absence which has occurred in the preceding 12 months.

OSP will not be paid until the fourth day of sickness (in-line with the statutory requirements under SSP) and a FIT note is received. The first three days of any absence will be unpaid leave. OSP will not be paid when a period of sickness occurs between a Friday and the following Monday.

OSP will also not be paid when a staff member is within a formal process such as a disciplinary.

A) RETURN TO WORK

1) You should notify your Line Manager as soon as you know on which day you will be returning to work, if this differs from a date of return previously notified.

2) If you have been suffering from an infectious or contagious disease or illness such as rubella or hepatitis you must not report for work without clearance from your own doctor.

3) On return to work after any period of sickness/injury absence (including absence covered by a medical certificate), you are also required to complete a self-certification absence form and hand this to your Line Manager.

4) Upon returning to work after any period of sickness/injury absence, you may be required to attend a "return to work" interview to discuss the state of your health and fitness for work. Information arising from such an interview will be treated with strictest confidence.

B) GENERAL

1) Submission of a medical certificate or sickness self-certification absence form, although giving us the reason for your absence may not always be regarded by us as sufficient justification for accepting your absence. Sickness is just one of a number of reasons for absence and although it is understandable that if you are sick you may need time off, continual or repeated absence through sickness may not be acceptable to us.

2) In deciding whether your absence is acceptable or not we will take into account the reasons and extent of all your absences, including any absence caused by sickness/injury. We cannot operate with an excessive level of absence as all absence, for whatever reason, reduces our efficiency.

3) We will take a serious view if you take sickness/injury leave which is not genuine, and it will result in disciplinary action being taken.

4) If we consider it necessary, we may ask your permission to contact your doctor and/or for you to be independently medically examined by our Occupational Health Specialists, Health Assured Limited.

C) BRADFORD FACTOR

The Company monitor sickness absence using a system known as 'The Bradford Factor' this is a simple calculation that is used to highlight frequent, short-term employee absence. Should the calculation identify unacceptable attendance levels the Company may further investigate the attendance record which could result in disciplinary action in accordance with our disciplinary procedures.

The formula used to calculate an employer's score is:
Number of times absent x number of times absent x total number of days absent.

27-199	Return to work and informal conversation regarding the impact on the business of the absence.
200-359	Return to Work and Letter of Concern issued.
360-599	Return to Work and Disciplinary hearing, possible written warning.
600-750	Return to work and Disciplinary hearing, possible final warning.
750+	Return to work and possible dismissal.

D) OCCUPATIONAL HEALTH

ERS Medical uses Health Assured as our occupational health provider. They are able to demonstrate their commitment to promotion of the health, safety, welfare and protection of people at work, by applying specialist skills and expertise to meet the individual and collective needs of ERS Medical.

Your manager will be able to provide you with further information.

Employee Assistance Programme

We recognise that sometimes you may face certain challenges in your work and home life that are difficult to deal with. We subscribe to a confidential and professional life management service which provides you with a qualified counsellor who can offer personal support for any practical or emotional challenges you may be facing.

WHAT IS AN EAP

An EAP is an online and telephone employee benefit designed to help you deal with personal and professional problems that could be affecting your home life or work life, health and general wellbeing.

Our EAP service through Health Assured provides a complete support network that offers expert advice and compassionate guidance 24/7, covering a wide range of issues. We strongly believe in providing an EAP service that offers not only reactive support when someone needs it but also proactive and preventative support to deliver the best possible outcomes.

Balancing everyday life with the requirements of work and home can create pressures for all of us. Work is a large part of people's lives. With increasing working hours as well as technological developments to support remote working, it is vital to ensure that there's a productive, healthy environment that is conducive to a healthy lifestyle.

Health Assured, in partnership with ERS Transition Ltd, provides all employees with complimentary access to an enhanced Employee Assistance Programme (EAP) to assist you in achieving this balance.

SERVICES AVAILABLE

Health Assured offers cover for you and your immediate family members*, 24 hours a day, 7 days a week, 365 days a year:

- Life Support: Unlimited access to counselling for emotional problems and a pathway to structured telephone counselling or face-to-face counselling sessions (employees only) at your convenience.

- Legal information: For any issues that cause anxiety or distress including debt management, accountancy, lawsuits, consumer disputes, property or neighbour legalities.

- Bereavement Assistance: Health Assured offers qualified and experienced counsellors who can help with grief and related stress plus a team of legal advisors to help with legal issues.

- Medical information: Qualified nurses are on hand to offer advice on a range of medical or health related issues. They can't diagnose but can offer a sympathetic ear and practical information and advice.

- CBT Online: We recognise the value of self-help tools in dealing with a range of issues, which is why we have a range of CBT self-help modules, informative factsheets and invaluable advice videos from leading qualified counsellors.

**Immediate family is defined as your legal partner and children aged 16-24 in full time education residing in the same household.*

WELLBEING PORTAL

In addition to the counselling support and advice, Health Assured also offer a virtual library of wellbeing information. These informative articles and self-help guides provide support on a range of health and advisory issues, as well as instant guidance to aid of an employee's physical and mental health.

We understand that the information needs to be available in a way that is suitable for you, whenever you require it. From simple lifestyle changes to advice for many of life's most common concerns, the portal offers:

- Interactive health assessment providing personal tailor-made dietary tips and fitness plans
- Fitness and lifestyle advice, such as detoxing methods
- Four-week self-help programmes
- Mini health checks

HEALTH e-HUB MOBILE APP

Sometimes it can be difficult to balance the pressures of work with the demands of home life. When daily life feels overwhelming you need help and support to deal with the practical and emotional challenges you may be facing. The free Health Assured app offers access to holistic health and wellbeing support at the tap of a finger anywhere and anytime.

- Support videos and webinars
- Four-week programmes
- Home life support and advice
- Work life assistance
- Physical and emotional health
- Mini health checks
- Life Support
- Emotional Health
- Physical Health
- Online CBT
- Wellbeing videos and webinars
- Medical information

To find out more information on what services Health Assured can provide, please visit ***** REDACTED *****

To gain access to the Health and Well-being Portal you will require the below login credentials:

***** REDACTED *****
***** REDACTED *****

The service is initially provided via telephone and online advice but face to face meetings will be arranged where this is felt clinically appropriate. This service is totally confidential. More details of this service are available from your Line Manager.

Safeguards

A) RIGHTS OF SEARCH

1) Although we do not have the contractual right to carry out searches of employees and their property (including vehicles) whilst they are on our premises or business, we would ask all employees to assist us in this matter should we feel that such a search is necessary.

2) Where practicable, searches will be carried out in the presence of a colleague of your choice who is available on the premises at the time of the search. This will also apply at the time that any further questioning takes place.

3) We reserve the right to call in the police at any stage.

B) CONFIDENTIALITY

1) All information that:

   a) is or has been acquired by you during, or in the course of your employment, or has otherwise been acquired by you in confidence;

   b) relates particularly to our business, or that of other persons or bodies with whom we have dealings of any sort; and

   c) has not been made public by, or with our authority;

   shall be confidential, and (save in the course of our business or as required by law) you shall not at any time, whether before or after the termination of your employment, disclose such information to any person without our prior written consent.

2) You are to exercise reasonable care to keep safe all documentary or other material containing confidential information and shall at the time of termination of your employment with us, or at any other time upon demand, return to us any such material in your possession.

3) You must make yourself aware of our policies on data protection in relation to personal data and ensure compliance with them at all times.

C) COMPANY PROPERTY AND COPYRIGHT

All written material, whether held on paper, electronically or magnetically which was made or acquired by you during the course of your employment with us, is our property and, where appropriate, our copyright. At the time of termination of your employment with us, or at any other time upon demand, you shall return to us any such material in your possession.

D) STATEMENTS TO THE MEDIA

Any statements to reporters from newspapers, radio, television, etc. in relation to our business will be given only by a Director or Head of HR.

E) DATA PROTECTION

The General Data Protection Regulation (GDPR) and the current Data Protection Act regulate our use of your personal data. As an employer it is our responsibility to ensure that the personal data we process in relation to you is done so in accordance with the required principles. Any data held shall be processed fairly and lawfully and in accordance with the rights of data subjects.

We will process data in line with our privacy notices in relation to both job applicants and employees.

You have several rights in relation to your data. More information about these rights is available in our "Policy on your rights in relation to your data". We commit to ensuring that your rights are upheld in accordance with the law and have appropriate mechanisms for dealing with such.

We may ask for your consent for processing certain types of personal data. In these circumstances, you will be fully informed as to the personal data we wish to process and the reason for the processing. You may choose to provide or withhold your consent. Once consent is provided, you are able to withdraw consent at any time.

You are required to comply with all Company policies and procedures in relation to processing data. Failure to do so may result in disciplinary action up to and including dismissal.

F) INVENTIONS/DISCOVERIES

An invention or discovery made by you will normally belong to you. However, an invention or discovery made by you will become our property if it was made:

a) in the course of your normal duties under such circumstances that an invention might reasonably be expected to result from those duties;

b) outside the course of your normal duties, but during duties specifically assigned to you, when an invention might reasonably be expected to result from these; and

c) during the course of any of your duties, and at the time you had a special obligation to further our interests arising from the nature of those duties, and your particular responsibilities.

G) VIRUS PROTECTION PROCEDURES

In order to prevent the introduction of virus contamination into the software system the following must be observed:

a) unauthorised software including public domain software, USBs, external hard drives, CDs or internet downloads must not be used; and

b) all software must be virus checked using standard testing procedures before being used.

H) USE OF COMPUTER EQUIPMENT

In order to control the use of the Company's computer equipment and reduce the risk of contamination the following will apply:

a) the introduction of new software must first of all be checked and authorised by your Line Manager before general use will be permitted;

b) only authorised staff should have access to the Company's computer equipment;
c) only authorised software may be used on any of the Company's computer equipment;

d) only software that is used for business applications may be used;

e) no software may be brought onto or taken from the Company's premises without prior authorisation;

f) unauthorised access to the computer facility will result in disciplinary action; and

g) unauthorised copying and/or removal of computer equipment/software will result in disciplinary action, such actions could lead to dismissal.

I) E-MAIL AND INTERNET POLICY

1) Introduction

The purpose of the Internet and E-mail policy is to provide a framework to ensure that there is continuity of procedures in the usage of internet and e-mail within the Company. The internet and e-mail system have established themselves as an important communications facility within the Company and have provided us with contact with professional and academic sources throughout the world. Therefore, to ensure that we are able to utilise the system to its optimum we have devised a policy that provides maximum use of the facility whilst ensuring compliance with the legislation throughout.

2) Internet

Where appropriate, duly authorised staff are encouraged to make use of the Internet as part of their official and professional activities. Attention must be paid to ensuring that published information has relevance to normal professional activities before material is released in the Company name. Where personal views are expressed a disclaimer stating that this is the case should be clearly added to all correspondence. The intellectual property right and copyright must not be compromised when publishing on the Internet. The availability and variety of information on the Internet has meant that it can be used to obtain material reasonably considered to be offensive. The use of the Internet to access and/or distribute any kind of offensive material, or material that is not work-related, leaves an individual liable to disciplinary action which could lead to dismissal.

3) Procedures – Acceptable/Unacceptable Use

a) unauthorised or inappropriate use of the internet system may result in disciplinary action which could result in summary dismissal.
b) the internet system is available for legitimate business use and matters concerned directly with the job being done. Employees using the internet system should give particular attention to the following points:

i) comply with all of our internet standards;

ii) access during working hours should be for business use only;

iii) private use of the internet is not permitted.

c) the Company will not tolerate the use of the Internet system for unofficial or inappropriate purposes, including:

i) accessing websites which put our internet at risk of (including but not limited to) viruses, compromising our copyright or intellectual property rights;

ii) non-compliance of our social networking policy;

iii) connecting, posting or downloading any information unrelated to their employment and in particular pornographic or other offensive material;

iv) engaging in computer hacking and other related activities or attempting to disable or compromise security of information contained on the Company's computers.

You are reminded that such activities (iii. and iv.) may constitute a criminal offence.

4) E-mail

The use of the e-mail system is encouraged as its appropriate use facilitates efficiency. Used correctly it is a facility that is of assistance to employees. Inappropriate use however causes many problems including distractions, time wasting and legal claims. The procedure sets out the Company's position on the correct use of the e-mail system.

5) Procedures - Authorised Use

a) unauthorised or inappropriate use of the e-mail system may result in disciplinary action which could include summary dismissal.

b) the e-mail system is available for communication and matters directly concerned with the legitimate business of the Company. Employees using the e-mail system should give particular attention to the following points:

i) all comply with Company communication standards;

ii) e-mail messages and copies should only be sent to those for whom they are particularly relevant;

iii) e-mail should not be used as a substitute for face-to-face communication or telephone contact. Abusive e-mails must not be sent. Hasty messages sent without proper consideration can cause upset, concern or misunderstanding;

iv) if the e-mail is confidential the user must ensure that the necessary steps are taken to protect confidentiality. The Company will be liable for infringing copyright or any defamatory information that is circulated either within the Company or to external users of the system; and

v) offers or contracts transmitted by e-mail are as legally binding on the Company as those sent on paper.

c) The Company will not tolerate the use of the e-mail system for unofficial or inappropriate purposes, including:

i) any messages that could constitute bullying, harassment or other detriment;

ii) personal use (e.g. social invitations, personal messages, jokes, cartoons, chain letters or other private matters);

iii) on-line gambling;

iv) accessing or transmitting pornography;

v) transmitting copyright information and/or any software available to the user; or

vi) posting confidential information about other employees, the Company or its clients or suppliers.

6) Monitoring

We reserve the right to monitor all e-mail/internet activity by you for the purposes of ensuring compliance with our policies and procedures and of ensuring compliance with the relevant regulatory requirements. This includes monitoring of any additional accounts you may be requested to set up for the purposes of performing your work tasks, which are subject to the same rules as your work email account. Information acquired through such monitoring may be used as evidence in disciplinary proceedings. Monitoring your usage will mean processing your personal data. You may read more about the data we hold on you, why we hold it and the lawful basis that applies in the employee privacy notice.

J) USE OF SOCIAL NETWORKING SITES

Any work-related issue or material that could identify an individual who is a client or work colleague, which could adversely affect the Company, a client or our relationship with any client must not be placed on a social networking site. This means that work related matters must not be placed on any such site at any time either during or outside of working hours and includes access via any computer equipment or mobile device.

K) CLOSED CIRCUIT TELEVISION

CCTV is operated on some Company premises. This is for a number of reasons, including the prevention of crime and the safety of employees and clients. CCTV footage is monitored regularly.

You should be aware that CCTV footage may be used and relied upon, where necessary, for disciplinary purposes. Similarly, if there were allegations of criminal activity by employees or claims brought against any member of the Company leading to civil proceedings by clients or employees the Company may use and/or submit the relevant footage to the relevant authorities.

Standards

A) WASTAGE

1) We maintain a policy of "minimum waste" which is essential to the cost-effective and efficient running of our organisation.

2) You are able to promote this policy by taking extra care during your normal duties by avoiding unnecessary or extravagant use of services, time, energy, etc. The following points are illustrations of this:

   a) handle machines, equipment and stock with care;

   b) turn off any unnecessary lighting and heating. Keep doors closed whenever possible;

   c) ask for other work if your job has come to a standstill; and

   d) start with the minimum of delay after arriving for work and after breaks.

3) The following provision is an express written term of your contract of employment:

   a) any damage to vehicles, stock or property that is the result of your carelessness, negligence or deliberate vandalism will render you liable to pay the full or part of the cost of repair or replacement;

   b) any loss to us that is the result of your failure to observe rules, procedures or instruction, or is as a result of your negligent behaviour or your unsatisfactory standards of work will render you liable to reimburse to us the full or part of the cost of the loss; and

   c) in the event of an at fault accident whilst driving one of our vehicles you may be required to pay the cost of the insurance excess up to the maximum value as detailed below.

      i. The policy excess is £250 in respect of Accidental Damage, Fire, Theft and Glass claims;

      ii. If the driver is between 21 and 24 the excess increases by £150;

      iii. If the driver is 25 or over with a provisional licence, the excess increases by £150;

      iv. If the driver is 25 or over but has held a full UK licence for less than on year, the excess is increased by £150;

      v. If the driver is 25 or over, has a full EU licence but has been in the UK for less than one year, the excess is increased by £150; and

      vi. If the driver is 25 or over and holds a full international licence, the excess is increased by £150.

4) In the event of failure to pay, we have the contractual right to deduct such costs from your pay.

B) STANDARDS OF DRESS

As you are liable to come into contact with clients and members of the public, it is important that you present a professional image with regard to appearance and standards of dress. Where uniforms are provided, these must be worn at all times whilst at work and laundered on a regular basis. Where uniforms are not provided, you should wear clothes appropriate to your job responsibilities, and they should be kept clean and tidy at all times.

C) HOUSEKEEPING

Both from the point of view of safety and of appearance, work areas must be kept clean and tidy at all times.

D) CLEAR DESK POLICY

We operate a Clear Desk Policy outside of the business hours. During business hours we acknowledge the need for files and documents and wherever possible they should be maintained in a professional, efficient and orderly manner. At the end of the working day employees are expected to tidy their desk and to lock away all office papers in the desk locker or filing cabinets provided.

The purpose of the policy is to:

1) Demonstrate the right image when our clients visit the Company;

2) Ensure confidential and sensitive information is kept secure and data protection adhered to at all times; and

3) Ensure efficiency and effectiveness.

Failure to comply with this policy may result in disciplinary action being taken.

Health, Safety, Welfare and Hygiene

A) SAFETY

1) You should make yourself familiar with our Health and Safety Policy and your own health and safety duties and responsibilities, as shown separately.
2) You must not take any action that could threaten the health or safety of yourself, other employees, clients or members of the public.
3) Protective clothing and other equipment which may be issued for your protection because of the nature of your job must be worn and used at all appropriate times. Failure to do so could be a contravention of your health and safety responsibilities. Once issued, this protective wear/equipment is your responsibility.
4) You should report all accidents and injuries at work, no matter how minor, in the accident book.
5) You must ensure that you are aware of our fire and evacuation procedures and the action you should take in the event of such an emergency.

B) REFRESHMENT MAKING FACILITIES

We provide refreshment making facilities for your use, which must be kept clean and tidy at all times.

C) STAFF ROOM

We provide a staff room for your use, which must be kept clean and tidy at all times. It may only be used during authorised breaks.

D) NO SMOKING POLICY

Smoking on the premises or in Company vehicles is not permitted. This includes e-cigarettes.

E) HYGIENE

1) Any exposed cut or burn must be covered with a first-aid dressing.
2) If you are suffering from an infectious or contagious disease or illness such as rubella or hepatitis you must not report for work without clearance from your own doctor.
3) Contact with any person suffering from an infectious or contagious disease must be reported before commencing work.

F) FITNESS FOR WORK

If you arrive for work and, in our opinion, you are not fit to work, we reserve the right to exercise our duty of care if we believe that you may not be able to undertake your duties in a safe manner or may pose a safety risk to others, and send you away for the remainder of the day with or without pay and, dependent on the circumstances, you may be liable to disciplinary action.

G) MANUAL HANDLING

You are required, in accordance with the Manual Handling Regulations 1992, to advise us of any condition which may make you more vulnerable to injury.

Accident Management

A) INTRODUCTION

The reporting of accidents, which arise out of the company's work activities or take place at premises or sites under the company's control, is necessary to:

- Ensure compliance with statutory requirements;
- Provide information in the event of legal action;
- Establish if existing safety provisions are adequate;
- Identify any trends or patterns of accidents.

B) ACCIDENT DEFINITION

An accident is an event that results in physical harm (injury or disease) to a person however slight. Injury accidents are classified as major or minor, major accidents are defined below. All other accidents are classified as minor.

For further information please refer to the BMS which can be found on Bamboo HR.

C) ACCIDENT REPORTING

Any major accident, which occurs directly from the company's work activities or takes place at any premise or site under the company's control, must be reported by the quickest practical means to your line manager.

D) CLASSIFICATION OF MAJOR ACCIDENTS

- Any work-related death;
- Any accident which is reportable in the UK to the Health and Safety Executive (HSE) or in Ireland to the Health and Safety Authority (HSA);
- Any accident which occurs on any premise or site under the company's control which results in a member of the being taken to hospital for treatment;
- Serious traffic accidents involving company vehicles;
- Any accident which involves any other regulators or any emergency service (police, fire, ambulance, etc) or in which there is media involvement.

E) REPORTING PROCEDURE

All accidents which involve company employees, contractors, visitors or members of the public resulting from activities or which take place on premises or sites under the company's control must be reported and investigated in line with company's procedures. A copy of the procedure can be found within the BMS.

F) RESPONSIBILITIES FOR ACCIDENT REPORTING AND INVESTIGATION

1) MINOR ACCIDENTS

The site Regional Manager is responsible for ensuring that all accidents are investigated and for submitting the completed Incident Report Form within 24 hours of the accident occurring.

2) MAJOR ACCIDENTS

Major accidents as defined above must be reported by the quickest possible means to the following:

- Emergency services (if required) and
- Line manager

Your line manager will be responsible for contacting:

- The relevant directors and senior managers
- A member of the compliance team.

All notifications to and communication with the relevant health and safety regulatory body will be undertaken by a member of the ESH team.

All major accidents will be fully investigated and corrective actions to prevent re-occurrence must be documented.

G) ABSENCE DUE TO INJURIES RECEIVED WHILST AT WORK

If any employee is unable to work as a result of an injury received whilst at work, their line manager will visit them as soon as possible.

The purpose of this visit is to:

- Show concern for the employee;
- Obtain full details of the circumstances that caused the absence as part of the investigation process;
- Ascertain a likely return to work date.

For an employee who will be absent from work as a result of an injury received at work for a protracted period the Regional manager will ensure that appropriate actions are taken in involving the ESH team, occupational health and the HR provider to investigate and report the accident and to facilitate the rehabilitation of the employee.

Payment during absence will be in line with the employee's contract of employment.

As far as is practicable this procedure will be followed for contractors, visitors or members of the public injured whilst on premises or sites controlled by the company.

H) PREVENTATIVE ACTION

On completion of the investigation, preventative actions must be detailed on the incident report to prevent a re-occurrence and to ensure that agreed actions are put in place. For major accidents, a Remedial Action Plan (RAP) form is used. For further information please refer to the BMS.

I) RECORD KEEPING

All documents relating to major accidents must be retained and be available for inspection for a period of 40 years following the event. For minor accidents, the period shall be five years.

An employee who chooses to pursue a civil claim against a customer or third party following an accident or incident at work whilst carrying out work activities on behalf of the Company, are required to advise their Line Manager of the details. The Company will endeavour to assist with any problem resolution associated with work activities with a third party where necessary.

J) INCIDENT MANAGEMENT (NO INJURIES)

1) INTRODUCTION

The reporting of incidents, which arise out of the company's work activities or take place at premises or sites under the company's control, is necessary to:

- Ensure compliance with statutory requirements;
- Provide information in the event of legal action;
- Establish if existing safety provisions are adequate identify any trends or patterns of accidents.

2) INCIDENT DEFINITION

An incident is an event that results in damage to property, a near miss, a loss or any combination of these effects. Incidents are classified as major or minor, major incidents are defined below. All other incidents are classified as minor.

3) INCIDENT REPORTING

Any major incident which occurs directly from company's work activities or takes place at any premise or site under company's control must be reported by the quickest means practical to your line manager.

Your line manager will be responsible for contacting:

- The relevant directors and senior managers;
- A member of the ESH team.

4) CLASSIFICATION OF MAJOR INCIDENTS

- Any dangerous occurrence which is reportable in the UK to the Health and Safety Executive (HSE) or in Ireland to the Health and Safety Authority (HSA);
- Any fire or explosion.

An environmental incident which has resulted in environmental damage or harm to human health or media involvement.

Working Time Directive

The Working Time Directive (WTD) came into force on 1 October 1998 and includes the following provisions:

Weekly Working Hours

The regulations set a limit of an average of 48 hours per week within a standard averaging period of 17 weeks, i.e. the maximum weekly working hours must not exceed 48 per week averaged over 17 weeks.

Non-mobile workers can consent in writing to opt out of the maximum weekly hours.

A) DAILY REST

Individuals are entitled to a minimum of 11 hours consecutive rest within a 24-hour period, i.e. individuals can only work a maximum of 13 hours per shift/day.

B) WEEKLY REST PERIOD

A minimum of 24 hours, per seven days in addition to the daily rest period of 11 hours, averaged over 14 days. A minimum of 24 hours may replace the 35 hours consecutive rest period (i.e. 11 hours + 24 hours) if justified by 'objective, technical or work organisation conditions', i.e. one day off per week.

C) ANNUAL LEAVE

All individuals are to receive a minimum of 5.6 weeks* holiday per year and may be issued in days, hours or shifts in line with your working arrangements. Leave entitlement will be pro-rated in line with working days per week. When employment commences or terminates mid-month, entitlement will be calculated on a pro-rata basis and rounded up to the nearest half or full.

Please refer to your contract of employment for individual entitlements.
* Including Public/Bank Holidays.

D) NIGHTTIME WORKING

Reasonable steps must be taken to ensure that the normal hours of work in respect of a night worker does not exceed an average of eight hours for each 24 hours over a 17-week period.

The averaging period may be extended in certain circumstances.

Night-time Worker Health assessments will be undertaken annually.

E) MONOTONOUS WORK

Where an employer intends to organise work according to a certain pattern then they must humanise that pattern. For example, measures such as regular breaks during working time must be introduced to alleviate monotonous work and work carried out at a rapid pace.
(No exemption is possible from this principle).

F) EXEMPTIONS

Please note that there are several exclusions and opt-outs included within the WTD. Please contact your line manager for further details.

Road Transport Directive (RTD)
The RTD only applies to employees who drive a goods vehicle which is greater than 3.5 tonnes.

G) THE BASIC RULES ARE:

1) Drivers must not work more than 60 hours per week;

2) Drivers must not work more than an average of 48 hours per week over a reference period (26 weeks under collective agreement);

3) Drivers must have a break of 45 minutes if driving time exceeds 4.5 hours;

4) Drivers must take a minimum break of 30 minutes if working time exceeds six hours or 45 minutes if working time exceeds nine hours;

5) Minimum holiday leave must be taken per year, which should be divided evenly over the reference periods. Holiday leave over and above the statutory minimum may be used to reduce average working time;

6) Drivers must report any infringements to their line manager;

7) All records of working hours must be retained for a period of two years after the period covered.

H) WORKING TIME INCLUDES:

1) Driving, loading or unloading a vehicle;

2) Vehicle cleaning and maintenance;

3) Overtime;

4) Any other work, including administrative duties;

5) Other work intended to ensure the safety of the vehicle and its cargo or passengers, including daily defect checks and reports;

6) Waiting time where the foreseeable duration is not known in advance or just before the start of the period in question - for example, queuing to load/unload or monitoring loading/unloading of the vehicle;

7) Training that is part of normal work and is part of the commercial operation.

I) WORKING TIME DOES NOT INCLUDE:

1) Periods of Availability (POA);

2) Breaks during shift whether paid or unpaid;

3) Evening classes or day release courses;

4) Daily or weekly rest.

J) PERIODS OF AVAILABILITY (POA)

1) A period of availability is time where the driver is available for work but is not required to undertake any work. The following conditions apply to a period of availability;
2) All POAs must be authorised by transport management;
3) The driver is not required to remain in the vehicle, but must be available to answer calls to start or resume driving or other work; and;
4) The period and its foreseeable duration are known in advance, either before departure or just before the start of the period in question.

K) OCCASIONAL DRIVERS

It is common for non-mobile and other workers to occasionally drive vehicles 'in scope' of this legislation. Where such workers drive more than ten days in a reference period that is less than 26 weeks or more than 15 days in a reference period that is 26 weeks or longer, they are subject to the Road Transport Directive.

Alcohol and Drugs Policy

Introduction

Alcohol and Drug/substance misuse can be a serious problem within the workplace. Employees who drink excessively or inappropriately and/or take unlawful substances, in relation to work are more likely to endanger their colleagues, have accidents at work, be absent from work and work inefficiently.

This policy applies to drugs and substances that are unlawful under criminal law and does not relate prescription medication.

Aims of the Policy

The employees of ERS Medical are its most valuable assets. However, ERS Medical recognises that, for a number of reasons, employees could develop alcohol-related problems during the duration of their employment. The aims of this policy are to:

Promote a Responsible Attitude to Drinking within ERS Medical by:

- Encouraging safe and sensible drinking habits;
- Identifying employees with possible problems relating to alcohol misuse at an early stage;
- Offering guidance and, where required, actively encouraging employees with possible problems to seek appropriate help;
- Offering employees known to have alcohol-related problems affecting their work referral to an appropriate agency for diagnosis.
- Making known to employees the harmful effects of drugs;
- Minimising problems and accidents at work arising from the misuse of drugs;
- Promoting the well-being and health of employees.
- Identifying employees with possible problems relating to drug misuse at an early stage;
- Offering guidance and, where required, actively encouraging employees with possible problems to seek appropriate help;
- Offering employees known to have drug-related problems affecting their work referral to an appropriate agency for diagnosis.
- Making known to employees the harmful effects of the excessive consumption of alcohol;
- Minimising problems and accidents at work arising from alcohol and its misuse;
- Promoting the well-being and health of employees.

Offer Assistance and Advice to Employees who need it by:

- Promote a responsible attitude to drugs by;
- Offer assistance and advice to employees who need it by.

Advice and counselling

It is ERS Medical's intention to deal constructively and sympathetically with an employee's alcohol-related and/or drug/substance related problems, such as alcohol and/or drug dependency. When it is known that an employee has an alcohol/drug problem, a line manager will be able to provide advice and guidance on how to seek suitable treatment. The primary objective of any discussions of this

type will be to assist the employee with the problem in as compassionate and constructive a way as possible.

Whilst certain personnel records will be necessary, any discussions of the nature of an employee's alcohol/drug/substance problems and the records of any treatment will be strictly confidential unless the employee agrees otherwise.

If you have an alcohol/drug/substance problem, you should seek appropriate help. If you have an alcohol/drug/substance problem which affects your conduct or performance at work and you refuse the opportunity to receive help, the matter will be referred for action under ERS Medical's disciplinary procedure as appropriate. Likewise, if after accepting counselling and assistance, and following review and evaluation, your conduct or work performance reverts to the problem level, the matter may also be dealt with through the disciplinary procedure.

Prohibition on Alcohol Consumption in the Workplace

Social drinking after normal working hours and away from ERS Medical's premises is, of course, a personal matter and does not directly concern ERS Medical, although ERS Medical is keen to raise the level of awareness amongst staff of the risks of alcohol abuse. ERS Medical's concern only arises when, because of the pattern or amount of drink involved, the employee's attendance at work, work performance or conduct at work deteriorates. Even a small amount of alcohol can affect work performance and, if an employee is found under the influence of alcohol at work, there could be serious health and safety consequences (see the section below on misconduct).

No alcohol must be brought onto or consumed on Company premises at any time. Staff must never drink alcohol if they are required to drive private or Company vehicles on Company business. Staff must also not drink alcohol when they are on operational standby or on call.

Employees representing ERS Medical at business functions or conferences, providing hospitality or attending Company organised social events outside normal working hours are expected to be moderate if drinking alcohol and to take specific action to ensure they are well within the legal limits if they are driving.

Prohibition of Drugs/Substances in the Workplace

If an employee is found under the influence of drugs/substances at work, there could be serious health and safety consequences. (see the section below on misconduct)

No drugs/substances must be brought onto or consumed on company premises at any time, and for these purposes this includes performance-enhancing drugs/substances, even if they are not unlawful under the criminal law, unless they have been medically prescribed by a doctor. Staff must never take drugs if they are required to drive private or company vehicles on company business. Staff must also never take drugs/substances when they are on operational standby or on call.

Employees representing ERS Medical at business functions or conferences, providing hospitality or attending Company organised social events outside normal working hours are absolutely prohibited from taking drugs on these occasions.

A breach of these provisions is a disciplinary offence and will be dealt with in accordance with ERS Medical's disciplinary procedure. Depending on the seriousness of the offence, it may amount to gross misconduct and could result in the employee's summary dismissal.

Alcohol-Related Misconduct

Whilst these rules are aimed at assisting employees with alcohol problems, action will nevertheless be taken under ERS Medical's disciplinary procedure if misconduct takes place at work as a result of drinking alcohol, or if an employee is found to be under the influence of alcohol whilst at work. Incapacity or misconduct caused by an excess of alcohol at work is a potential gross misconduct offence under ERS Medical's disciplinary procedure and the employee is therefore liable to be summarily dismissed.

ERS Medical reserves the right in any of these circumstances to arrange for the employee to be escorted from ERS Medical's premises immediately and sent home without pay for the rest of the day or shift. ERS Medical also reserves the right to suspend the employee on full pay while carrying out an investigation.

Drug-Related Misconduct

Whilst these rules are aimed at assisting employees with drug problems, action will nevertheless be taken under ERS Medical's disciplinary procedure if misconduct takes place at work as a result of taking drugs, or if an employee is found to be under the influence of drugs whilst at work. Incapacity or misconduct caused by drugs at work is a potential gross misconduct offence under ERS Medical's disciplinary procedure and the employee is therefore liable to be summarily dismissed. This also applies to any employee believed to be buying or selling drugs or in possession of or consuming drugs on ERS Medical's premises.

ERS Medical reserves the right in any of these circumstances to arrange for the employee to be escorted from ERS Medical's premises immediately and sent home without pay for the rest of the day or shift. ERS Medical also reserves the right to suspend the employee on full pay while carrying out an investigation.

Alcohol/Drug/Substance Screening/Testing

There is no specific health and safety law dealing with drugs and alcohol at work.

However, there are a number of laws that apply to ERS Medical. It is a criminal offence under the Misuse of Drugs Act for any person knowingly to permit the production, supply or use of controlled substances on their premises except in specified circumstances (such as when they have been prescribed by a doctor). The Medicines Act 1968 also controls the sale of drugs that are considered medicine.

Under the Road Traffic Act and the Transport and Works Act, drivers of road vehicles must not be under the influence of drugs or alcohol while driving, attempting to drive or when they are in charge of a vehicle.

Under the Health and Safety at Work Act 1974, the employer has a duty to ensure the health, safety and welfare of employees and develop a health and safety policy.

Section 7 of the Act requires employees to take reasonable care of the health and safety of themselves and others who may be affected by their acts or omissions at work. While the Management of Health and Safety at Work Regulations say, employers should conduct risk assessments. This would include the use or presence of drugs and alcohol at work, if there appears to be a risk to workers. The main causes must then be treated in the same way as any other workplace hazard by the implementation of preventive measures.

ERS Medical operate a random alcohol/drug/substance testing system. Line Managers will be asked to breathalyse staff at the start of their shift that have been chosen at random by the management team. The results will then be stored in a spreadsheet that only the Line Manager and the management team will have access to. All alcohol tests and results are confidential.

Under the Company's policies, the following are potentially disciplinary offences:

Refusal to Take an Alcohol or Drugs Test Without Good Cause
In addition, where an employee fails an alcohol or drugs test, or there is otherwise reasonable cause to believe an on-duty employee is exceeding the policy alcohol and/or drug limits, issues of work/individual safety arise in terms of their continued attendance at work.

This document provides general guidelines for management action in the above two situations; however, every case will be dealt with individually on its merits.

Refusal to Take an Alcohol or Drugs Test

a) Random testing/RPM testing

Where an employee refuses to take a test, then:

i. If there is otherwise no indication of impairment, the employee will be permitted to remain at work until further notice. The case will be treated as a potential breach of conduct, and if a disciplinary award is the outcome, it is likely that a 'for cause' test will follow subsequently;
ii. If there is otherwise an indication of impairment, then similar action will follow as 1(b) below.

b) 'For cause'

Where an employee refuses to take a test, the employee will be sent home, and advised to report for work on their next duty day/shift (for operational staff, this will be on light duties). A 'for cause' test will then be conducted on the employee's return to work:

i. If the employee again refuses to take a test, the employee will be sent home and suspended until the conclusion of a disciplinary process;
ii. If the employee takes a test, and this is negative, the employee will resume work as normal, and the original refusal will be treated as a potential breach of conduct;
iii. If the employee takes a test, and this is positive, see section (2) below.

Failing a Test

Where an employee fails an alcohol test, the employee will be sent home, and advised to report for work on their next duty day/shift (for operational staff, this will be on light duties). A 'for cause' test will then be conducted on the employee's return to work;

i. If the test is negative, the employee will resume work as normal, and the case will be treated as a potential breach of conduct;
ii. If the test is positive a second time, they will be sent home and suspended pending further information; this may be until the conclusion of the subsequent disciplinary process.

Employees who are sent home under these guidelines will remain on full pay

Where an employee fails an alcohol test and is in excess of the drink-drive limit (80mg of alcohol/100ml of blood), then if they have driven to work, they should be instructed not to drive home.

On the grounds of protecting health and safety and only where necessary to achieve a legitimate business aim, ERS Medical reserves the right to carry out random screening tests on employees in the workplace whose activities and job duties have a significant impact on the health and safety of others. The guidelines promulgated in ERS Medical's equal opportunities policy are to be followed in relation to alcohol screening.

If an employee receives a positive test result, this will be viewed as a potential gross misconduct offence and renders the employee liable to summary dismissal under ERS Medical's disciplinary procedure. Unreasonable refusal to submit to an alcohol screening test will be dealt with through the disciplinary procedure.

General Terms and Procedures

A) CHANGES IN PERSONAL DETAILS

You must notify us of any change of name, address, telephone number, etc., so that we can maintain accurate information on our records and make contact with you in an emergency, if necessary, outside normal working hours.

B) OTHER EMPLOYMENT

1) If you already have any other employment or are considering any additional employment you must notify us so that we can discuss any implications arising from such employment i.e. working time legislation, health and safety issues, conflict of interest.

2) You may not under any circumstances, whether directly or indirectly, undertake any other duties of whatever kind during your hours of work.

C) TIME OFF

Circumstances may arise where you need time off for medical/dental appointments, or for other reasons. Where possible, such appointments should be made outside normal working hours. If this is not possible, time off required for these purposes may be granted at the discretion of your Line Manager and will normally be without pay.

D) ELECTIVE SURGERY

Elective surgery is surgery that is not considered to be medically necessary, for example because it is concerned with the enhancement of appearance through surgical and medical techniques. It includes cosmetic surgery (such as breast implants and face-lifts) and other non-essential medical procedures such as laser eye treatment and vasectomies.

If you wish to take time off for elective surgery, you may use your existing paid annual leave entitlement, provided that you comply with the provisions relating to annual leave set out in your contract of employment. Any further time off is at the absolute discretion of ERS Medical and will be unpaid leave.

E) FERTILITY TREATMENT

Medical appointments in connection with the early stages of the fertility treatment process will be treated no less favourably than any other medical appointments and the section above on 'medical appointments' applies. If you wish to take additional time off for fertility treatment, you may use your existing paid annual leave entitlement. Any further time off is at the absolute discretion of ERS Medical and will be unpaid leave.

F) MATERNITY/PATERNITY/ADOPTION LEAVE AND PAY

You may be entitled to maternity/paternity/adoption leave and pay in accordance with the current statutory provisions. If you (or your partner) become pregnant or are notified of a match date for adoption purposes you should notify your Line Manager at an early stage so that your entitlements and obligations can be explained to you.

G) PARENTAL/SHARED PARENTAL LEAVE

If you are entitled to take parental leave or shared parental leave in respect of the current statutory provisions, you should discuss your needs with your Line Manager who will identify your entitlements and look at the proposed leave periods dependent upon your child's/children's particular circumstances and the operational aspects of the business.

H) TIME OFF FOR DEPENDANTS

You may be entitled to take a reasonable amount of unpaid time off during working hours to take action that is necessary to provide help to your dependants. Should this be necessary you should discuss your situation with your Line Manager who, if appropriate, will agree the necessary time off.

I) BEREAVEMENT LEAVE

Reactions to bereavement may vary greatly according to individual circumstances and the setting of fixed rules for time off is therefore inappropriate. You should discuss your circumstances with your Line Manager and agree appropriate time off.

J) JURY SERVICE AND WITNESS ATTENDANCE

Should you be called up for jury service or required to attend court to give evidence as a witness, you must notify your line manager as soon as reasonably practicable. Time off work will normally be granted in these circumstances. You will be required to provide a copy of the court summons to support your request for time off work.

You have no contractual or statutory right to be paid for time not worked due to jury service or witness attendance. Any payment of salary by ERS Medical during this period is done so in its absolute discretion and will be subject to the deduction of any monies received from the court in respect of loss of earnings. You must therefore submit a claim to the court for loss of earnings and claim the full allowance available to you.

If on any day on which you attend court you are told that your services are not required, you must then return to work and report to your line manager before starting work.
Other public duties

If you are a justice of the peace, you have a statutory right to take a reasonable amount of unpaid time off work for the purpose of performing any of the duties of the office.

If you are a member of one of the following bodies, you also have a statutory right to take a reasonable amount of unpaid time off work for the purpose of attendance at meetings of the body, or any of its committees, or undertaking other duties approved by the body for the purpose of discharging the body's functions:

- A local authority;
- A statutory tribunal;
- A police authority;
- An independent monitoring board for a prison or a prison visiting committee;
- A relevant health body (e.g. an NHS trust, an NHS foundation trust, a Strategic Health Authority, a Special Health Authority or a Primary Care Trust);
- A relevant education body (e.g. a managing or governing body of an educational establishment maintained by a local education authority, a governing body of a further or higher education corporation or the General Teaching Council for England or Wales);
- The Environment Agency or the Scottish Environment Protection Agency;
- You have no contractual or statutory right to be paid for time not worked due to performing

public duties. Any payment of salary by ERS Medical during this period is done so in its absolute discretion.

K) MEMBERSHIP OF THE ARMED FORCES RESERVES

If you are a member of the armed forces reserves, you may use your paid annual leave entitlement to carry out your duties, provided that you comply with the provisions relating to annual leave set out in your contract of employment. ERS Medical expects you to use your paid annual leave first before applying for further time off.

Otherwise, any further time off relating to membership of the armed forces reserves will only be granted at the absolute discretion of ERS Medical and you have no contractual or statutory right to be paid for this leave. Any payment of salary made by ERS Medical in such circumstances is done so in its absolute discretion. If you wish to apply for this type of leave, you should apply in writing to your line manager stating the period of leave requested and the reasons for it.

L) TRADE UNION SHOP STEWARDS

Shop Stewards, of unions recognised by the company, are entitled to take reasonable paid time off to attend to appropriate union duties and activities and attend training courses in respect of those duties.

If an employee is a member of a Trade Union that is not recognised by the company, they will be entitled to reasonable unpaid time off.

M) SAFETY REPRESENTATIVE

Accredited safety representatives have the right to take paid time off in order to carry out their duties and undergo any training.

N) TRAVEL EXPENSES

We will reimburse you for any reasonable expenses incurred whilst travelling on our business. The rules relating to travelling expenses will be issued separately. You must provide receipts for any expenditure.

O) EMPLOYEES' PROPERTY AND LOST PROPERTY

We do not accept liability for any loss of, or damage to, property that you bring onto the premises. You are requested not to bring personal items of value onto the premises and, in particular, not to leave any items overnight. Articles of lost property should be handed to your Line Manager who will retain them whilst attempts are made to discover the owner.

P) PARKING

Where parking facilities have been made available to you on our premises you must ensure that you observe all of our traffic requirements e.g. speed limits, etc. To avoid congestion, all vehicles must be parked only in the designated parking areas. No liability is accepted for damage to private vehicles; however it may be caused.

Q) MAIL

All mail received by us will be opened, including that addressed to employees. Private mail, therefore, should not be sent care of our address. No private mail may be posted at our expense except in those cases where a formal re-charge arrangement has been made.

R) FRIENDS AND RELATIVES CONTACT / TELEPHONE CALLS / MOBILE PHONES

You should discourage your friends and relatives from either calling on you in person or by telephone except in an emergency. Personal telephone calls, both incoming and outgoing are only allowed in the case of emergency. Permission to make outgoing personal calls should be sought from your Line Manager. Personal mobile phones should be switched to silent during working hours.

It is illegal to use a mobile phone without a hands-free set whilst driving. It is our policy that you should not use any mobile phone whilst driving without a hands-free set. You should pull over to the side of the road in an appropriate place before making or receiving any telephone calls. In the event of being unable to pick up a call because you cannot find a safe place to park, you must return the call as soon as conveniently possible.

S) COMPANY MOBILE PHONES AND OTHER DEVICES

The Company mobile phones and other devices are to be used for business purposes only except in the case of an emergency. Therefore, any personal use deemed by the Company to be excessive may be recharged back to you. This is an express written term of your contract of employment. Internet usage on Company mobile phones and other devices are subject to the same provisions set out in our E-mail and Internet Policy. The Company reserves the right to monitor all communications made on Company mobile phones in order to ensure compliance with our policies and procedures.

T) BUYING OR SELLING OF GOODS

You are not allowed to buy or sell goods on your own behalf on our premises or during your working hours.

U) COLLECTIONS FROM EMPLOYEES

Unless specific authorisation is given by your Line Manager no collections of any kind are allowed on our premises.

V) BEHAVIOUR AT WORK

You should behave with civility towards fellow employees, and no rudeness will be permitted towards clients or members of the public. Objectionable or insulting behaviour, or bad language will render you liable to disciplinary action.

You should use your best endeavours to promote the interests of the business and shall, during normal working hours, devote the whole of your time, attention and abilities to the business and its affairs.

Any involvement in activities which could be construed as being in competition with us is not allowed.

W) BEHAVIOUR OUTSIDE OF WORK

The Company recognises the importance of work/life balance. However, owing to the nature of the business, the Company insists on employing staff of the highest integrity, we expect you to maintain these standards outside of working hours. Activities that result in adverse publicity to ourselves, or which cause us to lose faith in your integrity, may give us grounds for your dismissal.

X) CLIENTS PREMISES

Whilst visiting or working at any of our clients/customers premises, it is imperative that you familiarise yourself and comply with all of their rules and requirements including (but not limited to) security, health and safety, smoking, parking, etc. Failure to comply with site rules could result in your removal from site and disciplinary action being taken in accordance with our disciplinary procedures.

Y) INCLEMENT WEATHER/TRAVEL ARRANGEMENT DISRUPTION

Every reasonable effort should be made to attend work in accordance with your contract. In the event that you are unable to attend work owing to inclement weather conditions and/or severe disruption to your travel arrangements, you should report your absence through the normal absence reporting procedures. Your absence will be unpaid unless you have sufficient annual leave in which case you may request to use this. Alternatively, you may be able to work additional hours to compensate for the lost hours at the sole discretion of the management and subject to availability.

Z) DRIVING LICENCE

If driving is a necessary, part of your role it is imperative that you maintain a valid driving licence suitable for the vehicle you operate at all times during your employment. You are required upon request to produce your driving licence to the management. We may also require you to provide us with the ability to access your driving licence details online. If at any time your licence is endorsed, or you are disqualified from driving, we must be informed immediately. Should you not be able to prove that your licence remains valid for the class of vehicle we require you to drive, your continued employment may be affected.

AA) CAR INSURANCE

If your position requires you to use your own car for business purposes, you must ensure that your car insurance provides adequate cover. Proof of adequate insurance, Driving Licence, Tax and an MOT Certificate must be produced for scrutiny by the Company, upon renewal and at any time when so requested.

BB) FINES

Any fines imposed by relevant authorities including (but not limited to) speeding and parking will be payable by the employee.

CC) THIRD PARTY INVOLVEMENT

We reserve the right to allow third parties to chair any meeting, for example disciplinary, capability, grievance, this is not an exhaustive list. We will seek your consent at the relevant time to share relevant 'special categories of data' where it is necessary for the purposes of that hearing.

DD) RECORDING OF FORMAL MEETINGS

We reserve the right to record any formal meetings whether conducted by us or a third party, a copy of the recording can be made available on request. All personal data collected for this purpose will be processed in line with the current Data Protection Act.

Anti-Bribery Policy

A) INTRODUCTION

Bribery is a criminal offence. The Company prohibits any form of bribery. We require compliance, from everyone connected with our business, with the highest ethical standards and anti-bribery laws applicable. Integrity and transparency are of utmost importance to us and we have a zero-tolerance attitude towards corrupt activities of any kind, whether committed by employees or by third parties acting for or on behalf of the Company.

B) POLICY

It is prohibited, directly or indirectly, for any employee or person working on our behalf to offer, give, request or accept any bribe i.e. gift, loan, payment, reward or advantage, either in cash or any other form of inducement, to or from any person or Company in order to gain commercial, contractual or regulatory advantage for the Company, or in order to gain any personal advantage for an individual or anyone connected with the individual in a way that is unethical.

C) SUSPICION

If we suspect that you have committed an act of bribery or attempted bribery, an investigation will be carried out and, in line with our disciplinary procedure where appropriate, action may be taken against you which may result in your dismissal, or the cessation of our business arrangement with you.

D) REPORTING

If you, as an employee or person working on our behalf, suspect that an act of bribery or attempted bribery has taken place, even if you are not personally involved, you are expected to report this to a Director or Head of HR. You may be asked to give a written account of events.

Staff are reminded of the Company's Whistleblowing Policy which is available in this Employee Handbook.

E) GIFTS AND HOSPITALITY

We realise that the giving and receiving of gifts and hospitality as a reflection of friendship or appreciation where nothing is expected in return may occur, or even be commonplace, in our industry. This does not constitute bribery where it is proportionate and recorded properly.

No gift should be given nor hospitality offered by an employee or anyone working on our behalf to any party in connection with our business without receiving prior written approval from your Line Manager.

Similarly, no gift or offer of hospitality should be accepted by an employee or anyone working on our behalf without receiving prior written approval from your Line Manager.

F) RECORD KEEPING

A record will be made by your Line Manager of every instance in which gifts or hospitality are given or received.

As the law is constantly changing, this policy is subject to review and the Company reserves the right to amend this policy without prior notice.

Anti Tax Evasion Policy

A) INTRODUCTION

Tax evasion is a criminal offence. The Company prohibits any form of tax evasion. Involvement in the criminal facilitation of tax evasion exposes the Company and the person facilitating the evasion to a criminal offence. It will also damage our reputation and the confidence of our customers, suppliers and business partners.

Indicators of tax evasion are: -

a) request for payment by cash;

b) overly complex payment mechanisms;

c) services/goods provided to jurisdictions that do not subscribe to Common Reporting Standards;

d) transactions involving overly complex supply chains;

e) transactions involving private banking facilities; and/or

f) records are incomplete or missing.

Our position is simple: we conduct our business to the highest legal and ethical standards. We will not be party to tax evasion or the facilitation of tax evasion of any form. Such acts would damage our reputation and expose us, and our staff and representatives, to the risk of fines and imprisonment.

We take a zero-tolerance approach to tax evasion facilitation by our people and our third party representatives. We are committed to:

a) rejecting the facilitation of tax evasion; and

b) not recommending the services of others who do not have reasonable prevention procedures in place.

We require compliance in regard to this from everyone connected with our business. Integrity and transparency are of utmost importance to us.

B) DEFINITIONS OF TAX EVASION

Tax evasion is the practice of using illegal methods to avoid paying tax. It frequently involves contrived; artificial transactions that serve no purpose other than to reduce tax liability.

C) POLICY

It is prohibited, directly or indirectly, for any employee or person working on our behalf to take part in any activity relating to tax evasion.

If we suspect that you have taken part in such activity, an investigation will be carried out and, in line with our disciplinary procedure where appropriate, action may be taken against you which may result in your dismissal, or the cessation of our business arrangement with you.

If you, as an employee or person working on our behalf, suspect any activity related to tax evasion or attempted tax evasion has taken place, even if you are not personally involved, you are expected to report this to a Director or Head of HR. You may be asked to give a written account of events.

D) TRAINING/MONITORING/REVIEW

The Company will ensure that it gives all relevant training for staff in relation to financial crime detection and prevention, it will ensure it monitors and enforces compliance with the prevention procedures and regularly review the effectiveness of prevention procedures, refining them where necessary.

E) CONCERNS

Staff are reminded of the Company's Whistleblowing policy, which is available in this Employee Handbook, or upon request.

Whistle-blowers

A) INTRODUCTION

Under certain circumstances, employees are protected from suffering any detriment or termination of employment if they make disclosures about organisations for whom they work.

B) QUALIFYING DISCLOSURES

1) Certain disclosures are prescribed by law as "qualifying disclosures". A "qualifying disclosure" means a disclosure of information that the employee genuinely and reasonably believes is in the public interest and shows that the Company has committed a "relevant failure" by:

   a) committing a criminal offence;

   b) failing to comply with a legal obligation;

   c) a miscarriage of justice;

   d) endangering the health and safety of an individual;

   e) environmental damage; or

   f) concealing any information relating to the above.

2) These acts can be in the past, present or future, so that, for example, a disclosure qualifies if it relates to environmental damage that has happened, is happening, or is likely to happen. The Company will take any concerns that you may raise relating to the above matters very seriously.

3) The Employment Rights Act 1996 provides protection for workers who 'blow the whistle' where they reasonably believe that some form of illegality, injustice or breach of health and safety has occurred or is likely to occur. The disclosure has to be "in the public interest". We encourage you to use the procedure to raise any such concerns.

C) THE PROCEDURE

1) In the first instance you should report any concerns you may have to the Head of HR & Training and contact for Whistleblowing and Freedom to Speak up who will treat the matter with complete confidence. If you are not satisfied with the explanation or reason given to you, you should raise the matter with the appropriate official organisation or regulatory body.

2) If you do not report your concerns to the Head of HR & Training and contact for Whistleblowing and Freedom to Speak up, you should take them direct to the appropriate organisation or body.

D) TREATMENT BY OTHERS

Bullying, harassment or any other detrimental treatment afforded to a colleague who has made a qualifying disclosure is unacceptable. Anyone found to have acted in such a manner will be subject to disciplinary action.

Capability Procedures

A) INTRODUCTION

We recognise that during your employment with us your capability to carry out your duties may deteriorate. This can be for a number of reasons, the most common ones being that either the job changes over a period of time and you fail to keep pace with the changes, or you change (most commonly because of health reasons) and you can no longer cope with the work.

B) JOB CHANGES/GENERAL CAPABILITY ISSUES

1) If the nature of your job changes or if we have general concerns about your ability to perform your job, we will try to ensure that you understand the level of performance expected of you and that you receive adequate training and supervision. Concerns regarding your capability will normally first be discussed in an informal manner and you will be given time to improve.
2) If your standard of performance is still not adequate you will be warned in writing that a failure to improve and to maintain the performance required could lead to your dismissal. We will also consider the possibility of a transfer to more suitable work if possible.
3) If there is still no improvement after a reasonable time and we cannot transfer you to more suitable work, or if your level of performance has a serious or substantial effect on our organisation or reputation, you will be issued with a final warning that you will be dismissed unless the required standard of performance is achieved and maintained.
4) If such improvement is not forthcoming after a reasonable period of time, you will be dismissed with the appropriate notice.

C) PERSONAL CIRCUMSTANCES/HEALTH ISSUES

1) Personal circumstances may arise which do not prevent you from attending for work, but which prevent you from carrying out your normal duties (e.g. a lack of dexterity or general ill health). If such a situation arises, we will normally need to have details of your medical diagnosis and prognosis so that we have the benefit of expert advice. Under normal circumstances this can be most easily obtained by asking your own doctor for a medical report. Your permission is needed before we can obtain such a report and we will expect you to co-operate in this matter should the need arise. When we have obtained as much information as possible regarding your condition and after consultation with you, a decision will be made about your future employment with us in your current role or, where circumstances permit, in a more suitable role.

2) There may also be personal circumstances which prevent you from attending work, either for a prolonged period(s) or for frequent short absences. Under these circumstances we will need to know when we can expect your attendance record to reach an acceptable level. This may again mean asking your own doctor for a medical report or by making whatever investigations are appropriate in the circumstances. When we have obtained as much information as possible regarding your condition, and after consultation with you, a decision will be made about your future employment with us in your current role or, where circumstances permit, in a more suitable role.

D) SHORT SERVICE STAFF

We retain discretion in respect of the capability procedures to take account of your length of service and to vary the procedures accordingly. If you have a short amount of service, you may not be in receipt of any warnings before dismissal.

Disciplinary Procedures

A) INTRODUCTION

1) It is necessary to have a minimum number of rules in the interests of the whole organisation.

2) The rules set standards of performance and behaviour whilst the procedures are designed to help promote fairness and order in the treatment of individuals. It is our aim that the rules and procedures should emphasise and encourage improvement in the conduct of individuals, where they are failing to meet the required standards, and not be seen merely as a means of punishment. We reserve the right to amend these rules and procedures where appropriate.

3) Every effort will be made to ensure that any action taken under this procedure is fair, with you being given the opportunity to state your case and appeal against any decision that you consider to be unjust.

4) The following rules and procedures should ensure that:

   a) the correct procedure is used when requiring you to attend a disciplinary hearing;

   b) you are fully aware of the standards of performance, action and behaviour required of you;

   c) disciplinary action, where necessary, is taken speedily and in a fair, uniform and consistent manner;

   d) you will only be disciplined after careful investigation of the facts and the opportunity to present your side of the case. On some occasions temporary suspension on contractual pay may be necessary in order that an uninterrupted investigation can take place. This must not be regarded as disciplinary action or a penalty of any kind;

   e) other than for an "off the record" informal reprimand, you have the right to be accompanied by a fellow employee at all stages of the formal disciplinary process;

   f) you will not normally be dismissed for a first breach of discipline, except in the case of gross misconduct; and

   g) if you are disciplined, you will receive an explanation of the penalty imposed and you will have the right to appeal against the finding and the penalty.

B) DISCIPLINARY RULES

It is not practicable to specify all disciplinary rules or offences that may result in disciplinary action, as they may vary depending on the nature of the work. In addition to the specific examples of unsatisfactory conduct, misconduct and gross misconduct shown in this handbook, a breach of other specific conditions, procedures, rules etc. that are contained within this handbook or that have otherwise been made known to you, will also result in this procedure being used to deal with such matters.

C) RULES COVERING UNSATISFACTORY CONDUCT AND MISCONDUCT

(These are examples only and not an exhaustive list.)

You will be liable to disciplinary action if you are found to have acted in any of the following ways:

a) failure to abide by the general health and safety rules and procedures;

b) smoking in designated non-smoking areas;

c) consumption of alcohol on the premises;

d) persistent absenteeism and/or lateness;

e) unsatisfactory standards or output of work;

f) rudeness towards clients, members of the public or other employees, objectionable or insulting behaviour, harassment, bullying or bad language;

g) failure to devote the whole of your time, attention and abilities to our business and its affairs during your normal working hours;

h) unauthorised use of e-mail and internet;

i) unauthorised use of company mobile phone for non-business purposes.

j) failure to carry out all reasonable instructions or follow our rules and procedures;

k) unauthorised use or negligent damage or loss of our property;

l) failure to report immediately any damage to property or premises caused by you;

m) use of our vehicles without approval or the private use of our commercial vehicles without authorisation;

n) failure to report any incident whilst driving our vehicles, whether or not personal injury or vehicle damage occurs;

o) if your work involves driving, failure to report immediately any type of driving conviction, or any summons which may lead to your conviction;

p) carrying unauthorised goods or passengers in our commercial vehicles or the use of our vehicles for personal gain; and

q) loss of driving licence where driving on public roads forms an essential part of the duties of the post.

D) SERIOUS MISCONDUCT

1) Where one of the unsatisfactory conduct or misconduct rules has been broken and if, upon

investigation, it is shown to be due to your extreme carelessness or has a serious or substantial effect upon our operation or reputation, you may be issued with a final written warning in the first instance.

2) You may receive a final written warning as the first course of action, if, in an alleged gross misconduct disciplinary matter, upon investigation, there is shown to be some level of mitigation resulting in it being treated as an offence just short of dismissal.

E) RULES COVERING GROSS MISCONDUCT

Occurrences of gross misconduct are very rare because the penalty is dismissal without notice and without any previous warning being issued. It is not possible to provide an exhaustive list of examples of gross misconduct. However, any behaviour or negligence resulting in a fundamental breach of contractual terms that irrevocably destroys the trust and confidence necessary to continue the employment relationship will constitute gross misconduct. Examples of offences that will normally be deemed as gross misconduct include serious instances of:

a) theft or fraud;

b) physical violence or bullying;

c) deliberate damage to property;

d) deliberate acts of unlawful discrimination or harassment;

e) possession, or being under the influence, of drugs* at work and/or testing positive for drug use in a random sample drug test in line with our policy; and

*For this purpose, the term 'drugs' is used to describe both illegal drugs and other psychoactive (mind-altering) substances which may or may not be illegal.

f) breach of health and safety rules that endangers the lives of, or may cause serious injury to, employees or any other person.

(The above examples are illustrative and do not form an exhaustive list.)

F) DISCIPLINARY PROCEDURE

1) Disciplinary action taken against you will be based on the following procedure:

OFFENCE	FIRST OCCASION	SECOND OCCASION	THIRD OCCASION	FOURTH OCCASION
Unsatisfactory Conduct	Formal verbal warning	Written Warning	Final written warning	Dismissal
Misconduct	Written Warning	Final written Warning	Dismissal	
Serious misconduct	Final written warning	Dismissal		
Gross misconduct	Dismissal			

2) We retain discretion in respect of the disciplinary procedures to take account of your length of service and to vary the procedures accordingly. If you have a short amount of service, you may not be in receipt of any warnings before dismissal.

3) If a disciplinary penalty is imposed it will be in line with the procedure outlined above, which may encompass a formal verbal warning, written warning, final written warning, or dismissal, and full details will be given to you.

4) In all cases warnings will be issued for misconduct, irrespective of the precise matters concerned, and any further breach of the rules in relation to similar or entirely independent matters of misconduct will be treated as further disciplinary matters and allow the continuation of the disciplinary process through to dismissal if the warnings are not heeded.

G) DISCIPLINARY AUTHORITY

The operation of the disciplinary procedure contained in the previous section, is based on the following authority for the various levels of disciplinary action. However, the list does not prevent a higher level of seniority progressing any action at whatever stage of the disciplinary process.

	PERSON AUTHORISED TO TAKE DISCIPLINARY ACTION IN THE CASE OF:	
	MANAGEMENT	OTHER EMPLOYEES
Formal verbal warning	Director or Head of HR	Manager or Head of HR
Written warning	Director or Head of HR	Manager or Head of HR
Final written warning	Director or Head of HR	Manager or Head of HR
Dismissal	Director or Head of HR	Manager or Head of HR

H) PERIOD OF WARNINGS

1) Formal verbal warning

A formal verbal warning will normally be disregarded for disciplinary purposes after a three-month period.

2) Written warning

A written warning will normally be disregarded for disciplinary purposes after a six-month period.

3) Final written warning

A final written warning will normally be disregarded for disciplinary purposes after a twelve-month period.

I) GENERAL NOTES

1) If you are in a supervisory or Managerial position, then demotion to a lower status at the appropriate rate may be considered as an alternative to dismissal except in cases of gross misconduct.

2) In exceptional circumstances, suspension from work without pay for up to five days as an alternative to dismissal (except dismissal for gross misconduct) may be considered by the person authorised to dismiss.

3) Gross misconduct offences will result in dismissal without notice.

4) You have the right to appeal against any disciplinary action.

Capability/Disciplinary Appeal Procedure

1) You have the right to lodge an appeal in respect of any capability/disciplinary action taken against you.

2) If you wish to exercise this right, you should apply either verbally or in writing to the person indicated in your individual Statement of Main Terms of Employment.

3) An appeal against a formal warning or dismissal should give details of why the penalty imposed is too severe, inappropriate or unfair in the circumstances.

4) The appeal procedure will normally be conducted by a member of staff not previously connected with the process so that an independent decision into the severity and appropriateness of the action taken can be made.

5) If you are appealing on the grounds that you have not committed the offence then your appeal may take the form of a complete re-hearing and reappraisal of all matters so that the person who conducts the appeal can make an independent decision before deciding to grant or refuse the appeal.

6) You may be accompanied at any stage of the appeal hearing by a fellow employee of your choice. The result of the appeal will be made known to you in writing, normally within five working days after the hearing.

Grievance Procedure

1) It is important that if you feel dissatisfied with any matter relating to your employment you should have an effective means by which such a grievance can be aired and, where appropriate, resolved.

2) Nothing in this procedure is intended to prevent you from informally raising any matter you may wish to mention. Informal discussion can frequently solve problems without the need for a written record. However, if you wish to raise a formal grievance you should normally do so in writing from the outset.

3) You have the right to be accompanied at any stage of the procedure by a fellow employee who may act as a witness or speak on your behalf to explain the situation more clearly.

4) If you feel aggrieved at any matter relating to your work (except personal harassment, for which there is a separate procedure following this section), you should first raise the matter with the person specified in your Statement of Main Terms of Employment, explaining fully the nature and extent of your grievance. You will then be invited to a meeting at a reasonable time and location at which your grievance will be investigated fully. You must take all reasonable steps to attend this meeting. You will be notified of the decision, in writing, normally within ten working days of the meeting, including your right of appeal.

5) If you wish to appeal you must inform a Director or Head of HR within five working days. You will then be invited to a further meeting, which you must take all reasonable steps to attend. As far as reasonably practicable, the Company will be represented by a more Senior Manager than attended the first meeting (unless the most Senior Manager attended that meeting).

6) Following the appeal meeting you will be informed of the final decision, normally within ten working days, which will be confirmed in writing.

Personal Harassment Policy and Procedure

A) INTRODUCTION

1) Harassment or victimisation on the grounds of the following protected characteristic: age, disability, gender reassignment, marriage and civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation is unacceptable.

2) Personal harassment takes many forms but whatever form it takes, it is unlawful under the Equality Act 2010 and will not be tolerated.

3) This policy will be reviewed regularly to ensure it remains up to date and in order to monitor its effectiveness.

B) SCOPE

We deplore all forms of personal harassment and seek to ensure that the working environment is sympathetic to all those who work for us. This includes employees, workers, agency workers, volunteers and contractors in all areas of our Company, including any overseas sites.

C) DEFINITIONS

Harassment
This is unwanted conduct related to a relevant protected characteristic that has the purpose or effect of violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person.

Unwanted conduct can include:

a) spoken words
b) banter
c) written words
d) posts or contact on social media
e) imagery
f) graffiti
g) physical gestures
h) facial expressions
i) mimicry
j) jokes or pranks
k) acts affecting a person's surroundings
l) aggression, and
m) physical behaviour towards a person or their property.

Sexual harassment
This is unwanted conduct of a sexual nature which has the purpose or effect of violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person.

a) sexual comments or jokes
b) displaying sexually graphic pictures, posters or photos
c) suggestive looks, staring or leering
d) propositions and sexual advances
e) making promises in return for sexual favours
f) sexual gestures
g) intrusive questions about a person's private or sex life or a person discussing their own sex

life

h) sexual posts or contact on social media
i) spreading sexual rumours about a person
j) sending sexually explicit emails or text messages, and
k) unwelcome touching, hugging, massaging or kissing.

Less favourable treatment for rejecting or submitting to unwanted conduct
This occurs when:

a) someone is subjected to unwanted conduct:
   i) of a sexual nature
   ii) related to sex, or
   iii) related to gender reassignment

b) the unwanted conduct has the purpose or effect of:
   i) violating their dignity, or
   ii) creating an intimidating, hostile degrading, humiliating or offensive environment for them, and

c) they are treated less favourably because they submitted to or rejected the unwanted conduct.

D) CIRCUMSTANCES WHICH ARE COVERED

1) This policy covers behaviour which occurs in the following situations:

a) a work situation

b) a situation occurring outside of the normal workplace or normal working hours which is related to work, for example, a working lunch or social event with colleagues;

c) outside of a work situation but against a colleague or other person connected to the Company, including on social media;

d) against anyone outside of a work situation where the incident is relevant to their suitability to carry out the role.

E) COMPLAINING ABOUT PERSONAL HARASSMENT

1) Informal complaint

We recognise that complaints of personal harassment, and particularly of sexual harassment, can sometimes be of a sensitive or intimate nature and that it may not be appropriate for you to raise the issue through our normal grievance procedure. In these circumstances you are encouraged to raise such issues with a senior colleague of your choice (whether or not that person has a direct supervisory responsibility for you) as a confidential helper. This person cannot be [Senior Manager] who will be responsible for investigating the matter if it becomes a formal complaint.

If you are the victim of minor harassment you should make it clear to the harasser on an informal basis that their behaviour is unwelcome and ask the harasser to stop. If you feel unable to do this verbally then you should hand a written request to the harasser, and your confidential helper can assist you in this.

2) Formal complaint

Where the informal approach fails or if the harassment is more serious, you should bring the matter to the attention of [Senior Manager] as a formal written complaint and again your confidential helper can assist you in this. If possible, you should keep notes of the harassment so that the written complaint can include:

a) the name of the alleged harasser;

b) the nature of the alleged harassment;

c) the dates and times when the alleged harassment occurred;

d) the names of any witnesses; and

e) any action already taken by you to stop the alleged harassment.

On receipt of a formal complaint we will take action to separate you from the alleged harasser to enable an uninterrupted investigation to take place. This may involve a temporary transfer of the alleged harasser to another work area or suspension with contractual pay until the matter has been resolved.

The person dealing with the complaint will invite you to attend a meeting, at a reasonable time and location, to discuss the matter and carry out a thorough investigation. You have the right to be accompanied at such a meeting by your confidential helper or another work colleague of your choice and you must take all reasonable steps to attend. Those involved in the investigation will be expected to act in confidence and any breach of confidence will be a disciplinary matter.

On conclusion of the investigation, which will normally be within ten working days of the meeting with you, the decision of the investigator, detailing the findings, will be sent in writing to you.

You have the right to appeal against the findings of the investigator in accordance with the appeal provisions of the grievance procedure.

F) DISCIPLINARY ACTION

1) If the decision is that the allegation is well founded, the harasser will be liable to disciplinary action in accordance with our disciplinary procedure. An employee who receives a formal warning or who is dismissed for harassment may appeal by using our capability/disciplinary appeal procedure.

2) When deciding on the level of disciplinary sanction to be applied, we will take into consideration aggravating factors such as abuse of power over a more junior colleague.

3) If you bring a complaint of harassment you will not be victimised for having brought the complaint. However, if it is concluded that the complaint is both untrue and has been brought with malicious intent, disciplinary action will be taken against you.

G) THIRD PARTY HARASSMENT

1) Third party harassment occurs when one of our workforces is subjected to harassment by someone who is not part of our workforce but who is encountered in connection with work. This includes our customers, suppliers, members of the public. Third party harassment of our workforce will not be tolerated.

2) In order to prevent third party harassment from occurring, we have:

THE FOLLOWING ARE EXAMPLES

a) attached signage to the walls of the areas within the workplace where customers are present to warn that harassment of our staff is not acceptable

Should you be subjected to third party harassment, you are encouraged to report this as soon as possible to [insert name].

Should a client or customer harass a member of our workforce, they will be warned that continued provision of our service to them will cease if they are to act in a similar way again. Should their behaviour recur, they will be informed that our service to them will cease. Any criminal acts will be reported to the police, and we will share information relating to the incident with our other branches to ensure that we maintain a consistent approach to the cessation of our services.

Equality, Inclusion and Diversity Policy

A) STATEMENT OF POLICY

1) The terms equality, inclusion and diversity are at the heart of this policy. 'Equality' means ensuring everyone has the same opportunities to fulfil their potential free from discrimination. 'Inclusion' means ensuring everyone feels comfortable to be themselves at work and feels the worth of their contribution. 'Diversity' means the celebration of individual differences amongst the workforce. We will actively support diversity and inclusion and ensure that all our employees are valued and treated with dignity and respect. We want to encourage everyone in our business to reach their potential.

2) We recognise that discrimination is unacceptable and although equality of opportunity has been a long-standing feature of our employment practices and procedure, we have made the decision to adopt a formal policy. Breaches of the policy will lead to disciplinary proceedings and, if appropriate, disciplinary action up to and including dismissal.

3) The aim of the policy is to ensure no job applicant, employee or worker is discriminated against either directly or indirectly on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation.

4) We will ensure that the policy is circulated to any agencies responsible for our recruitment and a copy of the policy will be made available for all employees and made known to all applicants for employment.

5) The policy will be communicated to all private contractors reminding them of their responsibilities towards the equality of opportunity.

6) The policy will be implemented in accordance with the appropriate statutory requirements and full account will be taken of all available guidance and in particular any relevant Codes of Practice.

7) We will maintain a neutral working environment in which no employee or worker feels under threat or intimidated.

B) RECRUITMENT AND SELECTION

1) The recruitment and selection process is crucially important to any equality, inclusion and diversity policy. We will endeavour through appropriate training to ensure that employees making selection and recruitment decisions will not discriminate, whether consciously or unconsciously, in making these decisions.

2) Promotion and advancement will be made on merit and all decisions relating to this will be made within the overall framework and principles of this policy.

3) Job descriptions, where used, will be revised to ensure that they are in line with this policy. Job requirements will be reflected accurately in any personnel specifications.

4) We will adopt a consistent, non-discriminatory approach to the advertising of vacancies.

5) We will not confine our recruitment to areas or media sources which provide only, or mainly, applicants of a particular group.

6) All applicants who apply for jobs with us will receive fair treatment and will be considered solely

on their ability to do the job.

7) All employees involved in the recruitment process will periodically review their selection criteria to ensure that they are related to the job requirements and do not unlawfully discriminate.

8) Short listing and interviewing will be carried out by more than one person where possible.

9) Interview questions will be related to the requirements of the job and will not be of a discriminatory nature.

10) We will not disqualify any applicant because he/she is unable to complete an application form unassisted unless personal completion of the form is a valid test of the standard of English required for the safe and effective performance of the job.

11) Selection decisions will not be influenced by any perceived prejudices of other staff.

C) TRAINING AND PROMOTION

1) Senior staff will receive training in the application of this policy to ensure that they are aware of its contents and provisions.

2) All promotion will be in line with this policy.

D) MONITORING

1) We will maintain and review the employment records of all employees in order to monitor the progress of this policy.

2) Monitoring may involve:

   a) the collection and classification of information regarding the race in terms of ethnic/national origin and sex of all applicants and current employees;

   b) the examination by ethnic/national origin and sex of the distribution of employees and the success rate of the applicants; and

   c) recording recruitment, training and promotional records of all employees, the decisions reached and the reason for those decisions.

3) The results of any monitoring procedure will be reviewed at regular intervals to assess the effectiveness of the implementation of this policy. Consideration will be given, if necessary, to adjusting this policy to afford greater equality of opportunities to all applicants and staff.

Termination of Employment

A) RESIGNATIONS

All resignations must be supplied in writing, stating the reason for resigning your post.

B) TERMINATING EMPLOYMENT WITHOUT GIVING NOTICE

If you terminate your employment without giving or working the required period of notice, as indicated in your individual Statement of Main Terms of Employment, you will have an amount equal to any additional cost of covering your duties during the notice period not worked deducted from any termination pay due to you. This is an express written term of your contract of employment. You will also forfeit any contractual accrued holiday pay due to you over and above your statutory holiday pay, if you fail to give or work the required period of notice.

C) RETURN OF OUR PROPERTY

On the termination of your employment you must return all our property which is in your possession or for which you have responsibility. Failure to return such items will result in the cost of the items being deducted from any monies outstanding to you. This is an express written term of your contract of employment.

D) RETURN OF VEHICLES

On termination of your employment you must return any Company vehicle in your possession to our premises. Failure to return the vehicle will result in the cost of its recovery being deducted from any monies outstanding to you. This is an express written term of your contract of employment.

E) GARDEN LEAVE

If either you or the Company serves notice on the other to terminate your employment the Company may require you to take "garden leave" for all or part of the remaining period of your employment.

NB.

During any period of garden leave you will continue to receive your full salary and any other contractual benefits.

Company Vehicle Rules

A) DRIVING LICENCE AND AUTHORITY TO DRIVE COMPANY VEHICLES

1) You must be in possession of a current driving licence and have the authority of your Line Manager to drive one of our vehicles.

1) Your driving licence must be produced for scrutiny by your Line Manager prior to driving any of our vehicles. We will also require you to provide us with the ability to access your driving licence details online with our company provider.

3) If at any time your licence is endorsed, or you are disqualified from driving, we must be informed immediately. Should you not be able to prove that your licence remains valid for the class of vehicle we require you to drive, your continued employment may be affected.

4) It is your responsibility to see that the vehicle is not used by anyone other than authorised employees. Special written permission must be obtained from your Line Manager for the vehicle to be used by any other person.

B) FIXTURES, FITTINGS AND MODIFICATIONS

1) No fixtures such as aerials, roof racks, towing apparatus, stickers, may be attached to any of our vehicles without prior written permission. When handing the vehicle back to us such attachments must remain unless adequate rectification work is carried out professionally to restore the vehicle to its former condition.

2) No change or alteration may be made to the manufacturer's mechanical or structural specification of the vehicle.

C) WARRANTY

All warranty work must be reported to us prior to it being carried out.

D) CLEANING AND MAINTENANCE

1) When you drive one of our vehicles it is your responsibility to ensure that it is kept clean and tidy and that it is returned to us in that condition after use.

2) Any maintenance or repair work, or replacement of parts, including tyres, must be reported to us so that we can organise for it to be carried out.

3) Failure to adequately clean the vehicle may mean you are subject to the cost of the valet being deducted from your pay.

E) USE OF MOBILE PHONE WHILST DRIVING

It is illegal to use a mobile phone whilst driving (without a hands-free set). It is our Company policy that you should not use any mobile phones whilst driving. You should pull over to the side of the road in an appropriate place before making or receiving any telephone calls. In the event of you being unable to pick up a call because you cannot find a safe place to stop, you must return the call as soon as conveniently possible.

F) NO SMOKING POLICY

It is our policy that all workplaces including vehicles are smoke free, which includes the use of e-cigarettes. This policy applies to all employees, contractors, clients or members of the public including using their own vehicle for Company business. You may only smoke during authorised breaks and in the designated areas.

Company disciplinary procedures will be followed if you do not comply with this policy. Those who do not comply with the smoke free law may also be liable for a fixed term penalty fine and possible criminal prosecution.

G) FUEL ETC.

1) In addition to keeping the vehicle regularly serviced, it is your responsibility to see that the oil and water levels, battery and brake fluid and tyre pressures are maintained and that the tread of all tyres conforms to the minimum legal requirements.

2) If you have been issued with a company registration fuel card, you are responsible for its security and safekeeping. In the event that it is lost or stolen, it is imperative that you report this to your Line Manager immediately. No private fuel should be charged on the company registration fuel card unless you are a company car driver, and this is stated in your terms and conditions and is recorded personally through your P11D details. Failure to comply with this procedure will result in disciplinary action which may result in dismissal.

H) FINES

We will not be held responsible for any fines (e.g. parking, speeding, etc.) incurred by you whilst working for us. If we receive the summons on your behalf, we may pay the fine and deduct the cost from any monies owing to you.

I) DAMAGE OR INJURY

1) If you are the driver of any of our vehicles and it is involved in an accident which causes damage to our vehicle or property, another vehicle, or injury to any person or animal, you must notify us immediately. You are required to give your name and address, the name and address of the Owner, the registration number of the vehicle and the name of the Insurance Company to any person having reasonable grounds for requiring such information. It is important that you give no further information. If for some reason it is not possible to give this information at the time of the accident, the matter must be reported to the police as soon as possible, but within twenty-four hours of the occurrence.

2) In addition, in the case of an incident involving injury to another person or to notifiable animals (i.e. dogs), you are responsible for notifying the police of the occurrence, and you must produce your insurance certificate to a Police Officer attending the accident, or any other person having reasonable grounds for seeing it. The accident must be reported to a police station or to a Police Officer within twenty-four hours. If you are not then able to produce the certificate, you must, in any event, produce it in person within five days after the accident, to such police station as you may specify at the time of first reporting the accident.

3) For security reasons, insurance certificates are kept by us. However, a copy of the certificate of insurance is provided with each vehicle and this will be renewed annually. You should make sure that it is with the vehicle at all times. Replacement copies can be obtained from us if necessary.

J) LOSS

1) In the case of theft of one of our vehicles, the police and ourselves must be informed immediately. Full details of the contents of the vehicle must also be given. If any contents are stolen from the vehicle the police and ourselves should be notified immediately.

2) Please note that only Company property is insured by us and you should make your own arrangements to cover personal effects.

3) The vehicle should be kept locked when not in use and the contents should be stored out of sight, preferably in the boot. If a vehicle is stolen, we are required to prove to the Insurance Company that there has been no negligence and, therefore, we must hold you responsible in the event of such negligence.

K) ACCIDENT PROCEDURE

1) It is a condition of the insurance policy that the insurers are notified of all accidents, even if apparently of no consequence. You must, therefore, as soon as possible after the accident, obtain an accident report form from us which must be completed and returned to us within twenty-four hours. All the information required on the form must be completed. You should note that whenever possible the following particulars should appear in the form: -

   a) The name and address of the other driver and the name and address of his/her insurers.

   b) The names and addresses of all passengers in both our vehicle and the third party's vehicle.

   c) Names and addresses of all witnesses. It will be of considerable assistance if statements can be obtained from all witnesses at the time of the accident.

   d) Particulars of the police attending i.e. name, number and division.

2) A detailed sketch must be provided showing the relative position of the vehicle before and after the accident, together with details of the roads in the vicinity, e.g. whether they are major or minor roads and as many relevant measurements as possible.

3) If our vehicle is undriveable you are responsible for making adequate arrangements for the vehicle to be towed to a garage, and the name and address of the garage where the vehicle may be inspected must be stated on the claim form.

4) We will organise for repairs to be carried out.

5) Under no circumstances may repairs be put in hand until the Insurance Company has given its Agreement. We will notify you when this has been done.

6) You should not under any circumstances express any opinion one way or the other on the degree of responsibility for the accident. Only exchange particulars mentioned in 1) above and nothing more.

L) ROAD FUND LICENCE

The road fund licence for each vehicle will be renewed automatically when due.

M) PERMITTED USE

Subject to the restrictions already stipulated, our vehicles may only be used for our authorised business unless previous arrangements for private domestic or social use have been agreed with us in advance. They may not be used for the carriage of passengers for hire or reward, nor may they be used for any type of motoring sport, including racing, rallying or pace making, whether on the public highway or on private land.

N) PERSONAL LIABILITY FOR DAMAGE TO VEHICLES

1) Where any damage to one of our vehicles is due to your negligence or lack of care, we reserve the right to insist on your rectifying the damage at your own expense or paying the excess part of any claim on the insurers.

2) Repeated instances may result in the use of the vehicle being withdrawn and disciplinary action being taken.

O) SECURITY TRACKERS

All Company vehicles are fitted with trackers for security and management information purposes. These enable the Company to monitor the vehicles' whereabouts at any time, both live and retrospectively. Vehicles are monitored to assist in the safety of lone workers, to verify movements and to track the vehicle in the event of theft.

P) ONBOARD VEHICLE CAMERAS

CCTV cameras are fitted to some of our vehicles. This is for a number of reasons, including the prevention of crime, the safety of employees and clients, and for reducing insurance and legal costs. The footage can be monitored live or retrospectively.

We also use a Dashcam tracking camera in our vehicles, this system records when a driver fails to meet a driving behavioural characteristic. A driver behaviour reporting system enables us to highlight speeding, harsh breaking, acceleration and cornering instances. These results improve driving styles and prompts staff to drive carefully and economically.

Employees should be aware that footage from the cameras may be used and relied upon, where necessary, for insurance purposes and for disciplinary purposes. Similarly, if there were allegations of negligence or careless driving made by clients or third parties against employees, or claims brought against any member of the Company leading to civil proceedings, by clients, third parties or employees the Company may use and/or submit the footage to the relevant authorities.

Q) OTHER GUIDELINES

1) It must be emphasised that you must never drive under the influence of alcohol, or drugs, including medicines which may affect your driving.
2) Use seat belts at all times and comply with local traffic conditions.
3) Always drive within the speed limit and reduce speed where weather conditions require you to.
4) DO NOT DRIVE if tired.
5) Always take regular breaks from the vehicle.

Question 1.11.1

Employment policies

Please provide details of your employment-related policies and their review date.

The Bidder has provided a details of the appropriate policies and their review date – Pass

The Bidder has failed to provide details of the appropriate policies and / or their review date – Fail

We have attached our Employee Handbook which provides an overview of all our employment related policies. We have also provided other key employment related policies. All policies are reviewed annually and we have provided the next review date for each of them.

Review Dates

Employee Handbook – 1st September 2021

Human Resources Policy – 10th September 2021

Annual Leave Policy – 8th July 2021

Stress Management Policy – 1st September 2021

Family Friendly Policy – 1st September 2021

Flexible Working Policy – 1st September 2021

ERS Medical

Stress Management Policy

Document Author:	*** REDACTED ***		Head of HR & Training	
Document Owner				
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Document Author:	*** REDACTED ***		Head of HR & Training	
Document Owner				
	Version No.:	2.0	Date Active:	24/10/2019

Stress Management Policy

A) POLICY ON MANAGING STRESS

1) We are committed to protecting the health, safety and welfare of our employees. We recognise that workplace stress is a health and safety issue and acknowledge the importance of identifying and reducing the causes of stress in the workplace.

2) This policy applies to everyone employed by the Company. Employees are responsible for their own health and safety as well as that of their colleagues. Managers are responsible for the implementation of this policy and the Company is responsible for providing the necessary resources to ensure its effective implementation.

B) DEFINITION OF STRESS

1) The Health and Safety Executive define stress as "the adverse reaction people have to excessive pressure or other types of demand placed on them". The definition helps to distinguish between pressure, which can be positive and motivational if managed correctly, and stress which can be detrimental to health.

2) The following policy and procedures outline the responsibilities of the Company, Managers and staff in ensuring that excessive pressures are minimised, and in the event that an adverse reaction arises, that work-related stress is managed effectively.

C) RESPONSIBILITIES

1) **The Company**

   a) We acknowledge our duty of care to all our employees, to provide a safe working environment as well as safe systems of work.

   b) We also acknowledge the importance of the health and safety of our employees in complying with relevant legislation.

   c) We will provide guidance to managers and raise awareness of stress, its effects and how to manage it.

   d) We will support managers in implementing recommendations arising from stress risk assessments.

   e) We will work with, and support, managers and individuals to find the best way to manage work related stress.

   f) We will provide the opportunity for employees to attend occupational health counsellors, where appropriate.

   g) We will aim to deal with and resolve instances of excessive pressure to avoid sickness absence occurring.

2) **Managers**

a) Conduct formal, recorded assessments of stress as part of the legal obligation to conduct general risk assessments.

b) Implement the recommendations arising out of those risk assessments.

c) Review risk assessments at least annually and following any changes in methods of work which may affect the likelihood of stress occurring.

d) Monitor sickness absence to ensure any trends that are stress related are identified and investigated.

e) Ensure effective communication between management and staff, in particular at times of organisational or procedural change.

f) Ensure that staff are fully trained to undertake the duties required of them.

g) Ensure that opportunities for development are available to staff.

h) Monitor workloads, to ensure that employees are able to undertake the agreed targets.

i) Monitor working hours and overtime to ensure that staff are not working excessive hours.

j) Monitor holidays to ensure that employees take their full leave entitlement.

k) Attend training as requested and be familiar with good management practice relating to health and safety in the workplace.

l) Ensure that bullying and harassment are not tolerated within their team.

m) Be able to offer additional support to members of staff who are experiencing stress outside work, e.g. bereavement or separation.

3) **Employees**

a) Employees have a legal obligation to take care of themselves and their colleagues whilst at work. This includes advising management of any circumstance that may cause or increase stress.

b) Employees must raise issues of concern with their line manager or a senior person in the organisation if it is not appropriate to raise them with the line manager.

c) Employees must communicate if they are feeling under pressure or are unable to cope with the demands being placed on them.

d) Take responsibility for managing their own workload and duties expected.

e) Identify what will help to reduce or manage excessive pressures.

f) Accept opportunities for counselling when recommended.

D) PROCEDURE

Stress may manifest itself in physiological or behavioural ways:

Physiological characteristics may include:

Sleeplessness, sudden headaches, breathlessness, ulcers, increased consumption (food, alcohol and cigarettes), lack of concentration, difficulty remembering things, careless mistakes, slow work, over-emotional behaviour, fatigue or depression.

Behavioural characteristics may include:
confusion and uncertainty, lack of confidence / seeking reassurance, inability to make decisions, mood swings, low motivation, increased sickness absence.

There are some types of personality where symptoms will not be displayed, and managers should be extremely vigilant in these cases.

The responsibilities outlined above form the basis of the procedure and attempt to identify and manage stress before absence from work occurs. In the event that an employee is absent from work due to stress, the following procedure should be followed:

a) Usual sickness absence and reporting procedures apply;

b) On receipt of a medical certificate stating "stress" obtain, using the access to medical reports procedure, a specialist medical opinion on the condition;

c) At the earliest possible opportunity, the manager must meet the employee to discuss the cause/s of stress (taking account of any medical opinion and recommendations) and what remedial action could be taken.

d) Return to work interviews must take place in all cases;

e) If the cause is related to the employee's personal life, the manager must be supportive and sympathetic as far as is reasonably practicable;

f) If the cause is work related, it should be identified using the approach recommended by the HSE which is to look at the following areas:

- organisational culture;
- demands on the individual;
- the control the individual has on how the work is carried out;
- relationships;
- change;
- job role;
- support, training.

g) The Manager must continue to monitor the employee's workload, hours, performance and behaviour;

h) The employee must keep the manager informed of his / her state of health.

i) At all stages of this procedure it is important to carefully consider the need for medical advice to ensure all the medical facts relevant to the situation can be obtained and acted upon as necessary.

In the event that a reduction in working hours or a job of lesser responsibility or status is agreed, it is likely that a reduction in salary in line with the new hours / role will be agreed.

Due to the individual nature of the causes of stress and subsequent symptoms, each case will be treated on an individual basis.

WI/2.01.06 Family Friendly Policy

Document Author:	*** REDACTED ***		Head of HR & Training	
Document Owner:	*** REDACTED ***		Managing Director	
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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Company Car Driving	BMS/2.04
Whistle-blowing (Raising Concerns at Work)	BMS/2.05
Disclosure and Barring Service Check Policy (DBS)	BMS/2.06
Alcohol and Drugs Policy	BMS/2.07
Recruitment and Selection	WI/2.01.01
Managing Probation Periods	WI/2.01.02
Sickness Absence Policy	WI/2.01.03
Disciplinary Procedure	WI/2.01.04
Grievance Procedure	WI/2.01.05
Family Friendly	WI/2.01.06
Managing Change	WI/2.01.07
Flexible Working	WI/2.01.08
Capability Policy – Managing Underperformance	WI/2.01.09
Home Working	WI/2.01.10
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Keeping in Touch (KIT) Record	F2.01.07

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3. Introduction

This document sets out ERS Medical's policy on maternity, paternity, shared parental leave and adoption. It sets out the statutory rights and responsibilities of employees who are pregnant or have recently given birth and covers the arrangements for ante-natal care, pregnancy-related illness, maternity leave and pay. ERS Medical implements the maternity rights set out in legislation.

ERS Medical recognises that, from time to time, employees may have a question or concern relating to their maternity/paternity rights. In this respect, it is our policy to encourage open discussion between you and your line manager to ensure that questions and problems can be aired and resolved as quickly as possible. It is our policy within ERS Medical that pregnant employees are supported throughout their pregnancy, taking into account the needs of the individual and ERS Medical.

The maternity/paternity/shared parental leave/adoption regulations are complex and so in any of these situations you should clarify the relevant procedures with your line manager to ensure that they are followed correctly.

Please note that additional paternity leave is not available where the expected week of childbirth, or the date of placement of the child for adoption, is on or after 5 April 2015.

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4. Responsibilities

a.	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Are responsible for setting ERS Medical objectives and allocating adequate resources to meet those objectives.
b.	**Senior Management Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
c.	**Head of HR and Training**	Is responsible for ensuring that ERS Medical's Family Friendly processes remain within the legislative framework, are fit for purpose. To also provide the necessary information to enable managers to support expectant mothers during their pregnancy and manage maternity leave provisions for employees. Are responsible for the training of personnel in relation to this work instruction and for monitoring, reviewing, approving and auditing the process outputs.
d.	**General / Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
e.	**H&S Manager / Advisors**	Are responsible for conducting risk assessments for new and expectant mothers and for ensuring any identified actions are completed.
f.	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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Maternity Leave

5. Introduction

All pregnant employees are entitled to a total of 52 weeks' maternity leave, irrespective of their length of service. We have set out below all of your rights and obligations should you become pregnant. We would ask that you notify us as soon as possible of your pregnancy so that we can ensure you are fully aware of all your entitlements and obligations and also so that we can take any necessary steps to ensure the health and safety of both yourself and your unborn child whilst you are at work.

6. Ante-Natal Care

You are entitled to paid time off during normal working hours to receive ante-natal care. Ante-natal care can include not only medical examinations, but also relaxation and parent-craft classes.

Other than for the first appointment, you must produce both a certificate confirming that you are pregnant and an appointment card (or similar document) from a registered medical practitioner, or a registered midwife, in the case of medical examinations or relaxation classes, or from a registered health visitor in the case of parent-craft classes, showing that an appointment has been made.

7. Maternity Leave

You are entitled to the following maternity leave; 52 weeks' in total, broken down as follows:

- 26 weeks' Ordinary Maternity Leave. You are not permitted to work for 2 weeks immediately after your baby is born, this is called Compulsory Maternity Leave.

- Additional Maternity Leave that starts immediately after Ordinary Maternity Leave and continues for a further 26 weeks'.

Maternity leave can commence at any time after the 11th week before the expected week of childbirth, and may commence as late as the day after the birth of your baby. In order to take advantage of the right to maternity leave you must give us the proper notifications. These are outlined below under the heading 'Notice Requirements'.

8. Notification Requirements

We would urge you to notify us as soon as possible of your pregnancy to enable us to ensure that, where appropriate, any reasonable steps are taken to ensure the safety of yourself and your unborn child and that you are not subject to any unnecessary risks.

To qualify for maternity leave you must, no later than the end of the 15th week before the expected date of childbirth or, if that is not reasonably practicable, as soon as is reasonably practicable notify us, in writing of the following:

1) your pregnancy;

2) expected week of childbirth (EWC); and

3) the date on which you intend your ordinary maternity leave period to start.

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In addition, you must supply us with a copy of your MATB1 form from a registered medical practitioner or registered midwife stating the EWC.

If you wish to vary the date on which you intend your OML to start, you must notify us of the new date at least 28 days' before the new date or, if that is not reasonably practicable, as soon as is reasonably practicable.

9. Commencement of Leave

The earliest date that you can start maternity leave is the beginning of the 11th week before the EWC.

The latest date that you may work up to is the birth of your child unless your leave is triggered by pregnancy related absence (see below).

Compulsory maternity leave commences on the day after the childbirth occurs. Its purpose is to ensure that you have at least 2 weeks leave after the birth of your baby.

There are two incidences in which the maternity leave period is triggered automatically:

1) Where childbirth occurs before the maternity leave period would otherwise commence.

   In the event of premature birth you are not required to notify us of the date on which you intend to take your leave, but must inform us as soon as is reasonably practicable after the birth, of the date on which you gave birth.

   Your maternity leave period will begin automatically on the day following the date of the birth.

2) If you are absent from work, wholly or partly due to your pregnancy, after the beginning of the fourth week before the EWC.

   If you are absent from work after the beginning of the fourth week before the EWC, wholly or partly due to your pregnancy, then again you must notify us as soon as reasonably practicable that you are absent for that reason and the date on which your absence began. Your maternity leave period will begin automatically on the day following the first day of such absence.

   Once you notify us of the date on which you intend to commence your maternity (or have commenced) we will write to you within 28 days', notifying you of the date on which you are due to return to work after the end of your additional maternity leave.

10. Changing your Return to Work Date

If you decide to return to work before the end of the date notified for additional maternity leave you must give us at least 8 weeks' notice of the new date on which you intend to return. For example, if you only wish to take the 26 weeks' ordinary maternity leave or the 39 weeks' paid maternity leave, you must give us 8 weeks' notice of your intended return date. If you attempt to return to work without giving the required notice we will postpone your return to a date that will ensure that there has been 8 weeks' notice of that return, or the original date of return, whichever is the lesser period of time.

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11. Returning to Work

If you are returning to work at the end of additional maternity leave, you simply present yourself for work at the end of that period.

If you return to work at the end of your ordinary maternity leave you are entitled to return to the same job, with the same terms and conditions, in which you were employed before your absence.

If you return to work after a period of additional maternity leave, you are entitled to return to the same job in which you were employed before your absence or, if that is not reasonably practicable, to another job which is both suitable and appropriate for you in the circumstances on terms no less favourable.

12. Keeping in Touch Days

You may by mutual agreement, work for up to 10 days' during your maternity leave period (but not during the compulsory maternity leave period) without losing statutory payments for that week, or ending your entitlement to leave.

For this purpose any work carried out on any day, even just an hour's work, is deemed to constitute "a day's work". Any days' work done under this provision will not have the effect of extending the total duration of the maternity leave period.

Payment in respect of these 'keeping in touch' days will be agreed beforehand.

13. Maternity Pay

Dependent upon your length of service, you may be entitled to Statutory Maternity Pay. If you do not qualify for such a payment, you may, dependent upon your circumstances, be eligible to receive allowances from the appropriate government departments.

3) **Eligibility**
You will qualify for Statutory Maternity Pay (SMP) if you meet the following criteria:

a) you have been continuously employed with us for at least 26 weeks' continuing into the 15th week before the week the baby is due.

b) your average weekly earnings are not less than the lower earnings limit relevant for National Insurance purposes.

c) you are still pregnant at the 11th week before the EWC or have given birth by that time.

d) you have complied with the relevant notification requirements, as detailed above.

4) **Length of Pay Period**
The period for which SMP may be paid is called the maternity pay period. The maternity pay period may start at any time from the start of the 11th week before the EWC and can continue for up to 39 weeks', even if you do not intend to return to work.

The starting date of the maternity pay period will usually be agreed between the employer and the employee however the final decision is yours. The maternity pay period and SMP can start on any day of the week. However:

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a) if you work up to the birth, the maternity pay period and SMP will start from the day following the date of the birth;

b) if you are absent from work because of a pregnancy related reason on, or after, the start of the fourth week before the EWC, the maternity pay period will start on the day following the first day you are off work for that reason; and

c) if you are absent on sick leave with an illness which is not pregnancy related, the maternity pay period will start as notified or from the date following the date of birth whichever is the earlier.

5) **Amount of Payment**
Payment will be made at the rate of 90% of your normal salary (or standard rate SMP whichever is the greater) for the first 6 weeks' of leave and then up to 33 weeks' at the Standard Rate SMP.

6) **The baby is born early or late**
If your baby is born before the maternity pay period is due to start, the pay period will begin from the day following the date of birth.

If your baby is born before you have given us a maternity certificate, you must, if reasonably practicable, provide us with medical evidence of the date the baby was born within 28 days'.

If your baby was born early and the maternity pay period has started, SMP will be paid in the normal way until the liability ends as if the baby had been born in the EWC.

If the baby is born after the EWC, the maternity pay period is not affected.

7) **The baby is stillborn**
In the unfortunate event that a baby is stillborn before the 25th week of the pregnancy, i.e. earlier than the 16th week before the EWC, SMP is not payable.

If a baby is stillborn after the start of the 16th week before the EWC, SMP will be paid as it would for a live birth.

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Paternity Leave

14. Introduction

If your partner becomes pregnant you may be entitled to take time off work for various reasons, and this policy explains what your right are.

15. Ante-Natal Appointment

Regardless of your length of service, you have the right to take time off to accompany your partner to ante natal appointments. An ante-natal appointment is one which has been made on the advice of a **registered medical practitioner, nurse or midwife**. Under this right, you are entitled to take time off to attend a maximum of 2 ante-natal appointments, to a maximum of 6.5 hours per appointment. This time is unpaid.

We may ask you to provide a declaration stating the date and time of the appointment that you qualify for the time off in terms of your relationship with the mother of the child or the child, and that the time off is for the purpose of attending the ante natal appointment.

You must be the:

- **Father of the child;**
- **The husband, civil partner or partner of the mother;**

The right applies whether the baby was conceived naturally or via donor insemination.

16. Ordinary Paternity Leave

You must have been continuously employed by us for a period of at least 26 weeks by the end of the 15th week before the expected week of the child's birth or, in the case of an adopted child, for at least 26 weeks leading into the week in which the adopter is notified of being matched with a child.

You must be the father of the child, or be married to, or the civil partner or "partner" of, the child's mother or adopter. "Partner" in relation to a child's mother or adopter means a person (whether of a different sex or the same sex) who lives with the mother, or adopter, and the child in an enduring family relationship but is not a relative of the mother or adopter (a relative is defined as a parent, grandparent, sister, brother, aunt or uncle).

You must have, or expect to have, responsibility for the upbringing of the child.

Only one period of leave is available irrespective of whether more than one child is born as a result of the same pregnancy or adopted as part of the same arrangement.

17. Notification Requirements

You are required to give us notice, in writing, of your intention to take paternity leave.

The notice must be given in on or before the 15th week before the expected week of the child's birth or, in the case of an adopted child, no more than seven days after the date on which the adopter was notified of having been matched with a child. In a case where it is not reasonably practicable for you to give notice in accordance with the above, it should be given as soon as is reasonably practicable.

The notice must specify:

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a) if applicable, the date on which the adopter was notified of having been matched with the child;

b) the expected week of birth or placement for adoption;

c) whether you wish to take one or two weeks' leave; and

d) when you want your leave to start.

You must also give us a signed declaration as to the purpose of the absence and that the eligibility conditions have been met.
You are able to change your mind about the date on which you want your leave to start providing you notify us at least 28 days in advance, unless this is not reasonably practicable. You must give us a further notice, in writing, as soon as is reasonably practicable after the child's birth or placement for adoption, of the date on which the child was born or placed.

18. Shared Parental Leave

You may be entitled to take shared parental leave if both you and your partner meet the eligibility criteria. Shared parental leave enables you and your partner to divide almost a year's leave between you after the child is born/adopted, and gives you more flexibility over who will take leave and when. If you choose to take shared parental leave, you are still entitled to take ordinary paternity leave.

If you would like more information on shared parental leave, please speak with your line manager.

19. Commencement and Duration of Leave

Leave may only be taken during the period beginning with the date of the child's birth or placement and ending 56 days after that date or, in a case where the child is born before the first day of the expected week of birth, 56 days after that day.

Subject to the above, you can choose to begin your leave:

(i) on the date on which the child is born or placed with the adopter;

(ii) ii. from a specified chosen number of days/weeks after the date of the child's birth/placement (whether this is earlier or later than expected); or

(iii) from a specified predetermined date which is later than the first day of the expected week of the child's birth or expected date of placement.

Leave can start on any day of the week and you can choose to take a block of either one week or two consecutive weeks. You cannot choose to take two separate single week blocks. During paternity leave you are entitled to the benefit of your normal terms and conditions of employment, except wages or salary, and you are bound by any obligations arising under those terms and conditions except in so far as they are inconsistent with the right to paternity leave. Most employees will be entitled to statutory paternity pay whilst on paternity leave.

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20. Returning to Work

If you return to work following an isolated period of paternity leave; or a period of parental leave of no more than four weeks, you are entitled to return to the job in which you were employed before the absence. In addition, seniority, pension and similar rights should be as they would have been had the absence not occurred, and other terms and conditions should not be less favourable than those which would have applied had the absence not occurred.

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Shared Parental Leave

21. Introduction

Shared Parental Leave will allow you to take leave in a much more flexible manner to care for your child(ren) and allows you to take a period of leave much earlier than under the maternity and paternity provisions.

22. Eligibility for Shared Parental Leave

If you meet the following criteria you are eligible for Shared Parental Leave:

e) 26 weeks service at the 15th week prior to expected week of childbirth (the qualifying week), or notification of a match in terms of adoption, and still be employed by us in the week before any shared parental leave is due to start;

f) have a partner who has worked (employed/self-employed) for 26 of the 66 weeks prior to the EWC/placement week and who has earned on average at least £30 per week in any 13 weeks;

g) Share the primary responsibility for the child with the other parent at the time of the birth/adoption;

h) Have properly notified us of their entitlement and have provided the necessary declarations and evidence.

23. How Much Shared Parental Leave Can Be Taken

You can decide how you wish to split Shared Parental Leave provided that your partner takes her compulsory maternity leave entitlement because this is a legal requirement. The remaining 50 weeks of leave can be split as decided by employees (subject to our approval in certain circumstances). Leave must be taken in minimum blocks of one week. Leave must end 52 weeks after the date leave started.

Partners (i.e. baby's father/mother's husband/mother's civil partner/mother's partner) are still entitled to take 2 weeks Ordinary Paternity Leave subject to qualifying conditions.

24. Booking Leave

You must submit various notices in order to take Shared Parental Leave:

i) the mother or primary adopter must provide a Curtailment Notice to end Statutory Maternity or Adoption Leave. This must be given after the 11th week prior to the EWC but at least 8 weeks prior to the start date of the first period of Shared Parental Leave;

j) You must provide a Notice of Entitlement setting out both their eligibility, and their partners eligibility to take Shared Parental Leave;

k) You must submit an approximate indication of how periods of Shared Parental Leave will be taken;

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l) You must provide the following details if requested within 14 days of such request;

(i) In relation to a birth, the birth certificate and their partner's employer's details;

(ii) In relation to an adoption, the name and address of the adoption agency; the date that the employee was notified of having been matched for adoption with the child; and the date on which the adoption agency expects to place the child with the employee.

m) You must submit a Period of Leave Notice in order to book a period of shared parental leave, giving at least 8 weeks written notice of the period of leave. The Period of Leave Notice must contain the start and end date of the leave requested. A Period of Leave Notice may notify details of one period of leave, or more than one period of leave.

The Curtailment Notice may only be revoked in limited circumstances. A Period of Leave may be amended providing that the amendment notice is given at least 8 weeks before leave starts/was due to start.

Period of Leave Notices, and amendments to Period of Leave Notices, may only be submitted on a maximum of 3 occasions.

25. Accommodating the Notification/Requests

If you request one continuous block of leave in a Period of Leave Notice, you are entitled to take this period of leave.

However, if you request more than one period of leave i.e. discontinuous blocks of leave in one Period of Leave Notice, we reserve the right to refuse this request. Discontinuous leave is, for example, where a period of 6 weeks Shared Parental Leave is requested, then you return to work for a period of 4 weeks and then take a further 6 weeks of Shared Parental Leave.

When discontinuous leave is requested, we will arrange to discuss the request with you. The outcome of the request will be one of the following:

n) Agreement to the request;

o) Proposal of alternative leave dates; or

p) Refusal of the request.

Should we refuse a request, the default provisions will apply which means you are able to withdraw the request. If the request is not withdrawn, the leave requested will be taken one continuous block, rather than in discontinuous blocks.

26. Working During Shared Parental Leave

During Shared Parental Leave, you may work for up to 20 days without statutory payments being affected. These days are called SPLIT days i.e. Shared Parental Leave In Touch days. We recognise the benefit of SPLIT days and encourage you to use them, however, they are optional and you are not obliged to use them and we are not obliged to permit them.

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You will be paid at normal rate for work on a SPLIT day. Any work done on one day will count as one SPLIT day.

27. Shared Parental Pay

Shared Parental Pay (SHPP) can be paid to both parents to a maximum of 39 weeks in total. This includes any Statutory Maternity or Adoption pay, and will be decided between the parents.

Only 37 weeks of paid leave will be shared to allow for the mother to take 2 weeks Compulsory Maternity Leave.

To be eligible to receive SPP, you must:

q) have been continuously employed for at least 26 weeks up to and including the "qualifying week" (the 15th week prior to the expected week of childbirth or placement for adoption).

r) have average earnings not less than the lower earnings limit for the payment of national insurance contributions in the 8 weeks prior to the qualifying week.

s) comply with the notification requirements.

28. Holidays and Benefits

We encourage you to take any outstanding annual leave due in the current holiday year before the commencement of Shared Parental Leave, or during periods of work in between periods of Shared Parental Leave.

You will continue to receive all contractual benefits (with the exception of salary) during Shared Parental Leave.

29. Contact Whilst Away from Work

For the benefit of both parties, we encourage communication during periods of leave. You should agree with your manager (before leave is due to start) the level of contact and how you would prefer to be contacted (phone call, letter, home visit, workplace visit etc.). The Company reserves the right in any event to maintain reasonable contact from time to time with you.

Near the end of your leave period, a manager may contact you. This may be to discuss plans for return to work, to discuss training that may be available, or simply to update you on developments at work during the absence.

If there are any business changes that impact your role whilst on leave, you will be considered in the same way as any other employee and this will be communicated with you.

30. Rights on or After Shared Parental Leave

After Shared Parental Leave, provided the total amount of leave taken by you (including maternity leave) does not exceed 26 weeks, you are entitled to return to the same job on the same terms and conditions of employment as if they had not been absent.

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When you are considering your return to work, for reasons of childcare, you may request a change to your previous working arrangements. Any such request will be considered in line with the operational requirements of the Company and there is no automatic right to return to work on altered conditions.

31. Surrogacy and Shared Parental Leave

If you are an intended parent in a surrogacy arrangement who intends to apply for, or has already applied for, a Parental Order and is eligible for adoption leave and pay, you may be entitled to Shared Parental Leave and Pay.

You must take at least two weeks of adoption leave before it can be curtailed. The remaining 50 weeks of leave can be split as decided by employees (subject to our approval in certain circumstances).

The above eligibility criteria apply to you.

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Adoption Leave

32. Introduction

If you are matched for adoption with a child, you may be entitled to either adoption leave or paternity leave. One parent cannot take both periods of leave, and it is up to you to decide which you wish to take (subject to eligibility).

Where you are to take adoption leave, you are entitled to a total of 52 weeks' leave. We have set out below all of your rights and obligations should you be matched for adoption. We would ask that you notify us as soon as possible of your situation so that we can ensure you are fully aware of all your entitlements and obligations.

33. Time Off to Attend Adoption Appointment

You are entitled to time off to attend adoption appointments in the period between notification of a match and the date of placement. For single adopters or the primary adopter in a joint adoption, you are entitled to paid time off to attend up to 5 appointments, with a maximum of 6.5 hours per appointment. The secondary adopter in a joint adoption will be entitled to unpaid time off to attend up to two appointments.

Where the time is paid, you will be paid at your normal hourly rate for this time.

34. Eligibility

You are entitled to adoption leave from the commencement of employment. Adoption leave is not available in circumstances where a child is not newly matched for adoption, for example when a step-parent is adopting a partner's child/children. You must have notified the adoption agency of agreement to the placement and of agreement to the date of the placement.

Only one period of leave is available irrespective of whether more than one child is placed for adoption as part of the same arrangement. However, if an additional child is adopted at a later date as a separate agreement then you could qualify again for a separate period of adoption leave.

35. Ordinary and Additional Adoption Leave

Adoption leave is divided into two categories, 'ordinary' and 'additional'. Each is for 26 weeks, with additional leave following on from ordinary adoption leave, giving 52 weeks leave in total. If you are eligible for ordinary adoption leave you will also qualify automatically for additional adoption leave.

During ordinary adoption leave you are entitled to the benefit of your normal terms and conditions of employment, except wages and salary (unless your contract of employment states otherwise). However, in the majority of cases, you will be entitled to Statutory Adoption Pay during this period.

During additional adoption leave the employment contract continues and you are entitled to the benefit of their normal terms and conditions of employment, except wages or salary (unless your contract of employment provides otherwise). However, in the majority of cases, you will be entitled to Statutory Adoption Pay during some of this period.

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36. Commencement of Adoption Leave

You can choose to start your adoption leave on the date of the child's placement (whether this is earlier or later than was expected), or on a predetermined fixed date no earlier than 14 days before the expected date of placement and no later than the date of placement. Adoption leave can start on any day of the week.

37. Notification Requirements

You are required to give us notice, in writing, of your intention to take adoption leave within seven days of being notified by the adoption agency that you have been matched with a child, unless this is not reasonably practicable. The notice must specify:

- the date the child is expected to be placed with you; and
- the date you want the adoption leave to start.

You should provide documentary evidence - a "matching certificate" - from the adoption agency. The certificate will include basic information on matching and expected placement dates.

You are able to change your mind about the date on which you want your adoption leave to start providing you inform us at least 28 days in advance, unless this is not reasonably practicable.

We will write to you to notify you of the date on which you are expected to return to work if the full entitlement to adoption leave is taken, within 28 days of the date on which you notified us of your intention to take leave, or, if you have varied the date originally chosen to start adoption leave, within 28 days of the date on which adoption leave began.

38. Returning to Work

If you are returning to work at the end of additional adoption leave, you simply present yourself for work at the end of that period.

If you intend to return to work before the end of your additional adoption leave, you must give us at least 8 weeks' notice of the date on which you intend to return. If you do not give us 8 weeks' notice, we may postpone your return to a date ensuring that there has been 8 weeks' notice.

39. Keeping in Touch Days

You can work for up to 10 days during your adoption leave period without losing statutory payments for that week, or ending your entitlement to leave.

For this purpose any work carried out on any day, even just an hour's work, is deemed to constitute "a day's work". Any days' work done under this provision will not have the effect of extending the total duration of the adoption leave period.

Payment in respect of these 'keeping in touch' days will be agreed beforehand.

40. Disrupted Placement in the Course of Adoption Leave

If you have begun a period of adoption leave in respect of a child before the placement of the child has taken place, and you are subsequently notified that the placement will not be made, your adoption leave period will end eight weeks after the week of that notification.

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If, during adoption leave, the child dies or is returned to the adoption agency, the adoption leave period will end eight weeks after the week in which the child dies; or is returned; or at the end of the 26 week additional adoption leave period, if that is earlier.

41. Pay

Dependent upon your length of service, you may be entitled to statutory adoption pay (SAP). If you qualify for SAP this will be paid for the first 6 weeks at 90% of your normal weekly earnings in the 8 week period up to the date of notification of a match, with the remainder paid at the earnings related limit or the statutory rate, whichever is lower. SAP will be paid in the same way as your wages would be paid if you were not on leave. If you do not qualify for such a payment, you may, dependent upon your circumstances, be eligible to receive allowances from the appropriate government departments.

42. Shared Parental Leave and Pay

You may be entitled to opt in to shared parental leave, sharing up to 50 weeks of leave and up to 37 weeks of pay (subject to availability). If you think you would like to take shared parental leave instead of adoption leave, please ask us for more information.

43. Surrogacy and Adoption Rights

If you are an intended parent in a surrogacy arrangement who intends to apply for, or has already applied for, a Parental Order **you may be entitled to either adoption leave and pay or paternity leave and pay. One parent cannot claim entitlement to both periods of leave and pay, and it is up to you to decide which you wish to claim (subject to eligibility**).

You will be entitled to take unpaid time off to accompany the surrogate mother to up to two antenatal appointments, of up to 6.5 hours per appointment.

You are entitled to adoption leave from the start date of your employment. This will be for a total of 52 weeks, split in to two periods of “ordinary” and “additional” adoption leave of 26 weeks each.

You are required to give us notice, in writing, of your entitlement to take adoption leave by the 15th week before the expected week of birth. You must also notify us of the actual date of birth as soon as is reasonably practicable after birth.

You should provide documentary evidence - a statutory declaration. This document will state that you have obtained, applied for or intend to apply for a Parental Order in respect of the surrogate child and, where not received, this is expected to be made.

If you have begun a period of adoption leave in respect of a child before approval of a Parental Order, and you are subsequently notified that the application is refused, your adoption leave period will end eight weeks after the week of that notification or the end of the adoption leave period, if that is earlier.

Dependent upon your length of service, you may be entitled to Statutory Adoption Pay (SAP). If you qualify for SAP this will be paid for the first 6 weeks at 90% of your normal weekly earnings in the 8 week period leading up to the end of the 15th week before the baby is due to be born, with the remainder paid at the earnings related limit or the statutory rate, whichever is lower. SAP will be paid in the same way as your wages would be paid if you were not on leave. If you do not

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qualify for such a payment, you may, dependent upon your circumstances, be eligible to receive allowances from the appropriate government departments.

44. Dual Approved Prospective Adopters and Adoption Right

If you are a dual approved prospective adopter, a local authority foster parent who has a child placed with you with an expectation to adopt that child in accordance with section 22C of the Children Act 1989, you may be entitled to either adoption leave and pay or paternity leave and pay. One parent cannot claim entitlement to both periods of leave and pay, and it is up to you to decide which you wish to claim (subject to eligibility).

You are entitled to adoption leave from the start date of your employment. This will be for a total of 52 weeks, split in to two periods of "ordinary" and "additional" adoption leave of 26 weeks each.

Only one period of leave is available irrespective of whether you go on to adopt the same child or children placed with you under section 22C. However, if an additional child is placed with you under section 22C at a later date as a separate agreement then you could qualify again for a separate period of adoption leave.

You can choose to start your adoption leave on the date of the child's placement (whether this is earlier or later than was expected), or on a predetermined fixed date up to two weeks before the placement of the child and no later than the date of placement. Adoption leave can start on any day of the week.

You are required to give us notice, in writing, of your intention to take adoption leave within seven days of being notified of the child's placement by the local authority in accordance with section 22C, unless this is not reasonably practicable. The notice must specify:

- the date the child is expected to be placed with you; and
- the date you want the adoption leave to start.

If you have begun a period of adoption leave in respect of a child placed with you under section 22C, and this placement does not proceed to a formal adoption, your adoption leave period will end eight weeks after the child is removed or the end of the adoption leave period, if that is earlier.

Dependent upon your length of service, you may be entitled to Statutory Adoption Pay (SAP). If you qualify for SAP this will be paid for the first 6 weeks at 90% of your normal weekly earnings in the 8 week period leading up to the date of notification, with the remainder paid at the earnings related limit or the statutory rate, whichever is lower. SAP will be paid in the same way as your wages would be paid if you were not on leave. If you do not qualify for such a payment, you may, dependent upon your circumstances, be eligible to receive allowances from the appropriate government departments.

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WI/2.01.09 Annual Leave Policy

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V2.	3.1/3.2 /3.3		5	08.07.20	*** REDACTED ***	Updated information inline with WTD and update in guidance.
V2.	6.2		7	08.07.20	*** REDACTED ***	New section on annual leave taken added
V2.				08.07.20	*** REDACTED ***	Change of policy name from Holiday & Holiday Pay Policy to Annual Leave & Holiday Pay Policy. Added section 8. Bank Holidays

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Disclosure and Barring Services (DBS) Checks	BMS/2.06
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04

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3. Introduction

3.1 It is important that employees are encouraged to take annual leave in order to rest and recuperate to ensure both their well-being and their effectiveness when at work. This is also a requirement under the Working Time Regulations. It is necessary however for the efficient management of the company, that all leave is monitored and kept within pre-determined parameters.

3.2 Under the Working Time Regulations 1998, employees are entitled to minimum 5.6 weeks of paid annual leave in each leave year, this entitlement includes public bank holidays.

3.3 Annual leave will convert into different entitlements for each employee dependent on their individual working arrangements. Individual contracts of employment will detail an employee's personal entitlement. For example, 5.6 working weeks leave will, by the nature of their working week, convert to fewer days or hours of annual leave for a part time employee when compared to a full-time employee. The pro-rata principle may also apply to other practical arrangements.

3.4 The aim of this policy is to provide a uniformed and equitable approach to the calculation of annual leave and general public bank holiday entitlements that take into account the relevant terms and conditions of employment.

3.5 All leave must be pre-authorised by the Company. Taking leave without authorisation will be considered a gross misconduct offence. Taking leave despite a declined request will be considered a gross misconduct offence. Gross misconduct offences may result in dismissal without notice. Further rules on booking leave from work are given below.

3.6 The Company's holiday year runs from January to December.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
5.3	**Head of HR and Training**	Is responsible for ensuring that Company HR procedures remain within the legislative framework, are fit for purpose and provide the necessary information to enable managers to undertake their duties.
5.4	**Regional, Operations Managers and Site Admin Support**	Is responsible for all annual leave to be recorded and tracked through Bamboo. To ensure that all staff are informed and understand this policy during their local induction. Are responsible for proactively encouraging employees to take their leave and benefit from the rest it provides. Line Managers are responsible for authorising annual leave requests ensuring sufficient resources are in place to meet the service needs of the Company.
5.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Booking Leave

6.1 Employees must give notice of their request to take leave. Applications should be sent to their line manager in writing/using the online holiday request through HR Bamboo.

6.2 The following notice periods apply to employees when requesting leave are as follows in line with our Employee Handbook:

Period of leave requested	Period of notice required
Over two weeks (15 days or more)	*At least three months*
A week or more (five days or more)	*At least four weeks*
Less than a week (one to four days)	*At least one week*

6.3 The Line Manager will notify the employee through HR Bamboo whether their request has been granted (if declined, a business reason should be provided).

6.4 Employees should not make any firm travel or accommodation arrangements, until they have received written confirmation that their request for leave has been granted. There may be circumstances where the company cannot grant the request, such as operational/staffing requirements. The company is not liable for any loss incurred by an employee, such as lost deposits etc., if they incur costs and make commitments prior to receiving confirmation.

6.5 A line manager will not normally approve leave of more than two weeks (including days off) unless in exceptional circumstance and as stated above at least three months' notice must be given.

6.6 There may be more requests than usual for leave that coincide with school holidays/half terms, due to the number of employees with children of school age. The company will make every effort to accept as many of these requests as possible.

6.7 The company asks employees to apply for leave as soon as possible in the holiday year to ensure operationally that there is sufficient cover for all work to be undertaken, considerations which sometimes need to take priority over granting all these types of requests.

6.8 The company asks staff, where possible to spread holidays evenly across the leave year using the three holiday quarters. This allows for organised operationally cover and support during busy times and ensures staff take regular breaks and holidays throughout the years.

Example:

Quarter One	Quarter Two	Quarter Three
Jan to April	May – August	September to December
1/ 2 weeks leave taken	1 / 2 weeks leave taken	1 / 2 weeks leave taken

7. Company Requirement

7.1 The company may ask an employee to cancel any previously agreed leave. There may be various reasons for this, such as operational or staffing issues, or business commitments that require the employee's presence. The Company recognises the inconvenience that this may cause an employee and, therefore, understands that the employee may refuse this request.

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7.2 The company will make a decision on whether, where the cancellation is agreed, and the employee suffers a financial detriment e.g. lost deposits etc, the employee is to be reimbursed.

7.3 Due to the needs of the business, it may be necessary for an employee to work on a public holiday. Where this happens, employees will be entitled to take a day's leave at another time in the leave year to be agreed with the line manager in accordance with business needs.

7.4 There may be occasion when the company asks an employee to take annual leave, for example if an employee has not requested any annual leave within the holiday first quarter or there is operational down time. The company will ensure that at least a week's notice is given dependent on the days leave they have asked the employee to take in line with current guidelines.

8. Bank Holidays

8.1 The eight Bank Holidays in the year are:

- New Year's Day
- Good Friday
- Easter Monday
- May Day
- Spring Bank Holiday
- August Bank Holiday
- Christmas Day
- Boxing Day

8.2 Public Holidays for staff on a rota are included within their leave entitlement.

8.3 Part-time employee's public holiday will be calculated on a pro-rata basis.

8.4 Public Holiday entitlement is included with the annual leave entitlement at the beginning of the leave year, giving an inclusive total annual leave. Public holidays must then be booked and taken in accordance with an employee working pattern.

8.5 Part time employees cannot change their days of work to avoid booking and taking public holidays.

8.6 Where a full-time employee is rostered and works on a public holiday, no hours will be taken from their leave entitlement.

8.7 Where the employee is rostered to work on a public holiday but takes annual leave then the employee's rostered shift hours will be taken from their annual leave entitlement.
Employees that have a rostered rest day on a public holiday will have no annual leave hours taken from their entitlement.

9. Holiday Pay

9.1 During annual leave, employees will receive their normal pay, unless shown otherwise in your statement of main terms.

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10. Zero Hours Holiday Pay

10.1 Zero hours workers are entitled to the statutory minimum paid holiday of 5.6 weeks per year (including bank holidays). Holiday entitlement is accrued in the same way, but due to the sporadic nature of the work, it is easier to calculate holiday pay based on hours.

10.2 If the worker is entitled to a pro-rata amount of 5.6 weeks holiday, this is equivalent to 12.07% of hours worked over a year and to calculate the accrual take the number of days worked a week and multiply by 5.6.

11. New Starters and Pre-Booked Leave

11.1 During the recruitment process, prospective employees may be asked whether they have any leave booked that would take place after commencement of employment. If the individual is recruited, the Company will normally allow such leave to be taken.

11.2 The rules on accrual of annual leave may mean that the employee has not, at the time that leave is to be taken, accrued such length of leave to cover their holiday. In this case, the employee and the line manager will agree how any time off in excess of accrued leave will be covered.

12 Holiday and Sickness

12.1 The normal sickness notification procedures will apply to an employee when they are on leave and wish to reallocate the period of leave as sickness with the result that reconvened leave may be taken at another time in the leave year.

12.2 Where the required notification is made, the company may permit those days to be classed as sick days and equivalent time off taken as paid leave later in the leave year provide the leave falls within the statutory minimum entitlement. The days on which the leave is to be taken must be agreed with the Company.

12.3 Employees who are on an overseas holiday when they fall sick should contact the company as soon as reasonably practicable.

13 Family Leave

13.1 Employees may become entitled to either maternity leave, paternity leave, shared parental leave or adoption leave. Family leave is in addition to the employee's statutory 5.6 weeks of annual leave.

13.2 Annual leave will continue to accrue during periods of family leave and, as part of a pre-l eave meeting that will be arranged between the employee and their line manager, a discussion will take place covering the taking of annual leave around family leave.

14. Untaken Annual Leave

14.1 ERS Medical encourages employees to use all of their leave entitlement each year so that they have the opportunity to rest. Employees should ensure they take at least four weeks annual leave in each leave year.

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14.2 Ordinarily, untaken leave cannot be carried forward into the next leave year and will be lost. Approval must be sought from your Line Manager to carry forward any annual leave into the next leave year. The line manager has sole discretion to permit or decline this, subject to the provisions on sickness below.

14.3 If sickness means that an employee cannot take their full leave entitlement in a leave year, the employee may be able to carry forward some of the leave to the next leave year. This is usually limited to a maximum of four weeks leave, minus any leave already taken (including public holidays).

14.4 Ordinarily, the Company will not permit payment in lieu of annual leave unless exceptional circumstances apply. In every case, payment in lieu of the statutory minimum entitlement will not be permitted.

15. Termination of Employment

15.1 When employment terminates part way through a leave year, their leave entitlement will be recalculated on a pro-rata basis. This will determine the amount of leave the employee would be entitled to, for the period of service during the leave year.

15.2 Any outstanding leave accrued but untaken will be paid to the employee in their final pay. This is subject to the right of the Company for the employee to take their outstanding leave during their notice period. Otherwise, the amount due for outstanding leave will be added to the employee's final pay.

15.3 If the employee has exceeded their pro-rata entitlement to holidays at the time they leave their employment, this will be classed as an overpayment and an amount to cover this will be deducted from their final pay, subject to the maximum that their final pay permits.

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WI/2.01.10 Flexible Working Policy

Document Author:	*** REDACTED ***		Head of HR and Training		
Document Owner:	*** REDACTED ***		Managing Director		
Version No:	2.0	**Date Active:**	03.09.2020	**Review Date:**	03.09.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Initial Policy Written	*** REDACTED ***	03.12.2018
Approved by the Managing Director	*** REDACTED ***	03.12.2018
Review carried out – no changes	*** REDACTED ***	03.09.2020

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	03.09.20	*** REDACTED ***	Annual Review/no changes

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS.1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Immunisations	BMS/2.03
Whistleblowing	BMS/2.04
Company Car Driving	BMS/2.05
Disclosure and Barring Service Checks (DBS)	BMS/2.06
Employee Handbook	

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3. Policy Statements

3.1 ERS Medical is committed to promoting equality and diversity by providing a supportive environment for staff who wish to integrate their working life, including the development of a career, with other responsibilities.

3.2 On this basis ERS Medical recognises that flexible working can provide benefits to both the employee (in achieving an appropriate work life balance) and the employer.

4. Responsibilities

4.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting Company objectives and allocating adequate resources to meet those objectives.
4.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
4.3	**Head of HR & Training**	Is responsible for ensuring that ERS Medical's Flexible Working processes remain within the legislative framework, are fit for purpose and provide the necessary information to enable managers to manage capability processes within the business. Is responsible for providing advisory services to managers to enable effective management of personnel in relation to this work instruction and for monitoring, reviewing, approving and auditing the process outputs.
4.4	**Senior Operations Managers / Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

5. Introduction

5.1 The Company believes that its staff members are its most valuable asset and is committed to attracting and retaining the very best and utilising all the talent and experience available within the community. It also appreciates that the UK workforce is becoming increasingly diverse and includes a high percentage of parents and individuals with other caring responsibilities, as well as those whose interests and aspirations impact on their time. It therefore appreciates that the standard Monday to Friday, 9.00 am to 5.00 pm working week is, in many cases, incompatible with increasing demand for a better work-life balance.

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5.2 The Company recognises the importance of helping its employees balance their work and home life by offering flexible working arrangements that enable them to balance their working life with other priorities. In turn it recognises that staffing levels must at all times remain in line with the demands of the business.

5.3 This policy statement aims to set out the ways in which flexible working can increase staff motivation, build better relationships between the Company and its employees, increase the rate of retention of staff, reduce absence, attract new talent, promote work-life balance and reduce employee stress, and in doing so improve the Company's efficiency, productivity and competitiveness. It provides a description of the issues involved, taking into account the possible benefits of each kind of flexible working to both employees and the Company, but also raising possible drawbacks and areas of potential concern.

5.4 The policy statement considers the following options, but the Company recognises that there may be alternatives, and that the working pattern that may suit any particular individual could be a unique one involving a combination of options:

- Job-sharing;
- Part-time working;
- Annualised hours;
- Compressed hours;
- Flexitime;
- Term-time working;
- Swapping hours;
- Voluntary-reduced working time;
- Working from home;
- Career breaks;
- Flexible shift working.

6. The Business Need

6.1 Although the Company is committed to providing the widest possible range of working patterns for its workforce, both management and employees need to be realistic and to recognise that the full range of flexible working options will not be appropriate for all jobs across all areas of the business.

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6.2 Where an instance of flexible working is proposed the Company will need to take into account a number of criteria including (but not limited to) the following:

- The cost of the proposed arrangement;
- The effect of the proposed arrangement on other staff;
- The level of supervision that the post-holder requires;
- The structure of the department and staff resources;
- Other issues specific to the individual's department;
- An analysis of the tasks specific to the role, including their frequency and duration;
- An analysis of the workload of the role.

7. Eligibility

7.1 Although it is recognised that not all of the flexible working patterns considered will be suitable for all sections of the Company's workforce, there should be no arbitrary barriers. Employees in all areas and levels of the Company will be considered for flexible working regardless of their age, sex, sexual orientation, race, or religion or belief, or whether they have a disability, their level of seniority, their current working pattern, or whether they are employed on a permanent or fixed-term basis.

7.2 However, there is no automatic right for employees to change to any of the flexible working patterns - each application will be considered on the basis of the particular work involved and any detrimental effect the change could have on individual, team or business performance.

8. Right to Request Flexible Working

8.1 Employees must have 26 weeks' continuous service to make a statutory request for flexible working. Employees must not have made a request for flexible working within 12 months previous to the date of their request.

8.2 While it is the Company's policy to be flexible on working patterns for all its employees, in order to ensure that it is complying with its legal obligations concerning the right to request flexible working, there may be situations where precedence has to be given to those who are eligible for this right.

9. The Application

9.1 An application must:

- Be made in writing and state that it is such an application;
- State whether a previous application has been made under this procedure and, if so, when;
- specify the change applied for and the date on which it is proposed the change should become effective;
- Explain what effect, if any, the employee thinks making the change applied for would have on the employer and how, in the employee’s opinion, any such effect might be dealt with;
- Be dated.

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9.2 The application must also state whether the variation requested is made in pursuance of a reasonable adjustment under the disability discrimination provisions of the Equality Act 2010.

10. Procedure with Dealing with an Application

Discussion with Employee

10.1 A discussion regarding the application will be held with the employee within 28 days of the application, unless the employer notifies the employee in writing of agreement to the variation. The time and place of the discussion will be convenient to both employer and employee.

Notice of Decision

10.2 Once a decision has been made by the Company, the employee will be informed within 14 days of the discussion. Where the employer's decision is to agree to the application, the notice will specify the contract variation agreed to and state the date on which the variation is to take effect. Where the decision is to refuse the application, the notice will state which of the specified grounds for refusal are considered to apply, with an explanation of why those grounds apply in relation to the application and set out the appeal procedure.

Right of Appeal

10.3 An employee may appeal against the Company's decision to refuse an application, within 14 days of the decision. The notice of appeal must be in writing, setting out the grounds for appeal and be dated.

10.4 The Company will discuss the appeal with the employee within 14 days after the employee's notice was given, unless, within that time period, the employer gives the employee written notification that the original decision has been overturned and specifies the variation which has now been agreed and the date on which it will take effect. If an appeal meeting is held, the time and place must be convenient to both employer and employee.

10.5 Within 14 days after the date of the appeal meeting the employer will give the employee written, dated, notice of the decision on the appeal. Where the employer upholds the appeal, the notice will specify the contract variation agreed to and state the date on which it is to take effect. Where the employer dismisses the appeal, the notice will state the grounds for the decision and contain a sufficient explanation as to why those grounds apply.

Acceptance of Variation

10.6 Where the Company accepts the employee's application, a permanent variation of the employee's contract will result, unless the Company agrees otherwise. This means that once a change has been made, there is no right for the employee to revert back to their previous terms and conditions. However, further applications for variations may be made provided they are made at least 12 months after the previous application.

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Timescale

10.7 An application for flexible working will be concluded within 3 months of the date of the application.

11. Withdrawal of Application by an Employee

11.1 The Company will treat an application as withdrawn under the statutory provisions where the employee:

- Has notified the employer, orally or in writing, that the application is withdrawn;
- Without reasonable cause, fails to attend a meeting or appeal meeting more than once; or
- Without reasonable cause, refused to provide the employer with information the employer requires in order to assess whether a contract variation should be agreed to.

11.2 The Company will confirm the withdrawal of the application to the employee in writing unless the employee has already provided written notice of the withdrawal.

12. Employee Consultation/Participation

12.1 While some approaches to flexible working practices will involve changes to individual contracts of employment and be relatively easy to implement, the Company recognises that others such as flexitime or the imposition of annualised hours will have a greater impact on sections of the workforce as a whole. Before any such working pattern is implemented it is therefore committed to in-depth consultation with employees and their representatives and recognises that gaining their agreement is likely to have a positive impact on the success of the scheme.

12.2 The Company works on the basis that consultation gives all parties the opportunity to raise the issues that are of greatest importance to them and ensures that they are considered from all angles.

12.3 Consultation will usually take the form of an employee survey followed by focus groups and a pilot scheme of the new working pattern. The findings of any consultation will be communicated to the workforce, along with any proposed action resulting from the consultation.

12.4 Where conflicting requests for flexible working are received from employees, the Company may require a compromise to be found so that all requests may be accommodated albeit on different terms as those set out in each request. If no compromise is achievable, the Company may use a random selection method to determine the granting of individual requests.

12.5 In pursuance of point 3 above, employees should be aware that, if a request is granted, the Company reserves the right to revisit those arrangements should circumstances arise where competing requests mean it may need to seek compromise on a wider scale.

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13. Training and Support

13.1 The Company recognises that both Managers and employees may benefit from training to accustom themselves to working patterns with which they are unfamiliar.

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Question 1.10.15

Contract Exit

Please detail how you will prepare for any Contract Exit in the event an alternative Provider winning a future ITT for the services or variants of the services.

The Bidder has provided a comprehensive and appropriate response to the question - Pass.

The Bidder has failed to provide a comprehensive and appropriate response to the question - Fail

Being a responsible supplier to the NHS, we maintain a process for undertaking service transfer to alternative providers. We have outlined the main aspects of how we will effectively transfer the service to another service provider in our Exit Plan below.

The aim of the plan is to ensure a seamless transition of the service to the new provider through;

- A project manager will be appointed
- Consultation, deciding who needs to be involved through the exit management process
- Ensuring that respective operational counterparts conduct pre-exit meetings to discuss major and minor issues and any nuances that need to be discussed as part of the handover

To ensure a seamless transfer of services our Exit Plan utilises the following 4 step process:

1. Initial Engagement
2. Consultation
3. Data Transfer
4. Transition

Ensuring a Seamless Transition to the Incumbent Provider

We will discharge responsibilities professionally and deliver what is agreed. We will keep the process simple by having a single point of contact with clearly defined responsibilities and timescales putting “patients first” at all times so there is no disruption to service.

Liaison with the CCG’s Staff

On notification of contract award to a new provider, we will agree and put a communication plan in place with the CCGs. We will work with the CCGs to communicate the service transition to Trust staff, healthcare sites and patients.

TUPE Exit Process

ERS has a wealth of experience transferring employees in and out of the business in line with the Transfer of Undertakings (Protection of Employment) regulations 2006 (as amended).

As part of the service provision change we will look to work with the transferee to ensure a smooth transfer for affected employees.

Data

All records including journey information (historic and booked), training, DBS, etc are stored on our systems electronically and can therefore be transferred to the incoming providing smoothly and effectively.

All information will be transferred securely. Any exchange of personal and/or sensitive data will be via an appropriate secure method and/or process.

We have also attached our demobilisation checklist template.

Question 1.11.3

Employment legislation review

Please detail how Employment Legislation is reviewed to ensure that they are kept up-to-date with current applicable UK employment Legislation and how these standards are upheld in your workforce policies, processes and practices.

The Bidder has provided details of the review process – Pass

The Bidder has failed to provide details of the review process – Fail

ERS recognises that our workforce is fundamental to our success and a professional approach to the recruitment processes and ongoing management is vital to help attract and appoint staff with the necessary skills and attributes to fulfil our aims and objectives.

As a business we believe that supporting staff through our HR policies and procedures is extremely important and fits within our core values. We use a HR specialist provider who provides a 24-hour client advice line. The advice line offers specialist and subject expert advice across all HR services and the full employee lifecycle. This service is available to all of our employees providing them with leading HR advice whenever it is convenient to them.

Our specialist HR provider also offers a contracts and documentation service, which delivers ERS with updated contracts / staff handbook and all HR policies in line with all legislation. They also consult with ERS regarding any legislation change and assist us to update our documentation accordingly. This ensures that we are always compliant with UK employment Legislation and it is reflected through our workforce policies, processes and practices.

Further to the services from our HR support provider outlined above all of our management staff also have access to weekly training webinars and two sets of management training. This training supports our managers to understand HR legislation and how to work with staff through the HR policies that we provide. All staff are also supported by our Head of HR *** REDACTED ***, an experienced HR professional.

Question 1.11.4

DBS

Please detail your approach to the Disclosure and Barring Service checking process including when checks are completed and for which roles

The Bidder has provided an appropriate approach to the checking of the Disclosure and Barring process and has detailed appropriate roles for which the checks are undertaken - Pass

The Bidder has failed to provide an appropriate approach to the checking of the Disclosure and Barring process and / or has failed to detail appropriate roles for which the checks are undertaken - Fail

All ERS staff, irrespective of grade or role undergo a DBS check prior to commencement of training and duties with all patient facing staff having an enhanced DBS.

ERS Medical uses the Disclosure Service of DBS via *** REDACTED *** to check the criminal records of all contractors and employees with direct contact with vulnerable groups in order to prevent unsuitable people working with vulnerable groups, including children.

*** REDACTED *** fully complies with GDPR requirements regarding the fair use and handling of disclosure information. It also complies with its obligations under this regulation and other relevant legislation in respect of the safe handling, use, storage, retention and disposal of disclosure information.

There is no statutory requirement for staff to be checked on a continuous basis however ERS Medical is a best practice employer and committed to the safety of vulnerable groups and children, and therefore the DBS checks are renewed every 3 years, with the DBS number and date of renewal stored in our HR system that provides reminders to staff and Managers of an up-coming renewal.

Staff are made aware of the contractual need to inform line managers of any changes to their circumstances that would affect the DBS status as outlined in the Company Handbook and DBS Policy.

If any convictions are shown on the DBS we would carry out a risk assessment in line with our policy.

Question 1.13.1

IG Toolkit

Please provide your Information Governance Toolkit Organisation Code and evidence of your latest IG toolkit submission (e.g. the assessment report that can be run from the IG toolkit).

Please advise whether your IG Toolkit submission has been subject to independent audit. If so, please provide the audit report. Please advise if no independent audit has been provided.

Attachments permitted

The Bidder has provided their Information Governance Toolkit Code and evidence of their latest IG toolkit submission. If an independent audit has been conducted a copy of the audit is provided – pass

The Bidder has provided their Information Governance Toolkit Code and evidence of their latest IG toolkit submission. The Bidder has confirmed no independent audit has been conducted – Pass

The Bidder has failed to provide their Information Governance Toolkit Code, and / or to provide evidence of their latest IG toolkit submission, and / or if an independent audit has been conducted a copy of the audit is not provided - Fail

Our latest IG Toolkit assessment is below and our Organisation Data Serviced (ODS) code is 8JR17

ERS Medical

NHS Digital Data Security and Protection Toolkit

Account Logout

ERS MEDICAL (8J167)

Organisation search News Help

Assessment Report an Incident Admin

Assessment

Assessment progress

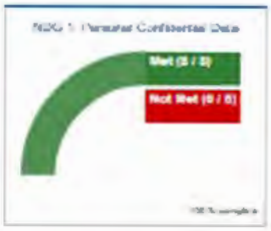
Export assessment

You can download your assessment as a spreadsheet (.xlsx) which can then be opened in Excel. This will not include any files that have been uploaded as evidence

Download Assessment

National Data Guardian Standards

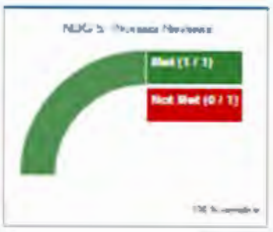
The National Data Guardian (NDG) standards have been calculated for your organisation based on the responses provided in your organisation profile.



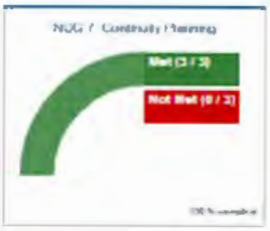


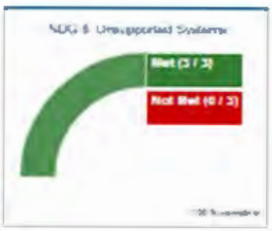






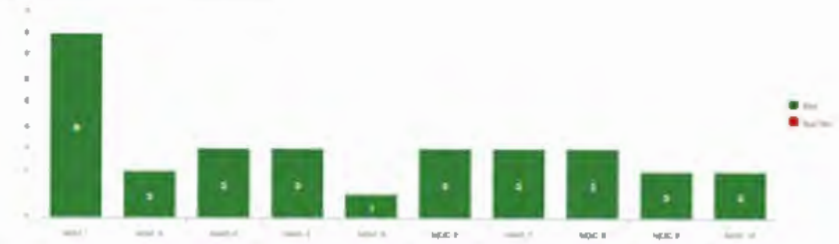












NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

ERS Medical

Question 1.13.2

Data Protection Number

Field Please provide your Data Protection Registration number.

The Bidder has provided their Data Protection Registration Number – Pass

The Bidder has failed to provide their Data Protection Registration Number – Fail

Registration number: ZA273037

ERS Medical

Stage 1 - Equality Impact Assessment Screening Tool

Contact information	
Person completing EIA:	
Business area or Site:	
Contact details:	
Date of screening:	

About the policy/project				
1. Name of policy or project				
2. What are the aims and objectives of the policy or project?				
3. How does it link to our key strategic aims?				
4. Who are the main stakeholders?				
☐ Staff	☐ Patients	☐ Visitors	☐ Community	☐ Other (please specify)

Data and evidence		
5. Have you considered the equality monitoring data for each of the main stakeholders identified in question 4 above?	☐ Yes	☐ No
6. Have you researched other sources of information to help inform this analysis?	☐ Yes	☐ No
7. Have you already consulted with people about this policy or project?	☐ Yes	☐ No
8. Please list below the information you have gathered and provide a brief summary of your findings.		
9. Are there any evidence gaps?	☐ Yes	☐ No
10. If you answered 'yes' to question 9, how will you fill these gaps?		

ERS Medical

Impact				
11. Based on the data and evidence above, please tick the appropriate boxes below and summarise your reasons where appropriate:				
Protected group	**Positive impact**	**Negative impact**	**No impact**	**Reasons and evidence**
Age	☐	☐	☐	
Disability	☐	☐	☐	
Gender	☐	☐	☐	
Gender reassignment	☐	☐	☐	
Marriage and civil partnership (employment only)	☐	☐	☐	
Pregnancy and maternity	☐	☐	☐	
Race	☐	☐	☐	
Religion and belief	☐	☐	☐	
Sexual Orientation	☐	☐	☐	
Other (please specify)	☐	☐	☐	

12. If you have indicated that there is a negative impact on any group, is the impact:		
Potentially discriminatory under the Equality Act 2010?	☐ Yes	☐ No
High or low?	☐ High	☐ Low

If the negative impact is potentially discriminatory or has a high impact, a full equality impact assessment must be completed. Please sign and date this form and move to stage 2 below.

If the negative impact is not discriminatory or has a low impact, please answer the questions below before submitting the form.

13. What action will you take to reduce any low-level negative impacts?

14. Can you adapt the proposed activity to promote equality or improve relations between different groups?
15. Please list the outcome following this screening (this could be no changes, some changes, further work needed around particular groups or stop development of the policy).
16. Please sign and date this form.

Signed:	**Date:**

ERS Medical

Stage 2 - Full Equality Impact Assessment

Summary	
Person completing EIA:	
Name of policy or project:	
Date:	

Evidence	
1. Looking back at the initial screening, what does it tell you about possible inequalities in relation to this policy or project? (Please list below and add additional rows if required)	
Protected group	**Negative impacts**

Consultation	
2. Who do you intend to consult with to address the negative impacts identified? (Please list below)	
3. Using the table below summarise the results of the consultation exercise (Please attach full records and add additional rows if required)	
Protected group	**Summary of consultation results**

Making a decision	
Based on the results of this full equality impact assessment and the evidence you have collected, please select how this policy or project will be taken forward.	
Decision	
4. Implement policy or project without making any changes	
5. Implement policy or project but make adjustments (listed below in action plan) to address impacts identified	
6. Implement policy or project as a pilot and monitor for impact	
7. Stop and remove the policy or project	

Action Plan		
Please list below the proposed actions that have arisen as a result of this equality impact assessment (add additional rows if required).		
Action	**By whom**	**By when**

Monitoring and review	
8. When will you review the policy or project?	
9. Who will be responsible for the review?	
10. How will you monitor the policy or project in the meantime?	

Sign off/Approval	
Signed (person completing EIA)	
Name:	**Date:**
Signed (member of SLT)	
Name:	**Date:**

Modern Slavery Statement for Financial Year 2017

This statement has been published in accordance with section .54 of the Modern Slavery Act 2015 (updated 30 July 2018). It is made by ERS Medical and sets out the steps that ERS Medical has taken and is continuing to take to ensure that modern slavery or human trafficking is not taking place within our business or supply chain and is not facilitated in any way.

ERS Medical actively opposes slavery, servitude, human trafficking and forced labour (Modern Slavery), and acts accordingly to demonstrate the ethical behaviour and conduct of our business operations with honesty, integrity and transparency in both our labour practices and supply chain. Effective systems and controls are in place to safeguard against any form of Modern Slavery taking place within our business or our supply chain.

Business Structure

ERS Medical is one the UK's leading private ambulance providers, patient transport and medical courier services at several locations within the UK mainland.

Risk of Modern Slavery

We have in place policies and systems to ensure that we identify, assess and mitigate potential risk areas in our supply chains, source goods and services ethically, identify individuals being forced to work against their will and protect whistle blowers. Details of these policies and systems are set out below.

We consider the risk of slavery and human trafficking in our own labour and employment practices to be non-existent. We are a highly professional business with compliant global labour practices and policies which ensure that we continue to provide employment opportunities free from discrimination, modern slavery and human trafficking. A summary of our labour policies is set out below.

We recognise an increased risk within our supply chains as we are at least one step removed from our operations and labour practices for some goods we procure to deliver the services. However, our supply chain policy and methods for selecting suppliers greatly mitigate this risk. We require all suppliers to sign up and adhere to our own Ethical Sourcing Policy and Supplier Code of Conduct and we conduct routine and regular supplier audits. A summary of our supplier policies is set out below.

We consider that the steps we are taking, and continue to take, are effective in ensuring we are not exposed to modern slavery and human trafficking. We have several communication channels and mechanisms for reporting concerns (anonymously if preferred) and we record and report any instances of concerns raised. Immediate action is taken where appropriate.

We believe that further improvements are most likely to come from increased collaboration with our suppliers, including increasing the depth and breadth of supplier assessments and audits.

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Ethical Policy

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include:

1. Modern Slavery Policy. This policy sets out ERS Medical's stance on modern slavery and explains how employees can identify it and where they can go for help;
2. Recruitment Policy. We operate a robust recruitment policy, including conducting eligibility to work in the UK checks for all employees to safeguard against human trafficking or individuals being forced to work against their will;
3. Suppliers Code of Conduct. This code explains the way in which we expect our suppliers to act;
4. Whistleblowing Policy. We operate a whistleblowing policy so that all employees know that they can raise concerns about how colleagues are being treated, or practices within our business or supply chain, without fear of reprisals.

Labour Policy

Wherever possible, ERS Medical employs team members directly. All recruitment is managed in accordance with a robust policy incorporating authorisation touch points. However, in the event the business needs to rely on agency support, it uses only specified, reputable employment agencies that have been approved through our supply chain management process to source labour.

ERS Medical is a good employer and provides conditions of work that are of a high standard. We provide decent and fair conditions of employment in line with market rates aligned with the designated job role, which are paid directly to the employees, subject only to deductions permitted by law. Compensation for overtime is in accordance with prevailing laws and regulations and ERS Medical respects the prohibition of mandatory / enforced overtime.

ERS Medical also provides decent and fair conditions of work with regards hours of work, holidays, sickness, maternity / paternity protection and the ability to combine work with family responsibilities. ERS Medical provides a work-life balance that is at least comparable to that offered by similar employers. ERS Medical encourages all employees, customer and other business partners to report any concerns related to the direct activities, or the supply chains of the organisation.

This includes any circumstances that may give rise to an enhanced risk of slavery or human trafficking. ERS Medical respects freedom of opinion and expression, therefore the whistleblowing procedure is designed to make it easy for employees to make disclosures without fear. Employees, customers and others who have concerns can use our confidential helpline/online service.

ERS Medical does not engage in activities that infringe, obstruct or impede the economic, social and cultural rights of any person.

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Procurement and Supply Chain Management Policy and Due Diligence Processes

ERS Medical will not support or deal with any business knowingly involved in slavery or human trafficking. We have zero tolerance for such activity in our supply chain. Our procurement activities encompass the planning and management of all activities involved in sourcing, procurement and logistics management. This includes coordination and collaboration with our partners, which can be suppliers, service providers and customers.

We ensure that all potential and incumbent suppliers are dealt with professionally, fairly and ethically and that we uphold the principles of sustainable procurement at all times. We favour suppliers that operate under recognised ethical codes of conduct and so our Ethical Sourcing Policy and Supplier Code of Conduct is circulated to all potential and incumbent suppliers. Suppliers are required to acknowledge and agree to the terms of these (or provide details of their equivalent policies) if they wish to maintain a relationship with ERS Medical.

Prior to new suppliers being added to our supply chain, we undertake due diligence audits using a prescribed 'supplier assessment questionnaire'. This addresses areas such as accreditation, registration, insurance policies, director checks, financial risk analysis, human resource policies, ethical sourcing and supplier code of conduct, anti-bribery, quality systems, manufacturing inspection and testing, equipment maintenance, returns and complaints processes and internal audits.

In addition to the above, as part of our contract with suppliers, we require that they confirm to us that:

1. They have taken steps to eradicate modern slavery within their business;
2. They hold their own suppliers to account in respect of modern slavery risks;
3. (For UK based suppliers) They pay their employees at least the national minimum wage / national living wage (as appropriate);
4. (For international suppliers) They pay their employees any prevailing minimum wage applicable within their country of operations;
5. We may terminate the contract at any time should any instances of modern slavery or human trafficking come to light.

Training

We have conducted training for our Procurement Team who are responsible for our supply chain so that they can recognise the signs of modern slavery or human trafficking and the appropriate action to take if they suspect that it is taking place within our supply chain.

Our Performance Indicators

We work in highly regulated sectors for a wide variety of public and governmental customers. We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if no reports are received from employees, the public, our customers, regulators or law enforcement agencies to indicate that modern slavery practices have been identified.

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We will review the effectiveness of the steps we have taken this year to ensure that there is no slavery or human trafficking in our supply chains, and in that review, we will identify further steps to combat slavery and human trafficking and our plans regarding on-going external audits.

Approval for this Statement

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 (updated 30 July 2018) and constitutes ERS Medical's slavery and human trafficking statement for the financial year ending 31st December 2020.

Name: [redacted]

Signature: 

Date: 10/01/2020

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Question 1.14.1

Equalities and Diversity policies

Equalities and Diversity policies - Please provide a copy of your process / policy / and an example or template of an equality impact and risk assessment relevant to the scope of the services which demonstrate how Equality and Diversity shall be embedded and monitored by your organisation in terms of service delivery (i.e. service users/patients) and for internal operations (i.e. workforce).

Your process / policy should include a commitment to current equality legislation which may include:

Equality Human Act 2010, Health and Social Care Act 2012, Modern Day Slavery Act 2015 where applicable .

Evidence may include:

Equality & Diversity Policy

Human Rights Policy

Equality Impact Assessment process

Mandated NHS Equality requirements - Accessible Information Standard, Workforce Race Equality Standard, Workforce Disability Equality Standard

Performance tool to demonstrate annual compliance to the equality legislation where applicable (e.g. Equality Delivery System)

The Bidder has evidenced they have appropriate policies in place– Pass

The Bidder does not have appropriate policies in place - Fail

We have attached our Modern Slavery statement and our Staff Handbook, which includes our Equality and Diversity policy.

Promoting and supporting diversity in the workplace is an important aspect of good people management - it's about valuing everyone in the organisation as an individual. However, to reap the benefits of a diverse workforce it's vital to have an inclusive environment where everyone feels able to participate and achieve their potential. While UK legislation – covering age, disability, race, religion, gender and sexual orientation among others – sets minimum standards, an effective diversity and inclusion strategy goes beyond legal compliance and seeks to add value to an organisation, contributing to employee well-being and engagement.

The moral case for building fairer and more inclusive labour markets and workplaces is indisputable, people matter, and organisations must ensure their people management approaches do not put any group at a disadvantage. Regardless of our identity or background, we all deserve the opportunity to develop our skills and talents to our full potential, work in a safe, supportive and inclusive

environment, be fairly rewarded and recognised for our work and have a meaningful voice on matters that affect us.

It is also vital for the sustainability of businesses and economies. Everyone stands to benefit when we embrace and value the diversity of thoughts, ideas and ways of working that people from different backgrounds, experiences and identities bring to an organisation. It helps people grow and learn, tackles under-utilisation of skills by enabling people to reach their full potential, improves decision-making, boosts engagement and innovation, and enables businesses to better meet the needs of a diverse customer base.

In 2020 we will be launching several initiatives to promote EDI in ERS Medical. These include;

Dementia friend vehicles

We are partnering with the Alzheimer's Society to assess the working practices of our operations and to implement Dementia Friendly processes and vehicles across the business. Our dementia friendly vehicles will look to include;

- Window covers – The window nearest the patients seat will be covered with a scene that contains key points to talk and reminisce about, including children playing to remind people of their youth and animals for patients to guess what they are
- Music provision – Our crews will have the ability to play music for the patients to help deliver positive reactions and memories.
- Provision of 'Twiddlemuffs' – a knitted hand muff, decorated with internal and external items, such as buttons and ribbons.
- Communication guide for staff – dementia friendly training for all staff had been rolled out throughout the company. The guide this guide provides advise to staff on how to use the changes to the vehicles to prompt conversation and communications styles for patient who may not be able to communicate verbally.

Armed Forces Covenant

We are committed to the Armed Forces Covenant through the Defence Employer Recognition Scheme (ERS). Reservists and veterans bring a variety of transferable skills and qualities to the civilian workplace, developed throughout their military careers that can add value to our organisation. It is important that whilst we continue to improve support for the minority of service leavers and their families who face challenges after leaving, as a business we also recognise and celebrate that most veterans leave enriched by their service.

Equality Impact and Risk Assessments (EIRAs)

We use Equality Impact and Risk Assessments (EIRAs) to ensure that our policies, work instructions and processes do not unlawfully discriminate against a protected characteristic (as identified in the 2010 Equality Act) or any other disadvantaged or marginalised group. The protected Characteristics are;

- Age
- Disability
- Gender reassignment
- Race
- Religion or belief

- Sex
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity

We have attached our Equality Impact Assessment.

Question 1.14.4

Patient dignity and privacy

Patient dignity and privacy - Please provide a copy of your proposed process to ensure you appropriately respect patient dignity and privacy?

The Bidder has evidenced they have appropriate proposed processes defined– Pass

The Bidder does not have appropriate proposed processes defined – Fail

We have attached our Care to Care policy which outlines how we respect patient dignity and privacy during the transport process.

The way in which patients are treated and spoken to, is critical to the way in which the service is perceived as the transport journey is an integral part of the patient's overall experience with the NHS. ERS believe that by delivering an efficient, effective and sustainable service that is on time, courteous and treats everyone with dignity we can impact on patients' lives positively and reduce the stress, anxiety and worry that patients may have at this time.

To ensure that patient privacy and dignity are embedded into the core of our service it makes up a module of our comprehensive induction programme for all of our staff. We also have annual refresher courses to ensure we continue to deliver a high-quality patient focused service throughout the term of the contract.

We also embed the NHS Values not only within our training, but within everything we do as a company. All of our staff embrace the following values while delivering services to the NHS;

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Should there be a complaint or a report of any inappropriate behaviour we will immediately inform the Authority's Contract Manager of the incident. The incident will also be reported on our compliance system, ***** REDACTED *****. This system has been designed specifically with the healthcare market in mind ***** REDACTED ***** and it allows ERS to quickly and efficiently capture and record incidents and fully investigate them. Any findings from our investigation are implemented across our business to ensure we continue to deliver high-quality services that fully incorporate the quality standards outlined in NICE guidance.

BMS/9.01 Health and Safety (Common Tasks for Managers)

Document Author:	*** REDACTED ***		Care Standards Manager		
Document Owner:	*** REDACTED ***		Head of Care Standards		
Version No:	4.0	**Date Active:**	31.07.2020	**Revision Date:**	31.07.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Original version re-formatted from previous SRCL version.	*** REDACTED ***	03.07.2017
Approved for use.	*** REDACTED ***	03.07.2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	26.04.18	*** REDACTED ***	Complete review of procedure.
2.1	-	-	-	01.02.19	*** REDACTED ***	Change of document author.
3.0	All	All	All	14.06.19	*** REDACTED ***	Annual Review
4.0	All	All	All	31.07.2020	*** REDACTED ***	Complete Review & Amendments as required in line with Covid-19

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
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Planning and Review	BMS/1.05
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Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Corona Virus (Covid-19)	BMS/2.11
Procurement and Supply Chain	BMS/4.01
Incident Reporting and Investigation	BMS/5.01
Major Incident Investigation	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity & EPRR	BMS/5.04
PPE & Uniform	BMS/9.02
Permit to Work and Isolation	BMS/9.03
COSHH / Chemical Risk Assessment	BMS/9.04
Fire and Emergency Evacuation Plan	BMS/9.06
Lone Workers	BMS/9.07

3. Purpose

3.1 To ensure a single procedure is defined and utilised at all locations within ERS Medical that provides instruction and guidance to Line Managers on common health and safety tasks.

3.2 To define the responsibilities of Line Managers in relation to common health and safety tasks, ensuring consistency is achieved throughout ERS Medical.

To define and set out procedures and methods of working that promotes a culture of protecting service users, employees and learners, including those on an apprenticeship scheme.

3.3 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.4 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Scope and Application

4.1 This procedure applies to all ERS Medical sites, employees, learners, including those on apprenticeships, visitors and contractors.

4.2 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to ERS Medical's Quality, Environmental, Safety and Health Policy.

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6. Responsibilities

6.1	**Managing Director**	The Managing Director has overall responsibility for the standards of Health and Safety in ERS Medical. As the accountable officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the ERS Medical subscribes and the legislation relative to the ERS Medical's operations.
6.3	**Head of Care Standards**	Is responsible for development, implementation and monitoring (through audit) of all Health and Safety processes.
6.4	**Care Standards Manager**	Is responsible for the writing and review of all ERS Medical Health and Safety policy, procedures and work instructions. In addition to this he/she has responsibility to ensure all H&S audits and inspection are completed in accordance with the audit & inspection schedule detailed within the Radar compliance system.
6.5	**Regional / Operations Managers**	Are responsible for ensuring that the procedures and resources provided for Health and Safety is communicated, available and utilised within their areas of control at all times.
6.6	**All Personnel and Learners**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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7. General Definitions

7.1 **At Work** – Includes all operational areas of ERS Medical's sites and all activities undertaken off-site by ERS Medical employees / leaner on an apprenticeship.

7.2 **Personal Protective Equipment (PPE)** – Specialised clothing or equipment worn by employees / leaner on an apprenticeship for protection against health and safety hazards.

7.3 **Hazard** – Source, situation or act with a potential for harm in terms of human injury or ill health or a combination of these.

7.4 **Risk** – Combination of the likelihood of an occurrence of a hazardous event or exposure and the severity of injury or ill health that can be caused by the event or exposure.

7.5 **Risk Assessment** – The process of evaluating risks, arising from a hazard, taking into account the adequacy of any existing controls and deciding whether or not the risks are acceptable.

7.6 **Site Management** – Due to the range of roles and titles within ERS Medical, the term "Site Management" is used to indicate the senior personnel at any facility

8. Introduction

8.1 This document sets out the responsibilities of Line Managers in relation to common health and safety tasks found at all ERS Medical facilities.

8.2 Due to their importance, specific topics and tasks are not covered here and instead have dedicated procedures written for them within the BMS to define the processes undertaken by ERS Medical. These are:

- BMS/1.07 – Risk Management;
- BMS/2.03 – Employee Health and Wellbeing;
- BMS/2.11 - Coronavirus Covid-19
- BMS/5.01 – Incident Reporting and Investigation;
- BMS/5.02 – Serious Untoward Incident Investigation;
- BMS/5.03 – Statutory Notifications;
- BMS/6.07 – Safer Person Handling and Dynamic Risk Assessments;
- BMS/9.02 – PPE & Uniform;
- BMS/9.03 – Permit to Work and Isolation;
- BMS/9.04 – COSHH;
- BMS/9.06 – Fire and Emergency Evacuation Plan;
- BMS/9.07 – Lone Workers.

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8.3 Each section of this procedure is laid out in a consistent manner that defines the key information relative to the subject and the process to be followed to ensure compliance is achieved. Each section contains:

- Purpose;
- Scope;
- Responsibilities – as they apply to the subject;
- Definitions – if required by the subject;
- Process overview;
- Key steps.

8.4 Risk assessments have been completed in relation to each subject contained within this procedure and should be consulted prior to commencing any work.

9. Appointment and Responsibilities of Site Safety Representatives

Purpose

9.1 To ensure communication and consultation with employees and learners, including those on apprenticeships on health and safety matters as required by legislation.

9.2 To ensure that the views of the workforce are effectively reflected to managers before decisions on health and safety matters are taken.

Scope

9.3 This procedure applies to all ERS Medical sites and employees and learners, including those on apprenticeships.

Responsibilities

9.4 **Site Management** – Are responsible for ensuring the appointment process is conducted every two years.

9.5 **Health and Safety Manager** – Responsible for ensuring the appointed person/s are competently trained in their role/s.

6.1 **HR Team** – Are responsible for sending confirmation letters to appointed employees / leaner on an apprenticeship.

Definitions

6.2 N/A

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Process Overview

9.6 The main responsibilities of a Site Safety Representative are given below:

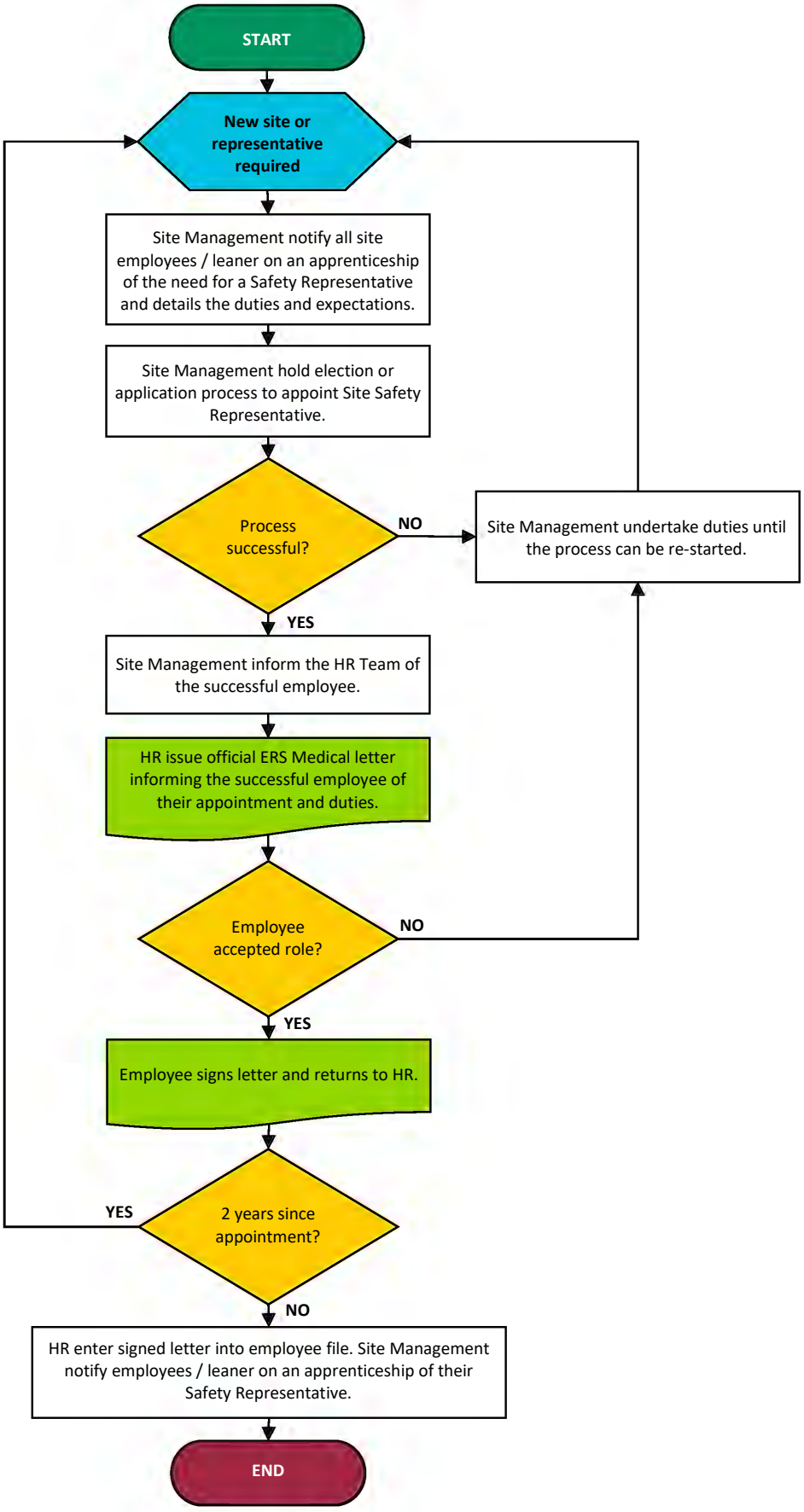
Inspections:	• Conduct monthly inspections to identify potential hazards or non-compliance with legislation, rules or safe practices and ensure safety equipment is in place and functional.
Involve Employees & Learners:	• On health and safety matters resulting from discussions between Site Management and the Care Standards Team.
Consult with Employers & Learners:	• Make representations on general health and safety matters which may affect the workforce. • On the introduction of any new technology into the workplace. • The planning and organisation of any health and safety training. • On relevant statutory provisions.
Involvement:	• Be involved with Site Management and the Care Standards Team on issues relating to safety awareness and aspects of training.
Enforcement:	• To bring to the attention of Site Management / Care Standards Team when ERS Medical policy and procedures are not being adhered to.

9.7 ERS Medical may from time to time require site safety representatives to undertake additional responsibilities to those detailed above.

9.8 All representatives will be given reasonable time off with pay and appropriate help and facilities, so they can carry out their roles and take part in training.

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10. Key Steps



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11. Monthly Inspections

Purpose

11.1 To ensure that ERS Medical facilities and workplaces are regularly inspected to specified format and that all necessary remedial actions are implemented.

Scope

11.2 This procedure applies to all ERS Medical sites and employees / leaner on an apprenticeship.

Responsibilities

11.3 **Site Management** – Are responsible for ensuring that monthly safety inspections are completed, and for completing actions where required.

11.4 **Site Safety Representatives** – Are responsible for completing monthly safety inspections and raising actions where required. If a site safety representative is not appointed, then the duty will fall onto another site nominated person.

11.5 **Care Quality Team** – Are responsible for checking completed monthly safety inspections. The Care Quality Team may also undertake the monthly inspection during site visits and between bi monthly audits. The Care Quality Team will also monitor actions where significant issues have been raised and sent for review.

Definitions

11.6 N/A

Process Overview

11.7 Monthly safety inspections shall be completed by each ERS Medical operational facility. A single form (**F9.01.01. Monthly Safety Inspections**), is used to record the inspection and document any actions necessary.

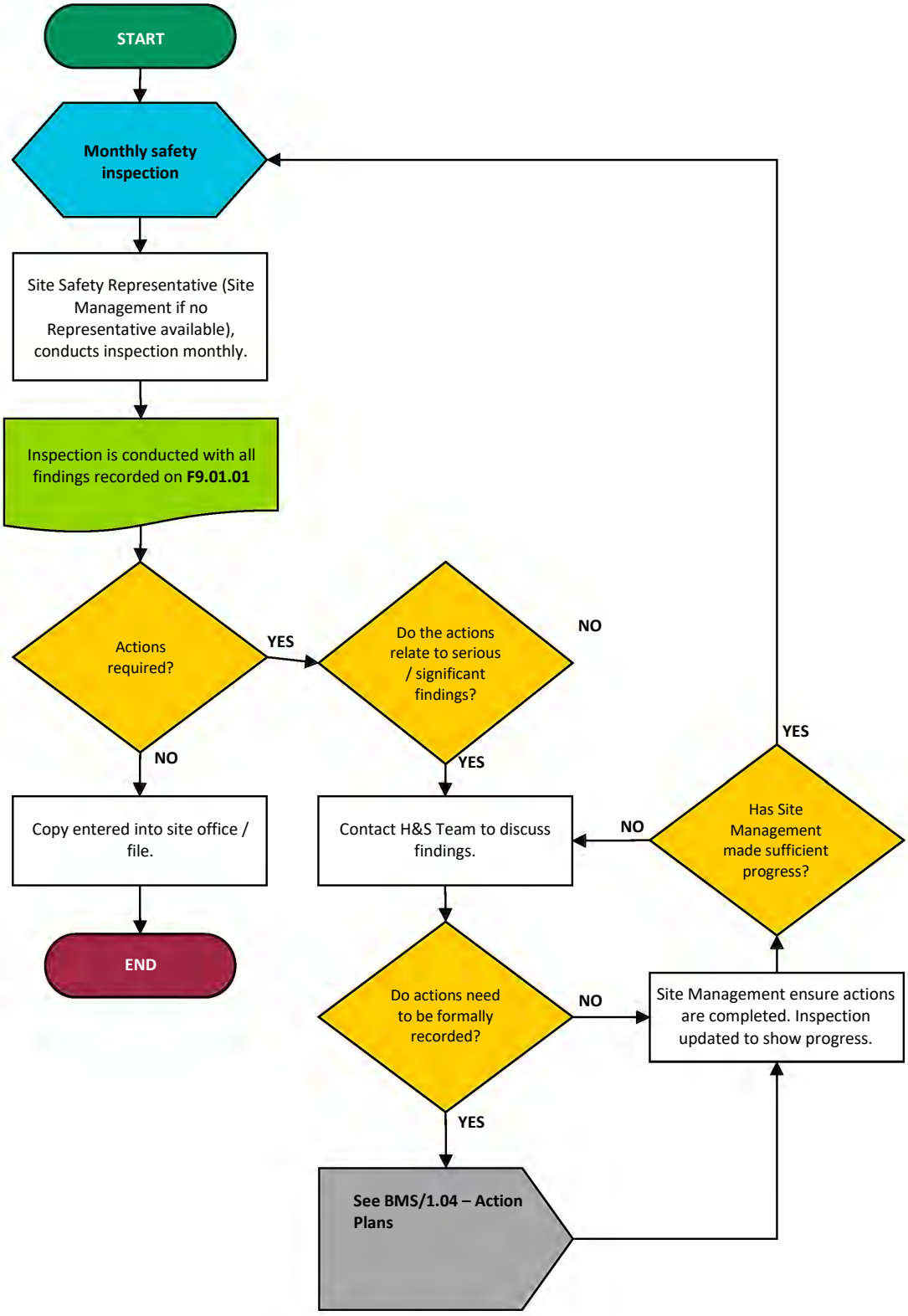
11.8 Once complete the Site Safety Representative will discuss the findings with Site Management. If no further action is required, then the report can be filed. If minor actions are required, then they should be documented on the inspection and monitored.

11.9 Any significant actions arising from the inspection or those that Site Management and /or the H&S Team wish to track should be documented in accordance with **BMS/1.04 – Action Plans.**

11.10 A copy of the inspection should only be forwarded to the Care Standards Team if significant / serious issues are detected or if Site Management fails to make adequate or sufficient progress with issues and actions.

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12. Key Steps



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13. First Aid Provisions

Purpose

13.1 To ensure adequate and appropriate training, equipment, facilities and personnel are provided to enable first aid to be given to employees / leaner on an apprenticeship if they are injured or become ill at work, as required by legislation.

Scope

13.2 This procedure applies to all ERS Medical sites and employees / leaner on an apprenticeship.

Responsibilities

13.3 **Site Management / Care Standards Team** – Have responsibility for ensuring that assessments are conducted, reviewed and that this procedure is put into practice at their respective sites.

Definitions

13.4 **Appointed Person** – An appointed person is an employee chosen to take charge when someone is injured or falls ill. This includes calling an ambulance (if required) and monitoring / maintenance of first aid equipment, e.g. restocking the first aid box.

13.5 **First Aider** – An employee who has undergone a training course in administering first aid at work and holds a current:

- First aid at work certificate (UK);

Process Overview

13.6 The Care Standards Team in conjunction with Site Management will conduct an assessment of First Aid requirements at each ERS Medical facility. The assessment will be conducted using **F9.01.02. First Aid Assessment**

13.7 This assessment involves the consideration of workplace hazards and risks, the size of the organisation and other relevant factors, to determine what first aid equipment, facilities and personnel should be provided.

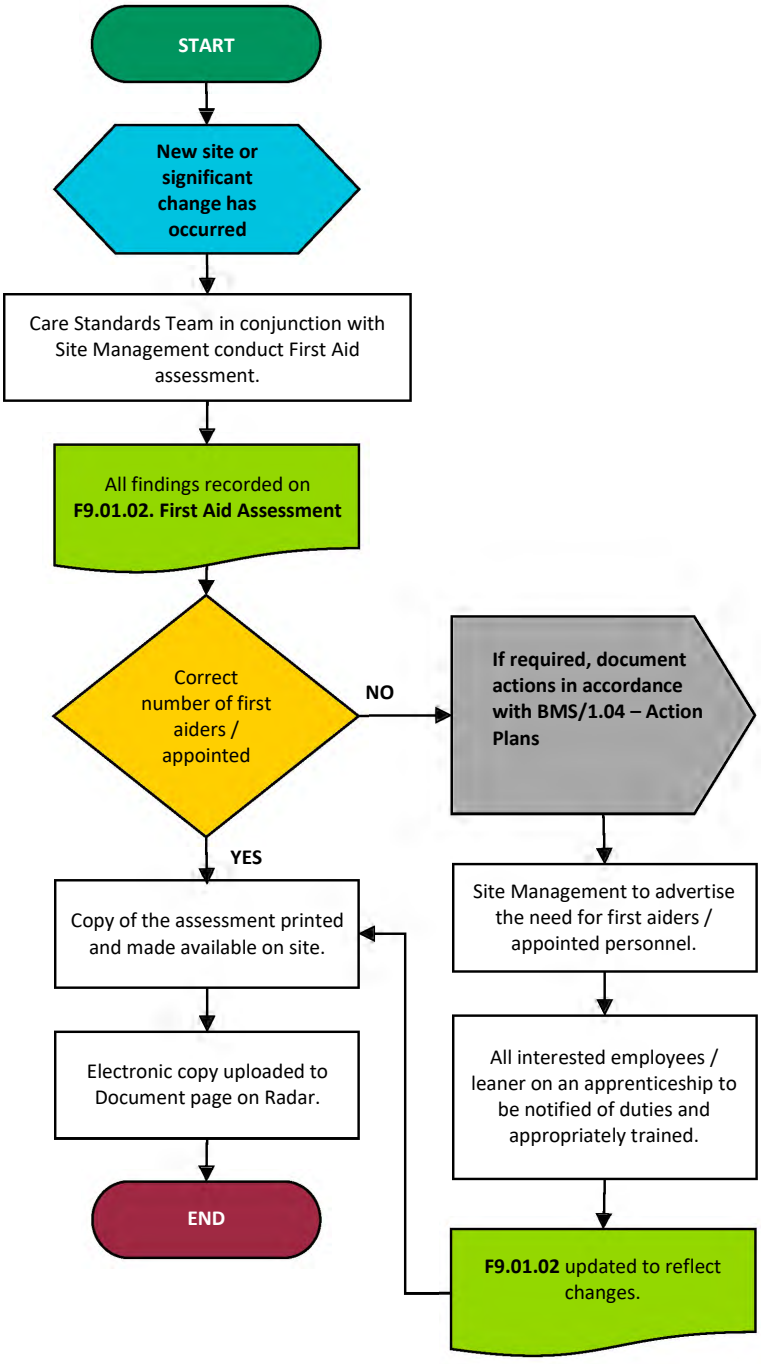
13.8 The number of first aid personnel required will depend on the results of the assessment. Each facility should have as a minimum, at least one appointed person / first aider per shift. Additional personnel are then required to ensure cover is available for holidays and to accommodate shift patterns.

13.9 Each site must clearly display the names (and certificates where possible), of the first aiders and appointed persons in a location visible to everyone.

13.10 First aid assessments will be reviewed and re-assessed every three years unless significant change occurs. All completed assessments will be stored on the Document section of Radar Healthcare

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14. Key Steps



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15. Asbestos

Purpose

15.1 To ensure the adequate and effective control of asbestos throughout ERS Medical premises in so far as it is reasonably practicable, in order to minimise the risk of exposure and to comply with the requirements of the Control of Asbestos Regulations 2012, the Control of Asbestos Regulations (Northern Ireland) 2012 and the Safety, Health and Welfare at Work (Exposure to Asbestos) (Amendment) Regulations 2010 (as applicable).

Scope

15.2 This procedure applies to all ERS Medical sites, employees / learner on an apprenticeship, visitors and contractors.

Responsibilities

15.3 **Site Management** – Are responsible for ensuring that assessments are undertaken, with any arising actions and maintenance schedules completed.

15.4 **Care Standards Team / Competent Contractor** – Are responsible for carrying out the assessment and raising any actions required.

Definitions

15.5 **Asbestos** – Is a naturally occurring mineral. It can be amphibole asbestos which includes crocidolite (blue) and amosite (brown) asbestos, or serpentine asbestos which is chrysotile (white) asbestos.

Process Overview

15.6 All ERS Medical facilities (except those constructed after 1999), require an assessment to be conducted to ascertain if asbestos is present. Only a competent external contractor are permitted to undertake these assessments. The assessment report file produced by the contractor must contain information on:

- Responsibility;
- Building construction;
- Site plan / Arial photograph;
- Asbestos register;
- Photographs demonstrating location and condition;
- Findings and recommendations;
- Action plan;
- Communication plan.

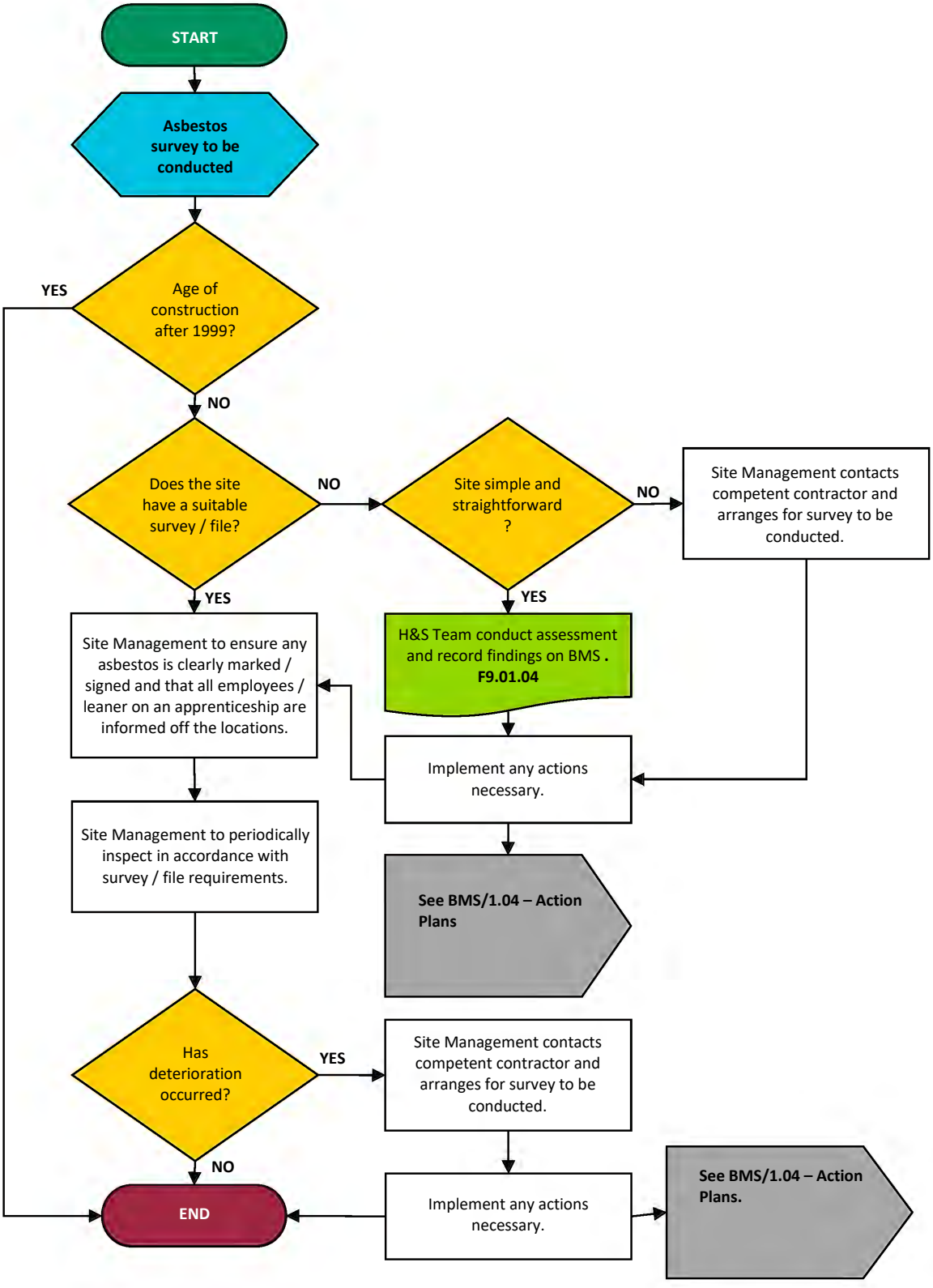
15.7 The results of the assessment must be communicated to the employees / learner on an apprenticeship at the facility (and made available to any visitors and contractors as required), and appropriate signage put in place to warn of the dangers. All remedial actions identified must be documented and actioned in accordance with **BMS/1.04 – Action Plans.**

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15.8 Periodic, (at least annually), visual inspections should occur to ensure there is no deterioration. The results of these inspections should be recorded by Site Management / Care Standards Team and held within the report file.

15.9 Should any remedial / removal work be required, a licensed contractor must be contacted and utilised. Under no circumstances must ERS Medical employees / learner on an apprenticeship attempt to undertake any work involving asbestos materials.

16. Key Steps



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17. Display Screen Equipment

Purpose

17.1 To ensure that all Display Screen Equipment (DSE), under the control of ERS Medical complies with relevant regulations pertaining to its use and that, in as far as is reasonably practicable, DSE is used in a manner which minimises the risk of injury.

17.2 To ensure that eye and eyesight tests are provided at ERS Medical expense to all users of DSE that require it. ERS Medical will fund (to a value set by HR), spectacles if they are prescribed for the distance at which the user requires them to view their screen.

Scope

17.3 This procedure applies to all ERS Medical sites and to all employees / leaner on an apprenticeship who are users of DSE.

Responsibilities

17.4 **Site Management / Line Managers** – Are responsible for ensuring that personnel under their control receive appropriate training, assessments are completed and that all resulting actions are completed.

17.5 **All Staff, Including Learners on Apprenticeships** – Are responsible for ensuring that they adhere to the training, complete the required assessment and report any equipment defects immediately.

Definitions

17.6 **Display Screen Equipment (DSE)** – Means any alphanumeric or graphical display screen, regardless of the process involved, including non-electronic systems such as production process panels.

17.7 **Eye Test** – Means a full examination of the eye by an ophthalmic optician or an ophthalmologist to detect disease.

17.8 **Eyesight Test** – Means a test of the function of the eyes.

17.9 **User** – Those employees / learners on an apprenticeship that use DSE for a significant part of their work. As a guide such employees / learner on an apprenticeship would be expected to work with DSE as an integral part of their job for continuous periods more than two hours.

17.10 **DSE Injury** – Means injury resulting from DSE related work and musculoskeletal problems (such as wrist, arm and shoulder pain), visual fatigue and mental stress.

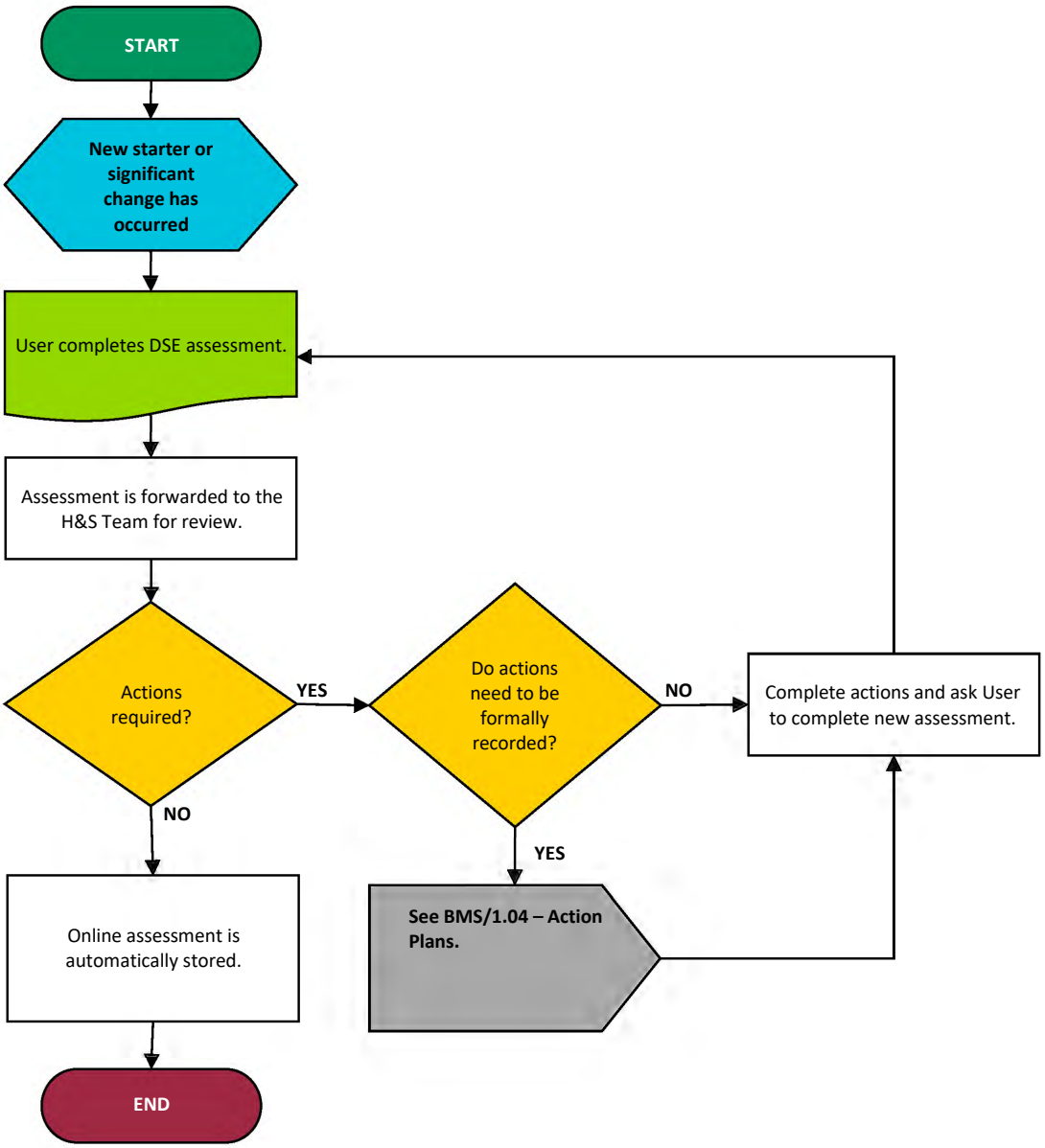
Process Overview

17.11 All employees / learner on an apprenticeship that are users of DSE must complete the workstation self-assessment. Immediate re-assessment must be undertaken when significant changes occurs or office moves are undertaken (e.g. pregnancy, diagnosis of a medical condition).

17.12 The results of these self-assessments will be reviewed by the Care Standards Team with any necessary actions taken

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18. Key Steps



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19. Security

Purpose

19.1 To ensure that Company sites and vehicles are secure always and that no lapses in security occur, that could have environmental consequences or could threaten the Company's compliance with the terms of its Authorisations and Registration Documentation.

Scope

19.2 This procedure applies to all Company sites, vehicles and personnel.

Responsibilities

19.3 **Site Management** – Have overall responsibility for site security.

19.4 **All Employees / Learners on an Apprenticeship** – Should be vigilant at all times and report any security breaches to Site Management.

Definitions

19.5 N/A

Process Overview

19.6 Due to the nature of the work undertaken by the Company, site and vehicle security forms an integral part of daily operations. Security is often stipulated as a requirement of our insurance and is regularly assessed and inspected by external regulators.

19.7 All visitors and contractors must sign in using the site visitor's book and fully complete all the details requested. They are also required to complete a temperature check during epidemics/pandemics for communicable diseases & record the result. Visitors will be provided with a visitor badge to be displayed at all times whilst on site. They are also required to have the prescribed site induction.

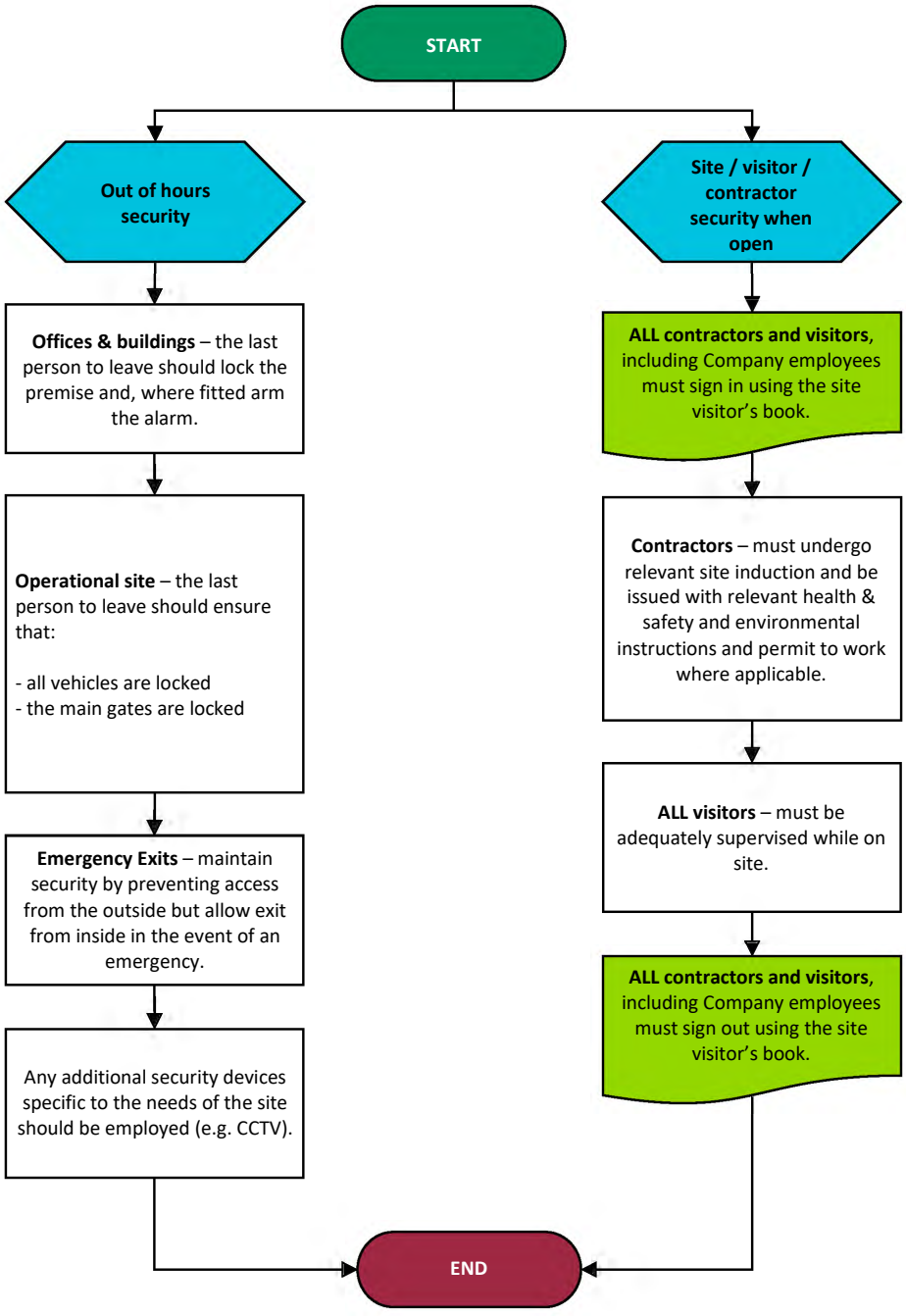
19.8 Site Management, or those entrusted with responsibility, must ensure that all vehicles, doors and gates are locked prior to leaving the facility.

19.9 Site Management or those entrusted with the responsibility, must ensure that all security features, (such as CCTV and alarms), are working correctly and activated prior to leaving the facility.

19.10 All breaches of security must be recorded as an incident (as per **BMS/5.02 – Serious Untoward Incident Investigation**) and the relevant departments and authorities notified. Additionally, ERS Medical insurance brokers must informed in a timely manner if a loss has occurred.

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20. Monthly Inspections



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21. Legionella

Purpose

21.1 To ensure the adequate and effective control of water systems throughout Company premises in so far as it is reasonably practicable, in order to minimise the risk of legionellosis and to comply with the requirements of the HSE Health Protection Surveillance Centre (HPSC) 'National Guidelines for the Control of Legionellosis in Ireland, 2009' along with the HSE Code of Practice 'The Prevention and Control of Legionellosis L8'.

Scope

21.2 This procedure applies to all Company sites, employees and contractors.

Responsibilities

21.3 **Site Management** – Are responsible for ensuring that assessments are undertaken, with any arising actions and maintenance schedules completed.

21.4 **Care Standards Team** – Are responsible for carrying out the assessment and raising any actions required.

Definitions

21.5 **Legionella** – Legionella bacteria which cause Legionnaires' disease are naturally widespread in water systems. The potentially fatal disease has symptoms similar to flu and pneumonia. Legionella present in external watercourses can easily be transferred to water used in buildings via air conditioning units and re-circulated hot and cold-water systems. Temperatures are crucial to the existence of legionella bacteria and can multiply to critical levels in water stored between 20°C and 45°C.

21.6 **Cold Water System** – Installation of plant, pipes and fittings in which cold water is stored, distributed and subsequently discharged.

21.7 **Hot Water System** – Installation of plant, pipes and fittings in which water is heated, distributed and subsequently discharged (not including cold water feed tanks or cisterns).

21.8 **Legionnaires' Disease** – A form of pneumonia caused by legionella bacteria.

Process Overview

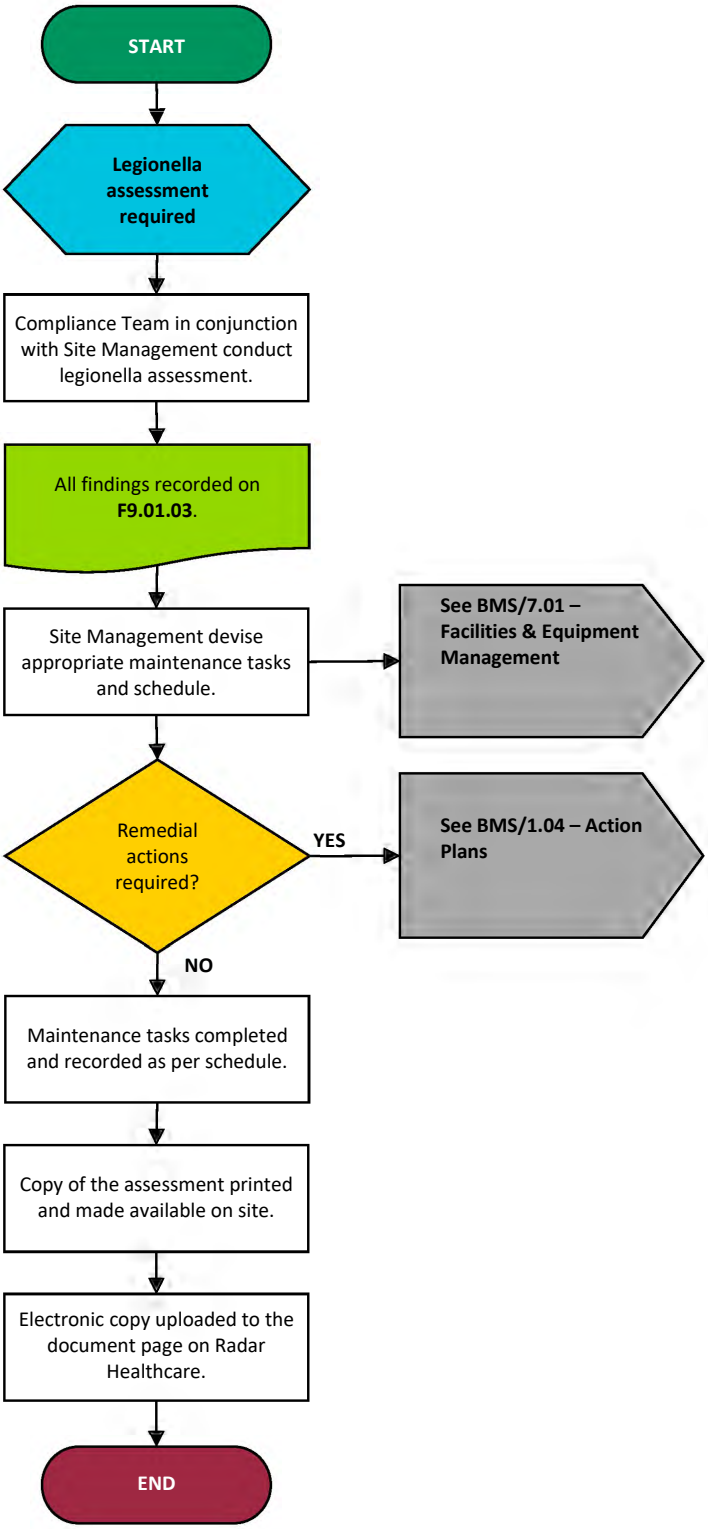
21.9 The Care Standards Team will complete a legionella assessment using **F9.01.03 Legionella Assessment** which identifies potential sources.

21.10 From this assessment a monthly legionella audit will be completed through Radar Healthcare (in accordance with **BMS/7.01 – Facilities & Equipment Management**. This audit schedule will be periodically assessed by the Care Standards Team and reviewed / re-issued every 3years.

21.11 Legionella assessments will be reviewed and re-assessed every three years unless significant change occurs. All completed assessments will be stored on the document and business management section of Radar Healthcare.

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22. Key Steps



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23. Contractors

Purpose

23.1 To ensure the adequate and effective control of contractors while on company premises in so far as it is reasonably practicable, in order to comply with the Health and Safety at Work Act 1974

Scope

23.2 This procedure applies to all Company sites, employees and contractors.

Responsibilities

23.3 **Site Management** – Are responsible for ensuring that they have received a copy of the contractors Public Liability and Employee Liability insurance prior to any tasks being undertaken. In addition to this they are also responsible for ensuring they have received a copy of the contractors Method Statement and Risk Assessment prior to any task being undertaken.

23.4 Site Management are also responsible for ensuring that all contractors read the **F9.01.05 Site Safety Leaflet** and sign the **F9.01.04 - Visitor Induction**.

23.2 **Care Standards Team** – Are responsible for carrying out Health and Safety audits and raising any actions required.

Definitions

23.3 N/A

Process Overview

23.4 Under the Health and Safety at Work Act 1974, ERS Medical have a responsibility not only to their own employees but, under section 3 of the Act, 'It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

23.5 All contractors engaged to work at ERS Medical sites must have been assessed under **BMS 4.01 – Procurement and Supply Chain Management**. In particular, the contractor must comply with the following:

- **BMS/4.01 - Section 10.12**: All suppliers who are successful in being appointed to complete work at ERS Medical facilities are required to provide full details of their insurance cover (employers' liability, public liability etc.).
- **BMS/4.01 – Section 10.13:** Written risk assessments and method statements (RAMS), for any work to be undertaken must be supplied to the relevant site management, 7 days in advance of the commencement date.

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- **BMS/4.01 – Section 10.14:** All RAMS documentation must then be reviewed by site management and if required, guidance and advice sought from an appropriate member of the Safety, Health and Compliance Team, with any discrepancies identified to the contractor.

23.6 All contractors must comply with all ERS Medical policies, procedures and instructions when undertaking work or providing services to the ERS Medical.

23.7 All contractors must follow **Section 19.7** and sign in the Visitor Book and display a Visitor Badge.

23.8 All contractors must read the **F9.01.05 - Covid-19 Sign in Sheet & Temperature recording** and then sign the **F9.01.04 - Visitor Induction**.

23.9 The reading of the **F9.01.05 – Covid-19 Sign in Sheet with Temperature record** and signing of the **F9.03.04 - Visitor Induction MUST** be refreshed every 12 months or, after any significant change to the **F9.01.05 - Covid-19 Sign in Sheet with Temperature record** has been made.

23.10 Copies of the contractor RAMS must be available at the site before commencement of any tasks. These should be checked by the Operational Manager or deputy. Copies of the RAMS are to be forwarded to the relevant Compliance Team member for approval. The RAMS will then be stored in the appropriate folder under Business Documents, Contractor RAMS on RADAR.

23.11 All contractors, at the completion of their tasks, will return their Visitor Badge to the Operational Manager or deputy and sign out in the Visitor Book.

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Health, Safety, Quality and Environment Policy Statement

To provide a reliable, caring service that puts people at the heart of everything we do.

Throughout all of its business activities, ERS Medical is committed to the continual improvement of its health, safety, quality and environmental performance and to the prevention of pollution.

The business will minimise risk and develop sustainably through the implementation of controls and procedures which align with and support this policy. To this end, ERS Medical will:

- Promote a strong quality, environmental, safety and health culture through effective training and awareness;
- Align with the requirements of BS EN ISO 9001 (Quality), BS EN ISO 14001 (Environment) and BS OHSAS 18001 (Health and Safety);
- Comply with all relevant health & safety and environmental legislation and other identified requirements in relation to the activities of the group;
- Systematically identify and reduce, where practicable to do so, significant health and safety risks which arise from ERS Medical's operational activities;
- Systematically identify the environmental aspects and reduce, where practicable to do so, the associated impacts which arise from ERS Medical's operational activities;
- Ensure that all complaints, health & safety and environmental incidents are reported, investigated and appropriate actions taken to prevent a reoccurrence;
- Provide a channel for raising concerns regarding confidentiality without fear, blame or recrimination;
- Periodically set, review and publish health, safety, quality and environmental objectives which align with the strategic direction of ERS Medical;
- Develop and maintain a schedule of internal audits to monitor compliance;
- Provide sufficient resources to implement this policy and ensure continual improvement of the health, safety, quality and environmental management system;
- Ensure that this policy is communicated to all necessary parties and is available upon request.

The ultimate responsibility for health, safety, quality and environment lies with the ERS Medical Managing Director who will ensure that it is given equal priority with other major business objectives and the strategic direction of the business. Implementation of this policy is a line management responsibility at all levels together with participation of all employees. Staff are reminded that adherence to this policy is a condition of employment.

The policy will be revised and updated as necessary by the Head of Care Standards for ERS Medical on an annual basis.



Signed: **Date:** **1st July 2020**

Managing Director ERS Medical **Version:** **4.0**

ERS Medical

Incident Report

Part A: Incident Details			Report No.	
Date/Time of incident:	/ / at :	**Date/Time reported:**	/ / at :	
Name of person completing this form:		**Position:**		
Where did the incident occur? - If company site provide site name - If not provide details including address / postcode				
Which site is involved?				

Please tick as appropriate:	
☐ A member of staff, a contractor or visitor to a Company site has been injured.	Annex A
☐ A Company vehicle has been damaged or caused damage to another vehicle or property.	Annex B
☐ A member of the public has been injured as a result of a collision with a Company vehicle.	Annex B
☐ A Company vehicle (or part of) has been stolen.	Annex B
☐ There has been an unauthorised release to the environment or complaint of a release.	Annex C
☐ There has been an operation of an emergency relief vent or emergency protection system.	Annex C
☐ There has been a loss, theft or breach of Company, personal or patient data / information.	Annex D
☐ There has been an incident that has or could in the future affect patient care or safety.	Annex E
☐ Has there been a breach of patient confidentiality.	Annex E
☐ There was a near miss involving any of the above (if required, complete the appropriate annex)	

Part B: What Happened

Describe clearly what happened: (List all persons involved, attach additional sheets if required)

Describe what actions were taken to control the situation:

Were any photographs taken?	YES ☐ NO ☐		
Did a regulator attend the incident?	YES ☐ NO ☐	**Which regulator?**	

NOW GIVE THIS FORM TO YOUR LINE MANAGER

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BEFORE PROCEEDING PLEASE COMPLETE ALL ANNEXES IDENTIFIED OVERLEAF
Part C: Incident Analysis
What was the primary root cause(s) of the incident?

What were the Contributing Factors? (Tick one or more boxes)					
Procedures not followed	☐	Lapse of attention	☐	Third party actions	☐
Lack of procedures	☐	Mistaken actions	☐	Equipment failure	☐
Inadequate procedures	☐	Deliberate actions	☐	Lack of maintenance	☐
Inadequate supervision	☐	Mistaken priorities	☐	Inadequate design	☐
Inadequate information	☐	Obstacle / Obstruction	☐	Defective / Unsuitable PPE	☐
Lack of understanding	☐	Weather conditions	☐	PPE not worn	☐
Lack of training	☐	Road conditions (RTA only)	☐	Pre-existing medical condition	☐

Prevention		
What action has been taken or is required to prevent a recurrence?	**By who?**	**By when?**

Now either call this into the Leeds CCO on [redacted] or raise direct on [redacted]

Part D: Regulatory Managers Comments

Are the actions above sufficient to prevent a recurrence of this incident?					YES ☐ NO ☐
Is a RAP required following this incident?	YES ☐ NO ☐			**RAP No.:**	
Is a procedural / risk assessment review required?					YES ☐ NO ☐
Are all actions complete?	YES ☐ NO ☐	**Closed by:**		**Date:**	

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The incidents within this report cover the period:

1st Spetember 2018 to **21st September 2020**

The report alos covers 5 CQC registered locations within ERS Medical, which are:

ERS Medical North-East
ERS Medical North
ERS Medical Midlands
ERS Medical East
ERS Medical South

All incidents recorded on the ERS Medical Radar Healthcare compliance system are detailed within that regions monthly Governance and Performane Review (**GaPR**) committee meeting, which is chaired by the regions CQC Registered Manager.

All regional GaPR committees report into the ERS Medical Patient Safety Committee **(PSC)**, which is chaired by our Medical Directorr.

Reference	Event Type	Region	Location	Event Date	Technical Review (Has the event resulted in an injury?)
CQ-059	Care Quality	North	Leeds - Teaching	23/09/2018	NO
RC-035	Running Call	North	Leeds - Teaching	27/09/2018	NO
CQ-060	Care Quality	North East	Blyth	28/09/2018	NO
CQ-062	Care Quality	North East	Durham	02/10/2018	NO
CQ-063	Care Quality	East	Norwich	03/10/2018	NO
CQ-066	Care Quality	North East	Durham	25/10/2018	NO
RC-043	Running Call	North	Manchester	29/10/2018	NO
CQ-067	Care Quality	North	Manchester	31/10/2018	NO
HS-098	Health and Safety	North	Crewe	31/10/2018	YES
CQ-069	Care Quality	North East	Blyth	03/11/2018	NO
IG-007	Information Governance/Security	East	Norwich	12/11/2018	NO
CQ-076	Care Quality	North	Arrowe Park Hospital	24/11/2018	NO
CQ-081	Care Quality	North	Manchester	05/12/2018	YES
CQ-079	Care Quality	East	Norwich	09/12/2018	NO
RC-046	Running Call	North	Manchester	09/12/2018	NO
CQ-082	Care Quality	North	Manchester	12/12/2018	NO
CQ-084	Care Quality	North	Mansfield	14/12/2018	NO
RC-047	Running Call	North	Leeds - Teaching	19/12/2018	NO
HS-126	Health and Safety	North East	Blyth	29/12/2018	NO
IG-009	Information Governance/Security	Head Office	Hetton - Head Office	18/01/2019	NO
HS-139	Health and Safety	North East	Blyth	19/01/2019	NO
CQ-090	Care Quality	North	Manchester	25/01/2019	NO
RC-053	Running Call	North	Manchester	12/02/2019	NO
RC-056	Running Call	North	Leeds - Teaching	06/03/2019	NO
CQ-110	Care Quality	East	Kings Lynn	02/04/2019	NO
CQ-112	Care Quality	North East	Blyth	05/04/2019	NO
CQ-114	Care Quality	North	Speke	09/04/2019	NO
CQ-116	Care Quality	North	Leeds - Teaching	14/04/2019	NO
CQ-117	Care Quality	North East	Blyth	15/04/2019	NO
RC-065	Running Call	North	Leeds - Teaching	28/05/2019	NO
CQ-132	Care Quality	North East	Durham	03/06/2019	NO
RC-068	Running Call	North East	Blyth	16/06/2019	NO
CQ-138	Care Quality	CCO	Leeds	20/06/2019	NO
CQ-141	Care Quality	North East	Durham	23/06/2019	NO
CQ-144	Care Quality	North East	Durham	30/06/2019	NO
CQ-146	Care Quality	North East	Blyth	06/07/2019	NO
CQ-147	Care Quality	North East	Durham	07/07/2019	NO
CQ-150	Care Quality	North East	Durham	08/07/2019	NO
CQ-154	Care Quality	North	Manchester	05/08/2019	NO
CQ-153	Care Quality	East	Kings Lynn	05/08/2019	NO
CQ-156	Care Quality	North	Manchester	13/08/2019	NO
CQ-159	Care Quality	North East	Durham	25/08/2019	NO
CQ-162	Care Quality	North East	Durham	28/08/2019	NO
CQ-163	Care Quality	East	Norwich	31/08/2019	NO
CQ-167	Care Quality	North East	Durham	05/09/2019	NO
CQ-169	Care Quality	North	Manchester	10/09/2019	NO
CQ-171	Care Quality	North	Leeds - Teaching	23/09/2019	YES
CQ-174	Care Quality	North East	Durham	27/09/2019	NO
CQ-175	Care Quality	North	Leeds - Teaching	04/10/2019	NO
CQ-177	Care Quality	North	Leeds - Teaching	07/10/2019	NO
CQ-182	Care Quality	North	Leeds - Teaching	19/10/2019	NO
CQ-183	Care Quality	North East	Blyth	20/10/2019	NO
CQ-185	Care Quality	East	Kings Lynn	24/10/2019	NO
CQ-186	Care Quality	North East	Durham	24/10/2019	NO
CQ-187	Care Quality	North	Manchester	26/10/2019	NO
CQ-192	Care Quality	North	Arrowe Park Hospital	01/11/2019	NO
RC-084	Running Call	CCO	Leeds	08/11/2019	NO
HS-231	Health and Safety	North	Crewe	11/11/2019	YES
CQ-193	Care Quality	North	Leeds - Teaching	19/11/2019	NO
CQ-194	Care Quality	CCO	Leeds	21/11/2019	NO
RC-087	Running Call	North	Manchester	25/11/2019	NO
CQ-197	Care Quality	North	Manchester	29/11/2019	NO
RC-089	Running Call	CCO	Leeds	02/12/2019	NO
RC-090	Running Call	North	Manchester	03/12/2019	NO
CQ-198	Care Quality	Midlands	Ashville	04/12/2019	NO
CQ-199	Care Quality	North East	Blyth	04/12/2019	NO
RC-092	Running Call	North	Manchester	05/12/2019	NO
HS-227	Health and Safety	Midlands	Mansfield - Notts	06/12/2019	YES
RC-093	Running Call	North	Manchester	06/12/2019	NO
CQ-201	Care Quality	Midlands	Mansfield - Notts	06/12/2019	NO
CQ-202	Care Quality	Midlands	Quorn Road	10/12/2019	NO
CQ-203	Care Quality	East	Kings Lynn	11/12/2019	YES
HS-243	Health and Safety	Midlands	Mansfield - Notts	27/12/2019	YES
CQ-209	Care Quality	Midlands	Mansfield - Notts	06/01/2020	NO
CQ-210	Care Quality	Midlands	Quorn Road	08/01/2020	NO
CQ-213	Care Quality	South	Homerton	20/01/2020	NO
CQ-223	Care Quality	Midlands	Quorn Road	29/01/2020	NO
CQ-216	Care Quality	East	Norwich	30/01/2020	NO
HS-268	Health and Safety	Midlands	Carlton Forest	04/02/2020	YES
HS-270	Health and Safety	North	Crewe	05/02/2020	YES
RC-095	Running Call	East	Norwich	06/02/2020	NO
HS-272	Health and Safety	Midlands	Ashville	08/02/2020	YES
CQ-222	Care Quality	North East	Durham	09/02/2020	NO
CQ-225	Care Quality	North	Leeds - Teaching	12/02/2020	NO
HS-277	Health and Safety	East	Norwich	13/02/2020	NO
CQ-226	Care Quality	North	Leeds - Teaching	17/02/2020	NO
CQ-227	Care Quality	East	Norwich	18/02/2020	NO
RC-097	Running Call	North	Manchester	23/02/2020	NO
RC-098	Running Call	CCO	Leeds	26/02/2020	NO
CQ-231	Care Quality	North East	Durham	26/02/2020	NO
CQ-234	Care Quality	East	Kings Lynn	01/03/2020	NO
RC-102	Running Call	Midlands	Ashville	03/03/2020	NO
HS-295	Health and Safety	Midlands	Ashville	09/03/2020	YES
CQ-240	Care Quality	North	Manchester	10/03/2020	NO
CQ-242	Care Quality	CCO	Leeds	13/03/2020	NO
CQ-252	Care Quality	Midlands	Ashville	25/03/2020	NO
RC-105	Running Call	North	Manchester	26/03/2020	NO
HS-312	Health and Safety	Midlands	Mansfield - Notts	27/03/2020	NO
HS-316	Health and Safety	Midlands	Ashville	01/04/2020	YES
HS-315	Health and Safety	Midlands	Carlton Forest	01/04/2020	YES
CQ-259	Care Quality	North East	Blyth	02/04/2020	NO
RC-106	Running Call	North	Manchester	06/04/2020	NO
CQ-260	Care Quality	North	Leeds - Teaching	07/04/2020	NO
HS-318	Health and Safety	Midlands	Ashville	07/04/2020	NO
CQ-262	Care Quality	North	Manchester	07/04/2020	NO
CQ-264	Care Quality	Midlands	Mansfield - Notts	08/04/2020	NO
RC-108	Running Call	North	Manchester	10/04/2020	NO
RC-109	Running Call	North East	Durham	13/04/2020	NO
CQ-273	Care Quality	Midlands	Quorn Road	24/04/2020	NO
CQ-276	Care Quality	East	Norwich	24/04/2020	NO
CQ-283	Care Quality	CCO	Leeds	25/04/2020	NO
RC-111	Running Call	CCO	Leeds	27/04/2020	NO
CQ-275	Care Quality	Midlands	Ashville	28/04/2020	NO
HS-328	Health and Safety	East	Norwich	28/04/2020	NO
CQ-279	Care Quality	Midlands	Mansfield - Notts	01/05/2020	NO
CQ-281	Care Quality	Midlands	Mansfield - Notts	04/05/2020	NO
HS-330	Health and Safety	East	Kings Lynn	04/05/2020	NO
RC-112	Running Call	CCO	Leeds	05/05/2020	NO
HS-333	Health and Safety	Midlands	Quorn Road	12/05/2020	NO
CQ-288	Care Quality	North	Manchester	12/05/2020	NO
CQ-292	Care Quality	East	Norwich	15/05/2020	NO
CQ-294	Care Quality	Midlands	Ashville	18/05/2020	NO
HS-339	Health and Safety	Midlands	Mansfield - Notts	18/05/2020	YES
RC-116	Running Call	CCO	Leeds	21/05/2020	NO
HS-345	Health and Safety	Midlands	Ashville	26/05/2020	NO
CQ-311	Care Quality	East	Norwich	06/06/2020	NO
CQ-316	Care Quality	Midlands	Ashville Control Room	12/06/2020	NO
CQ-319	Care Quality	East	Norwich	18/06/2020	NO
CQ-321	Care Quality	Midlands	Ashville	20/06/2020	NO
HS-369	Health and Safety	East	Kings Lynn	21/06/2020	YES
CQ-325	Care Quality	North	Leeds - Teaching	25/06/2020	NO
HS-412	Health and Safety	Midlands	Ashville	03/07/2020	YES
RC-126	Running Call	North East	Durham	07/07/2020	NO
CQ-332	Care Quality	Midlands	Ashville Control Room	08/07/2020	NO
CQ-351	Care Quality	North	Leeds - Teaching	08/07/2020	NO
HS-391	Health and Safety	North	Manchester	09/07/2020	YES
CQ-338	Care Quality	East	Kings Lynn	14/07/2020	NO
CQ-342	Care Quality	North East	Blyth	17/07/2020	NO
RC-129	Running Call	South	Homerton	28/07/2020	NO
CQ-355	Care Quality	East	Kings Lynn	30/07/2020	NO
HS-404	Health and Safety	East	Norwich	06/08/2020	YES
HS-410	Health and Safety	Midlands	Ashville	12/08/2020	YES
HS-415	Health and Safety	North	Leeds - Teaching	14/08/2020	YES
CQ-365	Care Quality	East	Norwich	14/08/2020	NO
RC-135	Running Call	North East	Durham	20/08/2020	YES
CQ-368	Care Quality	East	Norfolk Control	20/08/2020	NO
CQ-369	Care Quality	North	Manchester	20/08/2020	NO
CQ-372	Care Quality	North East	Durham	22/08/2020	NO
CQ-374	Care Quality	East	Norwich	24/08/2020	NO

Reference	Event Type	Region	Location	Event Date	Technical Review (Has the event resulted in an injury?)
CQ-204	Care Quality	North	Manchester	13/12/2019	NO
CQ-212	Care Quality	Midlands	Mansfield - Notts	15/01/2020	NO
CQ-233	Care Quality	East	Norwich	28/02/2020	NO
CQ-237	Care Quality	Midlands	Quorn Road	04/03/2020	NO
CQ-239	Care Quality	North	Leeds - Teaching	08/03/2020	NO
CQ-245	Care Quality	North	Manchester	17/03/2020	NO
CQ-253	Care Quality	East	Norwich	28/03/2020	NO
CQ-269	Care Quality	North East	Blyth	11/04/2020	NO
CQ-270	Care Quality	North East	Durham	14/04/2020	NO
CQ-287	Care Quality	East	Norwich	12/05/2020	NO
CQ-295	Care Quality	North	Leeds - Teaching	19/05/2020	NO
CQ-296	Care Quality	South	Homerton	21/05/2020	NO
RC-114	Running Call	CCO	Leeds	21/05/2020	NO
CQ-298	Care Quality	East	Norwich	21/05/2020	NO
CQ-312	Care Quality	Midlands	Ashville	08/06/2020	NO
CQ-313	Care Quality	East	Kings Lynn	09/06/2020	NO
CQ-320	Care Quality	East	Kings Lynn	19/06/2020	NO
CQ-340	Care Quality	North	Manchester	14/07/2020	NO
RC-133	Running Call	North	Leeds - Teaching	13/08/2020	NO
HS-431	Health and Safety	East	Norwich	28/08/2020	NO

Reference	Event Type	Region	Location	Event Date	Compliance Team Investigation (HSE notifiable)RIDDOR	Compliance Team Investigation (Date HSE notified)
HS-096	Health and Safety	North	Leeds - Teaching	29/10/2018	YES	15/11/2018
HS-098	Health and Safety	North	Crewe	31/10/2018	YES	23/11/2018
TRN-126	Transport	North	Leeds - Teaching	03/12/2018	YES	09/01/2019
CQ-081	Care Quality	North	Manchester	05/12/2018	YES	14/12/2018
HS-141	Health and Safety	South	Mitcham	22/01/2019	YES	01/02/2019
HS-185	Health and Safety	South	Ipswich Mail and Courier	18/06/2019	YES	25/06/2019
HS-231	Health and Safety	North	Crewe	11/11/2019	YES	17/12/2019
HS-253	Health and Safety	East	Kelling	26/11/2019	YES	24/01/2020
HS-257	Health and Safety	South	Homerton	20/01/2020	YES	24/01/2020
HS-330	Health and Safety	East	Kings Lynn	04/05/2020	YES	05/05/2020
HS-332	Health and Safety	East	Norwich	08/05/2020	YES	11/05/2020
HS-339	Health and Safety	Midlands	Mansfield - Notts	18/05/2020	YES	29/05/2020
HS-394	Health and Safety	North	Crewe	21/07/2020	YES	27/07/2020
HS-410	Health and Safety	Midlands	Ashville	12/08/2020	YES	10/09/2020
HS-415	Health and Safety	North	Leeds - Teaching	14/08/2020	YES	17/08/2020

BMS/1.07 Risk Management

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2. Related Documents & Legal References

BMS Manual	
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Communication	BMS/1.06
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
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Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
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Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Safer Person Handling & Dynamic Risk Assessments	BMS/6.07
COSHH / Chemical Risk Assessments	BMS/9.04
Business Impact Analysis	WI/1.07.01
Business Continuity Risk Assessments	WI/1.07.02
Information Security Risk Assessments	WI/1.07.03
Health and Safety Risk Assessments	WI/1.07.04
Safer Person Manual Handling Risk Assessments	WI/1.07.05

3. Policy Statements

3.1 Please refer to ERS Medical's Health, Safety, Quality and Environment Policy Statement.

3.2 Please refer to ERS Medical's Care and Treatment Policy Statement.

3.3 Please refer to ERS Medical's Corporate Social Responsibility Policy Statement.

3.4 Please refer to ERS Medical's Information Governance Policy Statement.

3.5 Please refer to ERS Medical's Business Continuity / EPRR Policy Statement.

3.6 Please refer to ERS Medical's Infection Prevention and Control Policy Statement.

4. Introduction

4.1 In line with the HASAW etc Act 1974, advises employers to follow 5 steps when carrying out workplace Risk Assessments. This procedure has been developed to document the ERS Medical's approach to the various aspects of risk and opportunity management in relation to its activities, standards to which it subscribes, legal and other requirements and the needs and expectations of interested parties and education of all employees.

By using this consistent methodology ERS Medical is able to record and evaluate risks and opportunities across a number of different areas to allow it to determine, understand, control and prioritise the mitigation of those risks through review.

4.2 Definitions of likelihood and potential impact or severity can differ from process to process to ensure that the terminology is relevant to the risk being assessed. These variations will be defined in each work instruction that provides the methodology to be followed.

4.3 By use of ERS's Corporate Risk Register as defined on RADAR Reporting system. Risk and opportunity management is a continual process that will follow a defined pathway to provide a method that identifies, assesses and reduces uncertainty in a structured way and be reviewed and updated as required by 'Assigned Owners' .

- Communications and consultations at all levels of the risk management process;
- Establish the context in which the risk is situated;
- Identification of hazards and the risk that they pose;
- Analysis of the risks;
- Evaluation of the risks;
- Treatment of the risks if the risk are not adequately managed and controlled;
- Monitoring and review;
- Enable individuals that they understand they have a right to protection and they to have to exercise responsibility.

4.4 Throughout all of these processes ERS Medical has adopted the mechanism demonstrated in the table below.

		Potential Impact or Severity				
		Minor (1)	Moderate (2)	Serious (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (4)	5	10	15	20	25
	Likely (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Extremely Unlikely (1)	1	2	3	4	5

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This procedure applies to all ERS Medical Team Members and facilities.

4.5 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with ERS Medical's Capability and Disciplinary procedures contained in the Staff Handbook.

Likelihood Score	1	2	3	4	5
Descriptor	Extremely Unlikely	Unlikely	Possible	Likely	Almost Certain
Frequency	This will probably never happen / occur	Do not expect it to happen but it is possible	Might happen occasionally	Will probably happen but is not a persisting issue	Will undoubtedly occur and possibly frequently

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting ERS Medical objectives and allocating adequate resources to meet those objectives.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Head of Care Standards & Care Standards Team**	Are responsible for ensuring that policies, procedures and associated documentation together with the required systems and associated training are developed and cascaded to individual Business Unit Leadership Teams to support the decisions of the Managing Director.
5.4	**Subject Matter Experts (Managers / Advisors)**	Are responsible for producing, documenting and publishing their specialist subject risk assessments based on all identified hazards and risks held by ERS Medical at all locations and for communicating the findings to local as well as the Senior Management / Leadership Teams.
5.5	**General / Operations Managers**	Are responsible for ensuring that all assessments are displayed at the locations or areas for which they are responsible and for communicating the findings to their teams via Team Briefs & Lessons Learned as distributed by Care Standards Team and saved to SharePoint. They are additionally responsible for completing any actions necessary to reduce the risk rating of a particular aspect.
5.6	**All Team Members**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

6. Communication and Consultation

6.1 Communication and consultation with both internal and external stakeholders and interested parties is essential within the risk management process to ensure ERS Medical has a full and complete picture of the risks it faces and as set out in Section 4.4 above are reviewed.

6.2 **Internal Communication and Consultation** – is aimed at informing and including all employees of:

- ERS Medical's risk management process;
- Seeking feedback in relation to the processes of risk management;
- The key risks owned by ERS Medical;
- Responsibilities relating to the management of these risks to include reporting events on RADAR in a robust and timely manner in line with BMS 5.01 Incident Management section 7.3 & 7.4

6.3 **External Communication and Consultation** – is aimed at:

- Communicating ERS Medical's risk management approach and process;
- The effectiveness and scope of ERS Medical's risk management process;
- The communication of their processes for the management and treatment of risks that may or may not affect our ability to maintain work activity;
- Provide two-way feedback on risk management processes in an open and transparent manner.

7. Establishing Risk Context

7.1 **Internal Context** – is aimed at understanding ERS Medical's organisational structure and elements and the manner in which they interact across all areas of the business. This includes but is not limited to:

- Business strategies;
- Capabilities and capacity;
- Company aims and objectives;
- Company resources;
- Culture;
- Management structure.

7.2 **External Context** – is aimed at the understanding and identification of Company external stakeholders and interested parties and to what degree their actions and ERS Medical's actions may affect and or impact each to realise their objectives. This includes but is not limited to:

- Business;
- Commercial (including Service Level Agreements and Key Performance Indicators);
- Contractual;
- Corporate Social Responsibility;
- Financial;
- Legislative as defined by Laws & rules made by the Government;
- Regulatory which is a specific requirement within Legislation.

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7.3 When establishing the risk context consideration must be given to the needs and expectations of relevant interested parties.

8. Identification of Risk

8.1 The identification of risk is a corner stone to any risk management process and is essential in ensuring that all risk are adequately controlled, managed to acceptable levels and / or receive suitable and sufficient further risk treatment.

8.2 Risk can be identified using various techniques and tools such as:

- Audit and Inspection Reports via RADAR;
- Trend identification through regular Audits;
- Experience;
- Discussions with Stakeholders;
- Interviews;
- Post Incident Reports and Investigations;
- Risk Identification Checklists;
- Employee and or External Feedback;
- Strategic and Business Plans;
- Surveys and Questionnaires.
- Lessons Learned

9. Analysis of Risk

9.1 Once a risk has been identified it should be subject to analysis of its components;

- Events – The likely factors that lead to a realisation of the risk;
- Cause – The cause(s) of the event;
- Probability & Impact – The impacts to ERS Medical on the realisation of a risk;
- Moment of Risk – Specific conditions that cause the likelihood/occurrence.

9.2 Risk analysis involves, but is not limited to:

- Identifying possible negative events or situations (this can be more easily achieved if historical incident data is available);
- Identifying the magnitude and potential outcomes that impacts ERS Medical on the realisation of the risk;
- Identifying existing controls in place to manage the risk, by either reducing the consequence or impact of the risk by using Risk Assessments as set out on Bamboo BMS **F1.07.04 – Health and Safety Risk Assessment;**
- Assessing the effectiveness of these existing controls through reporting and Audit Tools available on ERS Internal Systems such as Bamboo/RADAR/SharePoint.

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9.3 The effectiveness of existing controls can be ascertained by using several different processes. This includes but is not limited to:

- Control self-assessment;
- Internal audits;
- External audits;
- Incident investigation and reporting procedures.
- Standardised documentation on BMS and RADAR Systems;
- Information and communication e.g. Lessons Learned.

10. Evaluation of Risk

10.1 Risk evaluation involves the consideration of the risks overall rating, taking into account the Initial Risk Rating (IRR) without existing control measures being taken into account and determination of Recovery Time Objective (RTO) and the Residual Risk Rating (RRR) when these control measures have been applied.

1: Insignificant Impact;
2: Minimal Impact;
3: Moderate Impact;
4: Critical Impact;
5: Catastrophic Impact.

10.2 The RRR will then allow for a more accurate and informed evaluation phase to be conducted, where the risks are prioritised in order of importance, based on ERS Medical's risk appetite and then managed within an acceptable level based upon the objective evaluation of the risk(s).

11. Treatment of Risk

11.1 Risk treatment involves the examination of the RRR in order of priority, to best determine where Company resources should be provided and allocated for any treatment plans deemed necessary and appropriate to adequately manage the risk to within acceptable levels.

11.2 Treatment actions are required where current control measures are not managing a risk to within acceptable levels and or ERS Medical decide that even risk that are being adequately managed could be still improved upon because of the potential impacts these risks have.

11.3 Possible risk treatment options include:

- **Avoid the Risk** – Change the business process or objective;
- **Change the Likelihood** – Undertake actions aimed at reducing the cause of the risk;
- **Change the Consequence / Impact** – Undertake actions aimed at reducing the consequence / impact of the risk;
- **Share / Transfer** – Share / transfer the ownership of the risk and or liability to a third party;
- **Retain the Risk** – Accept the impact and consequences of the risk.

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11.4 It is important to note however that not all treatment options are available to all risk types. For example, a health and safety risk may be reduced to "as low as reasonably possible" (ALARP) and an environmental risk treated using "best available technique" BAT.

11.5 Risk treatment may not necessarily make a risk zero, so this would result in a Residual Risk to be managed through review.

11.6 When relevant and appropriate, risks and opportunities will be discussed at the various committees established by ERS Medical as detailed in **BMS/1.05 – Planning and Review**. Documented evidence of these meetings is retained, and Action Plans detailed and monitored.

11.7 Risk treatment may not necessarily make a risk zero, so this would result in a Residual Risk to be managed through review as part of **BMS/1.05 – Planning and Review**.

12. Monitoring, Planning and Review

12.1 All risk information requires regular monitoring and review to ensure currency and accuracy.

12.2 All Company risks will be reviewed and monitored in accordance with this procedure and the category specific work instructions using but not limited to the following:

- Audit and Inspection Reports/Trend analysis;
- Post Incident Reports and Investigations;
- Concerns or recommendations made an industry regulator;
- Employee and or External Feedback;
- A whistleblowing report (raising a concern);
- Employee interviews and surveys;
- Patient / Customer feedback through surveys and incident reporting on RADAR;
- Letters or complaint or compliments.
- Lessons Learned

12.3 ERS Medical will monitor and review all significant outputs arising from the managing risk processes and when deemed appropriate, will establish objectives and targets as per **BMS/1.05 – Planning and Review**.

12.4 ERS Medical's objectives and targets are reviewed as part of the annual management reviews (see **BMS/1.05 – Planning and Review**).

12.5 Taking into consideration the availability of resources, not all significant outputs will result in objectives and targets being established.

13. Business Continuity – Business Impact Analysis (BIA)

13.1 BIA is a process used by ERS Medical to analyse its activities at each location and to establish and understand the effect that a business disruption might have upon them. A work instruction **WI/1.07.01** has been devised and implemented, which defines the process to be followed.

13.2 For each activity identified at a location, a BIA (**F1.07.01**) will be completed by the BC subject matter expert, which identifies the following information:

- Site / Service Information;
- Specific Employee Numbers and Site Location;
- Stakeholders and Dependencies;
- Critical Service Function;
- Impact Assessment;
- Recovery of Service;
- Recovery of Service Resource Requirements;
- If an Objective and Target is required.

13.3 Once completed, these documents are uploaded to the BIA Register within the Business Continuity section of the Safety, Health & Compliance page on SharePoint.

13.4 Due to the potentially sensitive nature of these assessments, access to the on-line library will be restricted.

14. Business Continuity Risk Assessment (BCRA)

14.1 BCRA is a process used by ERS Medical to systematically identify, analyse, evaluate and treat the risk of disruptive incidents to its activities at each location. A work instruction **WI/1.07.02** has been devised and implemented, which defines the process to be followed.

14.2 For all identified risks at a location, BCRA (**F1.07.02**) will be completed by the Compliance Programmes and Systems Team, which identifies the following information:

- Threat / Hazard;
- Likelihood (Vulnerability);
- Consequence (Impact);
- Existing Control Measures;
- Control Assessment;
- Risk Rating;
- Risk Treatment;
- Action Plan.

14.3 Once completed, these documents are uploaded to the BCRA Register within the Business Continuity section of the Safety, Health & Compliance page on SharePoint.

14.4 Due to the potentially sensitive nature of these assessments, access to the on-line library will be restricted.

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15. Information Governance Risk Assessment (IGRA)

15.1 ISRA is a process used by ERS Medical to systematically identify, analyse, evaluate and treat risks in relation to its information assets at each location. A work instruction **WI/1.07.03** has been devised and implemented, which defines the process to be followed.

15.2 For all identified risks at a location, ISRA (**F1.07.07)** Information Governance RA will be completed by the Care Quality Team, which identifies the following information:

- Information Assets;
- Asset Attribution Scoring based on:
  - Confidentiality
  - Availability
  - Integrity
- Control Maturity Assessment (based on controls from ISO 27001 Annex A, this provides an essential tool for managing security. It provides a list of security controls to be used to improve the security of information. Instead, bringing together Physical security, HR management, organisational issues and legal protection, HR management, organisational issues and legal protection)
- Threats and Vulnerabilities;
- Impact Analysis (based on attribute scoring);
- Risk Assessment output.

15.3 Once completed, all relevant risk assessments are uploaded to the Information Security section of ERS Medical intranet system.

16. Health and Safety Risk Assessment (HSRA)

16.1 ERS Medical's process for undertaking Health and Safety risk assessments is detailed in **WI/1.07.04 – Health and Safety Risk Assessment**.

16.2 This process ensures that all work activities undertaken by ERS Medical are assessed for all potential risks involved. A risk assessment is an important step in protecting our workers and our business, as well as complying with legislation.

16.3 **WI/1.07.04** includes the processes for the following types of risk assessment which are subsequently recorded by the Care Standards Team on the forms as documented below:

- General risk assessments, including manual handling and noise (**F1.07.04**);
- Fire (**F1.07.05**);
- New and expectant mothers (**F1.07.04**);
- Young persons (**F1.07.04**);
- Dynamic risk assessment (**F1.07.05**).

16.4 A further document, **BMS/9.06** has been established for COSHH / Chemical Risk Assessments.

16.5 A separate process has been established for use when undertaking Safer Person Manual Handling Risk Assessments, please see **WI/1.07.05**.

A further document **BMS/6.07(ERS) -** Safer Person Handling & Dynamic Risk Assessments V4.1 has been established which provides information to ERS Medical personnel on the correct methods to be used and also the process of dynamic risk assessment.

16.6 Once completed, all relevant risk assessments are uploaded to the appropriate register within the Health and Safety section of the Safety, Health & Compliance page on SharePoint.

16.7 Due to the potentially sensitive nature of some of these assessments, access to the on-line library will be restricted.

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BMS/6.07 Safer Person Handling and Dynamic Risk Assessments

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2.1	All	All	All	13/04/18	[redacted]	Addition of review date
3.0	6	All	8	08.11.18	[redacted]	Addition of Capacity and Consent Section
3.0	13	13.10 & 13.11	23	08.11.18	[redacted]	Addition on guidance for the use of linen, sheets and blankets.
3.1	All	All	All	02.09.19	[redacted]	Addition for Homerton NHS Trust
4.0	All	All	All	12.11.19	[redacted]	Annual Review
4.1	10 & 15	10.5 & 15.3	Pg 15 & 23	20.01.20	[redacted]	Minor changes from CCG feedback

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Whistleblowing (Raising Concerns at Work)	BMS/2.05
Disclosure and Barring Service (DBS) Checks	BMS/2.06
Alcohol, Drugs and Substance Misuse	BMS/2.07
Incident Reporting and Investigation	BMS/5.01
Serious Untoward Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Care to Care	BMS/6.01
Patients Who Deteriorate in Transit	BMS/6.02
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding of Vulnerable Adults and Children	BMS/6.05
End of Life Care	BMS/6.06
Patient Communications and Control	BMS/6.08
Renal Patient Services	BMS/6.11
HDU NEPTS Operations	BMS/6.12
Health and Safety Management (in review)	BMS/9.01
Safer Person Manual Handling Risk Assessment	WI/1.07.05
Equality and Diversity	WI/2.01.13
ADHOC Journey Quotes and Bookings (CCT)	WI.6.08.04
CAD Bookings	WI/6.08.07
NEPTS Eligibility	WI/6.10.01
NEPTS Arrival Process	WI/6.10.02
Conflict Resolution	WI/6.13.02
NEPTS Loading Sheets	F6.10.02
NEPTS Loading Sheets (WAV)	F6.10.02a
Patient Mobility Flowchart	F6.03.03
Dynamic Bariatric / Plus Sized and Complex Needs Risk Assessment	F6.07.01
Patient Tissue Viability and Hydration Record Chart	F6.07.02
Daily Issue Log	F6.10.05

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3. Legislation & Regulation

The Health and Safety at Work Act 1974 (HSWA)
The Mental Capacity Act 2019
Manual Handling Operations Regulations 1992 (MHOR) (as amended 2002)
Management of Health and Safety at Work Regulations 1999
Provision and Use of Work Equipment Regulations 1998 (PUWER)
Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)

Sources:

Health and Safety Executive Website – Moving and handling in health and social care

4. Introduction

4.1 This procedure has been established to ensure ERS Medical has a consistent process for all safer person handling and the dynamic risk assessing of any work activities that requires either direct or indirect support in the handling or assistance to patients.

4.2 To reduce the risk of injury from all patient moving and handling operations and activities undertaken by or on behalf of ERS Medical.

4.3 To define the responsibilities of Company personnel in relation to completing safer person manual handling and dynamic risk assessments conducted ensuring consistency is achieved.

4.4 To ensure all Company personnel are aware of their responsibilities with regard to undertaking safer person manual handling activities.

4.5 The Manual Handling Operations Regulations 1992, as amended 2004 and Part 2, Chapter 4 of the Health and Welfare at Work (General Application) Regulations 2007, apply to a wide range of manual handling activities as defined at 8.14.

4.6 Whilst it is desirable to avoid the need for the manual handing of patient's (loads) by stimulating their functional mobility, if appropriate, it is recognised that due to the nature of their work, Company personnel may have no alternative but to move, handle or assist patient's with their mobility.

4.7 This work activity places significant force and stresses upon the musculoskeletal systems of handlers and patients alike and it is for this reason that ERS Medical has adopted a minimal lifting policy.

4.8 ERS Medical is required to follow the hierarchy of controls for manual handling operations, which are:

- **Avoid** the need for hazardous manual handling, so far as reasonably practicable;
- **Assess** the risk of injury from any manual handling that can't be avoided;
- **Reduce** the risk of injury from manual handling, so far as reasonably practicable.

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4.9 For the purposes of this procedure assessments will dynamic in nature. Formal safer person manual handling risk assessments are conducted and recorded in accordance with the requirements of **WI/1.07.05 – Safer Person Handling Risk Assessment**.

4.10 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.11 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

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6. Responsibilities

6.1	**Managing Directors**	Have overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director / Head of Care Standards**	Has the strategic responsibility for setting, directing and monitoring clinical standards, scope of practice and ensuring that patient safety remains the primary focus of all patient facing services within ERS Medical.
6.4	**Head of Care Standards**	Is responsible for developing, co-ordinating and implementing quality, health & safety and environmental policy, procedures and work instructions.
6.5	**Head of HR & Training**	Is responsible for the creation, implementation, monitoring of all manual handling training in line with Company targets and for supporting Clinical Instructors and the Care Standards Team in respect to the training and development of personnel. Is also responsible for reviewing outstanding training requirements and liaising with Managers to ensure all relevant / required training is undertaken in a timely manner and for maintaining centrally and locally held, physical and electronic training records
6.6	**Regional and Operations Managers**	Are responsible for the implementation and management of ERS Medical policy and procedures and to ensure that employees receive suitable and sufficient safer person manual handling training. Are responsible for writing operational risk assessments for areas under their control, monitoring, controlling and implementing the policy, procedures and work instructions for staff they manage.
6.7	**Manual Handling Key Workers**	To promote the benefits of using good safer person manual handling techniques and the principles of efficient movement at all times. To provide or seek further guidance for staff who have questions or concerns on matters relating to safer person manual handling.
6.8	**All ERS Medical Ambulance Crew**	Are responsible for undertaking dynamic (patient) risk assessments in accordance with applicable legislation / guidance and for the passing of any formally recorded assessments to their line managers for record retention.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2019 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

8. Definitions

8.1 **As Low As Reasonably Practicable (ALARP)** – Means that the risk has been reduced to such an extent that the cost of any further reduction in risk is grossly disproportionate to the benefits that would be achieved.

8.2 **At Work** – Includes all operational areas of ERS Medical's sites and all activities undertaken off-site by ERS Medical employees.

8.3 **Bariatric / Plus Sized** – Bariatric / Plus Sized service users are defined by NICE 2004 as being a patient whose weight is 40kg above their ideal weight and / or who has a body mass index(BMI) of >30kg/m2. However, for pre-hospital care the accepted criteria are 160kg / 25 stone or a BMI > 35. The realistic model should however be the impact the patient's weight, BMI, body shape and mobility impacts the crews ability to safely care for them and themselves, with the equipment to hand or available to them.

8.4 **Body Mass Index (BMI)** – A calculation of body fat that takes into account the age, height and weight of the patient.

8.5 **Dynamic Overload** – Is the stress placed upon the body from a moving and variable force or load.

8.6 **Dynamic Risk Assessment** – The continuous process of identifying and evaluating risks arising from a hazard, taking into account the adequacy of existing controls. This process includes the decision on the acceptability of risks and the deployment of additional control measures if necessary.

8.7 **Ergonomics** – Is a science concerned with the 'fit' between people and their work. It puts people first, taking into account their capabilities and limitations. It aims to make sure that tasks, equipment, information and the environment suit each worker.

8.8 **Functional Mobility** – The degree of an individual's ability to move and mobilise independently within their environment.

8.9 **Hazard** – Source, situation or act with a potential for harm in terms of human injury or ill health or a combination of these.

8.10 **Hazard Identification** – Process of recognising that a hazard exists and defining its characteristics.

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8.11 **Incident / Serious Incidents (S.I.)** – Work-related event(s) in which an injury or ill health (regardless of severity) or fatality occurred or could have occurred.

8.12 **Injury / Ill Health** – Identifiable, adverse physical or mental condition arising from and / or made worse by work activity and/or work-related situation.

8.13 **Lifting / Moving Aid** – For the purpose of this procedure is defined as a patient trolley, stretcher, wheelchair, carry-chair, PAT slide, turntable, banana board, slide sheet, handling belt.

8.14 **Load** – A load in the context of manual handling must be a discrete movable object. This includes for example, not only packages and boxes but also patient(s) receiving medical attention. An implement, tool or machine such as an ambulance trolley / carry chair is not considered to be a load when in use for its intended purpose.(*Inanimate – is defined for the purposes of this work instruction to be all manual handling with the exception of patient handling*).

8.15 **Manual Handling** – Is the pushing, pulling, lifting up, putting down, moving and carrying of a load or person.

8.16 **Manual Handling Operations** – Any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force.

8.17 **Musculoskeletal Disorder (MSD)** – Covers any injury, damage or disorder of the joints or other tissues in the upper or lower limbs or back.

8.18 **Patient with Complex Needs** – A patient will be deemed to have complex needs, if in the provision of their safe handling and transportation they require any additional planning and resourcing from that provided by a standard double manned ambulance.

8.19 **Personal Protective Equipment (PPE)** – Specialised clothing or equipment worn by employees for protection against health and safety hazards.

8.20 **Risk** – Combination of the likelihood of an occurrence of a hazardous event or exposure and the severity of injury or ill health that can be caused by the event or exposure.

8.21 **Risk Assessment** – The process of evaluating risks, arising from a hazard, taking into account the adequacy of any existing controls and deciding whether or not the risks are acceptable.

8.22 **Static Overload** – Is the stress placed upon the body from an unmoving and constant force or load.

8.23 **T.I.L.E.E.O.** – Task, Individual, Load, Equipment, Environment and Others.

8.24 **Transfer** – Is the movement of a patient from one place or position to another, without the handlers taking the persons full weight.

8.25 **W.T.O.R.S.** – Wheelchair Tie-down Occupant Restraint System.

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9. Principles of Efficient Movement

9.1 In order to ensure the safe handling of patient's and reduce the risk of sustaining, aggravating existing MSD's or causing complications to other medical conditions, all staff should follow the principles of efficient movement when carrying out safer person handling operations.

9.2 These principles are:

- Create and maintain a dynamic stable base of standing (this will also facilitate the introduction of momentum);
- Get as close to the patient (load) as possible;
- Adopt a good posture;
  - Knees bent slightly to facilitate smoother and more efficient movement;
  - Back Straight as possible maintaining neutral alignment and the backs natural curves;
  - Keep your head up looking in the direction of travel (aids breathing and hazard observation);
- Do not twist or rotate the body, move with the legs;
- Use the primary leg muscles to do the majority of the heavy movements;
- Hold the patient using palmer hold, try not to grab with fingers;
- Don't mobilise patients through their joints;
- Introduce gentle momentum prior to movement to reduce the force application required;
- Contract core muscles prior to any movement;
- Use smooth controlled movements, don't jerk as this may cause dynamic overload;
- Explain to the patient what you are planning and utilise their functional mobility as much as practicable;
- Avoid going into stress positions that may cause static overloads any earlier than required;
- Good communication with the patient and other handlers (Ready, Steady and then the action).

Manual Handling Key Workers

9.3 ERS Medical Manual Handling Key Workers should actively advocate and promote the principles of efficient movement and offer advice and guidance to all staff that are either observed or reported to use what ERS Medical deems to be poor practice or high-risk techniques in an inappropriate manner.

9.4 The key workers will also seek additional guidance and advice from the BTEC Level 3 and 4 Safer Person Handling Instructors, for all issues that fall outside of their knowledge and experience.

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10. Functional Mobility and Patient Mobility Categorisation

10.1 It is important to correctly ascertain a patient's level of mobility prior to beginning any safer person manual handling operation, in order to stimulate and retain their functional mobility. Patients can rapidly loose mobility if this is not conducted and once lost it can prove very problematic for them to regain.

10.2 It is essential that we have some knowledge of their mobility prior to transporting them, so that the CCO / Dispatch can categorise and allocate the appropriate resource to the booking. This will then serve to protect the patient's functional mobility, theirs and the crew's health and safety and the smooth running of the service being provided.

10.3 These mobility categories are:

Mobility Type	Description
	C - Driver only The patient can walk unaided to, and travel in a saloon car with the assistance of a driver for walking.
	C1 - Ambulance with driver and vehicle ramp The patient is a minimal falls risk and can walk with assistance of the x1 crew. The patient can manage the step or ramp onto the vehicle with steadying assistance only. The patient may require assistance to the vehicle in a wheelchair but can transfer to the seat of the ambulance. The destination location in known to have easy access (no multiple steps or stairs) and access can still be achieved with the assistance of x1 crew.
	C1(W) - Ambulance with driver and vehicle ramp; travelling in own wheelchair The patient has their own wheelchair been assessed as immobile and unable to transfer out of the wheelchair. The patient will transfer in their wheelchair (secured using WTORS). The destination location in known to have easy access (no multiple steps or stairs) and access can still be achieved with the assistance of x1 crew.
	C2 - Ambulance with driver and attendant plus vehicle ramp The patient cannot walk and requires either a wheelchair (secured using WTORS) or carry chair with the assistance of two ambulance staff to be transfer to and from the ambulance and / or the patients mental, physical condition requires the attention of two staff and or the patient requires oxygen whilst travelling to and from hospital.

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	C2 - Ambulance with driver and attendant plus tail-Lift Patient Travelling In Own Wheelchair The Patient is required to travel in their wheelchair (secured using WTORS) and cannot transfer. There are steps at home and / or their condition requires a two person crew.

Mobility Type	Description
	C2 (Str) - Stretcher Crew The patient has no independent mobility or must remain, for medical reasons, lying down for the duration of the journey, and / or has a full leg cast or patient is unable to bend their leg and cannot sit.
	C3 (Str) - 3 Man Crew Requires x3 Crew members to transport the patient safely due to patient mobility and or access and egress to either the collection or delivery destination or both.
	C4 (Str) - 4 Man Crew Require x4 crew members to transport patients due to mobility, weight and size in the case of Bariatric / Plus Sized patients or due to known access and egress issues to collection or delivery destination or both.
	C-Para - Paramedic Crew Due to the patient's presenting medical condition a paramedic intervention or monitoring crew is or may be required on route to safely convey the patient.

Escort Type	Description
	C+(E) - Relative or Medical Escort A nurse, clinical team or carer is required to travel due to the needs of the patient during the journey. Or a parent or relative is deemed necessary due to the needs of the patient either 1 or 2 relative may travel.
	C+ (CE) - Child Escort All children under 16 must travel with an escort.

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10.4 With the patient's mobility initially categorised, the CCT / Dispatch will then be able to assign the most appropriate resource to meet the patient's requirements.

	Vehicle Type				
Mobility Code	Car / Taxi	WAV	Amb (seats only)	Amb (Trolley)	HDU
C	✓	✓	✓	✓	✓
C1	✓	✓	✓	✓	✓
C1 (W)	X	✓	✓	✓	✓
C2	X	X	✓	✓	✓
C2 (W)	X	X	✓	✓	✓
C2(STR)	X	X	X	✓	✓
Bariatric / Plus Sized	X	X	✓	✓	✓

10.5 There will, on occasion, be times where some patient' can be moved outside of the parameters set in the table at 10.4, such as when a taxi company, approved through Due-diligence Supplier Assessment – **F4.01.05B**, has the capability to move wheelchair users in the prescribed manner detailed within the relevant safe systems of work.

10.6 Please refer to **F6.07.03** – Mobility Assessment Flowchart for details on how the mobility code is established for a patient requiring transport (NEPTS, Renal or HDU).

11. Dynamic (Patient) Risk Assessments

11.1 All patients should be risk assessed prior to their movement and / or transfer, based upon multiple factors that may include, but not be limited to:

- Additional resources that may either be present or required;
- Cognitive functionality i.e. their ability to consent or understand what is being planned or is required of them;
- Current medical or care treatment plans;
- Dynamic loading forces;
- Environmental conditions (temperature, lighting, space constraints, floor surface);
- Ergonomics (ability of the handlers to adopt and use the principles of efficient movement);
- Manual handling techniques (the ability of the attending crew to select the most appropriate method);
- Moving and handling equipment (the availability and suitability of equipment);
- Medications (take into account any direct effects or side effects of medications taken);
- Patient functional mobility (take into account what the patient is normally able to achieve);
- Patient weight, BMI, size and weight distribution (effects that these may have on selected equipment);
- Pre-existing medical conditions ;
- Static loading forces;

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- The right of the patient to play an active part in any decisions affecting their care;
- The training and experience of the attending handlers.

11.2 ERS Medical utilises two types of dynamic risk assessment for safer person handling. These are:

- **Informal Dynamic Risk Assessment** – An assessment conducted by all crews, based on their initial global overview of the patient, their presentation and their environment, taking into consideration the factors detailed at 11.1;
- **Formal Dynamic Risk Assessment** – The completion of **F6.07.01(ERS)** to record the assessment for Bariatric / Plus Sized and complex need patients. This should only be completed by staff who have attended and passed a Bariatric / Plus Sized Awareness training session and who are deemed to have suitable experience in dealing with Bariatric / Plus Sized and complex needs patients.

11.3 Informal dynamic risk assessment will be conducted dynamically by the attending crew and reflect the mobilisation code supplied by the CCT/dispatch from the information they received at the time of booking, if the journey was pre-planned.

11.4 Informal dynamic risk assessments, for urgent care and front line patients should be recorded on the Patient Record Form (PRF see figure 1) at the lifting and handling section. This assessment should be reviewed and amended as required during the patients ambulance transfer based on their medical presentation and local protocols.

11.5 All dynamic risk assessment should follow best practice of '**Think Before You Lift'** which requires an ergonomic approach to be adopted and used:

- **Task;**
- **Individual;**
- **Load;**
- **Environment;**
- **Equipment;**
- **Other factors.**

11.6 In the event that NEPTS crew arrive at the collection location for a patient and the circumstances, patient's location and mobility differs from the information provided at the time of booking and they have concerns about either the patients or their safety, they should contact their control room or Team Leader for further advice and guidance.

11.7 Crews should therefore consider the points detailed within the tables below when conducting any form of dynamic safer person handling risk assessment.

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TASK:	**What is the task?**	• What is the task and can it be avoided? • Does it involve strenuous pushing and pulling? • Does it involve carrying things over long distances? • Has it previously been risk assessed? • Is the task routine or emergency handling?
INDIVIDUAL:	**Who are the handlers and what are their abilities?**	• Do you need assistance? • Are you familiar with the technique and equipment? • How is your health, are you carrying an injury? • Do you require additional resources (equipment of staff? • Do you need PPE and are you wearing the appropriate clothing?
LOAD:	**What is the load and its characteristics?**	• Can the patient assist you (stimulate functional mobility)? • Do you know the weight? • Has it sharp edges or surfaces? • Is the load balanced or likely to move? • Is the load bulky, unwieldy or difficult to grasp?
ENVIRONMENT:	**Are there any environmental concerns or issues?**	• Environmental factors such as available light, cold, hot, wet, dry, even or uneven, physical obstructions?
EQUIPMENT:	**What equipment is available?**	• Have you been trained to use the equipment? • Has it been serviced and maintained correctly? • Is it suitable for the task after assessment? • Is it readily available? • Do you know the Safe Working Load?
OTHER FACTORS:	**Are there any other factors to consider?**	• Is time a factor? • Have you been supplied with accurate information? • Has the patient's condition changed since the point of booking?

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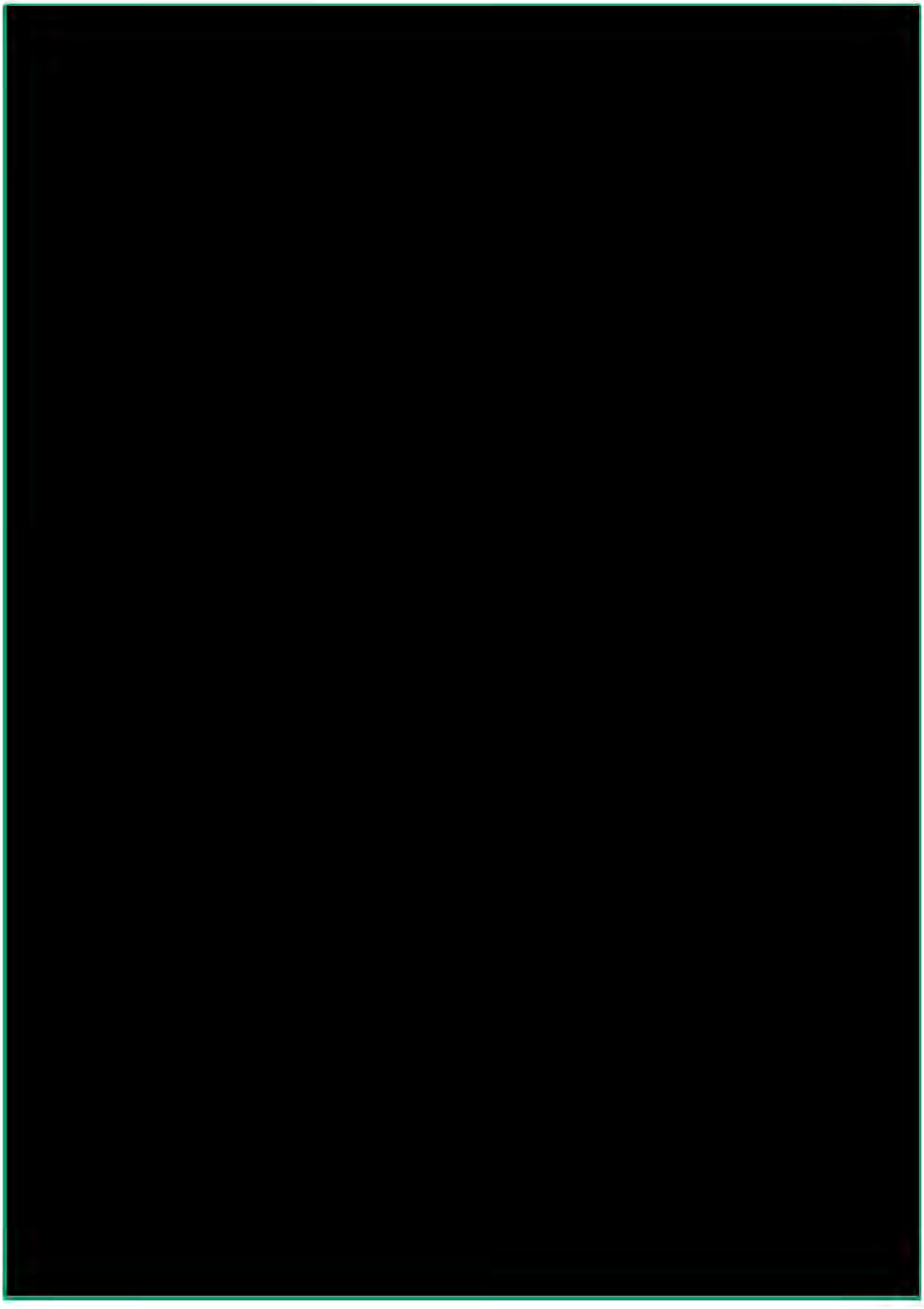
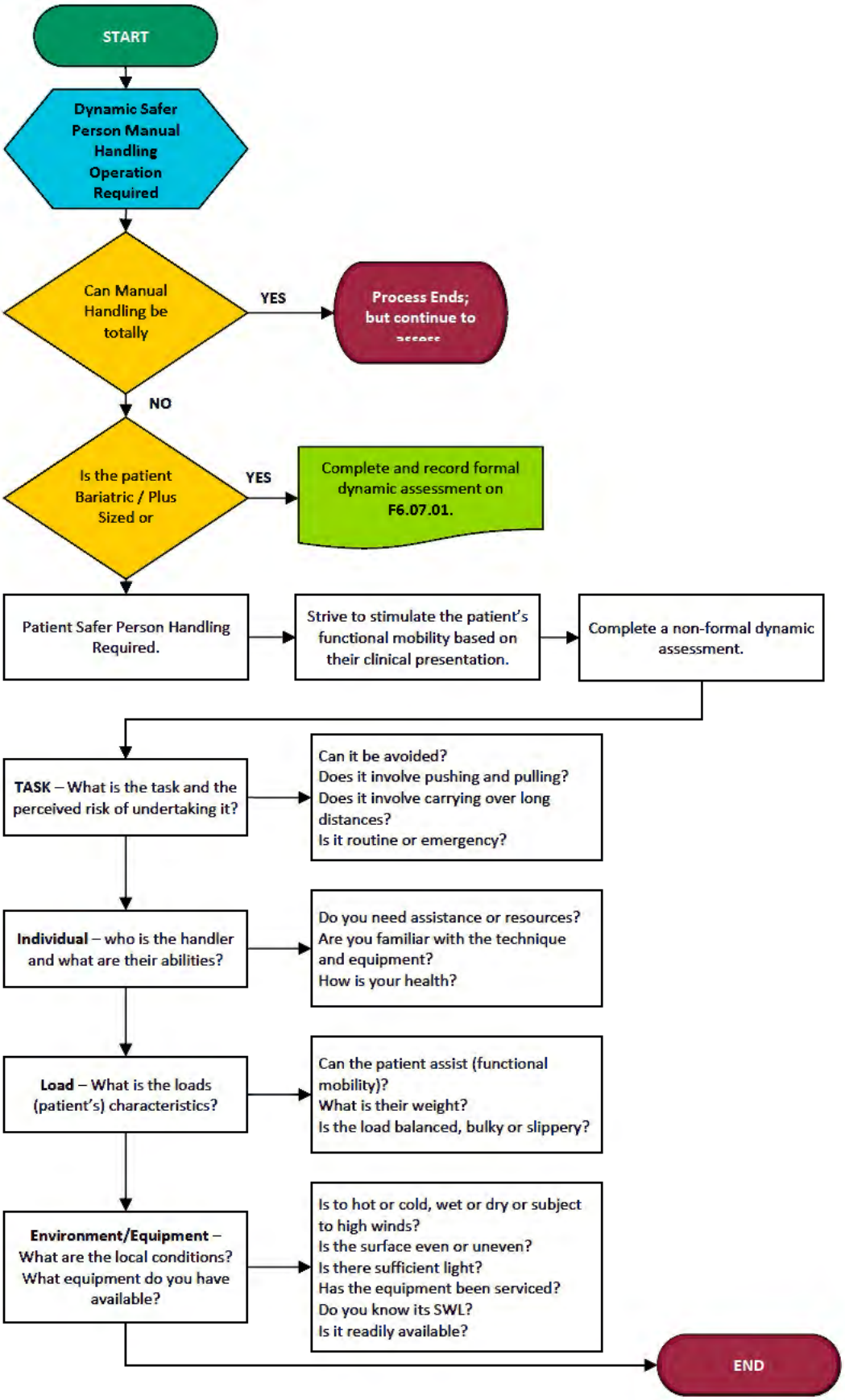


Fig 1: Patient Report Form (PRF)

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12. Key Steps


START
Dynamic Safer Person Manual Handling Operation Required
Can Manual Handling be totally
YES
Process Ends; but continue to
NO
Is the patient Bariatric / Plus Sized or
YES
Complete and record formal dynamic assessment on F6.07.01.
Patient Safer Person Handling Required.
Strive to stimulate the patient's functional mobility based on their clinical presentation.
Complete a non-formal dynamic assessment.
TASK – What is the task and the perceived risk of undertaking it?
Can it be avoided?
Does it involve pushing and pulling?
Does it involve carrying over long distances?
Is it routine or emergency?
Individual – who is the handler and what are their abilities?
Do you need assistance or resources?
Are you familiar with the technique and equipment?
How is your health?
Load – What is the loads (patient's) characteristics?
Can the patient assist (functional mobility)?
What is their weight?
Is the load balanced, bulky or slippery?
Environment/Equipment – What are the local conditions? What equipment do you have available?
Is to hot or cold, wet or dry or subject to high winds?
Is the surface even or uneven?
Is there sufficient light?
Has the equipment been serviced?
Do you know its SWL?
Is it readily available?
END

13. Bariatric / Plus Sized and Complex Need Patient Handling

13.1 All Bariatric / Plus Sized and complex needs patients will be considered a high-risk journey due to their often-complex medical presentations, history and the co-morbidities often associated with patients who are clinically classified in this manner.

13.2 Additionally, in the case of Bariatric / Plus Sized patients and due to their increased weight and size, including body weight distribution nuances, they can be at increased risks when patient handling and ambulance equipment is used in the provision of their care and treatment.

13.3 It is therefore, a requirement of ERS Medical that all planned Bariatric / Plus Sized and patients with complex needs should have their transport booked with a minimum of 24 hours' notice.

13.4 This 24 hour notice period is to allow ERS Medical time to complete for a formal dynamic risk assessment (**F6.07.01**).

13.5 This formal dynamic assessment will identify the most suitable method and appropriate resources to allocate for the booking, keeping patient and staff safety, dignity and welfare as its main priority.

13.6 Additionally, it is the policy of ERS Medical that all staff called upon to care, treat and transport Bariatric / Plus Sized patients, should prior to any such duty receive a Bariatric / Plus Sized patient awareness course.

13.7 It is important that when completing the formal dynamic assessment using **F6.07.01(ERS)**, staff tasked to undertake them take into consideration the following:

- The patient's known or estimated weight (will this exceed Safe or Max Working Loads of equipment including the ambulances carrying capacity;
- The patient's BMI;
- The nature of the patient's complex needs i.e. amputation, cognitive impairment;
- The number of suitably trained staff required to complete the journey safely;
- The patient's current functional mobility i.e. is the patient independent and mobile, do they require assistance;
- How the patient normally mobilises i.e. wall walks, sticks, frame, wheelchair;
- What the patients presenting medical complaint is (primary and co-morbidities);
- Is the patient's condition assessed as being time critical;
- Are additional medical resources required;
- The patient's position on arrival at scene (walking, lying, sitting);
- The patient's location at scene on arrival (downstairs, upstairs);
- The ease of access and egress to the property and facility;
- Any safer person handling / emergency handling equipment needed (wheelchair, carrychair, slide sheets, manger elk, orthopaedic scope, long board);
- Can the patient tolerate being supine (lying flat on their backs), as a small percentage of Bariatric / Plus Sized patients may encounter significant breathing problems if placed into this position;
- Is the patient compliant;

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- Is there a history of either verbal or physical abuse;
- Does the patient require an escort;
- The patient's tissue viability, do they have any pressure sores (if Yes, complete **F6.07.02**).

14. Handling Equipment

14.1 ERS Medical provides various items of ambulance borne equipment to maintain and potentially improve the clinical presentation and increase the safety and comfort of our patients and staff.

14.2 All ambulances will be equipped with a minimum standard of equipment and all staff should be trained and familiarised on each piece prior to use.

14.3 Specific details on what equipment is provided for each vehicle type can be found on the vehicle loading lists available on the BMS:

- **F6.10.02** – Vehicle Loading List (NEPTS);
- **F6.10.03** – Vehicle Loading List (WAV);
- **F6.12.01** – HDU / Frontline Medical Equipment Device Loading List.

14.4 Standard Ambulance Safer Person Handling Equipment:

- Ambulance Trolley (Ferno or Striker variants);
- Ferno Compact 2 Carrychair;
- Patient Wheelchair;
- Wheelchair Tie-down and Occupant Restraint System(WTORS);
- PAT Slide;
- Handling Belt;
- Slide Sheet(s);
- Patient Turntable;
- Banana Board;
- Ambulance Winch Assist.

14.5 All employees should familiarise themselves with the Safe Working Load (SWL) and / or the Maximum Working Load (MWL) of the piece of equipment they are using. Under no circumstances should the SWL be exceeded as this could cause equipment failure and result in an injury to either the patient staff member or both.

14.6 It is important to note that in the case of PAT slides there is no specific SWL / MWL, as this piece of equipment is not designed to take significant amounts of patient weight, but rather to act as a lateral transfer device between to flat surfaces, which should not be more the 150mm / 30cm apart.

14.7 Winch Assists are fitted to all new ERS Medical Ambulances and have been provided to reduce the force application required from staff when loading and unloading wheelchairs and ambulance trolleys, either loaded or unloaded with a patient.

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14.8 They are not however, provided to totally remove all physical effort. Ambulance crews will still be required to guide wheelchairs and trolleys up and down vehicle ramps to ensure that they follow the correct and safe line and to be there in the event of a winch failure.

14.9 Crews are not expected to use the winch assist on every wheelchair and trolley load or unload operation. They are expected to dynamically assess the situation using the T.I.L.E.E.O. system. For example:

- If a patient weighs 50kg and is positioned on a trolley, both crew members are physically fit with no existing MSD's and it is raining and cold. Staff could reasonably be expect to load and unload the patient manually, thus preventing the patient from getting cold and wet and reducing the load and unload times;
- If however one of the crew had an existing MSD and was protecting their health, it would be acceptable in this case to utilise the winch assist or in any other circumstance when it has been assessed as being required;
- It will remain the responsibility of each individual to keep their line managers informed of any medical conditions, such as MSD's that affect their fitness to work and carry out patient handling activities.

Linen, Sheets and Blankets

14.10 ERS Medical crew are **NOT** to use patient linen [blankets, sheets etc] for the purpose of restraining their patients', in line with the manual handling training they receive.

14.11 Patient linen is only to be used for the following purpose:

- Thermal comfort of the patient;
- Preservation of the dignity or patients' whilst manual handling operations and care is provided;
- The protection of delicate skin, whilst manual handling operations take place, such as but not limited to, the use and operation of:
    - Compact 2 or similar type of patient Carry Chair;
    - Lateral transfer from ambulance trolley to bed or vice versa.

15. Wheelchairs and W.T.O.R.S.

Wheelchairs

15.1 When using wheelchairs, irrespective of their origin (i.e. ERS Medical provided or the patient's own chair), staff must ensure that the lap safety strap is correctly fitted and secured around the patient's waist, where fitted. All ERS Medical supplied wheelchairs come with a fitted lap belt and this **MUST** be serviceable and used.

15.2 Hospital supplied porter wheelchairs are not designed to be used outside of the hospital and they do not come fitted with safety lap belts.

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15.3 ERS Medical crews should not use these outsides for the following reasons, unless ambulance are equipped with 'Donway Safety Belts':

- Their use outside of the hospital significantly increases the likelihood of an incident occurring and a patient being injured;
- Many NHS Trust clearly state that they should only be used indoors, so there use outside would negate the Trust own safety procedures as well as ERS Medicals;
- Any accidents or incidents that arise from their use would significantly increase the litigation risk to ERS Medical.

15.4 Under **NO** circumstances are wheelchairs to be lifted with a patient in situ. Wheelchairs are not designed to be operated in this manner and this practice is not compliant with either the manufacturers operating instructions or the training that staff receive.

15.5 This is a safety requirement of ERS Medical and a requirement for any on-going transportation required of ERS Medical.

15.6 If a patient refuses to comply with this request, the requirement should be politely explained to them so the fully understand that it is for theirs, other service users and staff safety.

15.7 If they continue to dispute the need, crews should contact the CCT / Control / Dispatch and inform them about the patient's refusal to comply with Company policy.



Wheelchair safety lap strap

Wheelchair Tiedown Occupant Restraint System (WTORS)

15.8 Whenever a wheelchair user is transported in their wheelchair it is essential that they and the wheelchair are secured safely within the vehicle.

15.9 In order to comply with this requirements of legislation and Company policy, ERS Medical provides a Wheelchair Tiedown Occupant Restraint System (WTORS) on the below listed NEPTS platforms:

- WAV;
- NEPTS Ambulance (Seating Only);
- NEPTS Ambulance (Stretcher).

15.10 ERS Medical uses either a system provided by 'Q-Straint' of 'Unwins'. Irrespective of it origin of manufacture all our systems follow the same basic principle of a 4 point anchor system for the wheelchair and a standard 3 point seat belt configuration for the patient.

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15.11 In order for these systems to work correctly they have to be applied in accordance with their stated manufacturer's instruction. **NO deviations from these instructions are permitted**.

15.12 All WTORS equipped NEPTS platform will come provided with both the manufacturers instruction manual and an information plate within the patient cabin, for their use and application. This information is provided to staff in addition to the training they receive.

15.13 Unless a patient has on their person and can present a valid seatbelt exemption certificate to the crew, at the time of transportation, they must wear, by law, the 3 point seat belt that is provided as part of the complete WTOR system.

15.14 NEPTS stretcher capable ambulances that have been provided with 2 set of WTORS must ensure that under **NO** circumstances are 2 wheelchairs and a stretcher patient, transported together at the same time.

15.15 Only 1 wheelchair and 1 stretcher patient at a time has been approved by both the ERS Medical Care Standards Team to ensure that all patients are transported in a safe manner and that the required standard of care and support can be provided for all.

16. Mobility Scooters and Powered Wheelchairs

16.1 Under **NO** circumstances are motability scooters to be transported by ERS Medical. There is no approved or authorised way in which to secure these scooters within the vehicle and their presence would be an unacceptable risk to patient and staff safety.

16.2 Service users powered wheelchairs should under **NO** circumstances be permitted to drive their wheelchairs either onto or off ERS Medical wheelchair compatible platforms.

16.3 They should be requested to:

- Place their powered wheelchair into a neutral gear position with the brakes on;
- The winch assist should be connected to the powered wheelchair at a suitable anchor point at the front;
- The powered wheelchairs brakes should then be disengaged and the crew slowly and carefully guide, load or unload the wheelchair and user from or to the vehicle, using the winch assist;
- The powered wheelchair should then have its brakes reapplied prior to the winch assist being disconnected;
- The patient can then, when in a safe location be requested to take control of the powered wheelchair again.

16.4 If a patient refuses to comply with this request, the requirement should be politely explained to them so the fully understand that it is for theirs, other service users and staff safety.

16.5 If they continue to dispute the need, crews should contact the CCO / Control / Dispatch and inform them about the patient's refusal to comply with ERS Medical policy.

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17. Tissue Viability (Pressure Sores) & Hydration

17.1 Prior to any safer person handling operations crews should enquire and be aware of any tissue viability issues in relation to their patient.

17.2 They should enquire from either family members, medical or care staff about:

- Any pre-existing and recorded pressure sores, their grade and location;
- Any pressure sore regimes that are in place (frequency of turns);
- The most comfortable position for the patient on the ambulance (sitting or lying).

17.3 They should also consider:

- The duration of the transfer or journey;
- Recording any actions that result in the preventative and proactive management of the patient to prevent pressure sores i.e. initiating a turns regime, including its frequency;
- Actions taken during a journey in the event of pressure sores or hot spots developing.

17.4 Details of any hot spots or sores should be recorded on **F6.07.02** – Patient Tissue Viability & Hydration Chart.

17.5 If required they should consider and be prepared to re-position the patient during the journey or transfer to relive the stresses to the patient in the known high pressure areas such as the hips, heels and tailbone.

This repositioning activity should always be conducted when the vehicle is stationary.

ERS Medical crews should not conduct examinations of patients to determine if they are developing or have existing pressure sores.

17.6 If a patient complains and or develops hot spots or pressure sores during a transfer / journey the crew should record their location and subsequent actions on **F6.07.02** - Patient Tissue Viability & Hydration Chart.

17.7 This information should be provided to a family member, medical or care staff at the receiving facility on handover or the patient.

17.8 For long distance transfers or transfers in excess of 1.5 hours, it can reasonably be expected that patient comfort and tissue viability issues will need to be acknowledged, managed and recorded.

17.9 Consideration should be given to the provision of pressure relieving materials such as, but not limited to:

- Beanie mattresses;
- Cushions and Pillows (IPC cleanable);
- Planned regular comfort breaks during the journey;
- Planned and regular stops to allow the proactive and preventative management of tissue viability issues, such as turns and repositioning.

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Hydration of Patients

17.10 The **F6.07.02** – Tissue Viability & Hydration Chart should also be used to record the management of hydration for our patients, whilst in our care.

17.11 Staff should follow any professional healthcare guidance provided to them in regards to a patients hydration needs i.e. frequency and amounts of water needed.

17.12 Staff should also record when patients request water. Staff should not refuse a request for water unless expressly instructed to do so as part of their on-going care plan

18. Emergency Situations & Patient Falls

18.1 In emergency situations, (e.g. medically time critical patient or in the event of fire), it may be necessary to manually handle people to a place of safety as a matter of urgency to protect life.

18.2 In such instances, employees should always attempt to use the best practical means of manual handling to safeguard their health and wellbeing without compromising the saving of a life.

18.3 Under **NO** circumstances should ERS Medical staff put their own safety at risk.

18.4 With an un-witnessed patient fall, ERS Medical employees should in the first instance try to ascertain from any persons in the vicinity (family members, medical or care staff); if there have been any injuries to the patient as a result of the fall and if there is a history of previous falls.

18.5 The recovery method from the floor should be based on the results of this initial assessment and the urgency of the patients presenting medical complaint or condition. Only suitably clinically qualified staff should do this. PTS staff are **NOT** deemed qualified to clinically assess the patient's injuries or determine the mechanism of fall i.e. medical or mechanical.

18.6 Where a patient falls whilst employees of ERS Medical are present, they should try and balance their own health, safety and welfare against that of the patient. As such they should try and refrain from the natural tendency to catch the patient or stop them from falling, as this can potentially make the situation worse.

18.7 Staff should base their decision, as to whether they are in a position to intervene, taking some for the following points into consideration:

- Their proximity to the patient (the closer they are the better they can manage the situation);
- The speed of the fall (not all patient falls are high speed);
- The weight and size differential between handlers and patient;
- The mechanism of fall (mechanical i.e. slip or trip or medical in origin, i.e. vasovagal);
- The environment (hazards that can increase injuries).

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18.8 Any patient in our care or found by our crews on the floor after a suspected fall, should be encouraged to go to hospital and or seek medical care. This may necessitate the ERS Medical crew, if PTS requesting a **999** response from their local ambulance service. A record of all patient initial observations and any care / treatment provided by ERS Medical should be recorded on a PRF. When appropriate the crew should contact the CCT and inform them of the incident on **0333 240 4107**.

18.9 Staff should not be in any hurry to recover the patient from a fall, until they have conducted a primary assessment of the patient and ascertain if there are any remaining medical issues that may result in another fall and or the patient has sustained any injuries that require either first aid treatment and or other medical attention.

18.10 This assessment should also determine if the patient's condition is deemed to be time critical. The emergency services should be called immediately if this is the case or the patient is to be transported to the nearest NHS accident and emergency unit if the crew are suitably qualified to do so.

18.11 ERS Medical staff that either treat or transport a patient post fall should ensure that they complete a patient report form.

18.12 Any such fall of a patient whilst in the care of ERS Medical staff, should be reported to family members, medical or care staff on handover of the patient.

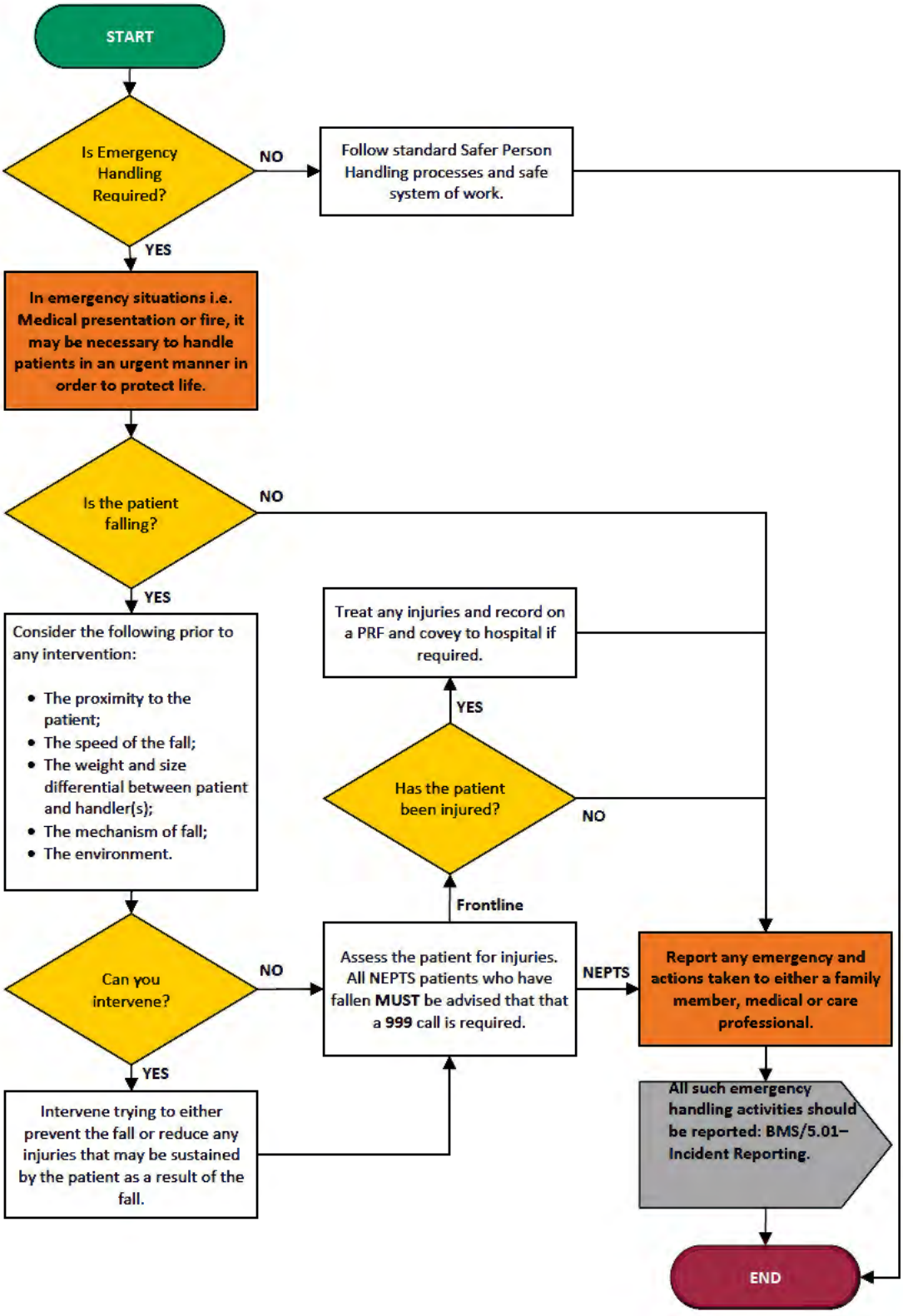
18.13 Following all emergency situations or incidents, employees are required to report the incident following the process defined in **BMS/5.01 – Incident Reporting and Investigation.**

18.14 An additional resource available for emergency handling is available from the UK Resuscitation Council at:

https://www.resus.org.uk/publications/guidance-for-safer-handling-during-cpr-in-healthcare-settings/

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19. Key Steps



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ERS Medical

BMS/9.04 Control of Substances Hazardous to Health (COSHH) / Chemical Risk Assessment

Document Author:	*** REDACTED ***		Care Standards Manager		
Document Owner:	*** REDACTED ***		Head of Care Standards		
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Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	04.05.18	*** REDACTED ***	Review of whole procedure
3.0	All	All	All	26.07.2019.	*** REDACTED ***	Review of full document & amendments
4.0	All	All	All	31.07.2020	*** REDACTED ***	Review of full document

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2. Related Documents

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
Human Resources	BMS/2.01
Personal Training & Development	BMS/2.02
Employee Health and Wellbeing	BMS/2.03
Incident Reporting and Investigation	BMS/5.01
Facilities Management	BMS/7.01
Health and Safety Management	BMS/9.01
PPE & Uniform	BMS/9.02
Working at Height	BMS/9.05
Fire and Emergency Evacuation Plan	BMS/9.06
Medical Gases Storage	WI/9.04.01
GDPR	BMS 1.10.01

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3. Purpose of Procedure

3.1 To set out the process for carrying out Control of Substances Hazardous to Health (COSHH) assessment for sites in the UK to ensure that all hazardous substances in the workplace are subject to such an assessment.

3.2 To ensure a single procedure is defined and utilised at all locations within the Company for COSHH / Chemical Risk Assessments.

3.3 To define the responsibilities of personnel with regards to COSHH / Chemical Risk Assessments.

4. Scope and Application

4.1 This procedure applies to all Company sites, and employees conducting work activities regardless of location.

4.2 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the Company's Capability and Disciplinary procedures as set out in WI 2.01.04

5. Policy Statement

5.1 It is the policy of the Company to ensure that, in as so far as it is reasonably practicable, that all substances and materials utilised, will be assessed and controlled to ensure that the risk to employees is minimised.

5.2 Please refer to the Company's Quality, Environmental, Safety and Health Policy available on the BMS Portal

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Management Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
6.3	**Care Standards Team**	Is responsible for conducting assessments and the development, implementation and monitoring (through audit) of all Health and Safety processes.
6.4	**Regional and Operations Managers**	Are responsible for ensuring that all assessments are displayed at the locations or areas for which they are responsible. They are additionally responsible for completing any actions necessary to reduce the risk rating of a particular aspect.
6.5	**All Personnel**	Are responsible for familiarising themselves with the COSHH / chemical risk assessment information relative to their work activities. They are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **At Work** – Includes all operational areas of the Company's sites and all activities undertaken off-site by Company employees.

7.2 **Personal Protective Equipment (PPE)** – Specialised clothing or equipment worn by employees for protection against health and safety hazards.

7.3 **Hazard** – Source, situation or act with a potential for harm in terms of human injury or ill health or a combination of these.

7.4 **Risk** – Combination of the likelihood of an occurrence of a hazardous event or exposure and the severity of injury or ill health that can be caused by the event or exposure.

7.5 **Risk Assessment** – The process of evaluating risks, arising from a hazard, taking into account the adequacy of any existing controls and deciding whether or not the risks are acceptable.

7.6 **MSDS** – A material safety data sheet details specific properties and dangers of the material or substance and the precautions to be taken when using them. The document also details storage, handling and emergency information enabling an assessment to be conducted.

7.7 **Hazardous Substance** – Solids, liquids, or gases that can harm people, other living organisms, property, or the environment.

7.8 **Exposure** – The condition of being subjected to a hazardous material or substance.

7.9 **Workplace exposure limit (WEL)** – Is the approved limit for exposure to a substance following a method of calculation as set from time to time by the relevant Health and Safety Regulator, refer to EH40/2005 - Workplace Exposure Limits document (UK) / 2011 code of practice SI No 619 of 2011 (ROI).

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8. Process Overview

8.1 Using hazardous substances can put people's health at risk. Legislation requires employers to control exposure to hazardous substances to protect both employees and others who may be exposed from work activities.

8.2 Employers are also required to assess the risks to the health of their employers arising from exposure to hazardous substances and to prevent and where this is not reasonably practicable, adequately control exposure by Health Surveillance as set out by the HSE checks may be required by law for employees who are exposed to noise or vibration, ionising radiation, dusts, biological agents and other substances hazardous to **health** (this is not a definitive list refer to Care Standards Team & http://www.hse.gov.uk/health-surveillance for further advice as required)

9. Undertaking a COSHH / Chemical Risk Assessment

9.1 Work must not be carried out, which could expose employees to hazardous substances, without first considering the risks and the necessary precautions. The risk assessment is undertaken by completing **F9.04.01** and requires:

1. Looking to see which hazardous substances are present;
2. Thinking about the risks they present to people's health;
3. Where there are significant risks, determining how much and how often the substance is used, in what format and how hazardous it is;
4. Choosing the control measures to be used (i.e. elimination, substitution, process change, enclose process);
5. Deciding the action needed to prevent exposure, for example, removing people from the process, mechanising the process so people are not exposed or the level of protective clothing to be worn;
6. Considering action that should be taken should an accident occur concerning the substance, for example, contact with a person, a spillage or a fire.

9.2 Training will be provided to ensure that all relevant personnel are aware of the requirements of COSHH / Chemical Risk Assessment and how to conduct the risk assessments.

9.3 The relevant personnel, using information from material safety data sheets (MSDS available on Sharepoint) and other relevant information, produce COSHH / Chemical Risk Assessments.

9.4 Once complete, COSHH / Chemical Risk Assessments are forwarded to the Care Standards Team for review / comment. Any changes recommended by the Care Standards Department must be implemented prior to the material being used. In some instances, a material may not be suitable for use and an alternative might need to be sourced and the process re-started.

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9.5 Once the assessment has been formally approved by the Care Standards Team, a completed copy will be made available to the site which will be held locally (e.g. in the site office or at the point of substance usage), enabling access for all employees.

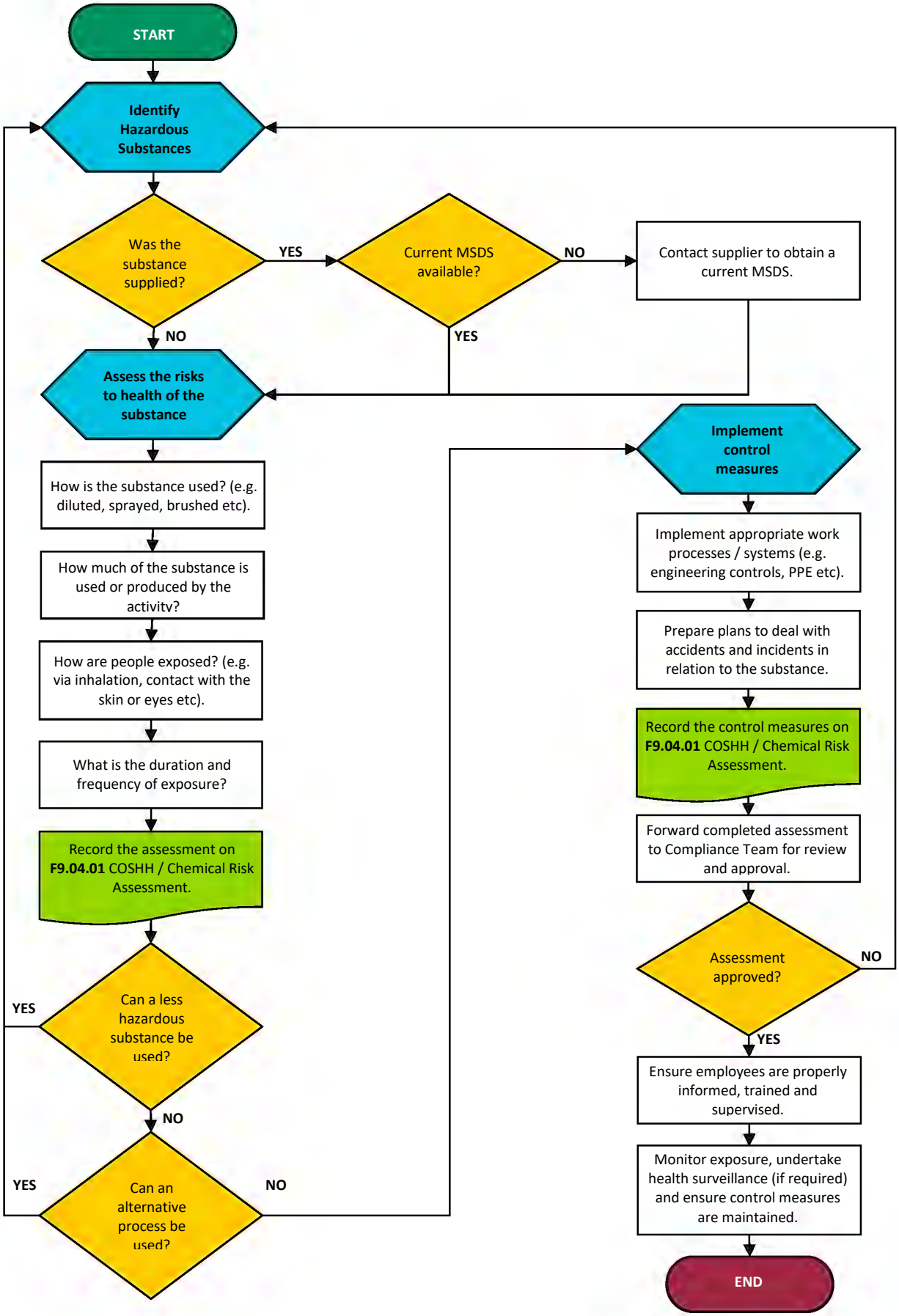
9.6 Electronic copies of all COSHH / Chemical Risk Assessments are held and available on the COSHH assessment page of Radar Healthcare and all COSHH / Chemical Risk Assessments will be periodically assessed to ensure their ongoing suitability.

9.7 The following are excluded from COSHH / Chemical Risk Assessment and need not be considered as part of this process:

1. Asbestos and Lead which have their own specific regulations;
2. Substances which are hazardous only because they are:
1. Radioactive;
2. Simple asphyxiants;
3. At high pressure;
4. At extreme temperatures;
5. Have explosive or flammable properties which are covered by the Dangerous Substances, Explosive Atmosphere Regulations (UK) / Guide to the Safety, Health and Welfare at Work (General Application) Regulations 2007 – part 8 Explosive Atmospheres at Places of Work (ROI);
6. Biological agents if they are not directly connected with work and are not in the Company's control.

This document forms part of the ERS Medical's BMS and as such is subject to controlled distribution and updating in accordance with: BMS/1.01 – Document Control and BMS/1.02 – Record Retention, Storage and Disposal. Uncontrolled when printed.

10. Key Steps



This document forms part of the ERS Medical's BMS and as such is subject to controlled distribution and updating in accordance with: BMS/1.01 – Document Control and BMS/1.02 – Record Retention, Storage and Disposal. Uncontrolled when printed.

Question 1.15.6

Health and Safety Training

Health and Safety Training - Please provide details of any Health and Safety training provided to staff to ensure they are competent to meet their duties. This should include what the training is, who in the Organisation is required to complete it, how long the training sessions are and how frequently must this training be completed/refreshed.

The Bidder has evidenced they have appropriate proposed training– Pass

The Bidder does not have appropriate proposed training - Fail

ERS have a structured training and development programme that is vital for our staff's competence, confidence and retention. Our training and development programmes empower staff members to continually develop throughout their careers resulting in a high level of staff retention.

All employees within our business are required to complete Health and Safety training to ensure they are able to do their job in a safe and effective manner at all times. Below we have provided an overview of the Health and Safety training our employees receive:

- Accident, Incident and Near Miss Reporting
- COSHH (Control of Substances Hazardous to Health)
- Fire Safety
- Health and Safety
- Information Governance (IG)
- Customer Care
- Infection Prevention Control (IPC)

As part of our annual update training and in line with our Training Prospectus, all employees receive Health & Safety Training, this includes face to face training for our crews and E-Learning for our office staff, which includes Level 1 Fire safety and Level 1 Health, Safety and Welfare. We also have trained Health & Safety reps at each of our sites and have a dedicated Health & Safety Manager for the North and South of the country that sit within our Care Standards Team.

All training is both internally quality assured by a qualified internal quality assurance manager who is HCPC registered paramedic along with external quality assurance exercises taking place. All of the clinical trainers have been certified in ROSPA level 3 Manual Handling Instructors certificate with regular External and internal CPD undertaken to ensure the clinical training team are up to date with best current practice. This ensures that all of our employees are competent to meet their duties.

All clinical trainers have been approved to teach the courses as laid down by the awarding bodies with a nominated clinical trainer for each region with a robust process for ensuring training and

governance. Our regional trainers not only deliver training but also provide on the job assessments of our employees to ensure their training is being applied throughout their day job.

	0830-0915	0915-1000	1000-1015	1015-1100	1100-1145	1145-1230	1230-1315	1315-1400	1400-1445	1445-1500	1500-1545	1545-1630
Subject	Introduction paperwork, Company News, Staff welfare resources, CPD	Safeguarding Refresher – including MCA.	**Break**	DNACPR, TEP, ADRT, LPOA	First Aid Basics, the Deteriorating Patient – including IPC & DoLs		**Lunch**	Adult and Paediatric Basic Life Support with AED Incl. Adult BLS Competency Assessment		**Break**	Safe Moving & Handling Update & Assessment	Information governance Local TBT/ Clinical Updates
Reference Materials		BMS 6.05 - Safeguarding of Vulnerable Adults and Children		BMS 6.06 End of Life Care	Ambulance Care Essentials & BMS 6.02 Patients Who Deteriorate in Transit			UK Resuscitation Council 2015 Guidelines				Provided on consultation with Care Quality Manager

NHS
Midlands and Lancashire
Commissioning Support Unit

Annex 3: Bid Declarations, Conflict of interest declarations, Freedom of Information 2000 & Environmental Information Regulations 2004 Caveats

Invitation to Tender for the Provision of Non-Emergency Patient Transport Service across Staffordshire.

On behalf of:
6 NHS Staffordshire Clinical Commissioning Groups and NHS Midlands Partnership Foundation Trust.

ITT 769

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This declaration confirms that the submitted bid for the provision of Non-Emergency Patient Transport services across Staffordshire for NHS Stafford and Surrounds CCG; NHS Cannock Chase CCG ; NHS South Staffordshire and Seisdon Peninsular CCG; NHS East Staffordshire CCG; NHS North Staffordshire CCG; NHS Stoke on Trent CCG and Midlands Partnership Foundation Trust has been submitted by a representative of the bidder's organisation who has the necessary consents, powers and authority from the organisation.

Declaration

I certify that I am a Bidder Member of **[ERS Transition (t/a ERS Medical)]** and that **[ERS Transition (t/a ERS Medical)]** has the necessary consents, powers and authority to bid for, and provide, the Services detailed in this ITT response.

An authorised signatory, in his/ her own name, on behalf of the potential Bidder and Relevant Organisations, must sign a copy of this declaration.

Signed	*** REDACTED ***
Name	*** REDACTED ***
Position	Managing Director
Date	27th October 2020

Declaration of Tendered Bid

This declaration confirms that the submitted bid for the provision of Non-Emergency Patient Transport services across Staffordshire for NHS Stafford and Surrounds CCG; NHS Cannock Chase CCG ; NHS South Staffordshire and Seisdon Peninsular CCG; NHS East Staffordshire CCG; NHS North Staffordshire CCG; NHS Stoke on Trent CCG and Midland Partnership Foundation Trust has been submitted accurately and compliantly.

Declaration

I certify that the information supplied in the questionnaire is accurate to the best of my knowledge and belief and accords with the basic criteria of eligibility as set out in the ITT and that we have not collaborated with other Potential Bidders in the completion of this ITT.

I also understand it is a criminal offence, punishable by imprisonment, to give or offer any gift or consideration whatsoever as an inducement or reward to any servant of a public body, therefore I hereby certify and undertake and bind and oblige ourselves and our Connected Persons (as defined below) that we and our Connected Persons have not canvassed or solicited nor will in the future canvass or solicit any officer or employee of the following organisations: NHS Midlands and Lancashire CSU or any person acting as an adviser for the groups listed above in connection with the selection of Bidders and/or the selection of any submissions, proposals or bids in relation to this project and that our Connected Persons have not nor will so canvass or solicit.

For the purposes of this declaration "Connected Persons" means any person connected with us within the meaning given by Section 839 of the Income and Corporation Taxes Act 1988 and any of the respective directors, officers, employees, solicitors, accountants, bankers or other financial or professional advisers of us and/or of our Connected Persons. Other expressions used in this declaration shall, unless otherwise stated, have the meanings assigned to them in the ITT issued by the above named organisations.

I agree that we shall be responsible for any failure on the part of Connected Persons to abide by such terms to the same extent as if such failure had been our own action or omission. I hereby declare that I am authorised by the under mentioned Potential Bidder to supply the information given above and that, at the date of signing, the information given is a true and accurate record.

An authorised signatory, in his/ her own name, on behalf of the potential Bidder and Relevant Organisations, must sign a copy of this declaration.

Signed	*** REDACTED ***
Name	*** REDACTED ***
Position	Managing Director
Date	27th October 2020

Conflict of Interest Declaration

This declaration identifies any, if any exist, potential conflicts of interest that may have an effect on the submitted bid for the provision of Non-Emergency Patient Transport services across Staffordshire for NHS Stafford and Surrounds CCG; NHS Cannock Chase CCG ; NHS South Staffordshire and Seisdon Peninsular CCG; NHS East Staffordshire CCG; NHS North Staffordshire CCG; NHS Stoke on Trent CCG. and Midlands Partnership Foundation Trust

By completing and signing this declaration, this is done so on the understanding that you have read and understood policy on Conflict of Interest held by: NHS Stafford and Surrounds CCG; NHS Cannock Chase CCG ; NHS South Staffordshire and Seisdon Peninsular CCG; NHS East Staffordshire CCG; NHS North Staffordshire CCG; NHS Stoke on Trent CCG policy on Conflict of Interest https://www.staffordsurroundsccg.nhs.uk/about-us/our-policies/corporate/452-conflicts-of-interest-policy-2017/file

Declaration

Please identify any potential conflicts of interest that could arise through participation in this ITT (taking into account all Relevant Organisations), and how these will be dealt with. Examples of circumstances in which potential conflicts could arise include (but are not limited to) where:

A Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation has carried or is carrying out any work for a CCG or a CSU or predecessor body in the last six months.

A Relevant Organisation is providing services for more than one potential Bidder in respect of this project or procurement process.

A conflict of interest shall not be deemed to arise solely by virtue of a person's employment or engagement by a Clinical Commissioning Group, Commissioning Support Unit or predecessor body, or other NHS body (although bidders are requested to disclose such relationships for information purposes only). For example, GPs engaged under a GMS contract will not be considered to have a conflict of interest by virtue of such practising arrangements.

If no potential conflict of interest is identified, please state this in the response.

Response
We can confirm there are no potential conflicts of interest

Signed	*** REDACTED ***
Name	*** REDACTED ***
Position	Managing Director
Date	27th October 2020

Freedom of Information 2000 and Environmental Information Regulations 2004 Caveats

This pro-forma should be completed and submitted where the Bidder considers that the information submitted or any part of it is confidential and/or commercially sensitive in relation to its bid for the provision of Non-Emergency Patient Transport services across NHS Stafford and Surrounds CCG; NHS Cannock Chase CCG ; NHS South Staffordshire and Seisdon Peninsular CCG; NHS East Staffordshire CCG; NHS North Staffordshire CCG; NHS Stoke on Trent CCG and Midlands Partnership Foundation Trust.

Pro Forma

No.	Section of the Final Tender (or other submission) which the Bidder wishes to designate as confidential and/or commercially sensitive	Reason(s) why the Bidder considers this information is confidential and/or commercially sensitive and why it should be exempt from disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004	Length of time during which the Bidder estimates such exemption should apply
1	Financial Template	Commercially Sensitive	Term of the contract

Signed	*** REDACTED ***
Name	*** REDACTED ***
Position	Managing Director

Date	10th February 2020

Get to know us or get in touch

 mlcsu

 Midlands and Lancashire Commissioning Support Unit

 midlandsandlancashirecsu.nhs.uk

Question 1.1.17

Vision and overview

Please provide a vision and overview of the proposed service (Guidance included in Annex 14)

Word count 1500

Total Word Count: 1497

ERS is a recognised national provider of non-emergency patient transport services (NEPTS) to the NHS and private healthcare sector. We are a leading provider of NEPTS across the UK and provide transport for over 500,000 patients per annum. Our approach to delivering service solutions is partnership led, recognising that the healthcare environment requires flexibility and responsiveness.

The NHS is recognising that the quality solutions that ERS can offer with long term partnerships established in Norfolk, Nottingham, Leeds, Homerton and the North East.

Proposed Service

Our service has been developed using the information provided as part of the ITT and looking into service trends, peaks and troughs.

Our analysis ensures that we can design a service the meets the need and requirements of the CCGs throughout the life of the contact. The below graph provides an overview of how our service is modelled again the number of journey per hours of the day.



ERS Medical



Through continually monitoring every aspect of our service our systems will continue to identify peaks, troughs and trends in demand throughout the contract ensuring we continually update and adjust our service to meet the requirements of the service.

"The provider had invested in six computer based business management systems to support various parts of their business which provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making."

Quality Report, Care Quality Commission

We also utilise state of the art systems to monitor and manage our governance requirements. [redacted] is our compliance software system for the management of clinical and other regulatory governance. This system has been designed specifically with the healthcare market in mind by [redacted]

[redacted] and it allows ERS to quickly and efficiently capture and record some of the main aspects required for evidencing compliance with the requirements of regulated activity.

All comments, complaints and compliments are recorded on [redacted] and we will provide reports during the contract review meetings which will show the number of complaints/incidents and their status on a cumulative basis.

Understanding of Requirements

We understand that over the last few years both Staffordshire and Stoke-on-Trent have gone through numerous changes to the configuration of the health services and that there is potential for further changes in the near future. Through delivering a service that works closely with the Commissioners we will assist in integrating any potential change into our service seamlessly.

Our service delivery methodology and partnership working approach will deliver a patient transport service that will:

- Function as a critical part of the local health economy system for ensuring smooth patient flow, capacity management and timely discharge
- Not be detrimental to patients health and wellbeing during their journey
- Deliver patients in a safe, compliant and timely manner
- Ensure patients don't spend an unreasonable amount of time on vehicles
- Ensure patients are collected promptly, in reasonable timescales following their appointment
- Patients will be treated with courtesy, dignity and respect at all times
- Reduce carbon emissions and the carbon footprint of the service where possible
- Be innovative in its approach to using best practice and technology
- Form a key part of the local health economy and Staffordshire Resilience Forum emergency response system

Service Model

We have designed a service that will meet the needs of the patients and CCGs 24/7. We have structured our shifts to make sure they are able to meet the peaks in demand. The table below provides an overview of the shifts throughout a typical day Monday to Friday.

Overview of total resource Monday to Friday



To deliver the CCGs with a comprehensive, complaint, safe and effective Patient transport service we will utilise the following vehicle mix.

Vehicle Type	Number
[redacted]	

The above fleet mix ensures we have the flexibility to meet service demands of each CCG. Our PTS vehicles are designed so they can be configured as either seater or stretcher vehicles as required. This allows use to easily alter the fleet mix of our service should it be required without having to go through the timely process of procuring new vehicles. It also enables us to flex our fleet mix day in day out meeting the ever-changing requirements of the NHS and deliver a bespoke daily service. All our PTS vehicles can be configured to accommodate Bariatric equipment.

Our analysis of the data also informed the positioning of our bases to deliver the service from. We do not believe in trying to fit transport services around existing facilities as one of the key factors in delivering an optimal service is the location of the transport hubs. The map below provides an overview of where the bases we have identified for this contract are located.



As part of delivering a patient focused service that assists in delivering a high-quality whole life patient experience we will partner and work alongside all stakeholder within the patient journey. This will include patient groups, Healthwatch, local community groups and Trust staff working groups.

Assumptions

The service solution design has been arrived at through a detailed methodology which has been proven successful in other areas of the UK. They key considerations we apply to understand the requirements and feasibility of the service delivery are:

- Patient journey concentration by area
- Patient mobility demands
- Patient journey and return mileage
- Booked Journey times

ERS applies several metrics to the data set we feel are achievable in year 1 and build up efficiencies throughout the contract life by focus and improving the metrics. Key metrics that drive our service solution are:

- Average patients per journey
- Average mileage per journey
- Mobility determining vehicle and crew requirements
- Anticipated calls from patients and trust staff

In terms of journey volumes, the model would provide some excess capacity to deal with demand peaks or small volume increases.

Key financial assumptions made to ensure the service remains viable throughout the contract life are:

- National minimum wage increases to £10.50 by 2024
- Inflationary rises of 2% per annum on all other expenses
- Ensure vehicle leases including maintenance, building leases and any IT costs are fixed throughout the contract life

These assumptions combined determine where we base our operations locations, vehicles numbers and capability, staff requirements and back office structure.

Benefits

We will deliver the Commissioners with a service that has achieved a rating of good/good with outstanding in all 4 of our regional CQC reports outlining the quality and compliance we provide.

We have a proven track record of delivering high quality services within large contracts. We are currently successfully delivering large scale NEPTS services across Nottinghamshire, Norfolk and Homerton.

By delivering a truly holistic partnership-based service we will ensure we become fully integrated into the healthcare economy and not only deliver a high-quality patient transport service but assist in improving the patients' healthcare experience.

We will also provide the commissioners with innovative service delivery including:

- Patient portal - Allowing patients to track their transport
- Green vehicle fleet – We will be the first ambulance private provider in the UK to receive a fully electric ambulance from Arrival
- Dementia friendly vehicles – We are working in partnership with the Alzheimer's Society to develop both dementia friendly vehicle and dementia awareness training staff

Risks

Facilities not being available – There is a risk that our new facilities will not be available for the start of the new contract. As we can run all our operations remotely, we are able to mitigate the impact of not having a facility on day one. We also have an experienced dedicated mobilisation team who have a proven track record of obtaining facilities within short mobilisation timeframes.

TUPE – Employee may choose not to transfer with the contract. To mitigate this, we would identify these individuals early in the mobilisation period and begin a recruitment drive to ensure we have a full complement of staff for the service commencement. We will also complete due diligence on potential subcontractors ensuring we have them as contingency.

Vehicles – Due to the uncertainty of the current climate vehicle manufacturers no longer maintain a stock of vehicle which increases the lead time on ambulances. We will utilise our relationships with leasing companies such as [redacted] to ensure we are able to obtain vehicles for the start of the contract.

Financial Risks

Further to the key financial assumptions made within our tender submission we can identify the following risks that could threaten financial stability of the contract:

- Government decisions on increasing minimum wages beyond the National Living Wage standards set currently – increases beyond £11.50 per hour would put the contract financial stability at risk
- Import duties increasing on new vehicles due to changing trade arrangements – low impact
- Fuel prices escalating beyond current inflationary levels due to global uncertainty – low impact

Experience

We deliver NEPTS services to 319 Trusts and CCG's across the UK and in 2019 we successfully mobilised 10 new NEPTS contracts including:

- October 2019, we retained our Norfolk contract through the OJEU procurement process and further mobilised additional aspects of the service – Contract Term 5 years, [redacted]
- November 2019, we completed the successful mobilisation of Homerton University Hospital NHS Foundation Trust NEPTS contract – Contract Term 5 years, [redacted]
- December 2019, we successfully mobilised the Nottinghamshire & Bassetlaw CCG's NEPTS contract, a combined procurement by 7 CCG's – Contract Term 5 years, [redacted]

Question 1.18.1

Delivery model

5% Please provide an overview of your proposed service model, based upon the service specification provided.

Word count 3000

Total word count: 2922

Our service delivery and management methodology has delivered a CQC rating of Good/Outstanding across our four inspected regions. Our firth region (Midland) is due to be inspected in 2021. This has led to the NHS recognising the benefit of the quality solutions that ERS can offer with long term partnerships established in Norfolk, Nottingham, the North East, North London and Devon.

Our approach to delivering service solutions is partnership led, recognising that the healthcare environment requires flexibility and responsiveness.

Operational delivery model

To ensure we deliver a service that is efficient, effective and sustainable we have conducted a detailed analysis of the data provided. Through analysing the time, day and seasonality of the journeys we have developed a service model that will meet the requirements of the service taking into account peaks in demand. The below table and graphs provide a summary of the resource we will utilise to deliver this service and how it meets demand.

Overview of total resource Monday to Friday



ERS Medical

Resource broken down by Facility

[redacted]

[redacted]

[redacted]

ERS Medical

[redacted]

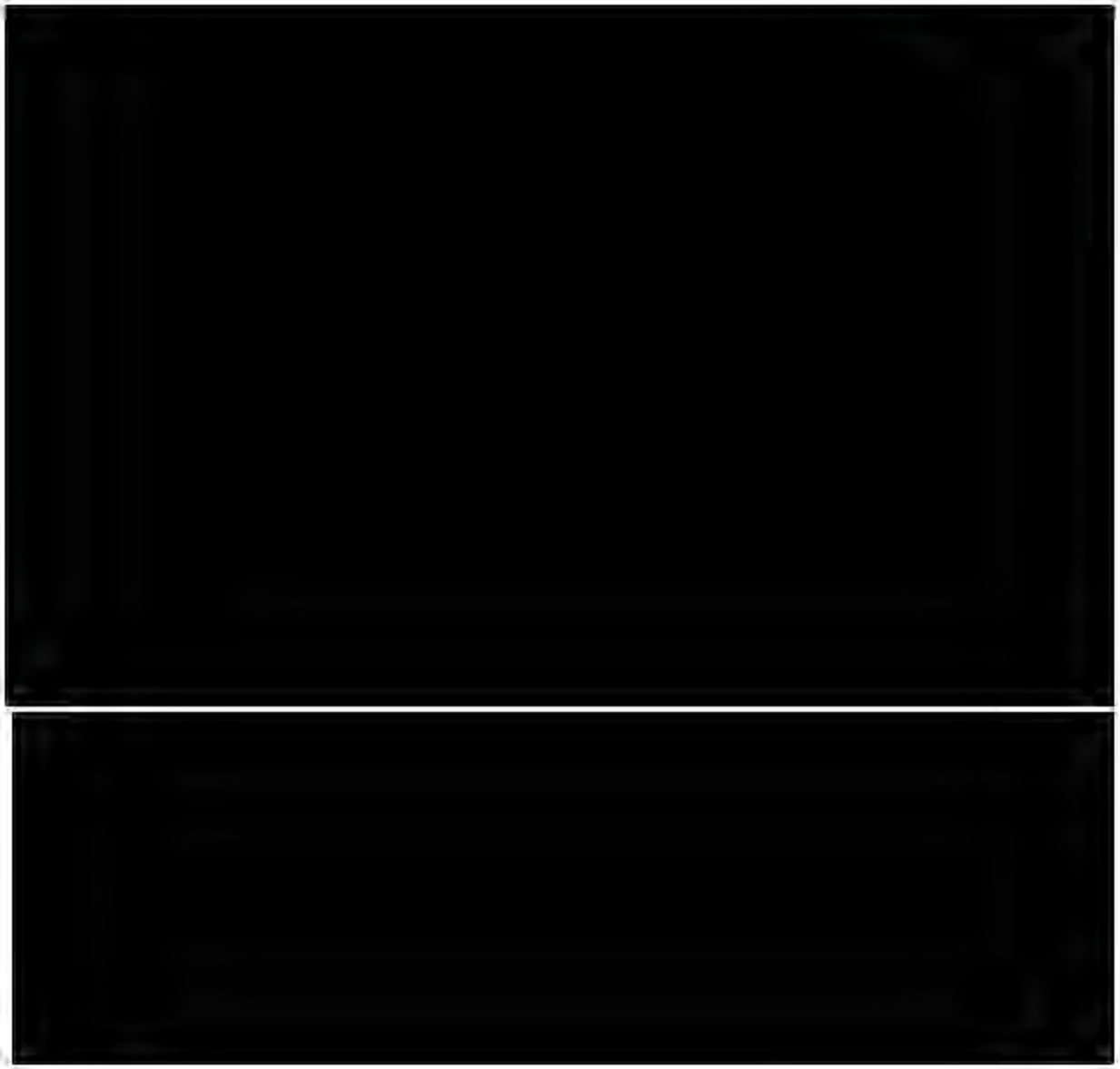
Total Requirements for Saturday

[redacted]

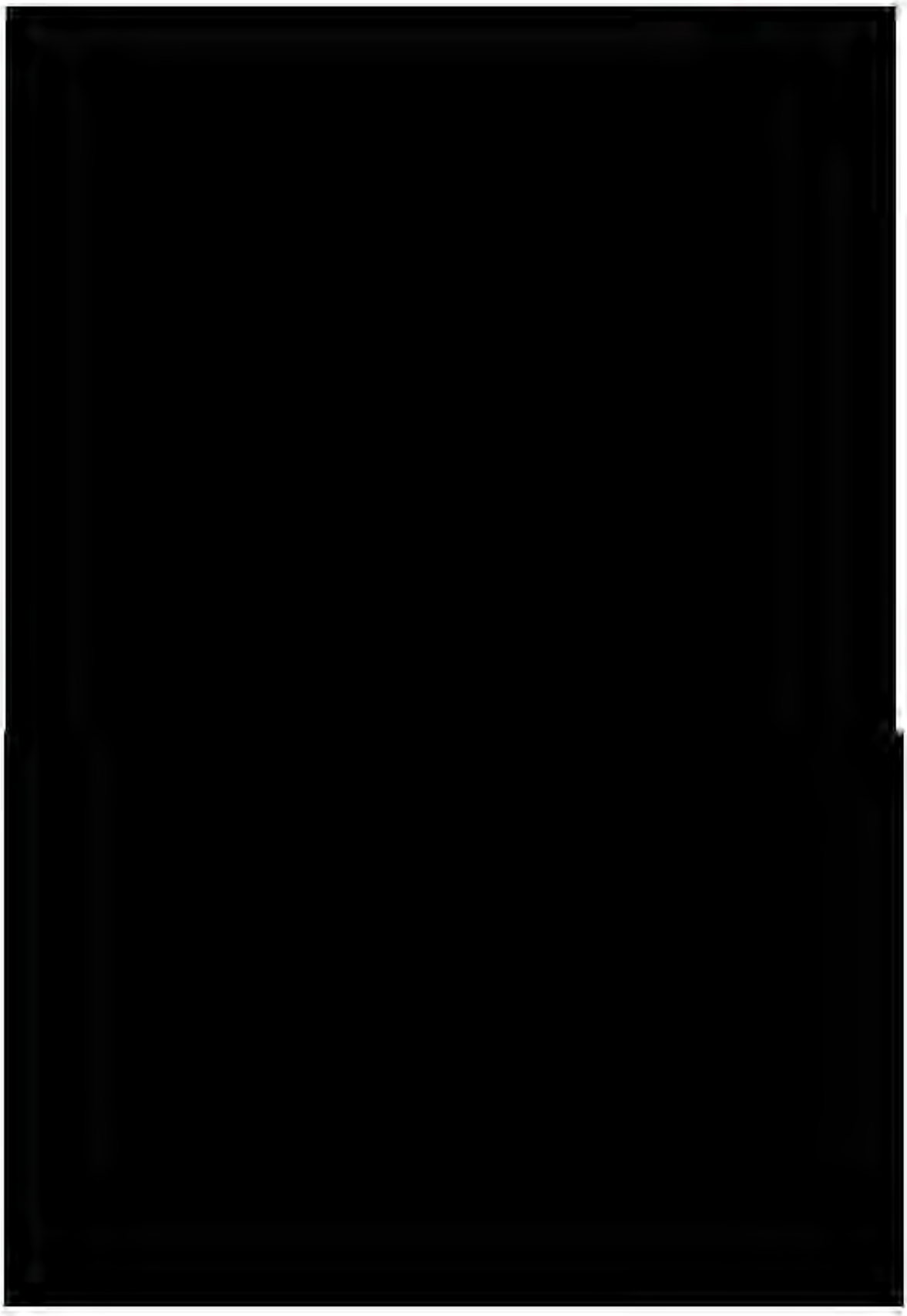
[redacted]

ERS Medical

Total Requirements for Sunday



Resource and contingency per site



Facility locations



Vehicle Resource

The indicative data provided has been analysed in detail and we have identified the required number of vehicles to ensure we meet the demand fluctuation throughout the day;

Vehicle Type	Number
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

The above fleet mix ensures we have the flexibility to meet service demands of each CCG. Our PTS vehicles are designed so they can be configured as either seater or stretcher vehicles as required. All of our PTS vehicles can be configured to accommodate Bariatric equipment. To reinforce our dedicated service model, we will also utilise Volunteer Drivers and Taxis to assist in the delivery of the service.

Robust Planning & Flexible service

Our solution design is modelled on existing county wide services in Devon, Norfolk and Nottinghamshire. The following key elements allow us to deliver a flexible and equitable service to patients;

Comprehensive data management – Inherent to our value proposition is [redacted] which plans, operates, manages and reports on our ambulance operations. All journeys are timestamped at every relevant action from the crew leaving base to pick up and drop off the patient. This allows our planner and dispatcher to actively manage our whole resource in real time to maximise its efficiency and ability to successfully manage peaks and troughs in demand.

Sustainable resource provision – Our service model is based on delivering a sustainable service that will deliver effective and efficient patient transport every day/every year. Our core resource of [redacted] vehicles and crew are designed to meet the forecast transport needs. Supported by [redacted] resilience vehicles, bank staff, material sub-contractors, volunteer groups and taxis, a flexible and responsive service will ensure we deliver on-time/every-time.

Flexing our scope of operations – Our detailed service model has accounted for the daily, weekly and monthly changes in service demand and we have resourced the service accordingly. Further to this we also have [redacted] sites within the East of England that we are able to mobilise additional vehicle from. We also have agreements in place with [redacted] subcontractors that can be called upon during peak times.

Out of area transport will be undertaken by our national resource to ensure that our local infrastructure is able to focus on delivering the core services.

Short notice journeys/Immediate bookings

Throughout the contract we will work with the CCGs to reduce the number of 'on the day' bookings to streamline the service and make cost savings.

As part of our service design we have used the information provided along with our knowledge of delivering similar services to build a data model for same day demand. We have then allocated resource that is aligned with this demand model. This will provide our planners and dispatchers with adequate resource to manage all same day/immediate bookings along with the pre-planned journeys.

Hospital	Number of "On the day" journeys per annum	% of Total Journey Volume
Royal Stoke University Hospital	[redacted]	[redacted]
Stafford County Hospital	[redacted]	[redacted]
New Cross Hospital	[redacted]	[redacted]
Queens Hospital Burton	[redacted]	[redacted]
Derby Royal Hospital	[redacted]	[redacted]

Our [redacted] system integrates directly with our Call Centre and frontend booking portal, allowing the CCGs to book journeys that then feed through to our control room.

Control staff manage a dynamic and responsive system that matches patient need/mobility with the most time efficient solution using planned and on the day vehicle resources. The [redacted] system provides control team members with real-time information that allows for informed decision making. Unallocated transports are clearly displayed, ensuring focus is kept on ensuring all transport needs are fulfilled.

A traffic light system is embedded that indicates journey efficiency against KPI targets pre-set within the Cleric operating system.

Seamless process

We will deliver both the patients and the clinical teams a seamless process from booking through to transportation and patient handover. Below we have provided an overview of how we will achieve this;

- A booking is made via our online portal or our dedicated 24/7 call centre. During this process the eligibility is assessed and approved
- The patient journey details are entered into our booking system, Cleric
- All bookings are planned by [redacted] and then reviewed by our planning team to ensure local knowledge of the road network etc is taken into account. Planning reviews are held at 0900 and 1600 each day and authorised by the Operations Manager
- Every patient journey is assigned to an appropriate crew with consideration to mobility, vehicle type and locality
- For pre-planned journeys every patient will receive an automated (SMS) or telephone call to confirm their journey they day before their transport is scheduled
- All patients receive a telephone call from their crew 30 minutes before pick-up
- Upon arrival the crew will introduce themselves and make the patient fully aware of the transport process
- The crews will ensure the patient is safe and comfortable on the vehicle prior to commencing the journey
- During the journey the crew will engage with the patient to ensure they are comfortable throughout the journey and to provide reassurance when necessary and all patients will be invited to complete a Patient Experience Survey
- On arrival crews will escort the patients directly to their appointment and deliver a full handover to the relevant HCP

To provide further ease of use of our service we offer an online booking portal that can be accessed by any authorised individual. This provides both patients and clinical teams with easy access to our booking portal allowing for not only booking to be made easily and effectively but also for any booking amendments that are required to be made after the initial booking. This leads to a seamless and efficient NEPT service. We will provide training and login details during the mobilisation period enabling the system to be used from day one of the service.

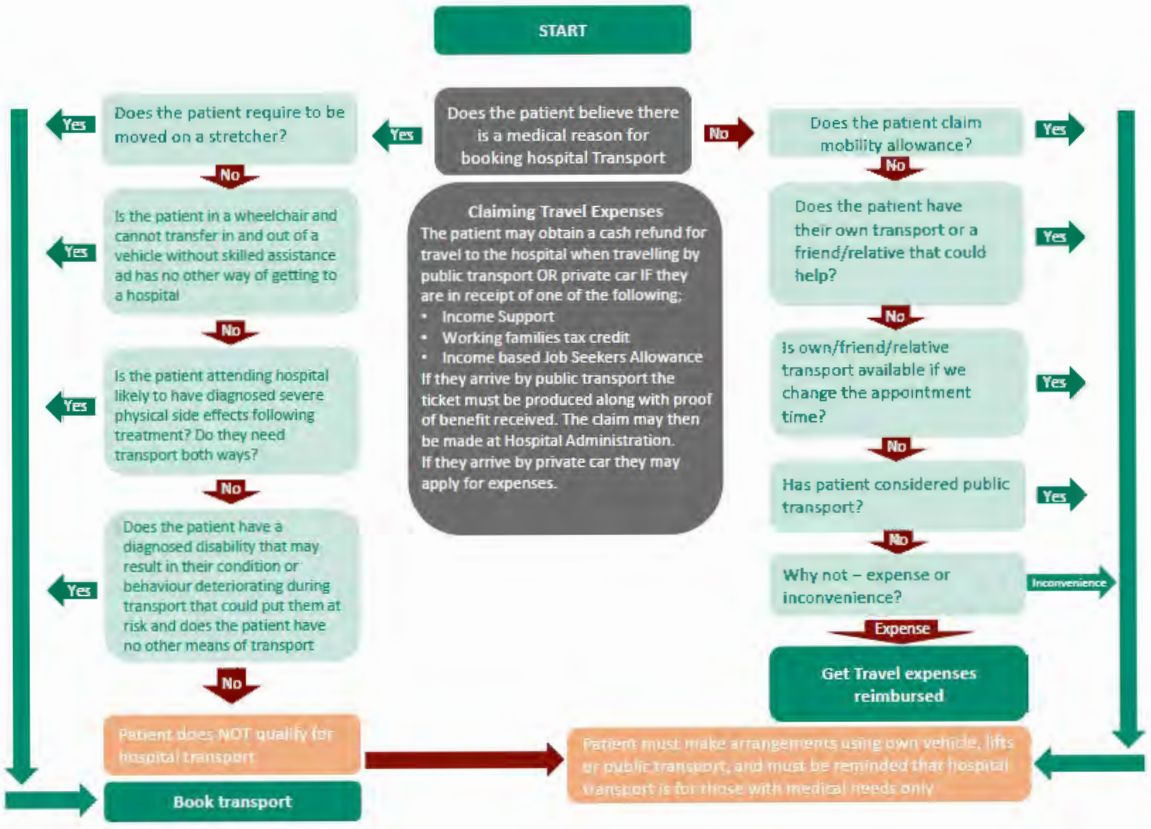
Clinically and operationally appropriate

As an experienced service provider to the NHS we are able to confirm that we will deliver a patient transport service that is;

- Safe
- Compliant with relevant standards
- Capable of providing a good experience of care for patients
- Capable of validating patient eligibility
- Capable of responding to operational needs or pressures at short notice
- Capable of enhancing the overall NHS service across the health economy

Within our service model we have taken into account all of the above to ensure that our service will meet the expectation and requirements of the commissioners. We have fully analysed all data provided as part of the ITT to ensure our vehicle mix, staff qualifications and facility locations meet the needs and requirements of both the patients and Commissioners enabling us to deliver a service that is safe, compliant, timely, flexible to meet demand and improve the patient experience as a whole whilst of enhancing the health economy.

To ensure that service is available to those eligible for transport we will utilise robust and fair application of the eligibility criteria. We have outlined our typical eligibility process below and will discuss this with Commissioners during the mobilisation.



Logistics system

[redacted] is our integrated system that plans, operates, manages and reports on our operations. It is specifically designed for the patient transport sector and provides effective and efficient support of multi-patient journeys and route planning. The system provides control team members with real-time information that allows for informed decision making. Unallocated transports are clearly displayed, ensuring focus is kept on ensuring all transport needs are fulfilled.



A Gant chart is used to represent all current activity. A traffic light system is embedded that indicates journey efficiency against KPI targets pre-set within the [redacted] operating system.

[redacted] shows full details of our service including planned journeys, on the day journeys and vehicle locations. This information can be displayed within the hospitals to ensure Trust staff have a full overview of the service in real-time. A recent system development has been put in place in conjunction with our NHS partners where an internet portal provides access to the following live data sets;

- 'Departure Stack' – shows all imminent departures with real-time journey data.
- 'Outgoing Stack' – A more comprehensive data set providing all discharge journeys and performance for the day.

This provides a full view of our service and allows us to work with Trust staff to maximise patient flow.

Cleric maintains a comprehensive data set. Over time the data set can be used to refine resource management to ensure the demand profile is aligned with resources throughout the life of the contract. Seasonal variations will undoubtedly be experienced, and again, Cleric will provide accurate and timely modelling data.

Subcontractors

For the delivery of this service we will have subcontracting partners to be used as and when required to ensure service continuity throughout the life of the contract. Our Due Diligence, continual monitoring and frequent service reviews ensures all of our subcontractors that are delivering services on our behalf are doing so to the required standard, in compliance with all relevant laws and legislation and utilising appropriately qualified and professionally registered staff. All of our Subcontractors will be equipped with our PDA's to ensure that all transport data is captured within our system and reported on monthly.

Operations Managers meet regularly with our subcontractors to review performance and, as part of this process, the Operations Managers call patients who have recently experienced journeys with

the sub-contractor to ascertain their level of satisfaction. Whenever a complaint is received from a patient travelling with the subcontractor, we seek statements and evidence in the usual way, and involve the senior leadership, often the owner of the business, in the investigation.

During our subcontractor reviews we also conduct full audits of driving licenses, DBS, staff training and professional qualifications to ensure they are in line with all relevant legislation and our own quality standards. We also check their relevant insurance credentials to ensure they are compliant.

Regular service users

Attending regular appointments such as renal dialysis forms an integral part of a patient's day to day routine which may also impact on family members. Renal patients must be considered essential patients with a service tailored to their specific needs.

The renal service will have dedicated vehicles that will not be diverted to any other service. Providing renal patients with a regular driver enables a rapport to be developed between our staff and the patients which helps us to deliver a tailored service to best meet each patient's needs. From our experience assigning regular drivers to a patient builds trust and understanding.

Our staff and sub-contractors receive specific training in line with our Renal Patient Services procedure and process. This includes closely monitoring all patients during transport for any change in their clinical presentation because patients can experience some side effects as a result of their dialysis. A regular driver/crew may well notice those small differences in patient presentation that can be invaluable.

To keep the service efficient, we will provide a shuttle bus service but will also have a variety of additional vehicles to provide a dedicated service dependent on the patients' mobility and clinical needs:

- Ambulance (stretcher) – including bariatric variant
- Ambulance (seated)
- WAV's
- Volunteer Car Drivers
- Taxis



Wheelchair Access Vehicle (WAV)



Renal & Ambulance (seated & stretcher variants)



Volunteer Car Drivers



Taxis

Co-ordinated Service

ERS Medical will provide a fulltime dedicated Renal Co-ordinator focused on patient care and Renal Dialysis Unit efficiency. This fulltime role will deliver a quality service to ensure we are 'on time every time'.

Due to the nature of renal patients we do not engage in the routine checking for renal patient eligibility for transport. Our operations team will liaise with the Renal Unit on a weekly basis to ensure that the renal list is kept up to date.

We have made a commitment to ensure we deliver a service to our patients and customers in a timely, effective and safe manner. We acknowledge the need to rapidly identify service delivery issues, so they can be resolved with the minimum impact to our patients.

Booking system

The booking system allows for block bookings for Renal and Oncology Patients up to three months in advance. Individual bookings can also be made on a regular basis.

The ERS Patient Zone on our website will allow renal patients to view current and future transport bookings, giving peace of mind.

Working with renal providers as partners

To deliver a cohesive, safe and patient focussed service to renal patients we will work in partnership with renal providers to ensure an effective user care pathway service. We will have regular stakeholder meetings and engagement days to allow us to continually integrate our services to make a simple seamless care pathway for all renal patients.

We will also work in partnership with the renal providers to understand their operational processes and procedures to ensure our service helps deliver them. We will also understand their expectations of us such as ideal patient arrival time and collection time. This will allow us to assist them in delivering a smooth service and avoid the creation of pinch points.

Experience and lessons learnt

We are an experienced Renal Transport service provider delivering services to the NHS throughout the UK including Norfolk, London, Nottinghamshire and Leeds. Through this experience we have developed a best practice to ensure we deliver an efficient, effective, timely and comfortable transport service for the patients. This includes:

- Regular drivers – rapport creates a relaxing atmosphere
- Regular routes – This provides continuity of service

- Designing routes to minimise time on vehicle – This takes into account traffic and road works to ensure we minimise the time patients spend of the vehicles
- Patient zone – Allows patient to see an ETA on their transport

Best practice

To ensure we continually deliver best practice all legislative and clinical requirements are managed by our Care Standards Team, which is made up of clinical, health, safety, environment and transport specialists, to ensure that all requirements continue to meet the highest standards. Clinical effectiveness is managed and monitored through clinical team meetings, clinical & governance audits & inspection, policy and procedures reviews and authorisations.

Overseen by our Clinical Director Dr Amjid Mohammed this team ensures that all staff are monitored and developed to enhance clinical knowledge and best practice through:

- Regular clinical memos and updates
- Mandatory and clinical update training days
- Mentorship programmes where required
- Encouragement to participate in continued professional development

All ERS Medical clinical staff are assessed by way of regular update events combined with personal clinical portfolios.

To ensure that our staff are kept up to date with current requirements and expectations in line with CQC regulations and standards, we operate a regular staff training programme aligned with our Personal Development and Training Policy, which includes specific training around CQC compliance.

Vehicles and equipment

All of the vehicles and equipment we utilise for the delivery of this service will meet all current requirement and legislation including BS EN 1789:2007. All ambulances used for stretcher and wheelchairs will meet M1 and M2 standards along with BN EN 1789:2007.

Our vehicles will be brand new at the start of this contract and will be clearly marked with our logo and the national NHS logo and be readily identifiable as an NHS service NEPTS vehicle. At any point during the contract 90% of the vehicles comprising our core fleet will be less than 5 years old and under 150,000 miles travelled.

All vehicles and equipment will be cleaned and decontaminated in line with all relevant infection prevention and control policies and standards.

Service designed to meet clinical needs

Our service model has been designed using the information provided by the Commissioners and our considerable knowledge of the patient transport sector. Our bespoke service design has been developed specifically to meet the clinical needs of the patients within the partnering CCGs.



Through our staff training and fleet selection we are able to assure the CCGs that we are able to deliver a safe, efficient and conscientious service too all mobilities.

We ensure during the booking process that we take the right information to ensure we provide the right acuity of crews, vehicles and equipment, and the required response time.

Contingency

Our Business Continuity Plan sets out how critical business activities will be maintained in the event of any incident/disruption that threatens delivery of core business and organisational priorities. This plan is aligned with ISO-22301 and 22313 and mirrors the requirements of the NHS England's Core Assessment Standards for Emergency Planning Resilience and Response. ERS Medical is also an active partner within local Healthcare Resilience Partnership Working Groups.

Question 1.18.2.1

Case study - renal patient

Describe in detail how a renal patient would experience the NEPTS service on an ongoing basis. Please include the process and experience for booking, collection, drop off and return journey. How would the clinical team be integrated into this process? Include in this scenario an example whereby a patient has experienced a delay, either for drop off or collection, showing how you would manage this situation and how you would implement any learning. The provider is encouraged to draw upon realistic experiences of its workforce and patients rather than idealised situations for these case studies.

Word count 1500

Total Word Count: 963

Booking Process

Due to the nature of renal patients' treatment, the Renal Unit can book up to 3 months appointments at one time with direct access to our booking facility, [redacted], through our on-line portal. During working hours, the unit has direct access to our Planning and Dispatching teams to make amendments to bookings and to make the dispatchers aware that a patient is ready to be picked up for their return journey home.

This is supported out of hours by a rota of On-Call Managers who are also supported by our 24/7 Call Centre. Both our managers and our Call Centre have access to our on-call clinician 24/7 should further advice be required.

Handover

Upon arrival at the renal unit we provide a comprehensive handover to unit staff for every patient as this is to key to the patients care and follows a set process that is incorporated into our Care to Care guidance for all road staff. As the transport provider we get to see the patient in their home environment, and we spend quality time with them in the vehicle on the way to and from the Renal Unit and over a period of time we build up relationships with these patients. Therefore, we have an insight to the patient, and we can provide valuable information about the patient – we may also pick up on issues not seen in the Unit and can in some circumstances make timely and important Safeguarding referrals. We have previously helped save patients lives as part of our collection process for renal patients in their home environment as we have come across patients who have collapsed or fallen and taken action to ensure they receive the medical care they need.

Once the patient has completed their treatment the unit staff will mark the patient as ready on our [redacted] system which is sent directly to the crews' PDA and provides an estimated time of arrival to the unit staff.

Upon arrival at the unit the crew will seek out a member of the clinical team to obtain a full handover as to how the treatment has gone and any side effects that the patient may be experiencing that may need to be monitored during the journey home.

The patient will be escorted to the vehicle by the crew and safely secured into the vehicle, ensuring the seatbelt is fastened and comfortable.

The driver will ensure the optimum route is taken, avoiding heavy traffic and roadworks which are notified through our crystal ball travel system, to minimise the time the patient spends on the vehicle. Throughout the journey the patient will be monitored and communicated with to ensure there is no deterioration in the presentation. Having regular drivers on the renal service enables a familiarity with the patients and can often lead to a crew member being able to identify the smallest changes in the individual patient's behaviours.

Should a patient deteriorate during the journey the crew follow our "Patient Deteriorating During Transport" policy and call 999.

Upon arrival at the patients place of residence, the crew will escort the patient into the property and ensure that they are comfortable and that they have everything they require to hand. They will also ensure that their surroundings are suitable for their care needs and that they have heating, electricity and nutritional supplies. In the current climate our crews ensure that when in a patients home they wear the appropriate PPE and adhere to social distancing rules.

Addressing Service Failures

Once a journey is at risk of being late and is flagged on [redacted] to the Dispatch Team, we endeavour to contact the relevant unit to advise them of the delay and to structure their expectation and that of their patient.

It is important that we work with the Unit when the patient becomes ready significantly earlier or later than planned especially if this is on a regular basis and review the original booking to reflect the obvious change in circumstances.

The NEPTS contract data flows from [redacted] and is available to the Operations Managers and Team Leaders in real time and is reviewed daily. All failed journeys are reviewed the following day to understand why the journey had not gone as planned and the KPI was missed and the patient and the clinical staff inconvenienced.

When ERS Medical are at fault it is important lessons are learnt and the patient and clinical staff involved receive an explanation and apology. It is much better that the Operations Manager contacts the patient or their family before a complaint has even been raised. In some cases, patients have been put on a 'watch list' for a period of time when their journeys are overseen by a member of the management team. In some cases, we can evidence where Operation Managers have gone out on the patient's next journey to meet them and listen to their concerns and to explain the circumstances and apologise.

It is also important in the regular meetings between the Renal unit Management and ERS Medical Operations Managers that all failed journeys are reviewed and an understanding of what went wrong and what has been done to try to ensure the same mistakes are not repeated. ERS Medical have Hospital Liaison Assistants who work with all hospital departments but who work closely with the Renal Units to build relationships as this always helps with communication which is the most important factor in delivering a successful NEPTS service. We also hold stakeholder events every 6 months using a Town Hall style meeting where we provide an overview of the service and then open up the floor to questions from all stakeholders. This allows us to gain direct feedback from this who use, and are impacted by, our service.

Clinical Care Memo

Date: 15/06/2020
Issue: CCM-040

COVID-19 – Government Recommendations for England NHS & Private Hospitals

Public Health England

Government Recommendations for England NHS and Private Hospitals

Following the Secretary of State for Health's announcement of 5 June 2020:

In all settings that are unable to be delivered as COVID-secure, using social distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate, the following should be adhered to:

All hospital staff (both clinical and non-clinical roles), when not otherwise required to use PPE to a higher level, should wear a facemask. This is worn to prevent the spread of COVID-19 by the wearer of the mask. This provision includes all ERS Medical staff who visit NHS & private hospitals in England.

Visitors and outpatients to hospital settings should wear a form of face covering for the same reason as NHS and ERS Medical staff are required to wear facemasks.

Public Health England's recommendation is for a Type I or Type II facemask to be worn to prevent the spread of infection from the wearer. ERS Medical provides Type IIR to its staff which sit above the standard for Type I and Type II.

All previous Care Memos can be accessed on SharePoint by clicking the link below:

[redacted]

Kind regards
Care Quality Team

Clinical Care Memo

Date: 06/04/2020
Issue: CCM-025

COVID-19: Guidance for Ambulance Trusts

*Source: Public Health England – COVID-19: Guidance for Ambulance Trusts – Updated 3 April 2020

Public Health England

On the 3 April 2020 Public Health England issued revised guidance to the previous guidance issued on the 13 March 2020. The guidance clearly now states that it is applicable to both emergency and non-emergency ambulance provision.

This clinical Memo has been issued to communicate the main elements of this guidance to all Managers and frontline patient facing staff at ERS Medical.

The main updates to the guidance are:

- Case Definitions;
- Clarification of Aerosol Generating Procedures (AGP's);
- Updates to Personal Protective Equipment (PPE).

The requirement for NHS Ambulance Trusts to provide HART resources for all inter-facility transfers has been removed.

ERS Medical has also taken the decision, for the safety of the crew and patient, that no suspected or confirmed COVID-19 patient should be transported by a single crewed vehicle i.e. seated ambulance or WAV.

1. Identification of Possible Cases

COVID-19 infection should be considered in all cases of respiratory infection. If patients meet the following criteria they are to be classified as a possible or confirmed case.

- Acute respiratory distress syndrome;

Or

- High temperature (of 37.8^{o}C or higher)

And have at least one of the following, which must be of acute onset:

- Persistent cough (with or without sputum);
- Hoarseness;
- Nasal discharge or congestion;
- Shortness of breath;
- Sore throat;
- Wheezing or sneezing.

2. On-scene Clinical Precautions

This guidance covers the use of PPE for the management and transfer of patients with possible or confirmed COVID-19. Staff should follow a dynamic risk assessment when collecting patients which can mean questioning patients, care providers and nursing staff about the patient's COVID-19 status and if they symptomatic or self-isolating.

Staff should also confirm the patient's COVID-19 status on their CAD booking and update control if there are any changes immediately.

Where risk assessment and or patient booking indicates a requirement for PPE, crews must don their PPE, to the appropriate level, before being within 2 metres of the patient.

The patient should be provided with a surgical mask to wear for the duration of the journey/care (if tolerated) unless oxygen therapy is indicated and required.

Where possible (bulkhead dependent), only one crew member would need to don PPE if the patient can be managed as a single person. This leaves the driver free to perform the journey without having to remove PPE and decontaminate before driving. The main factor for non-emergency transport in these cases will be that of the mobility of the patient.

Aerosol Generating Procedures (AGP)

AGPs generate tiny particles, small enough to remain in the air for extended periods, travel long distances and may be inhaled.

If an AGP is to be performed or expected ERS Medical should decline the booking / abort the journey. ERS Medical crews, to date have not been face-fit tested for the FFP3 respirator and have not received training in the donning and doffing techniques for the Level 3 PPE (see section on PPE).

If the national or local situation requires Level 3 PPE, ERS Medical will approach the regional NHS Ambulance Service or NHS Trusts for this testing and training, prior to any potential AGP journey being undertaken.

AGP relevant to ambulance Trusts and private providers, which have been determined as an AGP by Public Health (England, Scotland, Wales & Ireland) include:

- Procedures relating to cardiopulmonary resuscitation, for example advanced airway procedures such as laryngoscopy, intubation, extubation and surgical airway.
- Manual ventilation.
- Suctioning.
- Management of chocking and foreign body airway obstruction removal

The following are not considered AGP:

- Chest compressions.
- Defibrillation.
- Nebulisation.

If there is no bulkhead between the patient compartment and the cab then it will be necessary to wear a fluid repellent surgical mask (FRSM), if the patient will be within 2 metres of the driver while being conveyed.

Unless absolutely necessary and essential, AGPs should be avoided during the transportation of patients with COVID-19.

3. Personal Protective Equipment (PPE)

The ambulance sector PPE for COVID-19 is categorised by levels.

Level 1: Standard Infection Control Precautions

- Consider if any PPE is required based on risk of contact or splashing with blood or bodily fluids.

Level 2:

- Disposable gloves
- Disposable apron
- Fluid repellent surgical mask
- Eye protection (if risk of splashing)

Level 3:

- Disposable gloves
- Fluid repellent coveralls
- FFP3 or powered respirator hood
- Eye protection

Correct Use of PPE

- Appropriate level of PPE must be worn.
- Care should be taken to ensure that PPE is donned and doffed correctly to avoid inadvertent contamination.
- All PPE must be disposed of as category B clinical waste (orange bags) and any reusable items (for example eye protection) must be decontaminated according to manufacturers or ERS Medical instructions.
- FFP3 masks must only be worn by staff who have been face-fit tested.
- When FFP3 mask are worn they are effective for longer periods, the general recommendation would be to be wear the FFP3 for up to 3 hours.
- Fluid repellent surgical masks can be worn for the entire patient care episode. The Health and Safety Executive (HSE) has confirmed that the masks can be worn until damaged or wet.

Considerations for Cardiac Arrests

The majority of patients who get COVID-19 will have mild symptoms, and it is estimated about 4% to 5% may be critically ill.

In the event of a patient being unconscious or in cardiac arrest it will not always be possible to determine the potential COVID-19 risk of the patient. Therefore, it is recommended that staff wear Level 2 PPE (gloves, apron, fluid repellent surgical mask and eye protection) as a minimum.

Donning and Doffing of PPE

All ERS Medical staff should follow and adhere to the Toolbox Talk issued by the Care Standards Team for PPE issued on the 18th March 2020.

4. Patient Assessment

The recommended advice for possible and confirmed COVID-19 patients with mild symptoms is for them to stay at home until they are well.

5. Conveyance and Patient Handover

If the patient requires conveyance it is important to contact the receiving unit to have a discussion regarding where to take the patient as it may differ from the normal process within certain hospitals.

Utilising the most Appropriate Conveying Source

Possible cases must not be conveyed by:

- Car
- Air Ambulance

For vehicles where there is no closed bulkhead

- If the patient is over 2 metres away from the driver there is no requirement for the driver to wear PPE during conveyance. If this cannot be achieved the driver should wear a fluid repellent surgical mask.
- The patient must, wherever possible, wear a surgical mask during transportation.

The following guidance applies whenever a patient is conveyed:

1. Consider the removal of non-essential equipment from the vehicle or moving on-essential equipment to a closed compartment prior to loading the patient into the vehicle.
2. Avoid opening cupboards and compartments unless essential, if equipment is likely to be required then remove from the cupboard prior to loading the patient.
3. Consider if alternative transport options are available in liaison with Ambulance Control Rooms.
4. Air conditioning or ventilation on vehicles should be set to extract and not recirculate the air within the vehicle (where possible).
5. Non-essential persons (such as observers, family members, escorts) are not to travel within the patient compartment with a possible or confirmed case, unless the patient is a child. In this case it is acceptable for a parent or guardian to accompany the child.

6. Post Conveyance

- All linen should be managed as per local policy for the management of infectious / soiled linen.
- All waste should be disposed of as category B clinical waste (orange bags) as per ERS Medical policy.
- The crew are to remove PPE in designated areas at receiving units.
- All disposable PPE is to be disposed of as category B clinical waste.

7. Decontamination

As coronaviruses have a lipid envelope, a wide range of disinfectants are effective. PPE and good IPC precautions are effective at minimising risk but can never eliminate it.

It is possible that these viruses can survive in the environment with the amounts of virus contamination on surfaces likely to have decreased significantly after 72 hours, so thorough environmental decontamination is vital.

Possible or confirmed COVID-19 patient with no AGP Required

The vehicle will require an enhanced clean between patients to ensure decontamination of all exposed surfaces, equipment and contact areas before it is returned to normal operational duties. ChemEx, Neilsen, Universal wipes and Chlorine (1000ppm) based products are to be used.

- Appropriate PPE must be worn to decontaminate the vehicle. As a minimum this should be apron and gloves, but ERS Medical recommends Level 2 PPE.
- Any exposed equipment (that is not within closed compartments) left on the vehicle will require decontamination with sanitising wipes / ChemEx or Neilsen Product and blue roll, as per the standard between patient clean.
- All contact surfaces (cupboards, walls, ledges), working from top to bottom in a systematic process, will require decontamination.
- Pay special attention to touch points.
- Ensure that the stretcher is fully decontaminated, including underneath and the base.
- The vehicle floor should be decontaminated with a detergent solution (ChemEx/Neilsen).
- Where possible, hospitals should support this practice by working with ambulance colleagues to identify access to appropriate sluice facilities and designated mop and bucket storage for ambulance use.

Possible or confirmed COVID-19 patient with AGP Required

ERS Medical will issue further guidance on decontamination where AGPs have taken place at a time when we are required to move patients with this risk profile and staff have been suitable face-fit tested for the FFP3 mask and had suitable donning and doffing training for Level 3 PPE.

Issued by;

The Care Standards Team

Clinical Care Memo

Date: 16/04/2020

Issue: CCM-031

Use of approved PPE

By virtue of Section 9 of the Health and Safety at Work etc Act 1974, no charge can be made to the worker for the provision of PPE & in line with the Personal Protective Equipment Regulations 2002 and The Personal Protective Equipment at Work Regulations 1992 ERS Medical have sourced & supplied to all crews the appropriate PPE for protection against the risk of contracting the Corona Virus/Covid-19. The PPE has been provided in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH)

This PPE including 3 ply Surgical Masks is specifically aimed at producing a high level of fluid repellent and bacterial filtration & conform to EN14683, type IIR (Fluid Resistant Surgical Masks).

These form part of Public Health England's Level 2 PPE as defined in Table 3, & circulated as CCM-028 disseminated on 13/04/2020.

Whilst other masks are available via various Online outlets, many of these will not offer the correct protection required or be fit for purpose & may not offer the correct filtration to prevent droplet migration. There will have been no review or approval undertaken by the Care Standards Team, no Face Fit Testing will have been undertaken (Dependant on Mask type & requirements)

Please ensure that without exception you are only wearing the approved PPE provided by ERS Medical: Masks &/or Face Shields, Gloves, Aprons, Goggles/Safety Glasses. These items are provided to protect you, our service users & others with whom we may come into contact.

Remember that we all have responsibility for our Health, Safety & Welfare too.

These guidelines are recommendations around safe practice when caring for COVID-19 Patients

Issued by; The Care Standards Team

Question 1.18.2.2

Case study - Pandemic Response

Drawing upon your recent experiences, please describe how you were able to respond to the Covid-19 pandemic. Please include your initial response, your ongoing processes and procedures and your plans to mitigate the risks should we experience another increase in cases. Please include any challenges you experienced and how you overcame them. How do you ensure that you're able to produce a timely response to any new or updated national guidance?

Word count 1000

Total Word Count: 1000

As a leading provider of NEPTS in the UK we pride ourselves on our partnership approach to the services we deliver to our customers. We acted quickly at the beginning of the COVID outbreak and took steps, in partnership with our customers, to mitigate the impact of the virus on our patients, staff and services.

Our managing Director has implemented skills he learnt in the military into the business. One of the main military concepts he has applied is Mission Leadership. Mission Leadership is a military leadership model based on clear direction and boundaries, delegated decision-making and accountability at all levels. It establishes common purpose within teams and across an organisation and then allows people the freedom of action to support that intention.

In practice, this means that decisions are made on the ground, quickly, and in line with the overall mission.

This approach has a strong focus on operational priorities, communicated clearly through an organisation. This translates well to healthcare and ERS Medical, it has been an important factor in managing through the COVID-19 crisis.

To ensure we are continually protecting our patients and staff whilst delivering a robust and effective service we are:

Responsive – Our EPRR/Business Continuity systems and processes are well-positioned enabling us to react quickly, and our Care Standards team are experienced in managing a wide range of situations that may affect our services.

Measured – We base our decision making on evidence-based ‘best possible advice’ from authorities such as Public Health England (PHE), NHS England (NHSE), British Government departments, and the WHO. We avoid knee jerk reactions and only apply measures that are appropriate for our organisation.

Clear and Transparent – We communicate as much as is practically possible with our patients, staff and partners in the NHS. We have good communication links at all levels of the NHS.

As an organisation, we do everything we can to adapt quickly and calmly to protect our patients and staff and to minimise the impact of COVID-19 on the system.

Our comprehensive communication plan was praised and used as a case study by NHSE/I on how to deliver communication both within a business and out to customers.

Our response to COVID-19

Below we have provided an overview of how we ensure the pandemic has a minimal impact on our service delivery whilst maintaining the safety of our patients and staff.

PPE

Our front-line staff are the core of our organisation and we must ensure they can work safely. Making sure we provide staff and patients with adequate Personal Protective Equipment (PPE) in line with the national guidance has been key to achieving this.

Throughout the COVID-19 outbreak, there have been widely reported concerns regarding the adequate supply of compliant PPE. From the outset, we prioritised the procurement and management of PPE from multiple suppliers and have successfully maintained the correct levels at all sites across the UK. To overcome potential issues with quality, all orders are checked for suitability and compliance by an ERS Medical Quality Manager before entering the system.

This has been achieved by the swift implementation of our robust Business Continuity Plan and through our national escalation plan, ensuring the continual flow of information between all our sites. To ensure supplies are maintained, ERS Medical has implemented a dedicated stock management strategy, creating a central hub for fulfilment and distribution to our 19 operational sites across the UK.

As part of this strategy, weekly meetings with Operational Teams are conducted along with regular stock takes. This delivers accurate planning and forecasting to ensure adequate supplies, and any unforeseen events are addressed immediately.

Our Care Standards and Operational teams will continue to work with our multiple suppliers, both in the UK and overseas to ensure we secure enough PPE and other clinical consumables to keep our people safe.

New guidance and regulations

Throughout the pandemic, our Care Standards Team have been continually liaising with PHE and NHSE/I to ensure we have and are compliant with, the latest guidelines for vehicle modifications, decontamination, and PPE.

This understanding of the guidelines enabled us to modify our fleet of 500 vehicles and implement social distancing measures quickly and effectively. The dedication of our Care Standards and Operation teams has ensured we continue delivering vital services and enables us to safely transport 50,000 patients every month.

Our Care Standards Team will continue to liaise with NHSE/I and our customers to ensure that all new national and local guidance is implemented into our service delivery in a timely fashion.

Challenges we faced

Since the initial COVID-19 outbreak, existing policies needed to be checked and altered to align with new government guidelines, whilst adhering to the requirements stipulated in the guidance to Ambulance Trusts issued by PHE.

One of the challenges that ERS faced was keeping staff across our 19 operational sites updated with the relevant information, ensuring that the correct and right procedures could be implemented promptly. Therefore, using Care Quality Memos, site TV and Toolbox Talks, ERS has been able to keep crews informed with the latest information about how to prepare their vehicle and themselves from the countless issues raised by the pandemic. We have attached an example set of our memos.

When the government announce that all but essential workers should work from home, we had to implement home working quickly and effectively for all our back-office staff. Our cloud-based systems allowed us to organise this quickly and maintain service quality to our customers. We also implement daily welfare calls and provided links to our EAP to all staff. These are challenging times, and we want to ensure that our staffs wellbeing was at the forefront.

We hold daily operations and compliance calls with all management staff to ensure that all our employees were up to date with the latest information during a constantly changing period. We also provided our customers with detailed analysis of our services showing the impact regulations such as social distancing will have of the service and how we could work together to mitigate it.

Question 1.18.3

Robust Relationships

How will you establish robust relationships with NHS service providers that encounter operationally and agree operational protocols with clinical teams and departments? Drawing upon your experience how would you manage and improve a difficult working relationship?

Word Count 1000

Total Word Count: 996

A key element in developing relationships between NEPTS providers and Trust staff is the holistic integration of the patient transport services into the healthcare environment. By creating strong relationships and working in partnership we are not only able to increase the service efficiency but also improve patient satisfaction and assist the hospital in achieving their targets.

Instead of treating transport as a separate entity to the Trusts responsibility to the patient's care and hospital targets, involving the transport provider in the day to day planning of patient flow ensures a smoother and more productive service for all parties.

We will achieve this through continual stakeholder engagement and having dedicated onsite Hospital Liaison Assistants (HLAs) based at Royal Stoke Site and Queens Hospital Burton. We will also have HLAs that are available to be deployed to other hospital sites rapidly should the commissioners request it.

We will agree the operational hours of the HLAs with the Commissioners during the mobilisation, but typically we ensure they are available 10:00 – 18:00. Outside of these hours hospital staff will have direct access to our 24/7 booking centre and our online portal should they wish to make changes or cancel bookings or discuss other problems relating to the provision of the service.

Working relationships

In our experience the main areas that lead to difficult working relationships include:

- Lack of Communication
- Information
- Efficiency of transport

Lack of Communication

Communication is the key to all relationship building. To ensure this is done effectively and efficiently we will:

- Provide HLA based at each of the key Trust sites
- Deliver guidance to HCP's through our HLA's on vehicle types and mobility requirements, confirm equipment requirements for transport and monitor the patient's readiness for booked transport.

- Provide dedicated crews to each of the Trust premises to ensure relationship building
- Attend the daily bed meetings
- Provide clear lines of escalation
- Develop a partnership working approach to deliver a seamless and patient focused service
- Deliver support and training to the Trusts on appropriately determining eligibility and mobility requirements. Education and training sessions will be delivered a minimum of twice per year at each acute site, and a once a year open session for community healthcare and other providers.

Information

Not having the required information available in real-time can lead to frustration with hospital staff resulting in difficult relationships developing. To mitigate this and ensure difficult relationships don't develop we will not only ensure that we provide continual information with all relevant Trust staff, but also provide direct access to real-time information.

To provide the real-time information we will provide authorised Trust staff with access to our Cleric system so they are able to not only see what transport is currently being undertaken, but where in the transport process each vehicles is e.g. collection patient, in transport, at patient destination, returning to hospital, etc. We will also provide the discharge lounge with a screen showing the current patient stack in real-time which includes:

- 'Departure Stack' – shows all imminent departures with real-time journey data.
- 'Outgoing Stack' – A more comprehensive data set providing all discharge journeys and performance for the day

This information will ensure that Trust staff have all the information they require at their fingertips removing any frustration that could arise if the information was not available.

Efficiency

Having our HLAs on site will also allow for improved efficiencies as they will be able to assist crews to maximise the efficiency of the service. This may include:

- Ensuring the patient is ready at the right time
- Ensuring the patient has any required medication prior to being booked ready
- Ensuring the patient is in the right place for collection
- Helping crews find the right destination for patients.

Improving working relationships

Through our partnership approach we would find pragmatic solutions to improving any difficult relationships. We all want to achieve the same goal and ensure that patients are provided with the best experience possible. Ultimately the best way to prevent the deterioration of working relationships is through clear and continual communication.

We have in place numerous avenues to assist with improving relationship that are becoming difficult including internal and external mediation along with support from our Employee Assistance Programme.

Where it is identified that a relationship between an ERS employee and a member of the Trust's staff is becoming strained we will put mediation in place (internal or external) to look into why the relationship has become strained and what can be done to reduce any friction. Various process can be utilised including:

Reset the emotional tone – Talking through reasons for tension and what the key driver is to the deterioration of the relationship. Where possible we will suggest a "time out" where other parties take over the relationship between ERS and the CCGs for a period of time allowing those involved to reflect on the issues and move towards discussing solutions.

Craft a shared goal – All parties involved in the NEPTS hold the same ultimate goal of transporting patients safely, comfortably and on time. We will work with both parties to look at the shared goals they have and how they can work together to achieve them. We will look at what went wrong and reflect on how this can be avoided in the future.

Build an agile relationship – Structure future interactions to reduce friction leading to positive working relationships. If both parties engage with developing the future interaction strategy, they will feel invested significantly reduced the risk of future relationship breakdown.

Escalation plan

We will provide all hospital staff with a clear and concise escalation process that is to resolve any operational issues that may occur. This ensures that all issues can be resolved efficiently and effectively allowing us to maintain a positive working partnership throughout the duration of the contract.

Stakeholder engagement

To ensure we received continual feedback and engagement from all Stakeholders that are involved in the patient transport service including CCG Senior Management, Healthwatch, AgeUK, Advocate Groups, CCG Manager, etc. we hold 6 monthly townhall meetings.

Question 1.18.4

Capacity Planning

Describe in detail how you will organise the days journeys, including pre-booked, on the day local and on the day out of area (for example including a journey booked at 2pm for transport to Newcastle Upon Tyne whereby transportation is required on the same day). Specify your prioritisation process for bookings which are received on the day.

Word count 1500

Total Word Count: 1246

We have invested heavily in our Information Management & Technology infrastructure that supports the delivery of our services. We have developed a fully integrated cloud-based system that includes:

- Scheduling
- Communication and tracking for vehicles
- Data reporting and real-time information
- Call recording
- Compliance and incident management
- Employee training and compliance

Our recent CQC inspection rated as 'Good' made the following reference;

"The provider had invested in six computer-based business management systems to support various parts of their business which provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making"

Through streamlining our systems, we are able to deliver a reliable, efficient and effective service that is easy to navigate and report from. Our service model and all of our systems are fully integrated therefore we are able to interface with the CCGs to deliver real-time information of our whole operation directly into the hospitals.

[redacted] is our integrated system that plans, operates, manages and reports on our operations. [redacted] shows full details of our service including planned journeys, on the day journeys and vehicle locations. This information can be displayed within the hospitals to ensure Trust staff have a full overview of the service in real-time. We will work with the Commissioners during the mobilisation to identify the best position for the live data screens to ensure that we maximise their benefit.





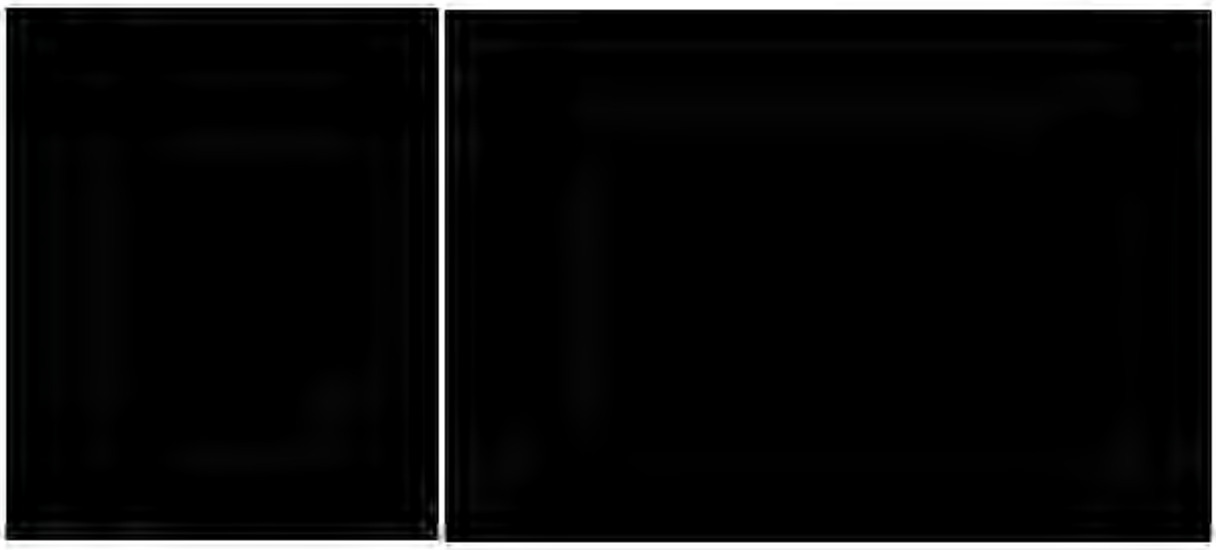
Managing and meeting demand for on the day requests

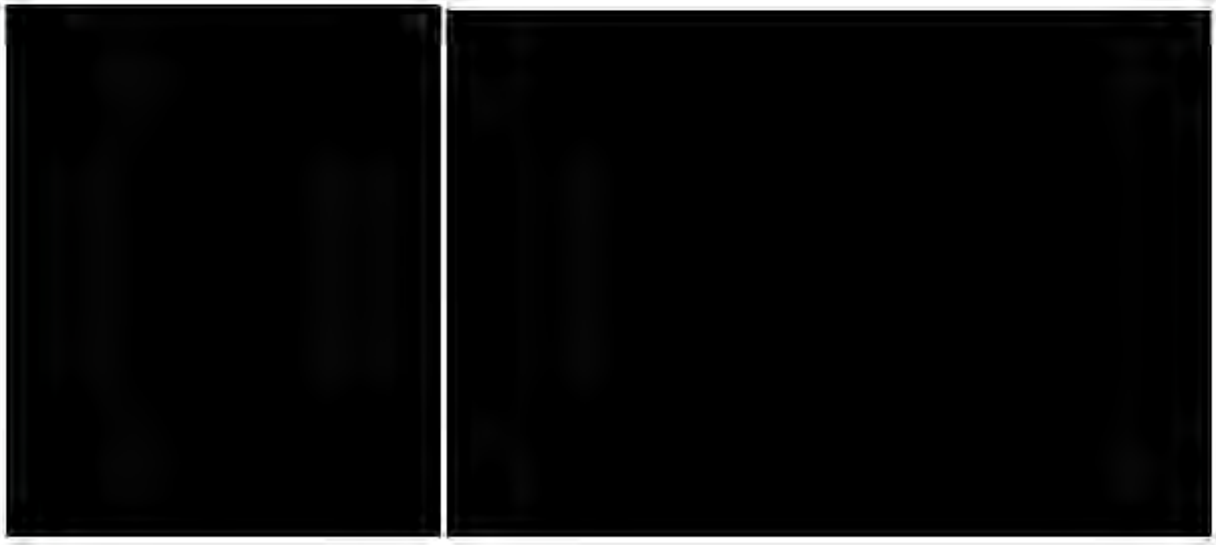
As one of the leading NEPTS providers in the UK, we have extensive knowledge of how the service demand can fluctuate throughout the day. Through analysing the data set provided we have been able to tailor our service model to ensure that our staffing and resource rota mirrors the peaks in daily demand to ensure we meet the demand of on the day requests. The below table outlines the key journey data and the resource we have in place to ensure we are able to deliver a comprehensive service.

Overview of total resource Monday to Friday

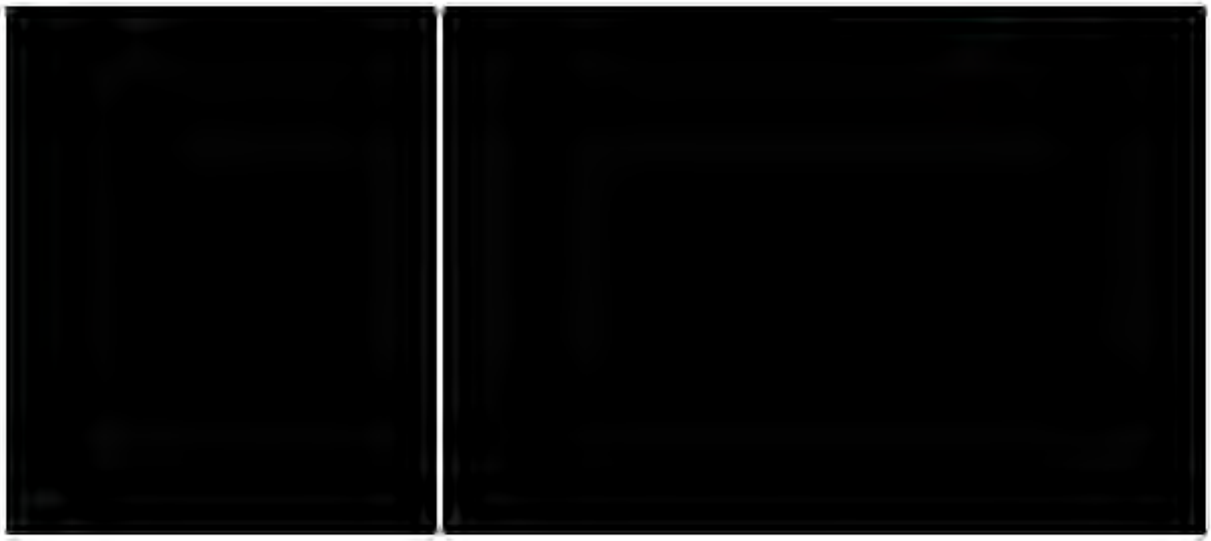


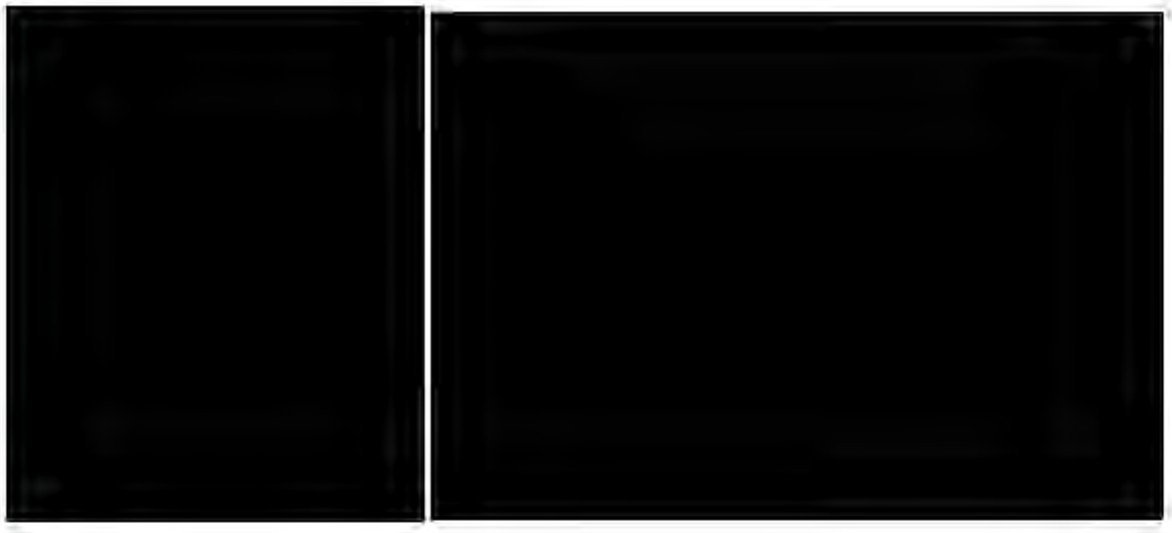
Resource broken down by Facility





ERS Medical





Total Requirements for Saturday

[redacted]

Total Requirements for Sunday

[redacted]

[redacted]

Resource and contingency per site

[redacted]

Robust Planning & Flexible service

Our solution design is modelled on existing county wide services in Norfolk and Nottinghamshire. The following key elements allow us to deliver a flexible and equitable service to patients;

Comprehensive data management – Inherent to our value proposition is [redacted] which plans, operates, manages and reports on our ambulance operations. All journeys are timestamped at every relevant action from the crew leaving base to pick up and drop off of patient. This allows our planners and dispatchers to actively manage our whole resource in real time to maximise its efficiency and ability to successfully manage peaks and troughs in demand.

Sustainable resource provision – Our service model is based on delivering a sustainable service that will deliver effective and efficient patient transport every day/every year. Our core resource of [redacted] vehicles and crew are designed to meet the forecast transport needs. Supported by [redacted] resilience vehicles, bank staff, material sub-contractors, volunteer groups and taxis, a flexible and responsive service will ensure we deliver on-time/every-time.

Flexing our scope of operations – Our detailed service model has accounted for the daily, weekly and monthly changes in service demand and resourced the service accordingly. Further to this we also have [redacted] sites within the Midlands where we can mobilise additional vehicles from. We also have agreements in place with [redacted] subcontractors that can be called upon during peak times.

We have factored in sufficient resources to accommodate the journeys that are long distance, however we can also call upon our national resource to ensure that our local infrastructure is able to focus on delivering the core services.

Proactive management of resources

To deliver a proactive transport service all pre planned journeys are modelled the day before to ensure we maximise vehicle utilisation and service efficiency and sustainability. At 4pm each day there is a full review of all of the pre-planned journeys for the following day that is led by and authorised by the Operations Manager. This ensures that the pre-booked journeys are arranged on the most efficient and effective schedule to fully optimise our vehicles. It also outlines the available resource we have to deal with on the day bookings. The planners and dispatchers work together during the day using their knowledge of the area and our crews to schedule the 'on the day' bookings. All unallocated transports are clearly displayed on [redacted] in real-time, allowing focus to be kept on ensuring all transport needs are fulfilled.

For example, if a booking comes in for transport to Newcastle Upon Tyne for 2pm the same day our planners will be able to identify the available resource through [redacted] to provide this journey and then allocate them to provide the transport. To ensure that out of area transport doesn't impact on the local transport service we will have specific out of area resource available on a daily basis to provide the service. Further to this we will also have agreements in place with local third-party providers who can be called upon to provide short notice transport should our crews be unable to provide the required on the day out of area transport. This allows us to provide the Commissioners with comfort that we will have the ability to deliver all required transport each and every day.

As part of our service design we have used the information provided along with our knowledge of delivering similar services to build a data model for same day demand. We have then allocated resource that is aligned with this demand model. This will provide our planners and dispatchers with adequate resource to manage all on the day bookings along with the pre-planned journeys.

To improve on the day patient-flow we will provide our HLAs with a daily schedule outlining the available capacity to be used for on the day discharges. The HLAs will work with the ward staff through attending morning bed meetings and identifying pinch points of peaks in demand in advance to develop an agreed solution and plan the dispatches in a way that maximises the utilisation of our vehicles.

To ensure we deliver continuity of service we plan our staff rotas 17 weeks in advance. The rota is designed in conjunction with historic data from the contract taking into account historic peaks and mobility type ensuring we resource our service accordingly. Through continually analysing the previous 12 months journey data we are able to flex and adjust our rotas to meet demand.

Ensuring sufficient capacity and resources are continually available to meet the fluctuating demand of the NEPTS service at different times of the day, week and year requires us to not only continually adjust our local resources, but at times to leverage our regional and national resources and subcontractors as well.

Prioritisation process

We understand that some patient's requirements become priority over other patients that are already allocated to transport. Managing this is key to the planning, efficient discharge and achievement of KPI's. We will work in partnership with the commissioners during the mobilisation period to agree and implement a structured process for prioritising patients.

Subcontractors

We currently have MOUs with [redacted] NEPTS transport providers who can be called upon to deliver safe, efficient and compliant transport if required. Further to this we will also have agreements in place with a minimum of [redacted] taxi providers to assist with service delivery when required.

Question 1.18.5

Describe the innovations you plan to implement over the life of the contract that will result in improved outcomes for patients.

Word Count 1000

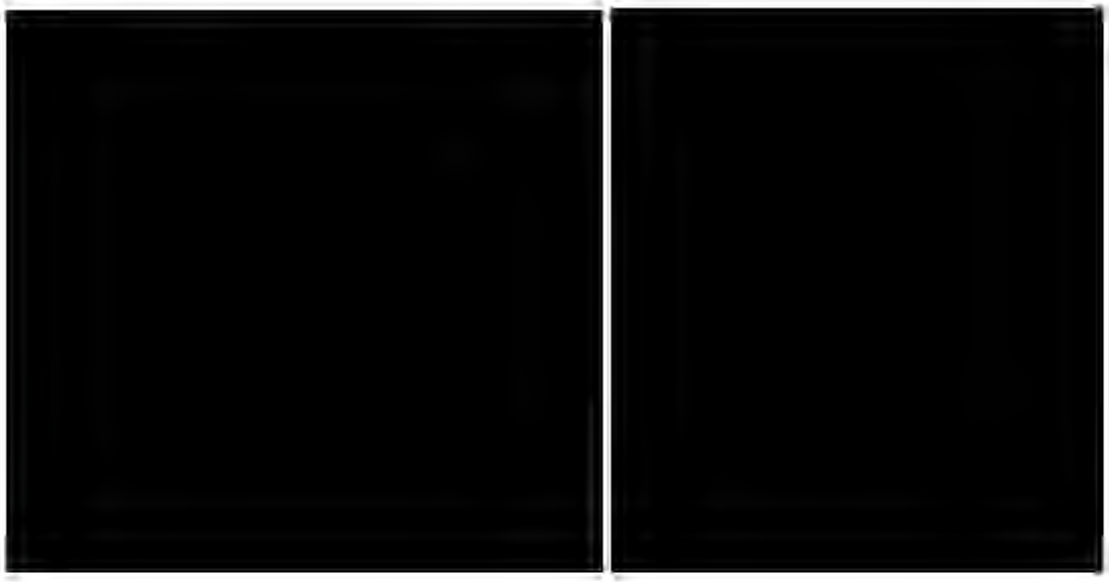
Total Word Count: 1000

Our high-quality and effective patient transport services are developed on the of our innovative and market leading solutions. We have embraced how technology can be utilise the improve the delivery of our services throughout making them more efficient and effective. The innovations we utilise include:

Online booking

We have a fully operational online booking portal that is accessible through the internet and via a phone application (currently being rolled out across the business). The online booking portal will not accept any bookings until all the eligibility questions have been successfully answered by the booker.

Sample question: *Question creation within criteria as an example:*



We will provide all Clinic/Authority locations with full training to allow staff to book patients 'ready to travel'. Our system provides Clinic/Authority staff with a simple but effective means of booking patient transport. It uses the latest internet technology and can be used by any authorised person with access to the system over a secure online network. The online booking service streamlines the booking process for Authority staff, allowing them not only to quickly and easily arrange transport for their eligible patients, but to also make alterations to their bookings should it be required. Further to this we also have a dedicated Call Centre that is available to take bookings directly from authorised staff.

We can monitor who books each journey and coupled with feedback from our crews and the Authority identify any inappropriate booking such as wrong mobility type, wrong time, wrong destination, etc. From this we can then deliver targeted refresher training for the individuals/wards/departments identified.

Patient stack in discharge lounge

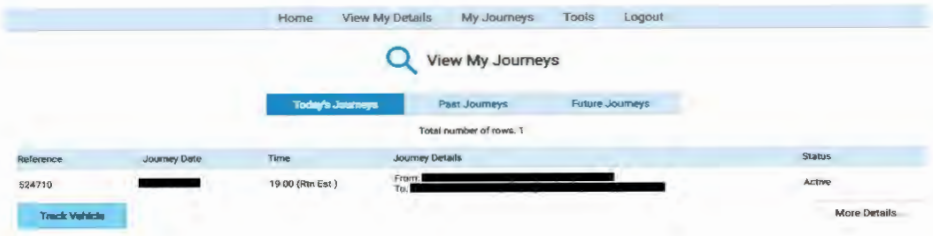
[redacted] shows full details of our service including planned journeys, on the day journeys and vehicle locations. This information can be displayed within the hospitals to ensure Trust staff have a full overview of the service in real-time. A recent system development has been put in place in conjunction with our NHS partners where an internet portal provides access to the following live data sets;

- 'Departure Stack' – shows all imminent departures with real-time journey data.
- 'Outgoing Stack' – A more comprehensive data set providing all discharge journeys and performance for the day.

This provides a full view of our service and allows us to work with Trust staff to maximise patient flow.

Patient portal

We have recently invested in an online patient portal called Patient Zone. Patient Zone enables patients to log-in to the portal, using their smart phone or any other internet enabled device. It provides patients with the ability to confirm their own details, track their current journey pick up time and the names of the crew members coming to them, and view past/future booked journeys to confirm booking accuracy. This is all in the aid of benefitting the patient in giving them more information regarding their transport.



The day before transport is required our CAD System automatically sends a text message to patients with a polite reminder message. Where texting is not a suitable method of communication, a phone call is available as an alternative.

On the day of transport, all ambulance crews are required to call patients at least 2 hours before their collection after 10:00 and the afternoon/evening before their booked journey for pickups before 10:00. In the event of a delay in transport due to road conditions or weather factors, crews will call well in advance to advise of an updated arrival time. If necessary, Clinics are advised of possible delays.

Renal bus

Our Renal Bus service is a dynamic planning solution for renal transport to maximise efficiency and patient comfort. This service is a dedicated resource to renal patients and is focussed on providing a regular and timely service that meets their needs and requirements. We successfully deliver this in

our Nottingham contract and would look to see if there would be any benefits in introducing it within this contract.

Customer portal

To enable our customers to access all of the relevant information relating to their contract we have a customer portal. Information stored on the portal include all of our relevant policies, marketing information (posters etc.), Health and Safety information, HR information and KPI packs. We will provide access to Authorised Officers though a unique username and password.

Staff benefits

We understand that our staff are a fundamental part of our business and therefore look for ways to deliver benefits and innovations to ensure they are highly trained, motivated, and most importantly happy in their work. Our current innovations include;

Wagestream

We have partnered with 'Wagestream' a charity backed organisation that allows staff to draw on their wages as they earn them. It moves us away from a rigid monthly pay cycle and enables people to manage their money as they see fit. It also reduces the likelihood of using expensive emergency short term loans and provides access to independent financial advice and savings accounts.

Employee Assistance Programme

The EAP was introduced in 2019 and provides a wide range of support for ERS employees and their families. From mental health advice to support with bereavement and legal information, the Health Assured EAP team are at the end of the phone 24/7 and are completely free to use.

ERS Academy

In 2020 we will be launching the ERS Academy. The aim of the academy is to provide career and personal development through apprenticeships for all ERS employees. As well as building a career development pathway for the ambulance sector, we will also be offering management and leadership courses from NVQ to master's level.

Future innovations



We are continually looking at innovative ways to develop our service offering and as part of our 'Green PTS' initiative we have adopted the governments road to zero strategy and aim to replace over 40% of our fleet with ultra-low emission vehicles by 2025. We are currently in discussions with Arrival, the UK's leading electric commercial vehicle builder, to develop and electric ambulance. Also, as part of this initiative we have set a target to become carbon neutral as a business by 2025.

Question 1.18.6

Local population

Please describe how your proposed service will address the needs of the local population taking into consideration the local varying demographics to ensure provision of a locally sensitive service.

Word Count 750

Total Word Count: 709

Through delivering NEPTS throughout the UK we are aware of the aging populations trends that are putting pressure on NHS services across the country. In 2017 21% of Staffordshire's population was over 65. Between 2019 and 2039 it is anticipated that the population of over 65 will increase from 192,100 to 257,600 an increase of 34.1% (using ONS data). During the life of this contract the population of 65 and over is set to increase by over 30,000. As a large proportion of patients requiring NEPTS are from the over 65 age range this will lead to increased pressure on the service. Within our financial model we have accounted for this increase in potential users to ensure we are able to deliver a high-quality service to all eligible patients throughout the life of the contract.

Through successfully delivering services in Norfolk, Devon and Nottingham ERS is experienced in delivering NEPT services in rural areas that have large areas surrounding central urban conurbations. We have used this experience to develop our operating solution to ensure we deliver the CCGs with an optimal yet sustainable transport service.

Assuming that the prevalence of dementia remains the same, the ageing population means that the total number of people aged 65 and over with dementia in Staffordshire is projected to rise from around 11,900 in 2019 to 15,600 in 2029; an increase of 32%. Our focus on delivering a dementia friendly service will ensure we are able to maintain our high-quality service and meet the future needs of the service.

Understanding the specific needs of the population

People living in the most deprived areas of the UK can expect to spend nearly 20 fewer years in good health compared with those in the least deprived areas and therefore are more statistically likely to use our service. Staffordshire is a relatively affluent area but with a few notable pockets of high deprivation. Based on the 2015 Index of Multiple Deprivation, 49 of Staffordshire's 528 lower super output areas (LSOAs) fall within the top 20% most deprived nationally making up 9% of its population (equating to 80,500 people. From our delivery of services in Nottinghamshire, Homerton and Norfolk we understand the impacts that this will have on our service.

Developing integrated place-based systems is key to ensuring the long-term sustainability of health and care services. We will work with the Commissioners to assist in the shift towards place-based healthcare as outlined in the NHS Five Year Forward Review. This will be done through moving away from the traditional separation of primary care, community services and hospitals to a more

integrated and patient centred approach. Initiatives that we can assist commissioners with to integrate their services include:

- The integration of the SEN home to school vehicles into the non-emergency patient transport to deliver a holistic countywide transport service that is robust and flexible.
- Providing the commissioners with a single point of contact call centre for all patients requiring transport within the county

We understand that there are four important elements that are required to deliver a holistic move towards population level change. These are:

- Engaged leadership – ERS will fully engage and work with all parties to deliver this shared ambition
- System leaders and complex systems – We will ensure that all of our employees have our shared goal in working to reduce healthcare inequalities
- Vision and strategy – We will align our health inequality vision and strategy with the commissioners to ensure we are all striving for the same goal
- Partnership and Governance – We will commit to partnership working wilth all parties involved

Key challenges to providers are:

- Strongly evidence-based interventions
- Engaging the public
- Accessibility
- Cost effectiveness
- Local services effectiveness

We will work with the commissioners to ensure that we provide detailed information from the delivery of our service to allow them to make evidenced based decisions on how to best evolve the service to reduce health inequality. We will also assist with engaging with the public through our marketing campaigns and open feedback channels. Through applying the agreed eligibility criteria, we will ensure that our service is accessible to those who need it and are qualified to utilise it. By delivering an efficient service we will ensure that it is cost effective and benefits the local community.

Question 1.18.17

Referral Management

Please describe your proposed systems and processes to monitor bookings in regards to eligibility criteria. Please include in your response how you would respond to patients who do not meet the eligibility criteria.

Word Count 750

Total Word Count: 749

Our [redacted] system allows for the monitoring of all journeys in real-time to provide our planners and dispatchers with a holistic view of our service. This delivers our customers with an efficient and proactive transport service.

Our system allows us to report on cancelled and aborted journeys and the system provides dropdown reasons for the cancellation of a journey. This report outlines reasons such as wrong mobility booked. We are also able to identify the hospital and ward where these cancellations and aborts are occurring to see if there are any patterns which may need to be managed through increased tailored training.

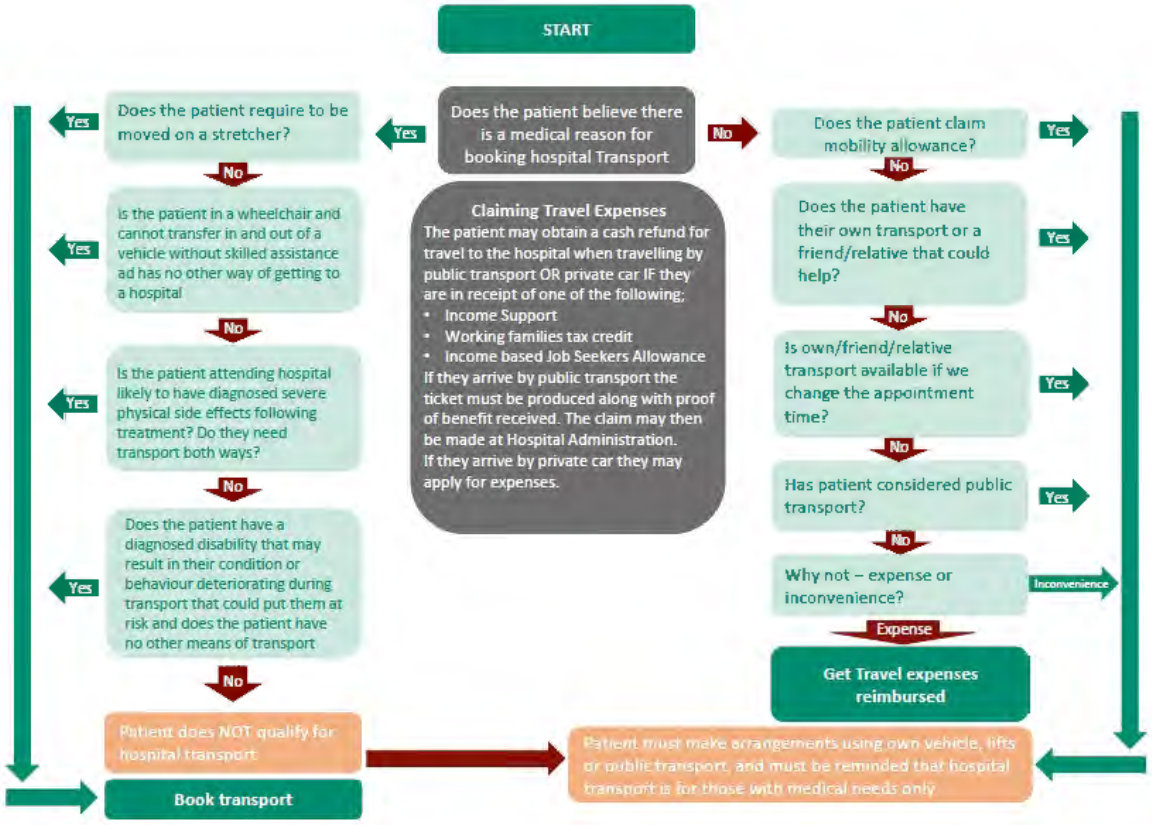
Eligibility

To ensure the robust and equitable application of the eligibility criteria we have comprehensive processes in place for both online and telephone bookings. Our online booking portal will not accept a booking until all the eligibility questions have been successfully answered by the booker.

Both our contact centre and online portal will be available 24/7 to allow staff to book transport at any time ensuring we provider a flexible service to meet the needs and requirements of the service.

Service users and carers will phone the booking through using a local rate 0330 number. Carers will be required to identify themselves and their details will be recorded. Eligibility will be checked before moving to the booking stage. As an NHS service provider, we already have in place a full step by step guide on booking/scheduling transport using the eligibility criteria. All our dedicated Call Centre staff are fully trained on our booking system and how to apply CCGs eligibility criteria.

The following diagram outlines our sample eligibility criteria and process:



This will be tailored to any local CCG specific requirements during the mobilisation period.

Throughout the booking, our telephone agents are trained to provide support, advice and information to the service users and carers. For most patients, eligibility is assessed at each appointment and transport request, as the patient's condition may have improved/deteriorated since the last request. Calls are recorded, and records of all eligibility assessments are retained and subjected to routine audits. For regular service users such as renal, the frequency of review will be 3 months.

We strive to uniformly apply the criteria in a fair and equitable manner. Any appeal by a patient deemed ineligible will initially be passed onto a Team Leader for review. If a satisfactory agreement cannot be reached it will be passed onto the Authorities Contract Manager.

Healthcare Travel Costs Scheme (HTCS)

The HTCS will be included in our booking script to assist patients who are not eligible for our patient transport service to find transportation. If the patient fails to qualify for patient transport against the Eligibility Criteria our signposting strategy will direct them toward alternative transportation options such as the HTCS.

Our booking script signposts ineligible patients onto alternative transport options such as public transport, community transport, community ride services, taxis, etc. We will engage with our third sector providers during mobilisation to ensure a full and up-to-date directory of the services in the local areas and their contact details, which will be reviewed quarterly to ensure they remain up-to-date. This will ensure that patients are fully aware of their options for transport to and from their appointments.

Monitoring clinical appropriateness

To monitor the clinical appropriateness of the bookings all our crews can make notes using Cleric which reports back to our operational team. This allows crews to identify any errors in the clinical appropriateness of the booking such as wrong mobility or wrong equipment requested. Where it is safe to do so the crews will provide the journey as planned, but still make note of the errors to ensure the correct booking is made in the future.

By using the reports from our crews and the booking details we are able to identify the ward responsible for making the incorrect booking and can therefore put processes in place to support them and ensure that future bookings are of the appropriate clinical requirement.

Managing inappropriate bookings

Through both our call centre and online booking service we monitor who books each journey. We use this coupled with feedback from our crews and the CCGs to identify any inappropriate booking such as wrong mobility type, wrong time, wrong destination, etc. From this we can then deliver targeted refresher training to the individuals/wards/departments identified. This proactive approach will not only increase the efficiency of the services we deliver but it will also reduce the number of cancelled and aborted journeys.

Question 1.18.8.1

Please provide details of your proposed premises, including location and opening hours, and the rationale for this proposal.

Word count 500

Total Word Count: 391

We have conducted a full analysis of the transport data provided and looked at journey volumes throughout the service area to establish the optimal sites for our service delivery bases. The below map provides an overview of where we will have sites for our [redacted] bases. The map also shows our existing bases in Mansfield and Nottinghamshire that will provide contingency services should they be required.



[redacted]

[redacted]

Out strategically situated bases ensure that we are close to the main hospitals to minimise dead traveling time and unnecessary mileage. It also enables us to provide the commissioners with a responsive flexible service.

To future proof the service and to make sure we are able to integrate the Birmingham transport journey seamlessly into our contract we have sited a base in [redacted] The facility we have selected will already have capacity to accommodate the additional vehicles required to deliver the Birmingham transport services.

Base facilities

All of our bases will be fitted out to meet the needs and requirements of a Non-Emergency Patient Transport Service. Each base will have the following facilities:

- WCs
- Fully equipped kitchen
- Parking for all vehicles
- Vehicle wash area
- Stockroom for consumables
- Offices
- Crew Room

In addition to all the above facilities our largest operating location in Stoke-on-Trent will have call centre facilities and be equipped with offices and training facilities.

Opening Hours and Service delivery

Through our data analysis we have determined that we will have services operational between the following hours for each location:

[redacted] Monday – Sunday 24/7; patient transport services and control and call handling services with overflow to our Leeds Head Office call centre

[redacted] Monday – Friday 24 hours a day, Saturday 06:00 – 00:00, Sunday 06:00 – 14:00; patient transport services

[redacted] Monday – Friday 06:00 till 22:00, Saturday 06:00 – 19:00, Sunday 14:00 – 22:00; patient transport services

[redacted] Monday – Friday 24 hours a day, Saturday 06:00 – 19:00, Sunday 09:00 – 18:00; patient transport services

There will be operational management on site during core hours with late and early shift starts and an on-call rota for the [redacted] and [redacted] locations.

ERS Medical

Question 1.18.8.2

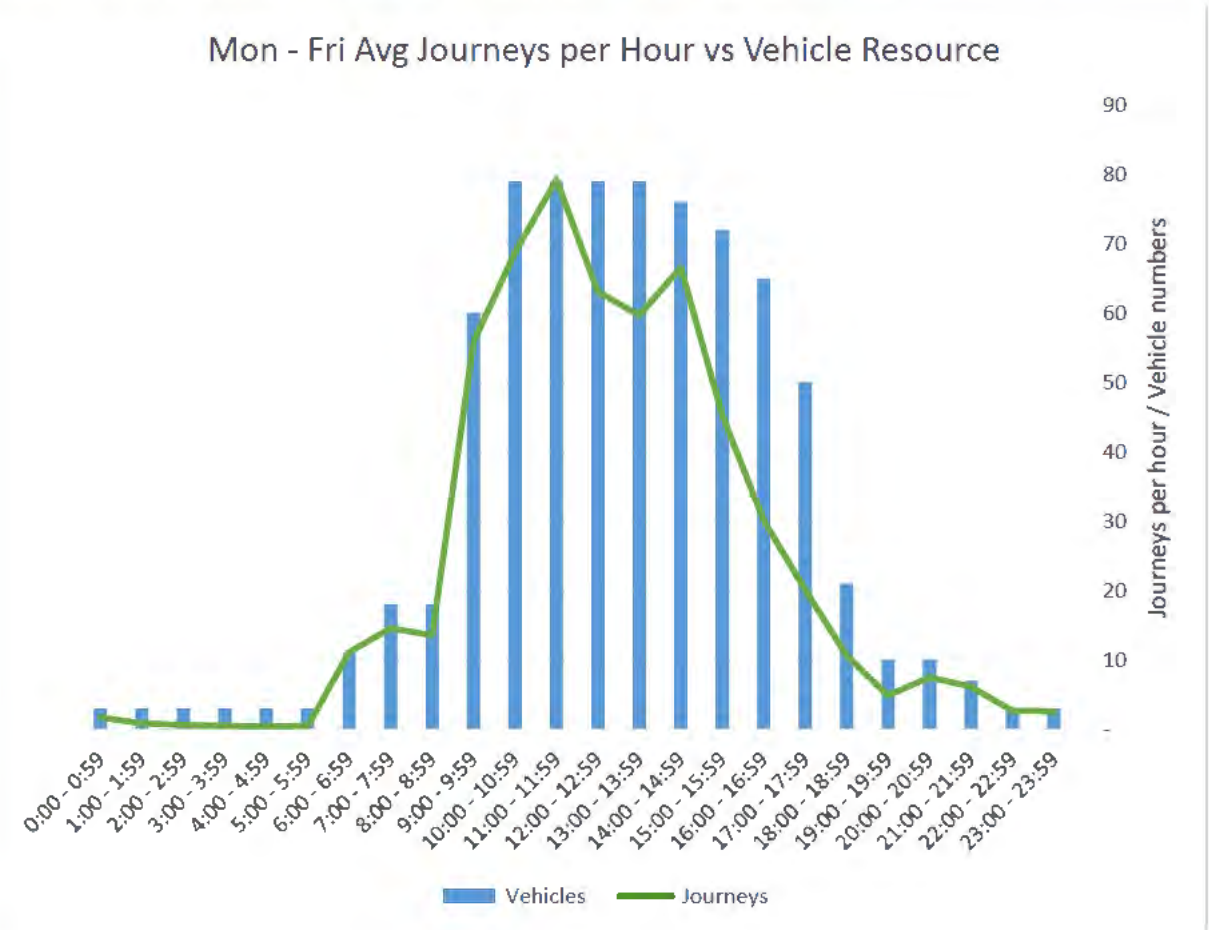
Vehicles

Please provide details of the proposed vehicle fleet and the maintenance and replacement programme you will utilise to deliver the service.

Word count 500

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The indicative data provided has been analysed in detail and we have identified the required number of vehicles to ensure we meet the demand fluctuation throughout the day:

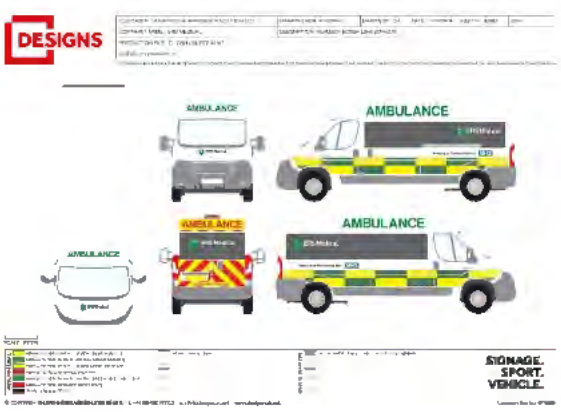


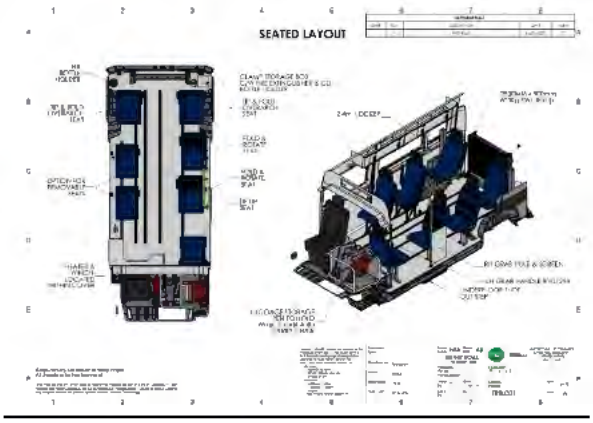
Service fleet mix:

Vehicle Type	Number
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

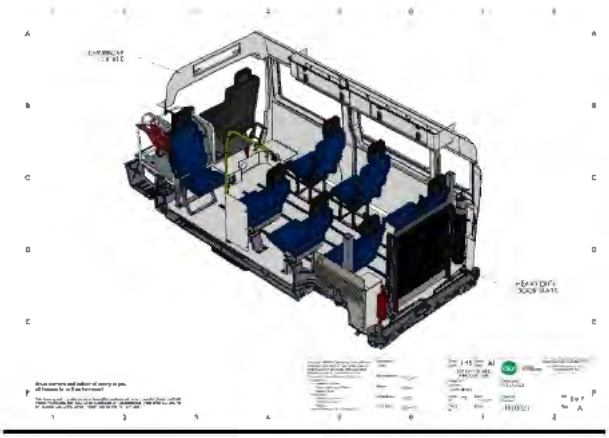
The above fleet mix ensures we have the flexibility to meet service demands of each CCG. Our PTS vehicles are designed so they can be configured as either seater or stretcher vehicles as required. All our PTS vehicles can be configured to accommodate Bariatric equipment. To reinforce our dedicated service model, we will also utilise Volunteer Drivers and Taxis to assist in the delivery of the service.

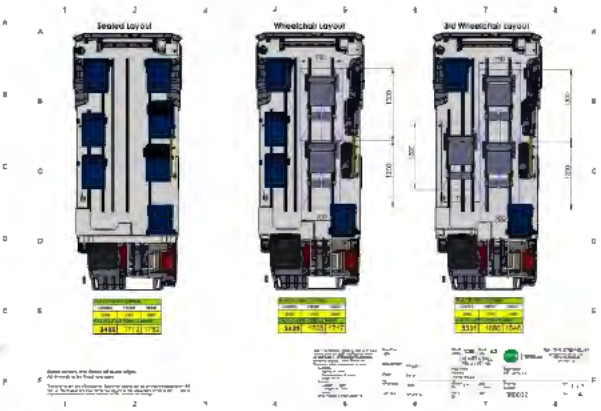
External

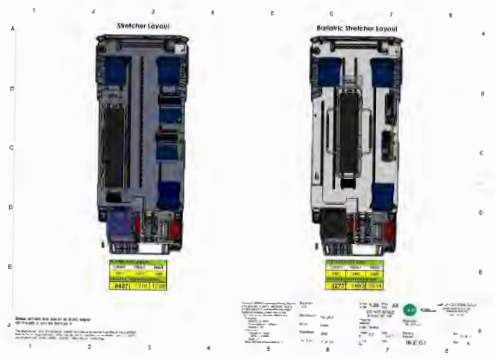




Internal







Equipment

All our vehicles will be equipped in accordance with UK/Department of Health/NHS specification for patient vehicles and equipment or equivalent including BSEN1789:2007 and any applicable relevant replacement standards introduced during the life of the contract. All ambulance vehicles used for Stretcher and Wheelchair's will meet M1 and M2 standards along with meeting the standard BSEN1789:2007.

Fleet selection and fleet management

Analysis of the data set and geographic area indicates that the vehicles will cover approx. 30,000 miles per annum each. This would result in 150,000 in the initial 5 years of the contract. Through careful vehicle redeployment and mileage management ERS will ensure the fleet deployed on the contract remains within the 150,000 tolerance.

ERS Medical has a strategic partnership with O&H Vehicle Technology. Due to their large 60,000 sq. ft. manufacturing facility they can turn around vehicle requirements very quickly at a high standard of quality. All conversions including parts are done in house and are 100% built in Britain.

Fleet management

Our FleetCheck system ensures that only vehicles that are registered, insured, taxed, licensed and within inspection periods are allowed on the public roads. All new legislations will be incorporated with the Vehicle Management Policy, which will ensure that they are adhered to throughout the life of the contract.

[redacted]

Safety is paramount in all our operations and is the responsibility of all company personnel to ensure all policies are adhered to. Individual vehicle maintenance record files are held electronically.

System Alerts

The Fleetcheck system then alerts Operations Managers in advance of their MOT, Tax, Deep Clean, etc. being due allowing them to schedule it in good time. Once the service is completed the Operations Manager enters the date and service certificate into the system and the FleetCheck automatically schedules the next service depending on the requirement e.g. 3 monthly, 6 monthly or annually. This ensures our vehicles are serviced and maintained to the highest standard.

Minimising environmental impact

As part of our 'Green PTS' initiative we have adopted the governments road to zero strategy and aim to replace over 40% of our fleet with ultra-low emission vehicles by 2025. We are currently in discussions with Arrival, the UK's leading electric commercial vehicle builder, to develop an electric ambulance. Arrival have just secured £85 million pounds of investment from Kia and Hyundai.



Question 1.18.8.3

Equipment

Please provide details of the proposed equipment and the maintenance and replacement programme you will utilise to deliver the service.

Word count 500

Total Word Count: 497

All the vehicles and equipment ERS will utilise in the delivery of this service will be fit for purpose, fully maintained and able to transport all required mobility categories safely and compliantly.

We will commission a brand-new fleet of vehicles that are equipped with a document folder, general aids, consumables, and safety equipment as per the tender specification for this service. All vehicles and equipment will be CEN compliant and be in line with the new NHS Improvements National Ambulance Vehicle Specification.

Depending on the requirements and needs of the patients the following equipment will be provided:

- Carrying chair
- Stretcher
- Wheelchair
- 1xHD oxygen cylinder complete with standard mask and tubing
- 1xCD oxygen cylinder complete with standard mask and tubing
- Blankets
- Mobile Phone
- Disposable paper roll
- Tissues
- Incontinence sheets
- Disposable gloves and wipes
- Vomit bowls
- Bedpan
- Cleaning and disinfection materials
- Spillage packs
- Bottled water
- Plastic beakers
- PAT slide

- Fully stocked first aid kit
- Basic road safety equipment (e.g. hazard triangle)
- Fire Safety Equipment
- PPE

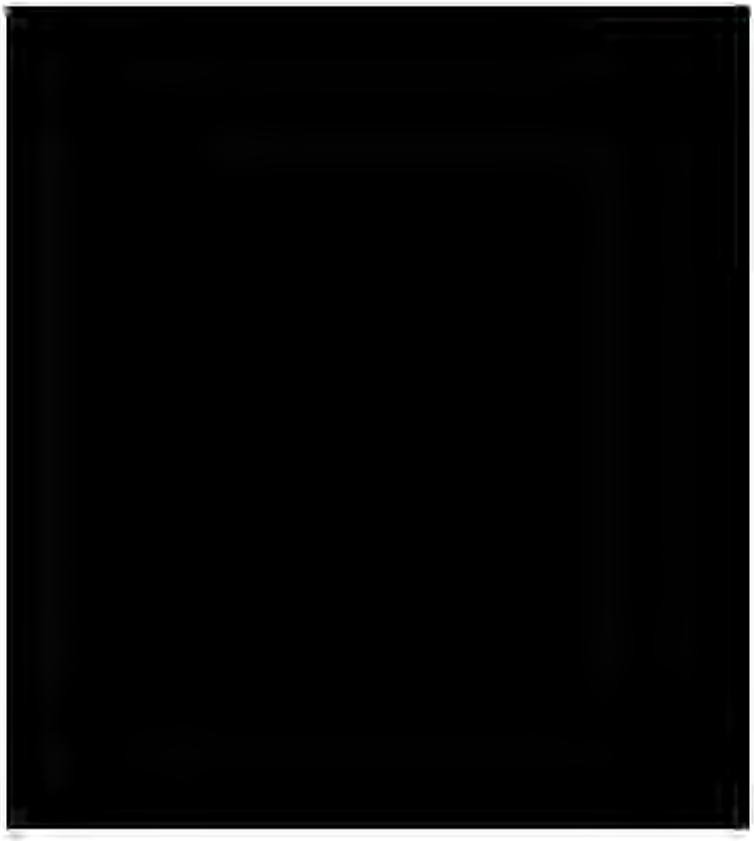
Our vehicles and equipment are checked daily and maintained in line with the manufacturer's guidelines to ensure they are safe, compliant and equipped to transport patients in comfort.

We regularly monitor vehicle requirements with the below schedules:

Daily	Weekly	Monthly
• Review Fleetcheck reminders for all planned servicing for the next four weeks • Book service needs with appointed garages • Review vehicle defect reports and prioritise actions • Review vehicle availability and resource as part of our start of the day review	• Confirm servicing schedule for the following week and confirm with garages • Review vehicle availability and resilience for the following week • Identify gaps and source temporary solutions	• Monthly vehicle compliance and utilisation reports • Mileage entered onto FleetCheck

Maintenance

All our vehicles and equipment are registered within our FleetCheck system. Each piece of equipment is given a maintenance and replacement schedule as per the manufacturer's recommendations. When maintenance is required the Operational Manager receives a notification from FleetCheck and they must acknowledge it and arrange for the maintenance to be completed. Once maintenance has been completed the signed documentation is uploaded into the system and the piece of equipment is signed off until its next scheduled maintenance.



FleetCheck is routinely audited by our Compliance Team as part of the overall site audits.

Individual vehicle maintenance record files are held centrally within our Fleetcheck system, including:

- V5
- MOT
- Vehicle Plate
- Road Fund Licence
- Operator's Licence disc
- Details of tyre sizes
- All defect sheets
- All invoices relating to work done on the vehicle

Our dedicated Fleet Manager is responsible for managing the FleetCheck system ensuring all our vehicles across the UK and fully insured and roadworthy.

Our CQC report noted, "There are effective processes to ensure vehicle and equipment maintenance is up to date".

Replacement Policy

All equipment that is used and stored is replaced in line with the manufacturer's specification. This ensures all equipment used by staff is compliant, safe, and reliable.

ERS have in a place a five-year rolling program for vehicles in usage. The program has established a rigid vehicle compliancy agenda within the business, making sure all vehicles remain fully maintained and compliant.

Covid-19

The COVID pandemic outlined the importance of maintaining adequate stock levels and to ensure our supplies were maintained we implemented a dedicated stock management strategy, creating a central hub for fulfilment and distribution to our 19 operational sites across the UK. This enabled us to continue to provide safe and effective services to all our customers during the pandemic.

Question 1.18.9

Please provide detail of how as a provider you will support the local economy through use of local supply chains and recruitment of local people (Public Service (Social Value) Act 2012)

Word count 500

Total Word Count: 499

ERS recognises its' responsibilities to the wider community and our purpose is aligned to providing services that represent value for money, respect and contribute to the environment in which we work.

As a responsible service provider, we have due regard to the Public Services (Social Value) Act 2012. We have implemented this Act into our business in many ways.

Social Benefits

- We are committed to the Armed Forces Covenant through the Defence Employer Recognition Scheme (ERS). Reservists and veterans bring transferable skills and qualities to the civilian workplace, developed throughout their military careers
- Within our contracts, we work in partnership with the Voluntary Sector. In our Norfolk contract, we have partnered with Voluntary Norfolk, providing full training for their drivers, and assisting them with managing their service
- Monitoring labour standards throughout our supply chain. All of our suppliers must complete our Due Diligence process before becoming an approved supplier
- Our staff are the company's greatest asset and as such, we invest heavily in training them to ensure that we deliver high-quality service and retain staff and continue to develop them throughout their career. All employees have a Personal Development Plan that is reviewed quarterly
- We have an Employee Assistance Programme in place. Health Assured provides all of our employees and their families access to free counselling and support 24/7

Economic Benefits

- Locally employed staff, providing work experience and apprenticeships
- Our engaged sub-contractors are all based locally
- Vehicle servicing and maintenance will be provided by local businesses.
- ERS will source consumables at a local level wherever possible

Environmental Benefits

ERS's modern fleet of vehicles complies with the latest emissions legislation. ERS has in the past delivered electric vehicles for courier services. ERS will always consider the latest technological developments available.

All vehicles are serviced regularly, and drivers receive training covering defensive and fuel-efficient driving techniques. Fuel savings of up to 20% have been achieved.

Our sustainability and environmental impact target and standards include:

- Active monitoring of staff travel – Through regular staff audits and feedback, we continually monitor how our staff travel to work, training courses and meetings. To reduce our staff reliance on vehicular transport, we have the following incentives in place:
    - Cycle to work scheme
    - Advocate train travel to training courses and meeting
    - Car share scheme
    - Training by Skype webinars
- Waste management – All of our staff are trained in waste segregation and storage, ensuring that all waste that is produced throughout the service delivery is segregated, stored, and disposed of correctly. To continually increase the sustainability of our service, we have a reduced packaging initiative with all of our suppliers, waste segregation at all of our facilities, reduced plastic in our offices, etc
- Energy consumption – Our 5-year replacement plan for our vehicles ensure we continually update our fleet to maximise its efficiency. This is achieved through our vehicles being serviced regularly on a schedule that is maintained within our FleetCheck system. Our smarter working policy and the promotion of sustainable travel reduces our energy consumption

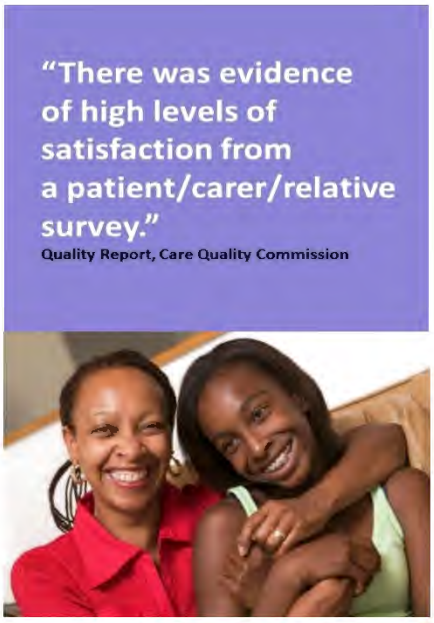
Question 1.18.10

How will you seek feedback from service users, and how will this feedback inform service improvements? Please include an example to demonstrate how you have done this.

Word count 1000

Total Word Count: 1000

We understand that to ensure service quality we must maximise the amount of feedback we receive regarding all aspects of our service. We are committed to working with all stakeholders to identify ongoing continuous improvement to our service through patient feedback, staff and patient engagement and steering groups. The main methods we use to gain feedback from the patients are:



- On-board surveys
- End of Call surveys
- Social media
- Dedicated complaints phoneline and email address clearly advertised in all our vehicles
- Website

To get feedback from our staff, Trust staff and user groups we use the following methods:

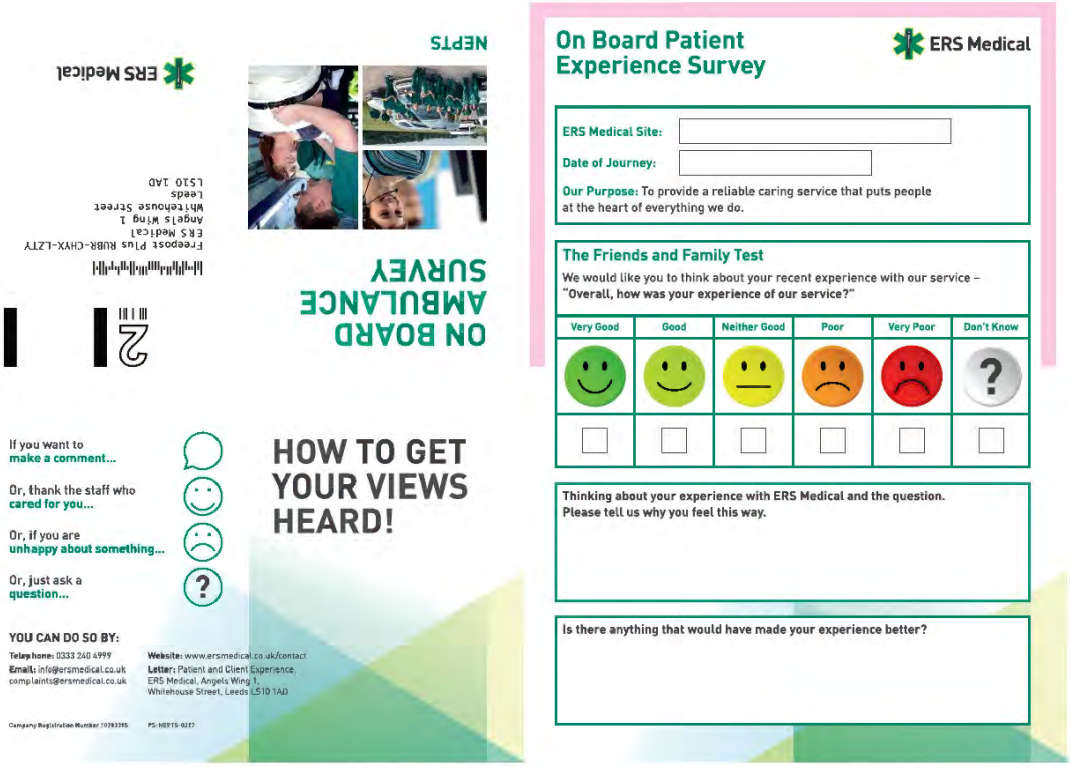
- Annual staff surveys
- Attend user group meeting
- Sit on steering groups

Patient Surveys

Our principal method of measuring patient satisfaction is through the use of on-board ambulance surveys which are given to patients on every journey.

Patients are invited to complete the survey on-board the vehicle or take it away with them to complete later. All surveys are issued on a pre-paid postage format to be returned at no cost to the patient.

We are aware that NHS England has decided that there will be no requirement to ask the Friends and Family question as of 1st April 2020. We will await the new requirements and will work with the CCG to update the survey as required.





Maximising Response Rates

As well as handing out patient surveys on every patient transport journey, we also advertise for feedback on our website and through our call handlers that take the transport bookings. We currently have a national response rate of 20%.

Staff Surveys

We understand that feedback from our staff is just as key to the development of our services as patient feedback. We employ an open and honest feedback policy that encourages all employees to identify issues/improvements. This information is collated along with patient feedback and any trends are identified.

Stakeholder Engagement

We actively engage with stakeholders on a monthly basis through contract review meetings to receive feedback.

Social Media

We utilise social media such as Twitter, LinkedIn and our website to enable patients and their carers to leave feedback on our services. All feedback received is included in our reports.

Regular service users

We understand that regular service users do not want to complete a patient survey on every journey they take with us. Instead we conduct a 6-monthly survey of the regular users either through the completion of our paper survey or via a face to face conversation.

Reacting to Findings and Trends

ERS put together a monthly Feedback Report. This report features as an agenda item at both our monthly Review Meeting with the Trust and our internal monthly management meeting to analyse results and determine trends. This information is then used to develop the ERS Medical Patient Satisfaction Programme.

Collated patient feedback looks for common themes and trends along with areas of concern. Positive feedback is shared throughout the business as best practice and action plans are developed for highlighted areas for improvement.

Sharing Feedback

We ensure all staff hear about patient feedback through regular team meetings, Site TV, our internal InTouch magazine and through their personal 121s. We also have an Employee Recognition scheme to recognise that they are delivering our services by living by our Company values.

Feedback led change

Our service model is based on our service user experience intelligence and this will continue to develop throughout the term of the contract. Examples of where service user experience intelligence has led to an improvement in our service include:

Patient Zone

Our patients requested the ability to be able to track details of their own transport online without having to call our contact centre. We developed Patient Zone which is an online portal that provides patients with access to their journey information through a unique username and password.

Suspension change

We received patient feedback about the ride quality of our ambulance suspension. Following a review, we identified a new suspension system that improved patient comfort. The new system was then used companywide in all new vehicles as standard.

Background noise in our call centre

At the end of each of our booking calls we ask the bookers for feedback on our service and any improvements that could be made. We received feedback about the background noise within our call centre making it hard for some patients to hear the booker properly. Following a full review of this we put in place two mitigations to improve the quality of our booking experience. Firstly, we implemented a new phone system that had background noise dampening technology. Secondly, we moved our call centre to a quieter part of the building to reduce the amount of background noise caused by the day to day operation of our business.

Patient mobility options

Engagement events with Occupational Therapist's (OT's) identified that there was insufficient knowledge of mobility options used in the transportation of patients. A series of workshops were organised to provide guidance around best options for patients with varied mobility challenges. The outcome was that OT's were able to make informed decisions regarding transport needs. This resulted in improved patient experience and timeliness of transport.

Renal transport options

Working with the Local Renal Patient Group and CCG Representatives ideas were shared around transport options for Renal Patients. Spend on renal transport is significant and consideration was given to providing personal budgets for transport options, including using family resource. A trial was introduced that allowed a small number of patients to allocate their budget between family, taxis and NEPTS core service. Financial saving was not the priority, with patient/family experience enhancement targeted. Outcome is yet to be reported.

Current feedback statistics

Our latest feedback figure from across our business are:

- Call centre patient satisfaction is 98%
- FFT results show that 86% of our patients are extremely likely to recommend our service

During the mobilisation we will work with the CCGs to tailor the patient survey questions to the service. This will ensure that all questions are relevant and lead to an increase in participation.

Question 1.18.11

Partnership working

2% With reference to the Service Specification, please describe how you will ensure effective and relevant partnership working with all stakeholders including how you would engage in the local development of the new models of care introduced as part of the Five Year Forward View.

Word count 1000

Total Word Count: 1000

Our service delivery and management methodology has delivered a CQC rating of Good/Outstanding across our four registered regions. This has led to the NHS recognising the benefit of the quality solutions that ERS can offer with long term partnerships established in Norfolk, Nottingham, The North East and Noth London.

Our approach to delivering service solutions is partnership led, recognising that the healthcare environment requires flexibility and responsiveness.

We understand that to ensure service quality we must maximise the amount of feedback we receive regarding all aspects of our service. We are committed to working with all stakeholders within the local population to identify ongoing continuous improvement to our service. To engage directly with stakeholders and develop partnerships we:

- Holding stakeholder townhall meetings
- Establishing service user groups
- Social media groups to allow those that may not attend user groups to have their say
- Working with Healthwatch
- Information materials at CCG and Trust facilities outlining the services we deliver and also how to feedback on our services
- Work with PALS and commissioners to implement a forum to engage with vulnerable and seldom heard patients

Through being on working groups and continually liaising with the local healthcare economy we will be engaged in the development locally of the new models of care introduced as part of the Five Year Forward View. To assist the NHS with achieving is Five Year Forward View we deliver services that:

- Deliver safe and compliant service for patients
- Integrate with local health and care services
- Are Sustainable and efficient
- Invest in technology to improve the NEPTS Industry
- Investing in technology to develop the NEPTS industry

In our East Region our recent CQC report stated *"The organisation has implemented a Hospital Liaison Assistant role at the acute hospital. The role had proven to be invaluable by supporting the crews, reducing aborted journeys and providing a communication line on the ground in the hospital"*

Key dependencies

The key dependencies allowing us to deliver a safe, efficient and compliant transport system are:

- Patient being ready on time
- Patients in correct area for collection
- Correct mobility booking
- TTOs ready prior to transport

We will work closely with Trust staff through our Hospital Liaison Assistants (HLA) to help deliver a efficient and effective patient flow. Our HLAs will provide Trust staff with training and advice on how to correctly book patients onto our system and make them ready at the right time. They will also attend bed meetings to work with the Trust staff to identify any pinch points that may occur and assist in organising mitigations to ensure there is a smooth patient flow.

NEPTS Partners

We will also work in partnership with other NEPTS providers within the area to ensure we are able to deliver a streamlined service to both the CCGs and the patients. We understand that having multiple NEPTS providers delivering services on the same site can cause issues such as booking confusion and waiting area congestion. We work with other NEPTS providers nationwide including ambulance Trusts such as NWAS, YAS and SCAS and many other private providers, with whom we develop partnerships to ensure we can deliver a holistic service to the Commissioners. To prevent booking confusion our call centre will transfer Trust staff who try and book a patient who is meant to be transported by a different provider to the correct contact centre. This ensures that they are able to book the required transport without delay or confusion. Our online portal has a set of specific questions that will prevent the wrong patient being booked onto our system.

We will arrange monthly meetings with the other NEPTS providers to develop an open and honest forum to discuss and resolve any issues that have arisen and discuss processes that could be put in place to prevent a reoccurrence. This will include agreeing protocols to resolve any issues independently and without the involvement of the Trust.

We understand the strength of partnering with other organisation to assist in the delivery of an efficient and effective transport service. In our Norfolk contract we have partnered with Voluntary Norfolk to improve the interface between hospitals and the services we deliver though the following initiatives:

Car Link Coordinator

The coordinator is an integral link between ERS's Operations Managers and the Voluntary Norfolk services. Through close and continual communications, we deliver a high-quality personalised transport service to the patients of Norfolk.

The coordinator manages a team of Car Link Dispatchers and workshops, training and regular feedback to improve communications and relationships with volunteers. This ensure ERS and Voluntary Norfolk deliver an integrated and effective service.

Patient Liaison Assistant (PLA)

The key roles of the PLA are:

Appointment reminder calls – the PLA calls the patient to remind them of their appointment (including time) and ask to confirm whether they intend to keep it and if they still require a volunteer driver which deliver a:

- Reduction in missed or delayed appointments (net benefit to NHS Trusts and CCGs)
- Reduction in driver time allocated to cancelled or delayed jobs
- Increased efficiency in use of volunteer driver resource
- Improvement in patient satisfaction

Hospital Volunteers

We are currently recruiting a team of 5 volunteers to work at the key Norfolk hospitals in partnership with our HLAs to assist in managing the logistics of supporting patients to and from their transport to their appointment. The volunteers will visit wards prior to transport arriving to establish readiness of the patient. If delays are envisaged dispatchers can be advised and transport re-scheduled, avoiding the need to abort Journeys. During busy periods, volunteers can be utilised to deliver patients to a dedicated pick up point within the hospital. This will increase transport availability with crews spending less time within the hospital.

The key outcomes of these roles are:

- Reduction in delays caused by drivers waiting for patients
- Increase in driver hours / fleet availability – not tied up with physically supporting patients to reach their appointment within the acute setting
- Improved driver satisfaction
- Enhanced relations with hospital teams, departments, clinics and wards

Question 1.19. 1

Continuous improvement

1% Please describe your approach to continuous quality and service improvement to ensure enhanced performance, and improved outcomes for patients.

Word count 1000

Total Word Count: 1000

Embedded and effective quality improvement system

As a leading provider of NEPTS throughout the UK, we understand it is crucial that we continually improve and enhance our service quality to ensure the very best patient outcomes at all times. We continuously monitor, review, and audit all our services to ensure they are being delivered to the highest standard. All new initiatives, legislation, and improvement are implemented correctly and being adhered to.

Our service quality system is embedded within our Business Management System (BMS), which is the backbone of how we deliver our business. Our policy is to regularly audit our activities against the requirements of the BMS, the standards to which it subscribes, and the legal and other essentials to identify non-conformances (including potential) and opportunities for service improvement.

A testament to our service quality is our external audits' outcomes from the Care Quality Commission (CQC). In the last 18 months, all 4 of our CQC registered sites have been inspected by the CQC and been awarded a rating of "Good" with one receiving an "Outstanding" for the Well Led portion of the assessment.

Focus on quality embedded in the organisational culture

Our staff are the company's greatest asset. As such, we invest heavily in training them to ensure that we not only deliver a high-quality service but to ensure we retain staff and continue to develop them throughout their career. Creating a culture of quality led service delivery throughout our organisation.

Quality and governance are central to ERS's transport offering. We have in place robust monitoring and management processes and policies to ensure we continually deliver a high-quality service throughout the contract's life.

We understand that for ERS to sustain a partnership with the CCGs, the service quality must be maintained. This will be achieved by delivering a quality and sustainable service that achieves our KPIs while remaining financially viable.

Our service is designed with the CCGs quality requirements embedded within it. To ensure we continually meet these quality requirements, we will proactively manage and monitor the service through:

- Embedding internal KPI's into [redacted] allowing planning and identifying possible compromise to performance in advance
- Data Analytics allows the management team to review past performance and identify trends
- Continually reviewing training and best practice
- Investigating all incidents, complaints, and near misses and implement new working practices where required

Learning lessons

It is company policy to report and investigate all accidents, incidents, and near misses to identify immediately any underlying root causes. These include:

- HSE incidents
- Clinical/Safeguarding incidents
- Transport incidents and occurrences
- Information Governance/Data Security incidents
- Environmental incidents
- Near misses
- Business Continuity/EPRR

This information is an essential part of developing our business, allowing us to continually learn from incidents and patient feedback, combining it with our experience, innovation, and best practices. This is disseminated to our employees through GaPS meetings, Clinical Memos, Notice Boards, and Team Meetings.

Culture of continuous improvement at all levels

All of our contracts are treated individually to ensure we meet the patients and customer's specific needs. Each contract has a Service Development Plan that ensures that all agreed proposed service improvements are planned, monitored, and implemented.

We monitor every aspect of the services we provide. By tracking every part of our service in real-time, we can provide our customers with continual snapshots of our service's performance. Each patient journey is assigned a unique reference number that, combined with the patient's NHS number, provides a full history of every event for that patient. Our Data Warehouse holds all data generated by our systems with an audit trail including:

- Activity Data
- Exceptional Journeys
- Qualitative information around core service
- Delivery indicators
- Complaint/concerns/compliment monitoring
- Mandatory data
- Incidents
- Patient Feedback

Further to this, our Care Standards Team conducts a rigorous schedule of Audits at each of our sites to ensure they remain clean, safe, and compliant, allowing our crews to focus on delivering a high-quality patient transport service. Along with regular audits, we also conduct CQC standard internal audits to ensure we are providing a service that meets our customers and patients' needs and requirements. This has led to us receiving "Good" with "Outstanding" in our latest CQC report making ERS Medical the leading private service provider.

Feedback lead improvements

At ERS, we understand that to ensure service quality; we must maximise the amount of feedback we receive regarding all aspects of our service. We are committed to working with all local population stakeholders to identify ongoing continuous improvement to our service. To engage directly with stakeholders, including those identified as vulnerable or seldom heard, we utilise the following methods:

- Holding stakeholder townhall meetings
- Establishing service user groups
- Social media groups to allow those that may not participate in user groups to have their say
- Working with Healthwatch
- Service information at CCG and Council facilities outline the services we deliver and how to provide feedback on our services.
- Work with PALS and commissioners to implement a forum to engage with vulnerable and seldom heard patients

Examples of where service user experience intelligence has led to an improvement in our service include:

Patient Zone

Our patients requested the ability to track their transport online without having to call our contact centre. We developed Patient Zone, which is an online portal that provides patients with access to their journey information through a unique username and password. By allowing patients to access information such as the ETA of the crew, we have found that it has reduced collection delays due to the patient not being ready for transport, so improving the journey's efficiency.

Suspension change

We received patient feedback about the ride quality of our ambulance suspension. Following a review, we identified a new suspension system that improved patient comfort.

Organisational Improvements

We continually look to develop our service offering at all levels of our organisation. Recently we have undertaken the following initiatives as part of our continual drive to develop:

- Became Investors in People certified
- Began our ISO accreditation audits
- Implemented a new financial system
- Provided mental health training for all management staff

ERS Medical

Are ERS Medical's services safe?

The CQC rated safe as 'good' because:

- Mandatory training compliance rates for staff was 96%.
- There were effective processes to ensure vehicle and equipment maintenance was up to date.
- There were effective processes to prevent the risk of infection.
- Medicines were managed well, in line with policy and national guidelines.
- Risk assessment and monitoring of patients was carried out to ensure patient safety during transport.

Quality Report, Care Quality Commission

Are ERS Medical's services effective?

The CQC rated effective as 'good' because:

- Policies and procedures were up to date and in line with national guidance.
- The service was performing well against the key performance indicators outlined in the non-emergency transport service contract.
- The service worked well with other health care providers to provide the best care for patients.
- Staff received annual competency update training to maintain their skills to deliver care to service users.

Quality Report, Care Quality Commission

ERS Medical

Are ERS Medical's services caring?

The CQC rated caring as 'good' because:

- We observed staff treating patients with kindness, dignity and respect.
- Staff told us that delivering good care was what they enjoyed most about their job.
- Patient survey results showed that 89% of service users felt staff were kind and treated them with dignity and respect.

Quality Report, Care Quality Commission

Are ERS Medical's services responsive?

The CQC rated responsive as 'good' because:

- The service was planned and managed in line with the commissioning agreement in place.
- There was information available to service users about how to make a complaint. Complaints were handled in line with the service complaints policy.
- The service had good oversight of the booking process. Pick up and drop off times were monitored and patients were informed about delays.

Quality Report, Care Quality Commission

ERS Medical

Is ERS Medical well led?

The CQC rate well led as 'outstanding' because:

- Managers at all levels in the organisation had the right skills and abilities to run a service providing high-quality sustainable care.
- The service proactively engaged and involved all staff and ensured that the voices of all staff were heard and acted on to shape services and culture.
- The service fully embedded a systematic approach to improvement and made patient experience pivotal for staff to learn and enhance the performance of the organisation.

Quality Report, Care Quality Commission

Question 1.19.2

Quality and governance approach

1% Please provide details of how quality and governance including clinical governance will be central to the delivery of this contract.

Word count 1500

Total Word Count: 1413

Quality and governance are central to ERS's transport offering. We have robust monitoring and management processes and policies to ensure we continually deliver a high-quality service throughout the life of the contract.

Clinical Governance

Clinical governance is defined as "A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." Our clinical governance process is built upon the seven pillars:

- Clinical effectiveness
- Risk Management
- Patient and carer experience and involvement
- Communication
- Staffing and staff management
- Education, training, and CPD
- Learning effectiveness

In short, it is doing the right thing, at the right time, by the right person. Therefore, we don't have a single specific clinical governance process as it covers the entirety of our services and impacts everything we do. Instead, we have it as the backbone of our Business Management System (BMS), and the seven pillar principles are interweaved throughout our policies, processes, Safe Operating Practices, and best practice.

Below we have provided an overview of how Clinical Governances is fully integrated into our service and is the cornerstone of everything we do. All information relating to clinical governance is recorded through our [redacted] system. This is reported within our One Report and managed by our Governance and Patient Safety team, who meet monthly to discuss all governance issues. The report focuses on:

- Audits
- Incidents

- Serious [Untoward] Incidents
- Safeguarding Referrals Raised by ERS
- Safeguarding Referrals Raised Against ERS
- Running Calls
- Complaints
- Compliments
- Surveys
- Vehicle Deep Clean Compliance
- Trend Analysis

Clinical effectiveness

Clinical audits are a way for us to ensure that the quality of service we are delivering meets the commissioner's standards and requirements and is compliant with all legislation. It is also an opportunity for us to identify any improvement areas that can be implemented to increase patient comfort and satisfaction with the service.

A comprehensive timetable of audit activities is managed for the National Care Standards team. The team consists of four experienced members, including a registered nurse and a qualified Health & Safety Inspector.

Risk management

Our [redacted] system is used to manage clinical and other regulatory governance and has been specifically designed for the healthcare market. It allows us to capture and record all incidents, complaints, and compliments in a single place to be reviewed, actioned, and lessons learned disseminated quickly and efficiently.

Patient and carer experience and involvement

At ERS, we are committed to working with all service users and stakeholders to identify ongoing continuous improvement to our service through feedback, staff, and patient engagement and steering groups. An onboard survey is provided to patients on every journey (excluding regular users) for them to complete and return. Feedback from these surveys is divulged at our monthly Governance and Patient Safety meeting. These meetings are used to discuss the feedback we have received to develop and improve our service.

Communication

We believe that open and honest communication with staff, commissioners, and stakeholders is the best way to deliver a safe, effective, and sustainable service to the local healthcare community. We communicate our service using several mediums:

- Monthly meetings with commissioners
- Regularly attending stakeholder and user group meetings
- Marketing collateral provided to all CCG facilities
- Social media

Staffing and staff management

ERS has a comprehensive, well trained, and motivated workforce managed by a dedicated and inspirational leadership team. All ERS Managers receive extensive training from subject matter experts on regulatory matters, including clinical, HR, Health & Safety, CQC compliance, and vehicle licencing and safety legislation.

Education, training, and CPD

We understand that it is vital that our staff delivering patient transport services have the knowledge and skills they need to do a good job. It is for that reason that they undertake mandatory induction training and annual refresher training throughout their career. We also provide all our employees with a professional development plan that continually develops new skills and abilities. This ensures that our staff are highly trained and provides a structured development path that is shown to improve staff happiness and retention.

Learning effectiveness

It is company policy to report and investigate all accidents, incidents, and near misses to identify immediately any underlying root causes. These include:

- HSE incidents
- Clinical/Safeguarding incidents
- Transport incidents and occurrences
- Information Governance/Data Security incidents
- Environmental incidents
- Near misses
- Business Continuity/EPRR

This information is an essential part of developing our business, allowing us to continually learn from incidents and patient feedback, combining it with our experience, innovation, and best practices. This is disseminated to our employees through GaPS meetings, Clinical Memos, Notice Boards, and Team Meetings.

Monitoring

ERS uses the [redacted] compliance software for its management of clinical and other regulatory governance. This system has been designed specifically with the healthcare market in mind by 'Smartgate' solutions, and it allows ERS to capture and record the main aspects required for evidencing compliance with the requirements of regulated activity quickly and efficiently.

All incidents, comments, complaints, and compliments are recorded on [redacted] allowing us to monitor our service's quality and clinical governance fully. The key indicators that we use to monitor our services' quality are incidents, complaints, near misses, patient feedback, staff feedback, and commissioner feedback. Through [redacted] we can observe, manage, and report all these critical indicators, providing both ourselves and the Commissioners with comprehensive information to ensure the service meets the delivery requirements.

We chose [redacted] because it provides a platform to allow ERS to improve its service offering through the following 5-stage process continually:

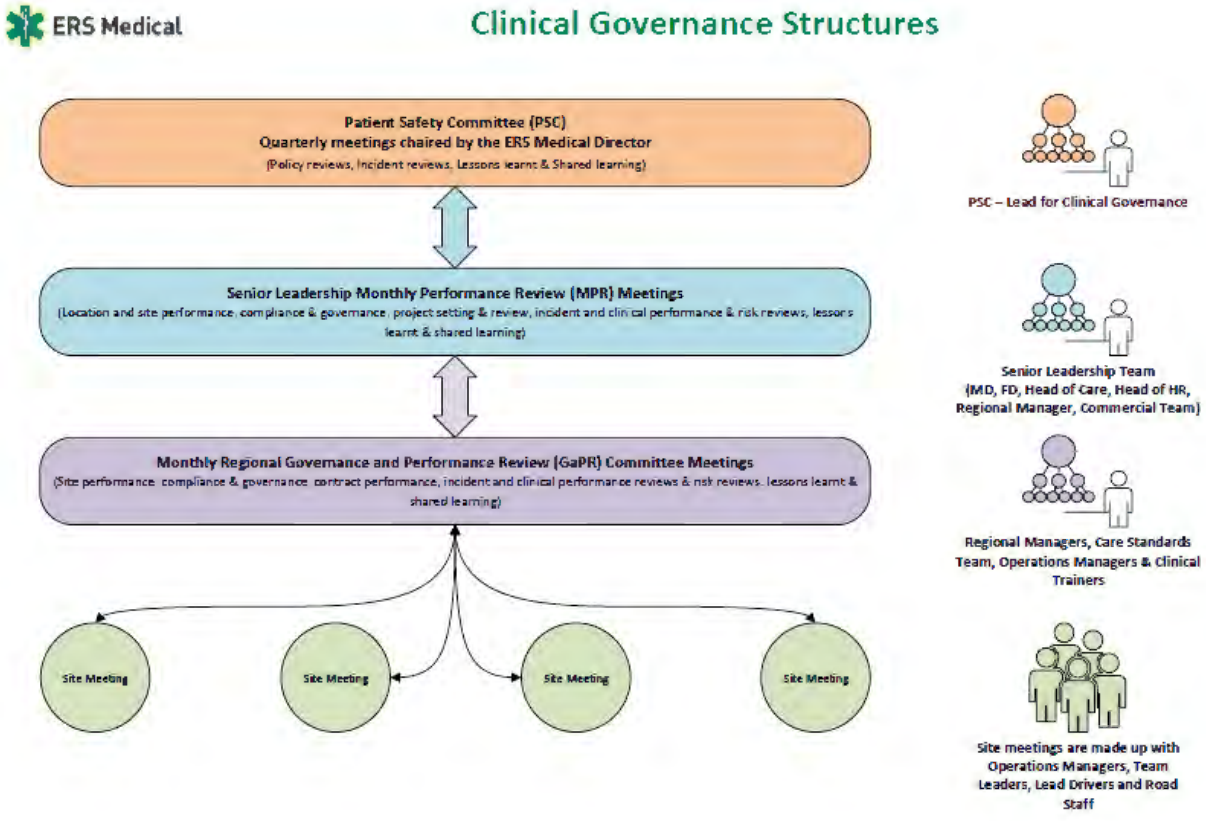
- Capture – [redacted] allows us to capture large amounts of data and translate it into comprehensive reporting formats
- Report – Accurate reporting is crucial to understanding trends, best practices, and early indicators. Through [redacted] we can do this quickly and efficiently.
- Action – [redacted] allows us to identify existing and potential non-conformances and supports us to create, execute and monitor corrective and preventative action plans
- Improve – Sustainable quality improvement is delivered through well-led engagement. [redacted] allows us to collate evidence-based data centrally and efficiently identify and share best practice
- Standardise – A systematic approach to identifying good practice through [redacted] allows us to turn good practice into standard behaviour

Clinical effectiveness

Clinical audits are a way for us to ensure that the quality of service we are delivering meets the commissioner's standards and requirements and is compliant with all legislation. It is also an opportunity for us to identify any improvement areas that can be implemented to increase patient comfort and satisfaction with the service.

A comprehensive timetable of audit activities is maintained for the National Care Standards team. The team consists of four experienced members, including a registered nurse and a qualified Health & Safety Inspector.

Roles & Responsibilities



The below table provides a full overview of the roles and responsibilities for this contract:

Managing Director	Has overall responsibility for setting and directing: • Quality • Environmental • Safety and health • Business continuity • Information security policy • Ensuring appropriate resources are available. Responsible for setting ERS Medical objectives and allocating adequate resources to meet those objectives.
Senior Management / Leadership Teams	Responsible for ensuring that all BMS requirements are established, implemented, maintained, and continually improved per the standards to which the ERS Medical subscribes and the legislation relative to the ERS Medical's operations.
Head of Care Standards	Responsible for ensuring that Clinical Governance and Compliance policies, procedures, and associated documentation and the required systems and associated training are developed and cascaded to all ERS Medical sites to support the Managing Director's decisions. Responsible for devising and maintaining internal and external audit schedules on the company intranet system.
Internal Audit Teams	Responsible for undertaking audits and developing and reviewing RAPs arising from those audits, whenever a non-conformance, observation, or opportunity for improvement is identified. Responsible for escalating any actions that have not been completed promptly. This may include making referrals to HR on the potential need for the disciplinary process to be utilised.
Senior Operations Manager & Operations Managers	Responsible for ensuring that sufficient time and resource is afforded to the Internal Audit Teams to allow ERS Medical's audit schedules to be achieved. Responsible for ensuring that sufficient time and resources are afforded to any external audit the Internal Audit Teams to allow the ERS Medical audit schedules to be achieved.
All Team Members	Responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times. Responsible for completing all actions they are allocated for promptly and notifying the issuer upon completion.

ERS Medical

Legislative Governance responsibilities



Question 1.19.3

Quality and governance approach

Describe how your management processes and policy systems will operate to ensure successful delivery of the contract.

Word count 1000

Total Word Count: 937

Our approach to governance and quality is to use procedures that monitor performance daily, weekly, and monthly, using a Red/Amber/Green (RAG) status to measure KPIs.

Our methodology for KPI monitoring includes the following three-tier approach.

- Tier 1 - Operations Manager – Reviews KPIs on a daily, weekly, and monthly basis
- Tier 2 - Regional Manager – Reviews performance breaches, a monthly review meeting of all KPIs
- Tier 3 - Managing Director – Quarterly performance reviews

When performance falls below an agreed KPI, depending on the severity of the breach, this triggers an automatic escalation to the appropriate Tier level for investigation and action.

Risks are managed using our incident reporting system and our online Risk Register, [redacted] which is accessible to all employees to record any serious issues that may impact patient care, service delivery, or the business as a whole.

These measures ensure that:

- Required standards and performance are being achieved
- An investigation takes place by our operational or governance teams when standards and performance do not meet agreed levels
- Once the investigation is completed, improvement plans are put in place with clear outcomes and timescales
- Processes and procedures are reviewed regularly to drive continual service and business improvements
- Areas of good practice in the service are highlighted and shared across the business and with the Commissioner
- We can identify and manage risks to clients and service delivery. Once a threat is identified, transparent processes are then put in place to reduce or eliminate the risk

Monitoring

ERS uses the [redacted] compliance software for its management of clinical and other regulatory governance. This system has been designed specifically with the healthcare market in mind by 'Smartgate' solutions, and it allows ERS to capture and record the main aspects required for evidencing compliance with the requirements of regulated activity quickly and efficiently.

All incidents, comments, complaints, and compliments are recorded on [redacted] allowing us to monitor our service's quality and clinical governance fully. The key indicators that we use to monitor our services' quality are incidents, complaints, near misses, patient feedback, staff feedback, and commissioner feedback. Through [redacted] we can monitor, manage, and report all of these critical indicators, providing both ourselves and the Commissioners with comprehensive information to ensure the service meets the delivery requirements.

We chose the [redacted] solution because it provides a platform to allow ERS to improve its service offering through the following 5-stage process continually;

- Capture – [redacted] allows us to capture large amounts of data and translate it into comprehensive reporting formats
- Report – Accurate reporting is crucial to understanding trends, best practices and early indicators. Through [redacted] we can do this quickly and efficiently.
- Action – [redacted] allows us to identify existing and potential non-conformances and supports us to create, execute and monitor corrective and preventative action plans
- Improve – Sustainable quality improvement is delivered through well-led engagement. [redacted] allows us to collate evidence-based data centrally and efficiently identify and share best practice
- Standardise – A systematic approach to identifying good practice through [redacted] allows us to turn good practice into standard behaviour

Sharing lessons learnt

All changes to policies or procedures must be approved and mandated by [redacted] our Clinical Director, before being implemented into our service delivery. Whilst capturing performance data to produce monthly performance reports for submission to the GaPR Committees and Senior Leadership Mission Performance Review (MPR), ERS's Care Standard's Team can check whether these standards have been implemented to our internal audit arrangements.

Compliance and quality are at the very core of our value proposition. Pivotal to this regime is our Business Management System (BMS), which has been written as an integrated set of policies and procedures to cover all aspects of our activities and is aligned to various ISO standards such as ISO 9001, 45001,22301, 14001 & 27001.



A typical [redacted] employee dashboard: This details any company and compliance 'Notices' which need to be read and acknowledged, Audits that are due, Assigned 'Actions' to complete, Incidents (events) which need to investigated and managed, Documents which require reviewing and any employees who have overdue items in their [redacted] dashboard.



A site-specific dashboard, which provides a quick reference oversight of compliance within the [redacted] system, for audits that have been undertaken.



Regional Trend analysis for all events. It can also be configured as below to drill down into specific incident types to provide more clarity on issues and drive forward improvements and highlight areas of concern.

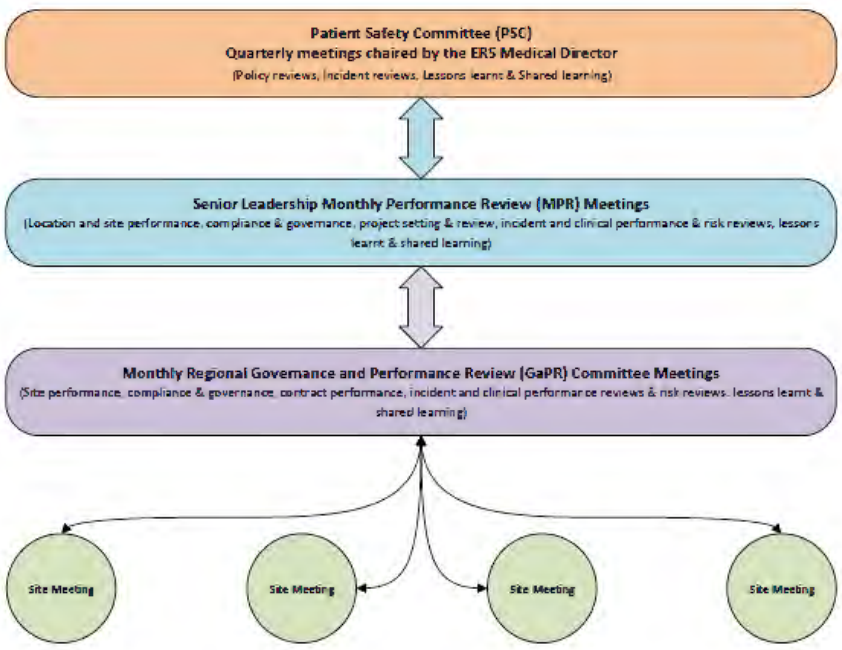


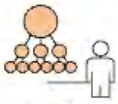
This shows Regional complaints which have been received and can show surges in complaints linked to specific times of the year.

ERS Medical

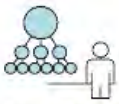
ERS Medical

Clinical Governance Structures





PSC – Lead for Clinical Governance



Senior Leadership Team
(MD, FD, Head of Care, Head of HR, Regional Manager, Commercial Team)



Regional Managers, Care Standards Team, Operations Managers & Clinical Trainers



Site meetings are made up with Operations Managers, Team Leaders, Lead Drivers and Road Staff

Roles & Responsibilities

Head of Care Standards – [redacted]

Is responsible for ensuring that policies, procedures, and associated documentation and the required systems and associated training are developed and cascaded to all ERS Medical sites to support the Managing Director's decisions.

Is responsible for devising and maintaining the internal and external audit schedules on the company intranet system.

Internal Audit Teams – [redacted] *and* [redacted]

Are responsible for undertaking audits and developing and reviewing RAPs arising from those audits, whenever a non-conformance, observation, or opportunity for improvement is identified.

Are additionally responsible for escalating any actions that have not been completed promptly. This may include making referrals to HR on the potential need for the disciplinary process to be utilised.

Senior Operations Manager & Operations Managers – [redacted]

Are responsible for ensuring that sufficient time and resource is afforded to the Internal Audit Teams to allow ERS Medical's audit schedules to be achieved.

They are also responsible for ensuring that sufficient time and resources are afforded to any external audit, the Internal Audit Teams undertake to allow the ERS Medical audit schedules to be achieved.

Question 1.19.4

Adoption of NHS principles

Please describe how you will adopt the principles inherent in the NHS Constitution and the stated values of the Clinical Commissioning Groups. Please include how you would instil the fundamental standards of conduct that support these principles and how you would ensure that your staff adhere to this when delivering the proposed service.

Word count 750

Total Word Count: 750

As a nationwide provider of NEPTS to the NHS, we have fully embedded the NHS Constitution and Values into our business and put them at the heart of our service delivery. This ethos carries over to our staff, as ERS acknowledges that they are not only ambassadors for our services, but also the client on behalf of who we are delivering the services.

NHS Values

The NHS provides a comprehensive service, available to all

We deliver a fair and equitable service with consistent eligibility.

Access to NHS services is based on clinical need, not an individual's ability to pay

ERS does not assess the ability to pay in any part of our service.

The NHS aspires to the highest standards of excellence and professionalism

ERS aspires to achieve the highest standards in line with the NHS specifications. Our current CQC rating is Good/Good with Outstanding

The patient will be at the heart of everything the NHS does

Patients are at the heart of everything we do and will always be treated with kindness and respect. Our operating systems are designed to provide the highest quality of patient experience. When making operational and commercial decisions, a challenge will always be "how does this affect the patient outcome"

The NHS works across organisational boundaries

As a national provider, we work across geographical and organisational boundaries. Although we are providing service on behalf of the NHS community in Staffordshire, organisational boundaries will never be considered a barrier to service quality and patient experience.

The NHS is committed to providing the best value for taxpayers' money

We will deliver a service that remains within the financial boundaries of the contract. We will work with commissioners and stakeholders to deliver service efficiencies throughout the contract.

The NHS is accountable to the public, communities, and patients that it serves

We consider our service to be part of healthcare provision and as such our accountabilities are aligned with the NHS. We will accept public scrutiny as and when required. We publish an annual Quality Account outlining the quality of the services we deliver.

CCG Values

After reviewing the values of the collated CCGs, they can be broken down in four distinct sub-sections:

Quality and Safety – Providing staff and patients with the utmost care and respect

At ERS, we do not solely employ staff based upon their qualifications. We understand that for a successful patient experience to be achieved, staff must convey a strong attitude of compassion, safety, and sociability. Once selected, all staff are subject to induction training that is refreshed regularly, leading to our staff achieving industry-leading compliance. Our in-house Training team ensure that staff are consistently adhering to the training that has been provided.

Honesty – Improving working relationships and working in partnership

ERS Staff are given clear communication channels, where they can raise any issues or concerns; allowing for an environment of transparency to occur between staff. This transparency carries over to our monthly stakeholder/manager meetings, which allow an open and honest environment to occur in which feedback and ideas surrounding the service can be discussed and developed.

Accessibility – Ensuring resources are used to capacity and capability

We deliver services to our customers that not only maximise the utilisation of our resources but are focused on delivering a positive patient experience. Our Cleric system shows full details of our service including patient and vehicle status and locations. This information can be displayed within the hospitals to ensure Trust staff have a full overview of the service in real-time allowing us to work with hospital staff to maximise patient flow.

Innovation – Empowering staff

Open communication channels throughout ERS not only enables but encourages staff to raise their opinions and thoughts at any time. ERS further offers staff two surveys a year, allowing staff to voice any implementations or changes that could benefit the service for themselves and patients. These changes are then reviewed and implemented based on the feedback that we are given, exhibiting to staff that their voices are heard and appreciated.

We share the CCGs values and ensure all our employees deliver services with Integrity, Compassion, Respect, Professionalism, Patient Focus, Innovation, and Partnership Working. As part of their continuing professional development, our staff are evaluated on how they embody and adhere to the values of the business and those of the customers that they serve. Through monthly training, toolbox talks, Team Leader ride-a-longs and 3 monthly appraisals, staff are assessed against our values and how they embody them within their day to day work.

ERS Medical

PREVENT REFERRAL PROCESS (Road Staff)

Member of ERS medical staff identifies a concern

If there is an immediate risk to life or immediate risk to the greater public

Call Police on 999 without delay

or directly to the

National counter Terrorism Hotline on 0800 789 321

Call through to CCO incident / safeguarding line on [redacted] without delay to explain you have a PREVENT referral to make - Give the CCO agent as much detail as possible (much like you would a normal safeguarding referral).

Please be factual with the information you provide.

Once the CCO agent has taken the concern / referral from you and this has been recorded, the CCO agent will escalate this to the safeguarding lead within ERS Medical immediately.

This information will then be processed sensitively and disseminated appropriately to the relevant bodies. The information you have provided is **strictly confidential**, please do not share this information with colleagues or make written records, this is not required CCO will document on your behalf.







ERS Medical

PREVENT REFERRAL PROCESS (CCO Staff)

Member of ERS medical staff identifies a concern

If there is an immediate risk to life or immediate risk to the greater public

Call Police on 999 without delay

or directly to the

National counter Terrorism Hotline on 0800 789 321

Record details accurately on both PREVENT referral form ([redacted] and on the Safeguarding Referral form (F6.05.01 ERS). Both must be saved in the usual way but it is crucial that these documents are encrypted.

Once you have completed both referral forms and created an incident the CCO agent must escalate this to the safeguarding lead within ERS Medical immediately (24 hours a day).

This information you pass will then be processed sensitively, and disseminated appropriately to the relevant bodies.

The information you have recorded is strictly confidential, please do not share this Information with colleagues.







Question 1.19.5

Safeguarding information

Please describe how Safeguarding information is disseminated to staff (including any staff employed by sub-contractors) and how you would ensure that staff are trained to recognise issues and respond appropriately as identified in the Intercollegiate document.

Word count 1000

Total Word Count: 662

ERS Medical recognises that our staff are at the frontline of our service delivery and therefore ambassadors of not only our services, but also the clients we are delivering the services on behalf of. We therefore provide all employees with customer services training ensuring they understand the importance of their role and conduct themselves accordingly. We provide qualifications through FutureQuals that are specific to and approved by the NHS.

All ERS staff throughout the business undertake Safeguarding Training Level 2 as part of their mandatory training during induction to ensure everyone understands their responsibilities. Our clinical staff, volunteer drivers and sub-contractors are required to complete Safeguarding Level 3 as part of their induction in line with the intercollegiate documents, with Senior Staff trained to Level 4. All staff training is recorded on our HR system, against their employee file. We have attached our ACA Safeguarding lesson plan to outline the training our crews receive.

Any training not completed on time will be flagged to their line manager as non-compliant to ensure the training is completed. All training is updated annually via e-learning refresher courses, toolbox talks and classroom-based training.

We are confident that our staff understand their safeguarding responsibilities as over the last 12 months we have reported 179 safeguarding concerns across our 4 CQC registered areas. Where appropriate we feed back any outcomes to the crews.

Recognising Issues

All staff are trained in recognising issues covering but not limited to:

- Physical Abuse
- Domestic Violence
- Sexual Abuse
- Psychological Abuse
- Financial or Material Abuse
- Modern Slavery and Human Trafficking
- Discriminatory Abuse

- Organisational Abuse
- Neglect and Acts of Omission
- Self-Neglect
- Mental Health
- Forced Marriages
- Female Genital Mutilation
- Prevent

Staff support

All of our crews have direct access to our clinical leads who are available 24/7 on a rota basis to access any advice, answer any questions and for general support with safeguarding concerns. They also have access to Operational Managers, Team Leaders and HR to raise and discuss any concerns and for any support they need.

Every employee also has access to free counselling via our partnership with Heath Assured our Employee Assistance Plan which is available 24/7.

Staff reporting of concerns

If ambulance road staff identify a vulnerable person to be at risk, they must:

- Identify if there is an immediate risk of harm or ill treatment to a vulnerable child or young person
- If the vulnerable person is deemed at immediate risk then the Police should be contacted without delay and it may be necessary to transport the vulnerable person to the nearest A&E department; if Police assistance is required then crews should either stay on scene or near scene, until the Police arrive. It is our policy to advise our employees not to put themselves or others at risks

All safeguarding referrals, whether at immediate risk or not, must:

- Make the referral to our designated staff incident reporting line where trained staff will receive, handle and if required escalate the incident
- Further safeguarding advice can be accessed, if required by contacting the designated staff incident line, who in turn can contact either the Regional Care Standards Advisor or for out of hours the on-call Care Standards Manager
- Once the referral has been made to the incident line, ambulance road staff MUST complete a Patient Report Form (PRF), providing as much detail as possible
- They must also complete a Road Staff Safeguarding Referral Form
- Both the PRF and Staff Safeguarding Referral Form must be returned to their site and handed into their line managers and or safeguarding secure drop box
- All safeguarding referrals are reported to the CCG within the monthly compliance ONE report and CQC (regulation 18) if required

Our Safeguarding policy is written by our Care Quality Manager who is Deputy Safeguarding Lead for ERS and a Registered Nurse. The document is reviewed by our Head of Care Standards and Medical

Director (Safeguarding Lead) and approved by our Patient Safety Committee. All ERS documents on the BMS are reviewed annually.

Lesson Plan

Course: ACA 1 day CPD

Subject: **Safeguarding Adults and Children Refresher**

Materials: PC and projector, whiteboard test paper

Time: 45 mins

Aim: To recognise vulnerable groups and forms of abuse and their role in reporting and documenting concerns

Objective- That the learner can	Trainer	Learners
Identify Vulnerable groups	Explain the groups who could be vulnerable	Listen, observe, discuss
Describe types of abuse	Explain the 7 types of abuse	Listen, observe, discuss
Identify their role and responsibilities in safeguarding	Explain that safeguarding is important to their role and the points to remember	Listen, observe, discuss
Describe the process of reporting Safeguarding suspicions	Explain the learners' role in safeguarding and what to do when a disclosure is made	Listen, observe, discuss
Complete safeguarding forms	Explain the importance of good documentation and what to document	Listen, observe, discuss
Confirm learning using safeguarding test paper	Handout test paper with instructions	Complete test paper as instructed.
Trainers: Introduce Safeguarding session explaining that some of the content may be upsetting but is important to recognise Safeguarding issues so to end abuse wherever possible. Should use safeguarding refresher PP presentation whilst engaging learners with questions and answers, undertaking formative assessment throughout the session.		

Question 1.19.6

National and Local Quality requirements

Please outline how you would ensure that the National and Local Quality Requirements outlined in the contract are delivered and reported on, and how any safeguards or remedial actions would be identified to ensure any shortfalls in delivery are captured and resolved promptly.

Word count 750

Total Word Count: 730

As a leading provider of healthcare transport solutions, ERS recognises and embraces the need for services provided on behalf of the NHS to be patient focused, efficient and value for money. We also understand that NEPTS play a crucial role in the local healthcare economy and the large benefits that can be delivered through smooth patient flow, capacity management and timely discharges.

In order to sustain a partnership with the CCGs the service quality must be maintained. This will be achieved through delivering a quality and sustainable service that achieves our KPI's while remaining financially viable.

Our service is designed to meet each of the CCGs requirements, including internal quality management, within the pricing envelope ensuring financial viability throughout the contract period. The mechanisms and systems that we have in to place proactively monitor and manage our service delivery are:

- Embedding internal KPI's into [redacted]
- Data Analytics
- Flexible Resource
- Dynamic Planning

Embedding internal KPI's into [redacted]

ERS's [redacted] system provides our Control Team members with real time information that allows for informed decision making. Unallocated transports are clearly displayed, ensuring focus is kept on ensuring all transport needs are fulfilled.

A traffic light system is embedded within [redacted] that indicates journey efficiency against KPI targets pre-set within the [redacted] operating system. This allows the controller to easily identify any patient that is nearing a breach of our KPI requirements enabling them to make an informed decision about the needs of the service as a whole, and the needs of the individual patient.

This proactive monitoring and management allow ERS to continually meet the KPI's set down within the draft contract and will also report on the following:

- There will be no detriment to patient's health and wellbeing during their journey
- Patients will arrive in a safe and timely manner

- Patients will not spend an unreasonable amount of time on vehicles
- Patients will be collected promptly, in reasonable timescales following their appointment
- Patients will be treated with courtesy, dignity and respect at all times

Data Analysis

ERS employs a Systems Specialist as part of The Care Standards Team. Data analysis is completed systematically for all contracts and reported on a daily/weekly/monthly basis allowing Operations Managers to review any trends or regular peaks and troughs by hour of the day or day of the week for example.

We will also report on aborted journeys, as these can have a huge impact on levels or resource required and the impact, they have on meeting the KPI requirements. We can report by Hospital and Ward to see if there are any significant differences in the average number of aborts between wards and maybe identify a training need and provide enhanced training to wards that have a significant number of aborts or above average percentage of aborts.

Flexing Resource

The controller or Operations Manager can run activity reports from [redacted] at any time of the day to see if we need to flex our resource at any point.

Ensuring sufficient capacity and resources to meet the fluctuating demand of the NEPTS service at different times of the day, week and year requires us to leverage the local, regional and national nature of our operations.

During mobilisation our intelligent planning and scheduling system will analyse historical data and assist us to predict future demand patterns to anticipate winter capacity, summer variation flows, and understand peak demand spikes by speciality and by site to allow us to resource effectively.

We will also create secure and robust subcontracting partnerships during the mobilisation period to ensure our service delivery model is truly flexible and able to meet the KPI requirements of the contract.

Dynamic Planning

All ERS control staff receive comprehensive training from industry experts and working groups have been established across the business to identify best practice and initiatives. Staffordshire based staff will receive an in-house training programme as part of mobilisation. This training with be maintained and updated throughout the contract period.

Monitoring

Our methodology for KPI monitoring includes the following three tier approach.

- Tier 1 - Operations Manager – Reviews KPI's on a daily, weekly and monthly
- Tier 2 - Regional Manager – Reviews performance breaches, monthly review meeting of all KPI's
- Tier 3 - Managing Director – Quarterly performance reviews

When performance falls below an agreed KPI, depending on the severity of the breach, this triggers an automatic escalation to the relevant Tier level for investigation and action.

Question 1.19.7

NHS Standard Contract Surveys

Describe how you would implement the nationally mandated surveys as specified in the NHS Standard Contract.

Word count 750

Total Word Count: 702

ERS understands the key elements of nationally mandated services of the NHS and specifically the Friends and Family Test (FFT). Our principal method of measuring patient satisfaction is through on-board ambulance surveys which are given to patients on every journey to complete the survey on-board the vehicle or take it away with them to complete later. All surveys are issued with a pre-paid postage.

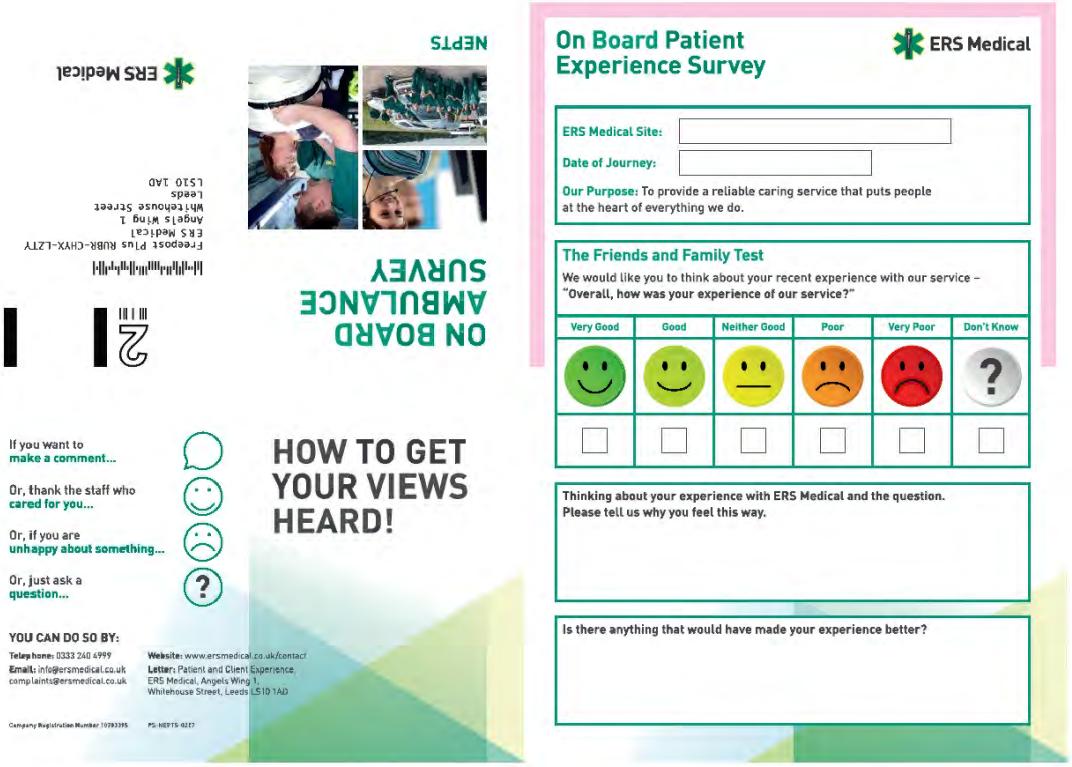
Our Customer Contact Centre also conducts end of call surveys after each call to ensure we receive feedback on all aspect of our service.

Patient Surveys

Our principal method of measuring patient satisfaction is via our on-board ambulance surveys which are given to patients on every journey (with the exception of regular patients such as renal patients).

Patients are invited to complete the survey on-board the vehicle or take it away with them to complete later. All surveys are issued on a pre-paid postage format to be returned at no cost to the patient.

We also conduct an End of Call survey on each of our booking calls to allow patients and HCPs to provide direct feedback on our booking service.





As a business stiving for excellence we aim to deliver a service that all of our patients would recommend our service to friends and family. Over 2019 and 2020 96% of our patients are either extremely likely or likely to recommend our service to friends and family.

Maximising Response Rates

As well as handing out patient surveys on every patient transport journey, we also advertise for feedback on our website and through our call handlers that take the transport bookings. Our current response rate for onboard patient surveys is around 10%. To gather additional feedback every

month we pick 50 random service users and send them patient feedback forms this has delivered a response rate of 40%.

Staff Surveys

At ERS we understand that feedback from our staff is just as key to the development of our services as patient feedback. We employ an open and honest feedback policy that encourages all employees to identify issues/improvements. This information is collated along with patient feedback and any trends are identified.

Stakeholder Surveys

We actively engage with stakeholders on a monthly basis through contract review meetings to receive feedback. We are also happy to set up meetings to allow member of the healthcare community to attend and provide feedback on our services.

Patient groups

We engage with patient groups such as Renal groups to discuss our services and any improvement/changes they would like to see to improve their transport experience.

Social Media

To make our service all-inclusive and ensure that all patients voices are heard we set up social media groups on the main social media networks including Twitter, LinkedIn and our website. This allows patients who are unable to attend user groups to have the ability to discuss our service and voice improvements or developments they would like to see. All feedback received is included in our reports.

Converting service feedback into service improvement

We deliver 500,000 patient journeys a year throughout the UK and offer every patient the ability to provide feedback and to engage with us. By listening to our patients, we can continually develop our service to meet their changing needs, requirements and expectations.



Our service model is based on our service user experience intelligence and this will continue to develop throughout the term of the contract. Examples of where service user experience intelligence has led to an improvement in our service includes;

Patient Zone

Our patients requested the ability to be able to track their own transport online without having to call our contact centre. We developed Patient Zone which is an online portal that provides patients with access to their journey information through a unique username and password. By allowing patients to access information such as ETA of crew we have found that it has reduced collection delays due to patient not being ready for transport, so improving the efficiency of the journey.

Suspension change

We received patient feedback about the ride quality of our ambulance suspension. Following a review, we identified a new suspension system that improved patient comfort. The new system was then used companywide in all new vehicles as standard.

Question 1.19.8

Performance monitoring

Please describe how you would ensure that the CCG receives regular performance updates in addition to the presentation of contractual Key Performance Indicators.

Word count 750

Total Word Count: 541

Through our true partnership approach, we will work closely with the Commissioners and be in continual communication with the Authorised Officers providing updates and overviews of the service.

We have invested heavily in our Information Management & Technology infrastructure that supports the delivery of our services. We have developed a fully integrated cloud-based system that includes:

- Scheduling
- Communication and tracking for vehicles
- Data reporting and real-time information
- Call recording
- Compliance and incident management
- Employee training and compliance

Our recent CQC inspection rated as 'Good' made the following reference:

"The provider had invested in six computer-based business management systems to support various parts of their business which provided real time reporting of information which allowed senior manager to track business performance, staff accountability and supported decision making"

Through streamlining our systems, we are able to deliver a reliable, efficient and effective service that is easy to navigate and report from. Our service model and all of our systems are fully integrated therefore we are able to interface with the CCGs to deliver real-time information of our whole operation directly into the hospitals.

This suite of systems coupled with our service delivery model will ensure that we are able to meet all the quality schedules set out within the contract.

[redacted] is our integrated system that plans, operates, manages and reports on our operations. [redacted] shows full details of our service including planned journeys, on the day journeys and vehicle locations. This information can be displayed within the hospitals to ensure Trust staff have a full overview of the service in real-time. We will work with the Commissioners during the mobilisation to identify the best position for the live data screens to ensure that we maximise their benefit.

Reporting

Our [redacted] system has the KPIs imbedded within it and therefore monitors our service against the KPIs in real-time. At any point during the service we are able to provide the Commissioners with a snapshot of our service delivery. Should the CCGs require we are able to provide access to our real-time KPI performance to allow continual monitoring. This fosters an open and honest reporting culture.

We will also provide a full report to the commissioners via an agreed standard minimum data set that includes the CCGs quality schedules, that is delivered as a monthly reporting pack and delivered to the commissioners along with all of the backing data. We are also happy to discuss any bespoke reports that the Commissioners would like to receive on a monthly basis and add them into our reporting pack. Through monitoring and reporting on every aspect of our service we are able to use the information gathered to continually improve our service delivery and target any areas that require improvement.

During the mobilisation period we will agree specific timeframes for regular updates such as weekly Friday calls to discuss the past week and identify any pinch point in the upcoming week. This will assist in ensuring the service is delivering to the standard expected by the CCGs. We also understand that there are certain points within the year where the CCGs may want more regular updates. During these periods we will agree to have more regular calls and face to face meetings to discuss the service delivery.

Question 1.19.9

Patient outcomes

Please outline your understanding of good patient outcomes for this service, and the methods you will use to review and improve these outcomes.

Word Count 1000

Total Word Count: 697

ERS recognises that patient experience and outcomes must be the primary measures of success for a patient transport service. Service delivery must focus on key indicators and success measured accurately and reported in a timely and consistent manner:

On Time

Patients expect, and health care providers require a timely service. The contract defines service KPI's that will be embedded in [redacted] our planning and control system. Experienced controllers and planners will use their skill and experience to plan multiple journeys that meet targets.

Safe

ERS has a responsibility to provide a safe and compliant service. This includes staff training, vehicle safety and compliance with healthcare governance set by the Care Quality Commission.

ERS maintains a comprehensive training programme for both new employees and those requiring update/refresher training. Training compliance is reported monthly and reviewed by the Senior Management Team. Training compliance will be shared with Commissioners as part of contract review meetings.

Vehicle safety is embedded in daily operating procedures. All vehicles are checked by crew prior to commencing duties and checks recorded via [redacted] ERS utilises specialist fleet software to manage fleet compliance. FleetCheck ensures all vehicles comply with prevailing legislation.

Caring

For many patients, a healthcare episode can be stressful and worrying time. A friendly face and a helping hand will go a long way towards a patient's wellbeing. All ERS ambulance crews are trained to respect patient's wishes, recognise their needs and maintain a patient's dignity at all times. Our Care to Care policy provides a full overview on how patients are to be cared for throughout their use of our service.

Available

Patients and healthcare professionals must have confidence in and access to the transport booking system. ERS will maintain a dedicated 24/7 booking service that provides a professional and efficient service.

Through our Patient Zone patients can access their personal transport bookings via any web enabled device to confirm that transport is planned, and arrival/collection times are correct.

Appointed healthcare professionals will have access to [redacted] our planning and control system which will provide detailed information on planned journeys. A departure stack will be available in real time to ensure that planned discharges are correct and allow adjustments/prioritisation to be made.

Measuring Our Success

In order to provide a responsive service that meets all stakeholders' expectations, ERS must gather informed opinions about their services. Data is collected in a number of ways:

- Patients will be invited to provide feedback at the end of their transport. This is completed using Freepost survey questionnaires that are held on all vehicles
- Renal patients will be invited to provide feedback on a quarterly basis via freepost
- On a monthly basis 50 patients selected at random will be invited to feedback via a mailing plan. Response rates to this currently average 40%
- Focus groups will be established for different patient mobility groups. Open meetings will be held quarterly to gain feedback
- The ERS website has a simple and logical process for patients to provide feedback
- Working groups will be established with healthcare representatives to provide suggestions and service improvements
- Working groups will be established with elected staff representatives. Employee working groups are established across all ERS operations, and experience suggests that some of the best ideas come from our ERS colleagues

All survey/feedback data is recorded in our RADAR compliance system. The system allows feedback, both positive and negative to be collated and statistics produced and analysed. As part of contract reporting data is shared with Commissioners and service improvements discussed.

Making It Happen

It is great to gain feedback from service users and the healthcare community; however, it is of little use if the information is not used.

ERS Medical holds NEPTS contracts across the UK and strives to develop service quality throughout the life of a contract. Every contract will have a Service Development Plan (SDP) which is a shared document with Commissioners and where appropriate Acute Trusts.

The SDP is a controlled document that is used to drive service improvement/development in a controlled manner and provides clarity around key stages:

- Improvements/developments (IDs) are recorded
- IDs are considered and adopted
- Responsibility assigned
- Timelines agreed
- Actions recorded and reviewed
- Outcomes assessed
- Tasks signed off as complete

Question 1.19.10

Environmental impact

The Authority is keen to understand how the successful Bidder will have regard to the Public Services (Social Value) Act 2012 in the delivery of the service, and what benefits their solution will offer in respect to reducing the environmental impact of the service through sourcing products and resources, energy efficiency, carbon reduction and use of energy efficient travel. Please set out how your proposal will support the national and NHS ambitions re reducing impact of climate change, reducing energy usage, carbon reduction, air quality improvement, and use of innovative solutions reduce the environmental impact over the lifetime of the contract.

Word Count 750

Total Word Count: 533

ERS operates a modern fleet of vehicles that comply with the latest emissions legislation, which is that 95% of all new vehicles registered in 2020 must comply with 95g CO_2 per km target. As the core of our business is centred around transport, vehicle selection is an essential consideration from a commercial and environmental perspective.

ERS have used electric vehicles for courier services as part of our drive to deliver sustainable and environmentally conscious services. As technology improves and develops, ERS will always consider the latest technological developments available. As part of our drive to develop the sustainability of the ambulance transport sector we are currently working in partnership with Arrival, the UK's leading electric commercial vehicle builder, to develop and electric ambulance and hope to begin trialling a vehicle in 2021.

Alongside technological developments, ERS is currently working towards ISO 14001, which is the internationally accepted model for crafting and implementing an environmental management system. Our environmental management system is already aligned with the ISO 14001 requirements and we are currently going through the formal audit process.

Our system is formed of processes, plans, policies, and records that outline how ERS go about interacting with the environment.

As part of our 'Green PTS' initiative, we have adopted the government's road to zero strategy and aim to replace over 40% of our fleet with ultra-low emission vehicles by 2025. We are currently in discussions with Arrival, the UK's leading electric commercial vehicle builder, to develop an electric ambulance. Also, as part of this initiative, we have set a target to become carbon neutral as a business by 2025. Carbon neutrality will be achieved through working in partnership with the Carbon Trust.

Our sustainability and environmental impact target and standards include:

Active monitoring of staff travel – Through regular staff audits and feedback, we continually monitor how our staff travel to work, training courses and meetings. Therefore, ERS's environmental policy is

deep-seated within our staff's understanding of the company and the day-to-day work they undertake.

To reduce our staff reliance on vehicular transport, staff have cooperated with ERS in complying with environmental management duties and the requirements imposed by management:

- Cycle to work scheme
- Advocate train travel to training courses and meeting
- Car share scheme
- Training by Teams webinars

Waste management – ERS have fostered vital environmental awareness and understanding in all employees working with key suppliers who demonstrate environment best practise/recycling/use of sustainable products within the procurement process.

All of our staff are trained in waste segregation and storage. An eco-driven workforce ensures that all waste that is produced throughout the service delivery is segregated, stored, and disposed of correctly. Through operating recycling schemes for paper, glass, cardboard, cans and toner cartridges, ERS aim to achieve a recycling rate of between 60% and 70%.

To continually increase the sustainability of our service, we have a reduced packaging initiative with all our suppliers, waste segregation at all of our facilities, reduced plastic in our offices, etc.

Energy consumption – Our 5-year replacement plan for our vehicles ensure we continually update our fleet to maximise its efficiency. To maximise the efficiency of our vehicles, they are serviced regularly on a schedule that is maintained within our FleetCheck system.

Question 1.19.11

Patient experience

Please outline the methods you will use to gather qualitative feedback from patients and carer to understand what matters most to them.

Word Count 750

Total word Count: 737

Patients are at the heart of everything we do therefore measuring patient satisfaction is fundamental to understanding what really matters to them and therefore our continuous improvement approach. We continually monitor patient feedback on each and every journey and following each booking call. This information is collated and discussed each month as part of our company wide Governance Board Meeting to identify trends and agree the implementation of service improvements. To enhance the patient experience, we strive to:

- Always be on time and minimise delays
- Treat all patients with dignity
- Be easily accessible through online portal services

Gaining feedback

We understand that our transport represents an important part of the patient's overall experience of their interaction with the Healthcare system and therefore it is crucial that we deliver a service that meets their requirements and expectations.

To gain information on their experience as well as their satisfaction with the service our patient surveys have a free text area allowing the patients to provide a more comprehensive overview of their experience if they wish. Response rates for general surveys is circa 10%.

ERS is working on improving response rates. For a twelve-month period, survey forms have been posted to home addresses on a random basis. Response rate increased to 40% and survey forms were completed comprehensively. This trial will be offered to Staffordshire patients.

Over 2019 and 2020 our patient feedback has shown that 96% of our patients are extremely likely or likely to recommend our service to friends and family.

Patient Groups and Forums

We recognise that we cannot capture all the feedback on our patients experience solely through patient surveys and we therefore engage with key stakeholder groups on a regular basis. These groups include:

- Renal groups

- Healthwatch
- PALS

As service user experience is a fundamental part of service development, we will liaise with the patient representative groups during the mobilisation period to understand any service improvements that can be made prior to the commencement of the new contract. We will also agree the frequency of meetings with each of the groups to ensure we continue to develop the service and improve patient experience throughout the contract term.

Healthcare Stakeholders

ERS will always look to engage with representatives across the healthcare community. In the normal course of business, we will have regular planned contract review meetings, addressing all contractual and performance matters. This is always a good opportunity to understand service delivery performance and ongoing initiatives, but it does not really facilitate a forum for ideas, issues and challenging the norm.

ERS has found that the best way to engage with the healthcare community is to establish a healthcare stakeholder group that meets on a quarterly basis. Representatives from Acutes, community care establishments, occupational health, care homes and CCG representatives are encouraged to make positive contribution to service development.

Our latest CQC report marked "GOOD" stated;

> **"The management team embraced the value of the organisation's contribution to the wider healthcare system. They were also open to a changing footprint of the organisation and possibilities to improve the sector through further integration and development of services for the benefit of patients."**
>
> **Quality Report, Care Quality Commission**

Working with Healthwatch

We will look to work in partnership with Healthwatch to gather qualitative data on carer and patient experience regarding the patient transport service. Recent feedback suggests communication between the transport providers and the patients/hospital staff could be improved.

Utilising feedback we receive

Examples of where service user experience feedback has led to an improvement in our service include:

Patient Zone

Our patients requested the ability to be able to track details their own transport online without having to call our contact centre. We developed Patient Zone which is an online portal that provides patients with access to their journey information through a unique username and password. By allowing patients to access information such as ETA of crew we have found that it has reduced collection delays due to patient not being ready for transport, so improving the efficiency of the journey.

Background noise in our call centre

At the end of each of our booking calls we ask the bookers for feedback on our service and any improvements that could be made. We received feedback about the background noise within our call centre making it hard for some patients to hear the booker properly. Following a full review of this we put in place two mitigations to improve the quality of our booking experience. Firstly, we implemented a new phone system that had background noise dampening technology. Secondly, we moved our call centre to a quieter part of the building to reduce the amount of background noise caused by the day to day operation of our business.

Question 1.19.12

Outcome measures

How will the Bidder translate the business intelligence gathered from patients and carers into outcome measures that are person centred and which involve putting patients and their families and carers at the heart of their care?

Word count 750

Total Word Count: 748

All feedback we receive is collated and analysed on a monthly basis to identify any trends that require improvement or outline any best practice and compliments we receive. This information is then shared through our Governance and Patient Safety (GaPS) monthly meetings. The meeting involves Operational Managers from around the country, Regional Managers, Safety and Compliance Manager and our Managing Director. This not only enables any required changes in service delivery to be agreed, but also that any best practice and positive feedback is shared throughout the business ensuring each and every one of our patients receives the same high quality, safe and compassionate service.

Our service model is based on our service user experience intelligence and this will continue to develop throughout the term of the contract. Examples of where service user experience intelligence has led to an improvement in our service include:

- Patient zone
- Suspension change
- Background noise in our call centre
- Patient mobility options for Occupational Therapists (OTs)

Patient Zone

Our patients requested the ability to be able to track details of their own transport online without having to call our contact centre. We developed Patient Zone which is an online portal that provides patients with access to their journey information through a unique username and password. By allowing patients to access information such as ETA of crew we have found that it has reduced collection delays due to patient not being ready for transport, so improving the efficiency of the journey. As it provides real time information directly to the patient, they are able to be kept fully informed of any service delays which reduces anxiety and unnecessary waiting.

Suspension change

We received patient feedback about the ride quality of our ambulance suspension. Following a review, we identified a new suspension system that improved patient comfort. The new system was then used companywide in all new vehicles as standard.

Background noise in our call centre

At the end of each of our booking calls we ask the patient/carers/HCP's for feedback on our service and any improvements that could be made. We received feedback about the background noise within our call centre making it hard for some patients to hear the booker properly. Following a full review of this we put in place two mitigations to improve the quality of our booking experience. Firstly, we implemented a new phone system that had background noise dampening technology. Secondly, we moved our call centre to a quitter part of the building to reduce the amount of background noise caused by the day to day operation of our business.

Patient mobility options

Engagement events with OT's identified that there was insufficient knowledge of mobility options used in the transportation of patients. A series of workshops were organised to provide guidance around best options for patients with varied mobility challenges. The outcome was that OT's were able to make informed decisions regarding transport needs. This resulted in improved patient experience and timeliness of transport.

Renal transport options

Working with the Local Renal Patient Group and CCG Representatives ideas were shared around transport options for Renal Patients. Spend on renal transport is significant and consideration was given to providing personal budgets for transport options, including using family resource. A trial was introduced that allowed a small number of patients to allocate their budget between family, taxis and NEPTS core service. Financial saving was not the priority, with patient/family experience enhancement targeted.

Timeliness

Common feedback from patients is that they would like clearer and more accessible communication from the service providers especially where there are delays to their transport. This is echoed in Healthwatch's assessment of patient feedback in Staffordshire.

Our Patient Zone portal provides patients with real time access to their transport information including ETA of the ambulance. By providing patients with access to real time information we can reduce any anxiety that comes from not knowing when their transport will arrive.

We have also developed our [redacted] system to automatically send out a transport reminder message both 24 hours prior to transport and 30 minutes before the patient's collection on the day. Should texting not be a suitable method of contact with the patient we provide a phone call from our local call centre.

Should there be any unforeseen delays to a patient's transport our crews will contract the patients directly to explain the situation and provide an ETA. The patient will then be kept full updated throughout the delay to ensure they are kept informed of the situation.

Question 1.19.13

High quality Outcomes

Please describe the intended quality benefits to be delivered by the proposed service with specific reference to:

• Patient Experience

• Capturing / validating / recording information relevant to clinical quality at the time of the booking
• Safety transport of patients

• Accessibility and Timeliness of Services

• Clinical Effectiveness of Services.

Word count 1200

Total Word Count: 749

Patient Experience

Patients are at the heart of everything we do therefore measuring patient satisfaction is fundamental to our continuous improvement approach. We continually monitor patient feedback on each journey and following each booking call. This information is collated and discussed each month as part of our company wide Governance Board Meeting to identify trends and agree the implementation of service improvements. To enhance the patient experience, we strive to:

- Always be on time and minimise delays
- Treat all patient with dignity
- Be easily accessible through online portal services

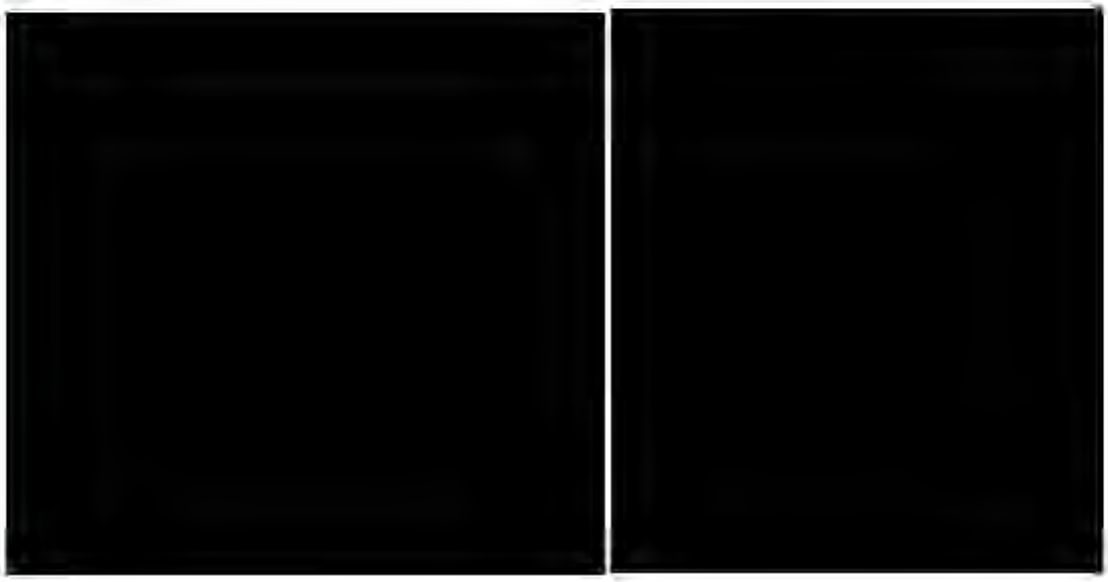
Our recent CQC report emphasises our dedication to delivering a patient focused service.



Capturing/validating/recording information relevant to clinical quality at the time of the booking

To ensure we deliver a service that is easily accessible for both service users and Healthcare Professionals we will provide a single point of access that is available both online and via a dedicated call centre.

We have a fully operational online booking portal that is accessible through the internet and via a phone application. The online booking portal will not accept any bookings until all the eligibility questions have been successfully answered by the booker.



Our online portal is set up to ensure we capture and record all the relevant booking information at the time of booking to ensure we deliver a high quality clinically focused service. This includes any special equipment or information that our crews need to know. To streamline future bookings any equipment information or special requirements are saved on the patient's profile and will be automatically flagged at the point of their next booking.

We monitor who books each journey and coupled with feedback from our crews and the Authority identify any inappropriate booking such as wrong mobility type, wrong time, wrong destination, etc. From this we can then deliver targeted refresher training for the individuals/wards/departments identified.

Safety transport of patients

The safety of service users and staff is paramount to ERS. Our training, policies, processes, work instruction, monitoring and management ensure that we consistently deliver efficient, effective and safe transport Services. Our Care to Care policy provides a full overview of how we will deliver a safe and effective patient transport service from start to finish.

ERS Medical

Are ERS Medical's services safe?

The CQC rated safe as 'good' because:

- Mandatory training compliance rates for staff was 96%.
- There were effective processes to ensure vehicle and equipment maintenance was up to date.
- There were effective processes to prevent the risk of infection.
- Medicines were managed well, in line with policy and national guidelines.
- Risk assessment and monitoring of patients was carried out to ensure patient safety during transport.

Quality Report, Care Quality Commission

From collection through to handover at the destination, our crew continually monitor their patients through observation and communication, checking all needs are met so they have the best experience possible. We have detailed work Instructions within our BMS, outlining procedures should a patient deteriorate during the transport.

If a patient is travelling to a home address, crews will ensure that the patient is comfortable and safe prior to leaving and will consider safeguarding risks.

Accessibility and Timeliness of Services

Our robust application of the eligibility criteria ensures that our service is accessible to all those who are eligible. To ensure all patients that require transport receive it we will also signpost ineligible patients to alternative modes of transport such as the Hospital Travel Scheme, Volunteer groups, Community Transport and Taxi firms.

Our [redacted] system uses set parameters to schedule all pre-booked transport for the following day. Using these parameters, it can auto-plan the transport for the following day taking into account distance, location and time. This is then sense checked using the local knowledge of our planners who can apply any additional information to the schedule such as road works, road closures etc. The planning staff can make changes to the schedule to maximise the efficiency of the service. The schedule is then fully reviewed by our operations manager and signed off. For 'on the day' transport our dispatchers work in unison with the [redacted] system to identify the most appropriate crew to deliver the requested service. This considers the crew's destination prior to the proposed transport and any traffic/road issues there might be which could affect the scheduled collection time. This ensures we deliver a fully schedule timely service to the patients.

Clinical Effectiveness of Services

We monitor every aspect of the services we provide. Through monitoring every aspect of our service in real-time we can provide our customers with continual snapshots of the performance of our service. This allow us to fully monitor and manage the clinical effectiveness of our services. All information relating to clinical effectiveness and governance is recorded through our Radar Healthcare system. This is managed by our Governance and Patient Safety (GaPS) team who meet monthly to discuss all governance issues, best practice and lessons learnt ensuring that we continually develop the clinical effectiveness of our service.

BMS/6.02 Patients Who Deteriorate in Transit

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	3.0	**Date Active:**	14.11.2019	**Review Date:**	30.11.2020

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1.1	All	All	All	13.04.18	[redacted]	Addition of review date
2.0	All	All	All	19.11.18	[redacted]	Annual Review and Addition of Capacity & Consent Section.
3.0	All	All	All	14.11.19	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Management and Reporting	BMS/5.01
Serious Untoward Incident (SUI) Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity & EPRR	BMS/5.04
Care to Care	BMS/6.01
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding of Vulnerable Adults and Children	BMS/6.05
End of Life Care	BMS/6.06
Safer Person Handling and Dynamic Risk Assessment	BMS/6.07
Patient Communications and Control Operations (CCO)	BMS/6.08
Non-Emergency Patient Transport Services	BMS/6.10
Renal Patient Services	BMS/6.11
High Dependency Unit (HDU) (NEPTS)	BMS/6.12
Mental Health Services	BMS/6.13
Patient Tissue Viability & Hydration Record	F6.07.02

3. External Guidance Publications

- The Mental Capacity Act 2019;
- Resuscitation Council Guidelines 2015;
- NICE Guidelines;
- NG10 – Violence and aggression;
- NG53 – Transition between inpatient mental health settings and community or care home settings;
- NG54 – Mental health problems in people with learning disabilities;
- NG108 – Decision making and mental capacity;
- JRCALC Guidelines 2019.

4. Introduction

4.1 Patients transported by the NEPTS, Mental Health and HDU services have the potential for deterioration during both planned and urgent journeys.

4.2 The service supports patients of all ages with a wide range of medical conditions and post traumatic injury.

4.3 All staff are trained to universal standards to manage patients that deteriorate on route.

4.4 The purpose of this procedure is to outline the actions to be taken should a patient deteriorate during a journey.

4.5 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.6 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting Company objectives and allocating adequate resources to meet those objectives.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Head of Care Standards**	Is responsible for setting the strategic direction and interpretation of the Health and Social Care standards as they relate to the regulated activity the ERS Medical is registered with the CQC to provide.
6.4	**Regional & Operations Managers**	Have the responsibility to ensure that this procedure is available on all operational ambulances work for or on behalf of ERS Medical.
6.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken and this can be a powerful but often subtle powerful influence.

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7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

8. Objectives

8.1 To provide a structure for the management of patient who deteriorate on route within nationally accepted guidelines.

8.2 To ensure that appropriate advice is given to personnel regarding the management and transfer of these patients.

8.3 Priorities when a patient deteriorates in transit:

- To ensure the safety of the patient and crew;
- To prioritise and initiate lifesaving treatment where required;
- To access assistance at the earliest opportunity;
- To ensure the patient is conveyed to an appropriate receiving facility.

9. Patients Who Suffer Cardio / Respiratory Arrest in Transit

9.1 The crew should stop as soon as possible in a safe place and attend the patient. Resuscitation should commence immediately in line with the training guidelines and using equipment such as oxygen and defibrillator where available. It is not effective to undertake effective CPR alone in a moving vehicle.

9.2 Therefore unless the vehicle is within the hospital grounds or expected arrival at an Emergency Department is imminent the crew should stop the vehicle and undertake full resuscitative efforts as per the resuscitation guidelines. **999** must be called for paramedic assistance as soon as possible. Once the **999** crew arrive they will assume responsibility for the patient, treatment and conveyance. All assistance requested by the emergency crew should be given.

9.3 Patients with a valid DNAR order in place should be managed in accordance with the resuscitation procedure. Resuscitation should not commence, however the crew should stop and call for paramedic **999** assistance in order that death can be confirmed and a discussion with local services about management of the deceased can take place. The crew should call the incident line on [redacted] at the earliest possible opportunity and guidance sought from the Care Quality on call service if required.

9.4 A PRF must be completed to accompany the incident report.

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10. Patients Who Become Unwell In Transit

10.1 The crew should stop as soon as possible in a safe place and attend the patient. The crew should being to administer treatment in accordance with their training and in line with ERS Medical guidelines.

10.2 The decision to convey the patent in the NEPTS Mental Health or HDU vehicle will depend on the skill level of the crew. IHCD Tech and Paramedic HDU crews are free to use their own clinical judgement in making a decision to continue to the planned destination or divert to ED or other appropriate destination such as a Cath Lab for example.

11. Patients Who Suffer a Fall or Injury in Transit

11.1 IHCD Tech and Paramedic HDU crews are free to use their own clinical judgement in making a decision to continue to the planned destination or divert to ED.

11.2 ACA, Mental Health and ECA staff should not continue transportation or move a patient who is injured unless the patient has been assessed by a clinician. Crews should offer support and treatment as per training and competence and call for assistance if required at the scene, In most cases this will be done by calling the **999** service. If in close proximity to assistance and able to transport the patient safely and legally the crew may elect to transport to that facility.

11.3 In all cases the crew must call the Incident reporting line on [redacted] and guidance sought from the Care Quality on call service if required.

11.4 A PRF must be completed to accompany the incident report.

11.5 ACA, Mental Health and ECA staff should not continue transportation as a matter of course. Treatment should be initiated and call for assistance. In most cases this will be achieved by calling the **999** service. If within hospital grounds or very close proximity to the hospital the crew may decide to convey a patient who has deteriorated to an Emergency Department, they should not convey the patient to any other destination as this may be clinically inappropriate for the patient and place the patients care in further jeopardy.

11.6 The patient that is deteriorating should not be conveyed back to a ward or nursing home or other facility as a matter of course.

11.7 Once **999** has been called and if the situation permits the crew must call the Incident reporting line on [redacted] and guidance sought from the Care Quality on call service if required.

11.8 The on-call team may make recommendations for treatment or transport options, in such cases the crew should follow the advice given by the on-call clinical team.

11.9 A PRF must be completed to accompany the incident report.

11.10 This process is also defined with **BMS/6.07 - Safer Person Handling and Dynamic Risk Assessment**.

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12. Care of Others in Transit

12.1 Care should be taken to minimise the exposure of others on board the vehicle. Ideally patients will be screened during treatment or resuscitation by using blankets etc.

12.2 This may not be possible and additional resources should be called to the scene to assist these patients and convey them to a safe location or final destination. Witness to a resuscitation attempt can be very frightened and distressed. The crew must call the Incident reporting line on [redacted] and guidance sought from the Care Quality on call service if required.

12.3 Local management should be contacted by the CCT at an early stage to ensure that any other patients affected by the incident can be managed and supported as needed.

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ERS Medical

BMS/6.07 Safer Person Handling and Dynamic Risk Assessments

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
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2.0	13	13.1 to 13.3	21	22/11/17	[redacted]	Addition and clarification to use of Hospital supplied wheelchairs
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3.0	13	13.10 & 13.11	23	08.11.18	[redacted]	Addition on guidance for the use of linen, sheets and blankets.
3.1	All	All	All	02.09.19	[redacted]	Addition for Homerton NHS Trust
4.0	All	All	All	12.11.19	[redacted]	Annual Review
4.1	10 & 15	10.5 & 15.3	Pg 15 & 23	20.01.20	[redacted]	Minor changes from CCG feedback

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Whistleblowing (Raising Concerns at Work)	BMS/2.05
Disclosure and Barring Service (DBS) Checks	BMS/2.06
Alcohol, Drugs and Substance Misuse	BMS/2.07
Incident Reporting and Investigation	BMS/5.01
Serious Untoward Incident Investigations	BMS/5.02
Statutory Notifications	BMS/5.03
Care to Care	BMS/6.01
Patients Who Deteriorate in Transit	BMS/6.02
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding of Vulnerable Adults and Children	BMS/6.05
End of Life Care	BMS/6.06
Patient Communications and Control	BMS/6.08
Renal Patient Services	BMS/6.11
HDU NEPTS Operations	BMS/6.12
Health and Safety Management (in review)	BMS/9.01
Safer Person Manual Handling Risk Assessment	WI/1.07.05
Equality and Diversity	WI/2.01.13
ADHOC Journey Quotes and Bookings (CCT)	WI.6.08.04
CAD Bookings	WI/6.08.07
NEPTS Eligibility	WI/6.10.01
NEPTS Arrival Process	WI/6.10.02
Conflict Resolution	WI/6.13.02
NEPTS Loading Sheets	F6.10.02
NEPTS Loading Sheets (WAV)	F6.10.02a
Patient Mobility Flowchart	F6.03.03
Dynamic Bariatric / Plus Sized and Complex Needs Risk Assessment	F6.07.01
Patient Tissue Viability and Hydration Record Chart	F6.07.02
Daily Issue Log	F6.10.05

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3. Legislation & Regulation

The Health and Safety at Work Act 1974 (HSWA)
The Mental Capacity Act 2019
Manual Handling Operations Regulations 1992 (MHOR) (as amended 2002)
Management of Health and Safety at Work Regulations 1999
Provision and Use of Work Equipment Regulations 1998 (PUWER)
Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)

Sources:

Health and Safety Executive Website – Moving and handling in health and social care

4. Introduction

4.1 This procedure has been established to ensure ERS Medical has a consistent process for all safer person handling and the dynamic risk assessing of any work activities that requires either direct or indirect support in the handling or assistance to patients.

4.2 To reduce the risk of injury from all patient moving and handling operations and activities undertaken by or on behalf of ERS Medical.

4.3 To define the responsibilities of Company personnel in relation to completing safer person manual handling and dynamic risk assessments conducted ensuring consistency is achieved.

4.4 To ensure all Company personnel are aware of their responsibilities with regard to undertaking safer person manual handling activities.

4.5 The Manual Handling Operations Regulations 1992, as amended 2004 and Part 2, Chapter 4 of the Health and Welfare at Work (General Application) Regulations 2007, apply to a wide range of manual handling activities as defined at 8.14.

4.6 Whilst it is desirable to avoid the need for the manual handing of patient's (loads) by stimulating their functional mobility, if appropriate, it is recognised that due to the nature of their work, Company personnel may have no alternative but to move, handle or assist patient's with their mobility.

4.7 This work activity places significant force and stresses upon the musculoskeletal systems of handlers and patients alike and it is for this reason that ERS Medical has adopted a minimal lifting policy.

4.8 ERS Medical is required to follow the hierarchy of controls for manual handling operations, which are:

- **Avoid** the need for hazardous manual handling, so far as reasonably practicable;
- **Assess** the risk of injury from any manual handling that can't be avoided;
- **Reduce** the risk of injury from manual handling, so far as reasonably practicable.

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4.9 For the purposes of this procedure assessments will dynamic in nature. Formal safer person manual handling risk assessments are conducted and recorded in accordance with the requirements of **WI/1.07.05 – Safer Person Handling Risk Assessment**.

4.10 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

4.11 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the ERS Medical Business Continuity Policy.

5.3 Please refer to the ERS Medical Information Security Policy.

6. Responsibilities

6.1	**Managing Directors**	Have overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
6.3	**Medical Director / Head of Care Standards**	Has the strategic responsibility for setting, directing and monitoring clinical standards, scope of practice and ensuring that patient safety remains the primary focus of all patient facing services within ERS Medical.
6.4	**Head of Care Standards**	Is responsible for developing, co-ordinating and implementing quality, health & safety and environmental policy, procedures and work instructions.
6.5	**Head of HR & Training**	Is responsible for the creation, implementation, monitoring of all manual handling training in line with Company targets and for supporting Clinical Instructors and the Care Standards Team in respect to the training and development of personnel. Is also responsible for reviewing outstanding training requirements and liaising with Managers to ensure all relevant / required training is undertaken in a timely manner and for maintaining centrally and locally held, physical and electronic training records
6.6	**Regional and Operations Managers**	Are responsible for the implementation and management of ERS Medical policy and procedures and to ensure that employees receive suitable and sufficient safer person manual handling training. Are responsible for writing operational risk assessments for areas under their control, monitoring, controlling and implementing the policy, procedures and work instructions for staff they manage.
6.7	**Manual Handling Key Workers**	To promote the benefits of using good safer person manual handling techniques and the principles of efficient movement at all times. To provide or seek further guidance for staff who have questions or concerns on matters relating to safer person manual handling.
6.8	**All ERS Medical Ambulance Crew**	Are responsible for undertaking dynamic (patient) risk assessments in accordance with applicable legislation / guidance and for the passing of any formally recorded assessments to their line managers for record retention.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2019 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

8. Definitions

8.1 **As Low As Reasonably Practicable (ALARP)** – Means that the risk has been reduced to such an extent that the cost of any further reduction in risk is grossly disproportionate to the benefits that would be achieved.

8.2 **At Work** – Includes all operational areas of ERS Medical's sites and all activities undertaken off-site by ERS Medical employees.

8.3 **Bariatric / Plus Sized** – Bariatric / Plus Sized service users are defined by NICE 2004 as being a patient whose weight is 40kg above their ideal weight and / or who has a body mass index(BMI) of >30kg/m2. However, for pre-hospital care the accepted criteria are 160kg / 25 stone or a BMI > 35. The realistic model should however be the impact the patient's weight, BMI, body shape and mobility impacts the crews ability to safely care for them and themselves, with the equipment to hand or available to them.

8.4 **Body Mass Index (BMI)** – A calculation of body fat that takes into account the age, height and weight of the patient.

8.5 **Dynamic Overload** – Is the stress placed upon the body from a moving and variable force or load.

8.6 **Dynamic Risk Assessment** – The continuous process of identifying and evaluating risks arising from a hazard, taking into account the adequacy of existing controls. This process includes the decision on the acceptability of risks and the deployment of additional control measures if necessary.

8.7 **Ergonomics** – Is a science concerned with the 'fit' between people and their work. It puts people first, taking into account their capabilities and limitations. It aims to make sure that tasks, equipment, information and the environment suit each worker.

8.8 **Functional Mobility** – The degree of an individual's ability to move and mobilise independently within their environment.

8.9 **Hazard** – Source, situation or act with a potential for harm in terms of human injury or ill health or a combination of these.

8.10 **Hazard Identification** – Process of recognising that a hazard exists and defining its characteristics.

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8.11 **Incident / Serious Incidents (S.I.)** – Work-related event(s) in which an injury or ill health (regardless of severity) or fatality occurred or could have occurred.

8.12 **Injury / Ill Health** – Identifiable, adverse physical or mental condition arising from and / or made worse by work activity and/or work-related situation.

8.13 **Lifting / Moving Aid** – For the purpose of this procedure is defined as a patient trolley, stretcher, wheelchair, carry-chair, PAT slide, turntable, banana board, slide sheet, handling belt.

8.14 **Load** – A load in the context of manual handling must be a discrete movable object. This includes for example, not only packages and boxes but also patient(s) receiving medical attention. An implement, tool or machine such as an ambulance trolley / carry chair is not considered to be a load when in use for its intended purpose.(*Inanimate – is defined for the purposes of this work instruction to be all manual handling with the exception of patient handling*).

8.15 **Manual Handling** – Is the pushing, pulling, lifting up, putting down, moving and carrying of a load or person.

8.16 **Manual Handling Operations** – Any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force.

8.17 **Musculoskeletal Disorder (MSD)** – Covers any injury, damage or disorder of the joints or other tissues in the upper or lower limbs or back.

8.18 **Patient with Complex Needs** – A patient will be deemed to have complex needs, if in the provision of their safe handling and transportation they require any additional planning and resourcing from that provided by a standard double manned ambulance.

8.19 **Personal Protective Equipment (PPE)** – Specialised clothing or equipment worn by employees for protection against health and safety hazards.

8.20 **Risk** – Combination of the likelihood of an occurrence of a hazardous event or exposure and the severity of injury or ill health that can be caused by the event or exposure.

8.21 **Risk Assessment** – The process of evaluating risks, arising from a hazard, taking into account the adequacy of any existing controls and deciding whether or not the risks are acceptable.

8.22 **Static Overload** – Is the stress placed upon the body from an unmoving and constant force or load.

8.23 **T.I.L.E.E.O.** – Task, Individual, Load, Equipment, Environment and Others.

8.24 **Transfer** – Is the movement of a patient from one place or position to another, without the handlers taking the persons full weight.

8.25 **W.T.O.R.S.** – Wheelchair Tie-down Occupant Restraint System.

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9. Principles of Efficient Movement

9.1 In order to ensure the safe handling of patient's and reduce the risk of sustaining, aggravating existing MSD's or causing complications to other medical conditions, all staff should follow the principles of efficient movement when carrying out safer person handling operations.

9.2 These principles are:

- Create and maintain a dynamic stable base of standing (this will also facilitate the introduction of momentum);
- Get as close to the patient (load) as possible;
- Adopt a good posture;
  - Knees bent slightly to facilitate smoother and more efficient movement;
  - Back Straight as possible maintaining neutral alignment and the backs natural curves;
  - Keep your head up looking in the direction of travel (aids breathing and hazard observation);
- Do not twist or rotate the body, move with the legs;
- Use the primary leg muscles to do the majority of the heavy movements;
- Hold the patient using palmer hold, try not to grab with fingers;
- Don't mobilise patients through their joints;
- Introduce gentle momentum prior to movement to reduce the force application required;
- Contract core muscles prior to any movement;
- Use smooth controlled movements, don't jerk as this may cause dynamic overload;
- Explain to the patient what you are planning and utilise their functional mobility as much as practicable;
- Avoid going into stress positions that may cause static overloads any earlier than required;
- Good communication with the patient and other handlers (Ready, Steady and then the action).

Manual Handling Key Workers

9.3 ERS Medical Manual Handling Key Workers should actively advocate and promote the principles of efficient movement and offer advice and guidance to all staff that are either observed or reported to use what ERS Medical deems to be poor practice or high-risk techniques in an inappropriate manner.

9.4 The key workers will also seek additional guidance and advice from the BTEC Level 3 and 4 Safer Person Handling Instructors, for all issues that fall outside of their knowledge and experience.

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10. Functional Mobility and Patient Mobility Categorisation

10.1 It is important to correctly ascertain a patient's level of mobility prior to beginning any safer person manual handling operation, in order to stimulate and retain their functional mobility. Patients can rapidly loose mobility if this is not conducted and once lost it can prove very problematic for them to regain.

10.2 It is essential that we have some knowledge of their mobility prior to transporting them, so that the CCO / Dispatch can categorise and allocate the appropriate resource to the booking. This will then serve to protect the patient's functional mobility, theirs and the crew's health and safety and the smooth running of the service being provided.

10.3 These mobility categories are:

Mobility Type	Description
	C - Driver only The patient can walk unaided to, and travel in a saloon car with the assistance of a driver for walking.
	C1 - Ambulance with driver and vehicle ramp The patient is a minimal falls risk and can walk with assistance of the x1 crew. The patient can manage the step or ramp onto the vehicle with steadying assistance only. The patient may require assistance to the vehicle in a wheelchair but can transfer to the seat of the ambulance. The destination location in known to have easy access (no multiple steps or stairs) and access can still be achieved with the assistance of x1 crew.
	C1(W) - Ambulance with driver and vehicle ramp; travelling in own wheelchair The patient has their own wheelchair been assessed as immobile and unable to transfer out of the wheelchair. The patient will transfer in their wheelchair (secured using WTORS). The destination location in known to have easy access (no multiple steps or stairs) and access can still be achieved with the assistance of x1 crew.
	C2 - Ambulance with driver and attendant plus vehicle ramp The patient cannot walk and requires either a wheelchair (secured using WTORS) or carry chair with the assistance of two ambulance staff to be transfer to and from the ambulance and / or the patients mental, physical condition requires the attention of two staff and or the patient requires oxygen whilst travelling to and from hospital.

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	C2 - Ambulance with driver and attendant plus tail-Lift Patient Travelling In Own Wheelchair The Patient is required to travel in their wheelchair (secured using WTORS) and cannot transfer. There are steps at home and / or their condition requires a two person crew.

Mobility Type	Description
	C2 (Str) - Stretcher Crew The patient has no independent mobility or must remain, for medical reasons, lying down for the duration of the journey, and / or has a full leg cast or patient is unable to bend their leg and cannot sit.
	C3 (Str) - 3 Man Crew Requires x3 Crew members to transport the patient safely due to patient mobility and or access and egress to either the collection or delivery destination or both.
	C4 (Str) - 4 Man Crew Require x4 crew members to transport patients due to mobility, weight and size in the case of Bariatric / Plus Sized patients or due to known access and egress issues to collection or delivery destination or both.
	C-Para - Paramedic Crew Due to the patient's presenting medical condition a paramedic intervention or monitoring crew is or may be required on route to safely convey the patient.

Escort Type	Description
	C+(E) - Relative or Medical Escort A nurse, clinical team or carer is required to travel due to the needs of the patient during the journey. Or a parent or relative is deemed necessary due to the needs of the patient either 1 or 2 relative may travel.
	C+ (CE) - Child Escort All children under 16 must travel with an escort.

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10.4 With the patient's mobility initially categorised, the CCT / Dispatch will then be able to assign the most appropriate resource to meet the patient's requirements.

	Vehicle Type				
Mobility Code	Car / Taxi	WAV	Amb (seats only)	Amb (Trolley)	HDU
C	✓	✓	✓	✓	✓
C1	✓	✓	✓	✓	✓
C1 (W)	X	✓	✓	✓	✓
C2	X	X	✓	✓	✓
C2 (W)	X	X	✓	✓	✓
C2(STR)	X	X	X	✓	✓
Bariatric / Plus Sized	X	X	✓	✓	✓

10.5 There will, on occasion, be times where some patient' can be moved outside of the parameters set in the table at 10.4, such as when a taxi company, approved through Due-diligence Supplier Assessment – **F4.01.05B**, has the capability to move wheelchair users in the prescribed manner detailed within the relevant safe systems of work.

10.6 Please refer to **F6.07.03** – Mobility Assessment Flowchart for details on how the mobility code is established for a patient requiring transport (NEPTS, Renal or HDU).

11. Dynamic (Patient) Risk Assessments

11.1 All patients should be risk assessed prior to their movement and / or transfer, based upon multiple factors that may include, but not be limited to:

- Additional resources that may either be present or required;
- Cognitive functionality i.e. their ability to consent or understand what is being planned or is required of them;
- Current medical or care treatment plans;
- Dynamic loading forces;
- Environmental conditions (temperature, lighting, space constraints, floor surface);
- Ergonomics (ability of the handlers to adopt and use the principles of efficient movement);
- Manual handling techniques (the ability of the attending crew to select the most appropriate method);
- Moving and handling equipment (the availability and suitability of equipment);
- Medications (take into account any direct effects or side effects of medications taken);
- Patient functional mobility (take into account what the patient is normally able to achieve);
- Patient weight, BMI, size and weight distribution (effects that these may have on selected equipment);
- Pre-existing medical conditions ;
- Static loading forces;

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- The right of the patient to play an active part in any decisions affecting their care;
- The training and experience of the attending handlers.

11.2 ERS Medical utilises two types of dynamic risk assessment for safer person handling. These are:

- **Informal Dynamic Risk Assessment** – An assessment conducted by all crews, based on their initial global overview of the patient, their presentation and their environment, taking into consideration the factors detailed at 11.1;
- **Formal Dynamic Risk Assessment** – The completion of **F6.07.01(ERS)** to record the assessment for Bariatric / Plus Sized and complex need patients. This should only be completed by staff who have attended and passed a Bariatric / Plus Sized Awareness training session and who are deemed to have suitable experience in dealing with Bariatric / Plus Sized and complex needs patients.

11.3 Informal dynamic risk assessment will be conducted dynamically by the attending crew and reflect the mobilisation code supplied by the CCT/dispatch from the information they received at the time of booking, if the journey was pre-planned.

11.4 Informal dynamic risk assessments, for urgent care and front line patients should be recorded on the Patient Record Form (PRF see figure 1) at the lifting and handling section. This assessment should be reviewed and amended as required during the patients ambulance transfer based on their medical presentation and local protocols.

11.5 All dynamic risk assessment should follow best practice of '**Think Before You Lift'** which requires an ergonomic approach to be adopted and used:

- **Task;**
- **Individual;**
- **Load;**
- **Environment;**
- **Equipment;**
- **Other factors.**

11.6 In the event that NEPTS crew arrive at the collection location for a patient and the circumstances, patient's location and mobility differs from the information provided at the time of booking and they have concerns about either the patients or their safety, they should contact their control room or Team Leader for further advice and guidance.

11.7 Crews should therefore consider the points detailed within the tables below when conducting any form of dynamic safer person handling risk assessment.

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TASK:	**What is the task?**	• What is the task and can it be avoided? • Does it involve strenuous pushing and pulling? • Does it involve carrying things over long distances? • Has it previously been risk assessed? • Is the task routine or emergency handling?
INDIVIDUAL:	**Who are the handlers and what are their abilities?**	• Do you need assistance? • Are you familiar with the technique and equipment? • How is your health, are you carrying an injury? • Do you require additional resources (equipment of staff? • Do you need PPE and are you wearing the appropriate clothing?
LOAD:	**What is the load and its characteristics?**	• Can the patient assist you (stimulate functional mobility)? • Do you know the weight? • Has it sharp edges or surfaces? • Is the load balanced or likely to move? • Is the load bulky, unwieldy or difficult to grasp?
ENVIRONMENT:	**Are there any environmental concerns or issues?**	• Environmental factors such as available light, cold, hot, wet, dry, even or uneven, physical obstructions?
EQUIPMENT:	**What equipment is available?**	• Have you been trained to use the equipment? • Has it been serviced and maintained correctly? • Is it suitable for the task after assessment? • Is it readily available? • Do you know the Safe Working Load?
OTHER FACTORS:	**Are there any other factors to consider?**	• Is time a factor? • Have you been supplied with accurate information? • Has the patient's condition changed since the point of booking?

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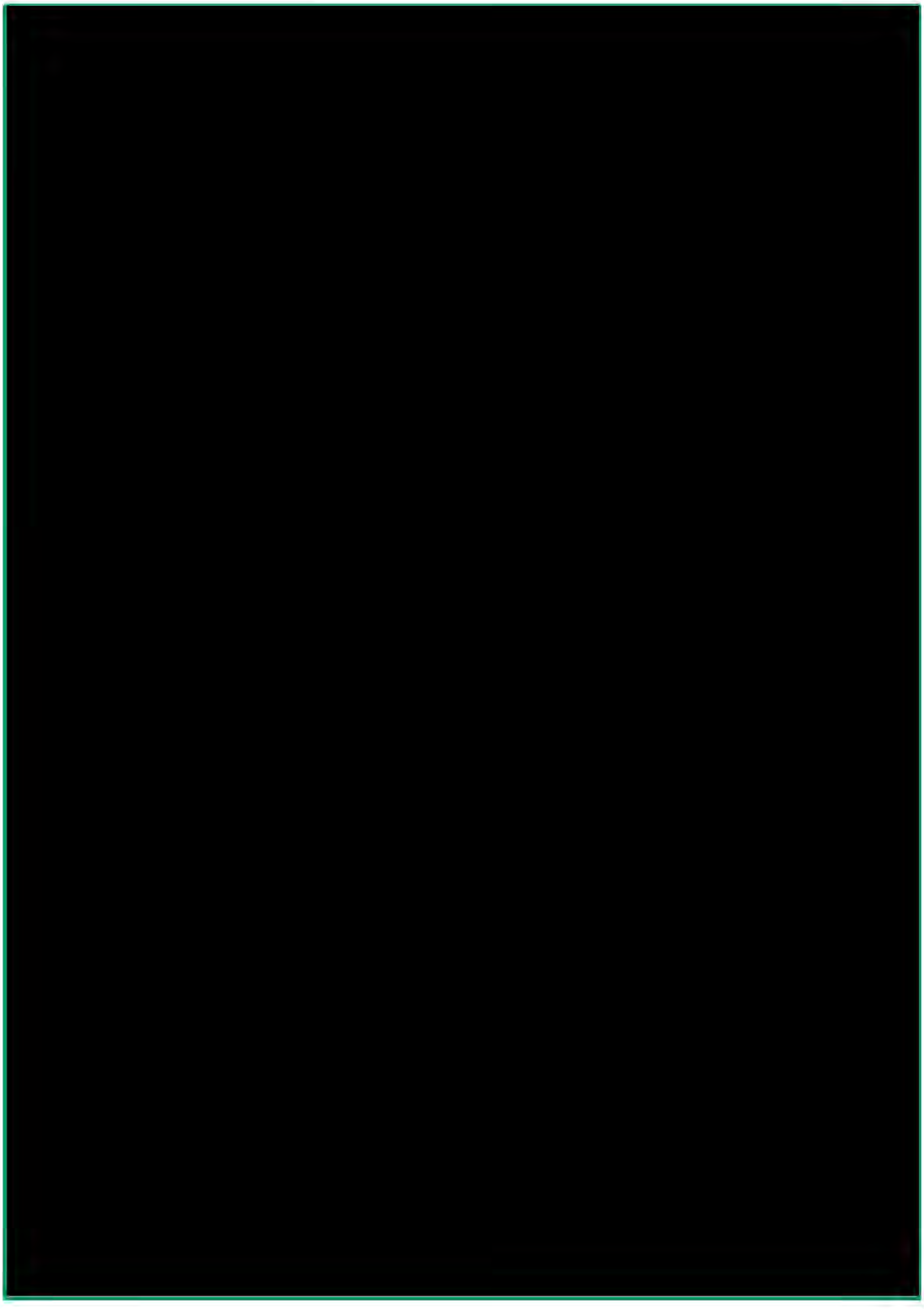
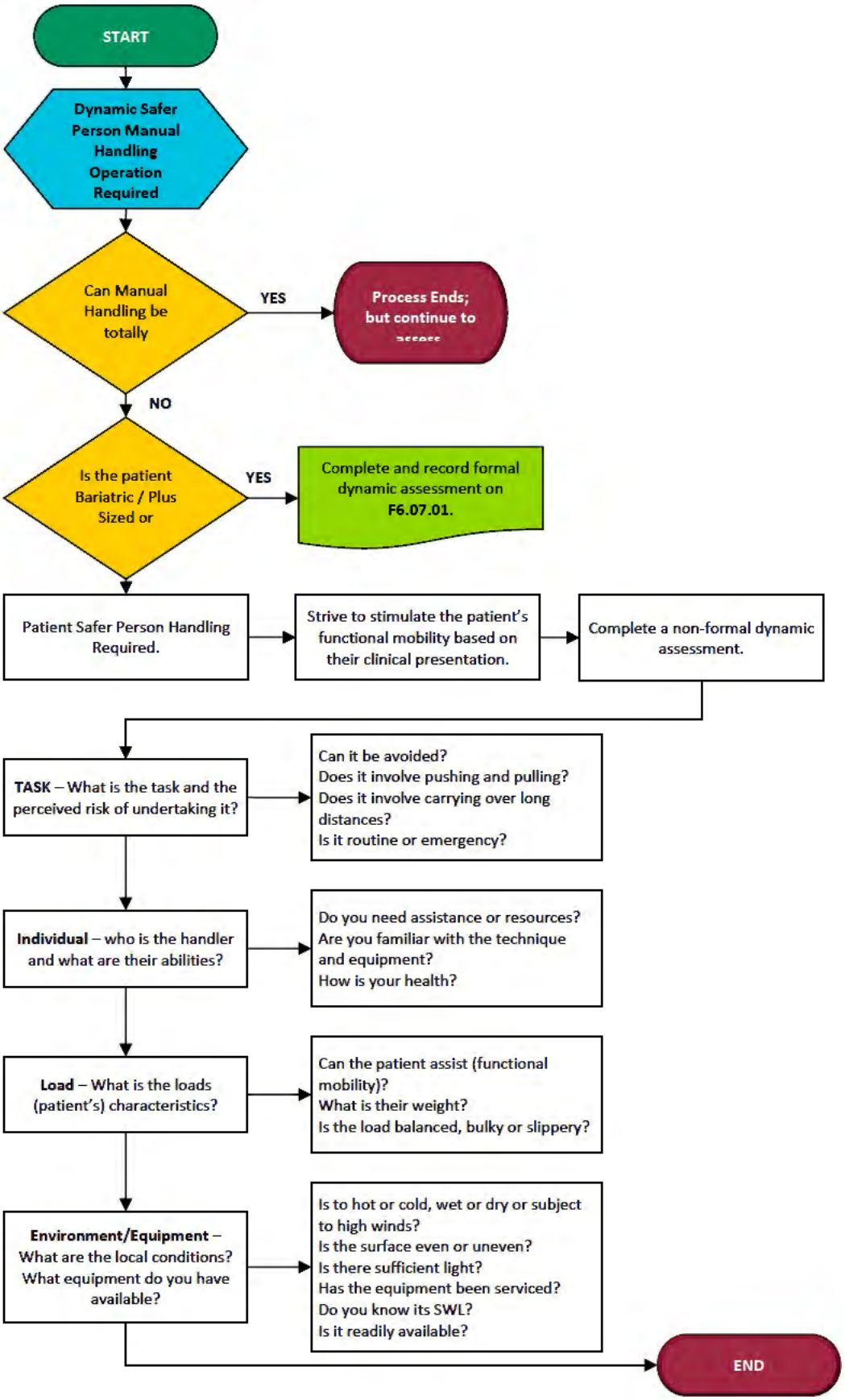


Fig 1: Patient Report Form (PRF)

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12. Key Steps


START
Dynamic Safer Person Manual Handling Operation Required
Can Manual Handling be totally
YES
Process Ends; but continue to
NO
Is the patient Bariatric / Plus Sized or
YES
Complete and record formal dynamic assessment on F6.07.01.
Patient Safer Person Handling Required.
Strive to stimulate the patient's functional mobility based on their clinical presentation.
Complete a non-formal dynamic assessment.
TASK – What is the task and the perceived risk of undertaking it?
Can it be avoided?
Does it involve pushing and pulling?
Does it involve carrying over long distances?
Is it routine or emergency?
Individual – who is the handler and what are their abilities?
Do you need assistance or resources?
Are you familiar with the technique and equipment?
How is your health?
Load – What is the loads (patient's) characteristics?
Can the patient assist (functional mobility)?
What is their weight?
Is the load balanced, bulky or slippery?
Environment/Equipment – What are the local conditions? What equipment do you have available?
Is to hot or cold, wet or dry or subject to high winds?
Is the surface even or uneven?
Is there sufficient light?
Has the equipment been serviced?
Do you know its SWL?
Is it readily available?
END

13. Bariatric / Plus Sized and Complex Need Patient Handling

13.1 All Bariatric / Plus Sized and complex needs patients will be considered a high-risk journey due to their often-complex medical presentations, history and the co-morbidities often associated with patients who are clinically classified in this manner.

13.2 Additionally, in the case of Bariatric / Plus Sized patients and due to their increased weight and size, including body weight distribution nuances, they can be at increased risks when patient handling and ambulance equipment is used in the provision of their care and treatment.

13.3 It is therefore, a requirement of ERS Medical that all planned Bariatric / Plus Sized and patients with complex needs should have their transport booked with a minimum of 24 hours' notice.

13.4 This 24 hour notice period is to allow ERS Medical time to complete for a formal dynamic risk assessment (**F6.07.01**).

13.5 This formal dynamic assessment will identify the most suitable method and appropriate resources to allocate for the booking, keeping patient and staff safety, dignity and welfare as its main priority.

13.6 Additionally, it is the policy of ERS Medical that all staff called upon to care, treat and transport Bariatric / Plus Sized patients, should prior to any such duty receive a Bariatric / Plus Sized patient awareness course.

13.7 It is important that when completing the formal dynamic assessment using **F6.07.01(ERS)**, staff tasked to undertake them take into consideration the following:

- The patient's known or estimated weight (will this exceed Safe or Max Working Loads of equipment including the ambulances carrying capacity;
- The patient's BMI;
- The nature of the patient's complex needs i.e. amputation, cognitive impairment;
- The number of suitably trained staff required to complete the journey safely;
- The patient's current functional mobility i.e. is the patient independent and mobile, do they require assistance;
- How the patient normally mobilises i.e. wall walks, sticks, frame, wheelchair;
- What the patients presenting medical complaint is (primary and co-morbidities);
- Is the patient's condition assessed as being time critical;
- Are additional medical resources required;
- The patient's position on arrival at scene (walking, lying, sitting);
- The patient's location at scene on arrival (downstairs, upstairs);
- The ease of access and egress to the property and facility;
- Any safer person handling / emergency handling equipment needed (wheelchair, carrychair, slide sheets, manger elk, orthopaedic scope, long board);
- Can the patient tolerate being supine (lying flat on their backs), as a small percentage of Bariatric / Plus Sized patients may encounter significant breathing problems if placed into this position;
- Is the patient compliant;

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- Is there a history of either verbal or physical abuse;
- Does the patient require an escort;
- The patient's tissue viability, do they have any pressure sores (if Yes, complete **F6.07.02**).

14. Handling Equipment

14.1 ERS Medical provides various items of ambulance borne equipment to maintain and potentially improve the clinical presentation and increase the safety and comfort of our patients and staff.

14.2 All ambulances will be equipped with a minimum standard of equipment and all staff should be trained and familiarised on each piece prior to use.

14.3 Specific details on what equipment is provided for each vehicle type can be found on the vehicle loading lists available on the BMS:

- **F6.10.02** – Vehicle Loading List (NEPTS);
- **F6.10.03** – Vehicle Loading List (WAV);
- **F6.12.01** – HDU / Frontline Medical Equipment Device Loading List.

14.4 Standard Ambulance Safer Person Handling Equipment:

- Ambulance Trolley (Ferno or Striker variants);
- Ferno Compact 2 Carrychair;
- Patient Wheelchair;
- Wheelchair Tie-down and Occupant Restraint System(WTORS);
- PAT Slide;
- Handling Belt;
- Slide Sheet(s);
- Patient Turntable;
- Banana Board;
- Ambulance Winch Assist.

14.5 All employees should familiarise themselves with the Safe Working Load (SWL) and / or the Maximum Working Load (MWL) of the piece of equipment they are using. Under no circumstances should the SWL be exceeded as this could cause equipment failure and result in an injury to either the patient staff member or both.

14.6 It is important to note that in the case of PAT slides there is no specific SWL / MWL, as this piece of equipment is not designed to take significant amounts of patient weight, but rather to act as a lateral transfer device between to flat surfaces, which should not be more the 150mm / 30cm apart.

14.7 Winch Assists are fitted to all new ERS Medical Ambulances and have been provided to reduce the force application required from staff when loading and unloading wheelchairs and ambulance trolleys, either loaded or unloaded with a patient.

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14.8 They are not however, provided to totally remove all physical effort. Ambulance crews will still be required to guide wheelchairs and trolleys up and down vehicle ramps to ensure that they follow the correct and safe line and to be there in the event of a winch failure.

14.9 Crews are not expected to use the winch assist on every wheelchair and trolley load or unload operation. They are expected to dynamically assess the situation using the T.I.L.E.E.O. system. For example:

- If a patient weighs 50kg and is positioned on a trolley, both crew members are physically fit with no existing MSD's and it is raining and cold. Staff could reasonably be expect to load and unload the patient manually, thus preventing the patient from getting cold and wet and reducing the load and unload times;
- If however one of the crew had an existing MSD and was protecting their health, it would be acceptable in this case to utilise the winch assist or in any other circumstance when it has been assessed as being required;
- It will remain the responsibility of each individual to keep their line managers informed of any medical conditions, such as MSD's that affect their fitness to work and carry out patient handling activities.

Linen, Sheets and Blankets

14.10 ERS Medical crew are **NOT** to use patient linen [blankets, sheets etc] for the purpose of restraining their patients', in line with the manual handling training they receive.

14.11 Patient linen is only to be used for the following purpose:

- Thermal comfort of the patient;
- Preservation of the dignity or patients' whilst manual handling operations and care is provided;
- The protection of delicate skin, whilst manual handling operations take place, such as but not limited to, the use and operation of:
    - Compact 2 or similar type of patient Carry Chair;
    - Lateral transfer from ambulance trolley to bed or vice versa.

15. Wheelchairs and W.T.O.R.S.

Wheelchairs

15.1 When using wheelchairs, irrespective of their origin (i.e. ERS Medical provided or the patient's own chair), staff must ensure that the lap safety strap is correctly fitted and secured around the patient's waist, where fitted. All ERS Medical supplied wheelchairs come with a fitted lap belt and this **MUST** be serviceable and used.

15.2 Hospital supplied porter wheelchairs are not designed to be used outside of the hospital and they do not come fitted with safety lap belts.

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15.3 ERS Medical crews should not use these outsides for the following reasons, unless ambulance are equipped with 'Donway Safety Belts':

- Their use outside of the hospital significantly increases the likelihood of an incident occurring and a patient being injured;
- Many NHS Trust clearly state that they should only be used indoors, so there use outside would negate the Trust own safety procedures as well as ERS Medicals;
- Any accidents or incidents that arise from their use would significantly increase the litigation risk to ERS Medical.

15.4 Under **NO** circumstances are wheelchairs to be lifted with a patient in situ. Wheelchairs are not designed to be operated in this manner and this practice is not compliant with either the manufacturers operating instructions or the training that staff receive.

15.5 This is a safety requirement of ERS Medical and a requirement for any on-going transportation required of ERS Medical.

15.6 If a patient refuses to comply with this request, the requirement should be politely explained to them so the fully understand that it is for theirs, other service users and staff safety.

15.7 If they continue to dispute the need, crews should contact the CCT / Control / Dispatch and inform them about the patient's refusal to comply with Company policy.



Wheelchair safety lap strap

Wheelchair Tiedown Occupant Restraint System (WTORS)

15.8 Whenever a wheelchair user is transported in their wheelchair it is essential that they and the wheelchair are secured safely within the vehicle.

15.9 In order to comply with this requirements of legislation and Company policy, ERS Medical provides a Wheelchair Tiedown Occupant Restraint System (WTORS) on the below listed NEPTS platforms:

- WAV;
- NEPTS Ambulance (Seating Only);
- NEPTS Ambulance (Stretcher).

15.10 ERS Medical uses either a system provided by 'Q-Straint' of 'Unwins'. Irrespective of it origin of manufacture all our systems follow the same basic principle of a 4 point anchor system for the wheelchair and a standard 3 point seat belt configuration for the patient.

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15.11 In order for these systems to work correctly they have to be applied in accordance with their stated manufacturer's instruction. **NO deviations from these instructions are permitted**.

15.12 All WTORS equipped NEPTS platform will come provided with both the manufacturers instruction manual and an information plate within the patient cabin, for their use and application. This information is provided to staff in addition to the training they receive.

15.13 Unless a patient has on their person and can present a valid seatbelt exemption certificate to the crew, at the time of transportation, they must wear, by law, the 3 point seat belt that is provided as part of the complete WTOR system.

15.14 NEPTS stretcher capable ambulances that have been provided with 2 set of WTORS must ensure that under **NO** circumstances are 2 wheelchairs and a stretcher patient, transported together at the same time.

15.15 Only 1 wheelchair and 1 stretcher patient at a time has been approved by both the ERS Medical Care Standards Team to ensure that all patients are transported in a safe manner and that the required standard of care and support can be provided for all.

16. Mobility Scooters and Powered Wheelchairs

16.1 Under **NO** circumstances are motability scooters to be transported by ERS Medical. There is no approved or authorised way in which to secure these scooters within the vehicle and their presence would be an unacceptable risk to patient and staff safety.

16.2 Service users powered wheelchairs should under **NO** circumstances be permitted to drive their wheelchairs either onto or off ERS Medical wheelchair compatible platforms.

16.3 They should be requested to:

- Place their powered wheelchair into a neutral gear position with the brakes on;
- The winch assist should be connected to the powered wheelchair at a suitable anchor point at the front;
- The powered wheelchairs brakes should then be disengaged and the crew slowly and carefully guide, load or unload the wheelchair and user from or to the vehicle, using the winch assist;
- The powered wheelchair should then have its brakes reapplied prior to the winch assist being disconnected;
- The patient can then, when in a safe location be requested to take control of the powered wheelchair again.

16.4 If a patient refuses to comply with this request, the requirement should be politely explained to them so the fully understand that it is for theirs, other service users and staff safety.

16.5 If they continue to dispute the need, crews should contact the CCO / Control / Dispatch and inform them about the patient's refusal to comply with ERS Medical policy.

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17. Tissue Viability (Pressure Sores) & Hydration

17.1 Prior to any safer person handling operations crews should enquire and be aware of any tissue viability issues in relation to their patient.

17.2 They should enquire from either family members, medical or care staff about:

- Any pre-existing and recorded pressure sores, their grade and location;
- Any pressure sore regimes that are in place (frequency of turns);
- The most comfortable position for the patient on the ambulance (sitting or lying).

17.3 They should also consider:

- The duration of the transfer or journey;
- Recording any actions that result in the preventative and proactive management of the patient to prevent pressure sores i.e. initiating a turns regime, including its frequency;
- Actions taken during a journey in the event of pressure sores or hot spots developing.

17.4 Details of any hot spots or sores should be recorded on **F6.07.02** – Patient Tissue Viability & Hydration Chart.

17.5 If required they should consider and be prepared to re-position the patient during the journey or transfer to relive the stresses to the patient in the known high pressure areas such as the hips, heels and tailbone.

This repositioning activity should always be conducted when the vehicle is stationary.

ERS Medical crews should not conduct examinations of patients to determine if they are developing or have existing pressure sores.

17.6 If a patient complains and or develops hot spots or pressure sores during a transfer / journey the crew should record their location and subsequent actions on **F6.07.02** - Patient Tissue Viability & Hydration Chart.

17.7 This information should be provided to a family member, medical or care staff at the receiving facility on handover or the patient.

17.8 For long distance transfers or transfers in excess of 1.5 hours, it can reasonably be expected that patient comfort and tissue viability issues will need to be acknowledged, managed and recorded.

17.9 Consideration should be given to the provision of pressure relieving materials such as, but not limited to:

- Beanie mattresses;
- Cushions and Pillows (IPC cleanable);
- Planned regular comfort breaks during the journey;
- Planned and regular stops to allow the proactive and preventative management of tissue viability issues, such as turns and repositioning.

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Hydration of Patients

17.10 The **F6.07.02** – Tissue Viability & Hydration Chart should also be used to record the management of hydration for our patients, whilst in our care.

17.11 Staff should follow any professional healthcare guidance provided to them in regards to a patients hydration needs i.e. frequency and amounts of water needed.

17.12 Staff should also record when patients request water. Staff should not refuse a request for water unless expressly instructed to do so as part of their on-going care plan

18. Emergency Situations & Patient Falls

18.1 In emergency situations, (e.g. medically time critical patient or in the event of fire), it may be necessary to manually handle people to a place of safety as a matter of urgency to protect life.

18.2 In such instances, employees should always attempt to use the best practical means of manual handling to safeguard their health and wellbeing without compromising the saving of a life.

18.3 Under **NO** circumstances should ERS Medical staff put their own safety at risk.

18.4 With an un-witnessed patient fall, ERS Medical employees should in the first instance try to ascertain from any persons in the vicinity (family members, medical or care staff); if there have been any injuries to the patient as a result of the fall and if there is a history of previous falls.

18.5 The recovery method from the floor should be based on the results of this initial assessment and the urgency of the patients presenting medical complaint or condition. Only suitably clinically qualified staff should do this. PTS staff are **NOT** deemed qualified to clinically assess the patient's injuries or determine the mechanism of fall i.e. medical or mechanical.

18.6 Where a patient falls whilst employees of ERS Medical are present, they should try and balance their own health, safety and welfare against that of the patient. As such they should try and refrain from the natural tendency to catch the patient or stop them from falling, as this can potentially make the situation worse.

18.7 Staff should base their decision, as to whether they are in a position to intervene, taking some for the following points into consideration:

- Their proximity to the patient (the closer they are the better they can manage the situation);
- The speed of the fall (not all patient falls are high speed);
- The weight and size differential between handlers and patient;
- The mechanism of fall (mechanical i.e. slip or trip or medical in origin, i.e. vasovagal);
- The environment (hazards that can increase injuries).

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18.8 Any patient in our care or found by our crews on the floor after a suspected fall, should be encouraged to go to hospital and or seek medical care. This may necessitate the ERS Medical crew, if PTS requesting a **999** response from their local ambulance service. A record of all patient initial observations and any care / treatment provided by ERS Medical should be recorded on a PRF. When appropriate the crew should contact the CCT and inform them of the incident on **0333 240 4107**.

18.9 Staff should not be in any hurry to recover the patient from a fall, until they have conducted a primary assessment of the patient and ascertain if there are any remaining medical issues that may result in another fall and or the patient has sustained any injuries that require either first aid treatment and or other medical attention.

18.10 This assessment should also determine if the patient's condition is deemed to be time critical. The emergency services should be called immediately if this is the case or the patient is to be transported to the nearest NHS accident and emergency unit if the crew are suitably qualified to do so.

18.11 ERS Medical staff that either treat or transport a patient post fall should ensure that they complete a patient report form.

18.12 Any such fall of a patient whilst in the care of ERS Medical staff, should be reported to family members, medical or care staff on handover of the patient.

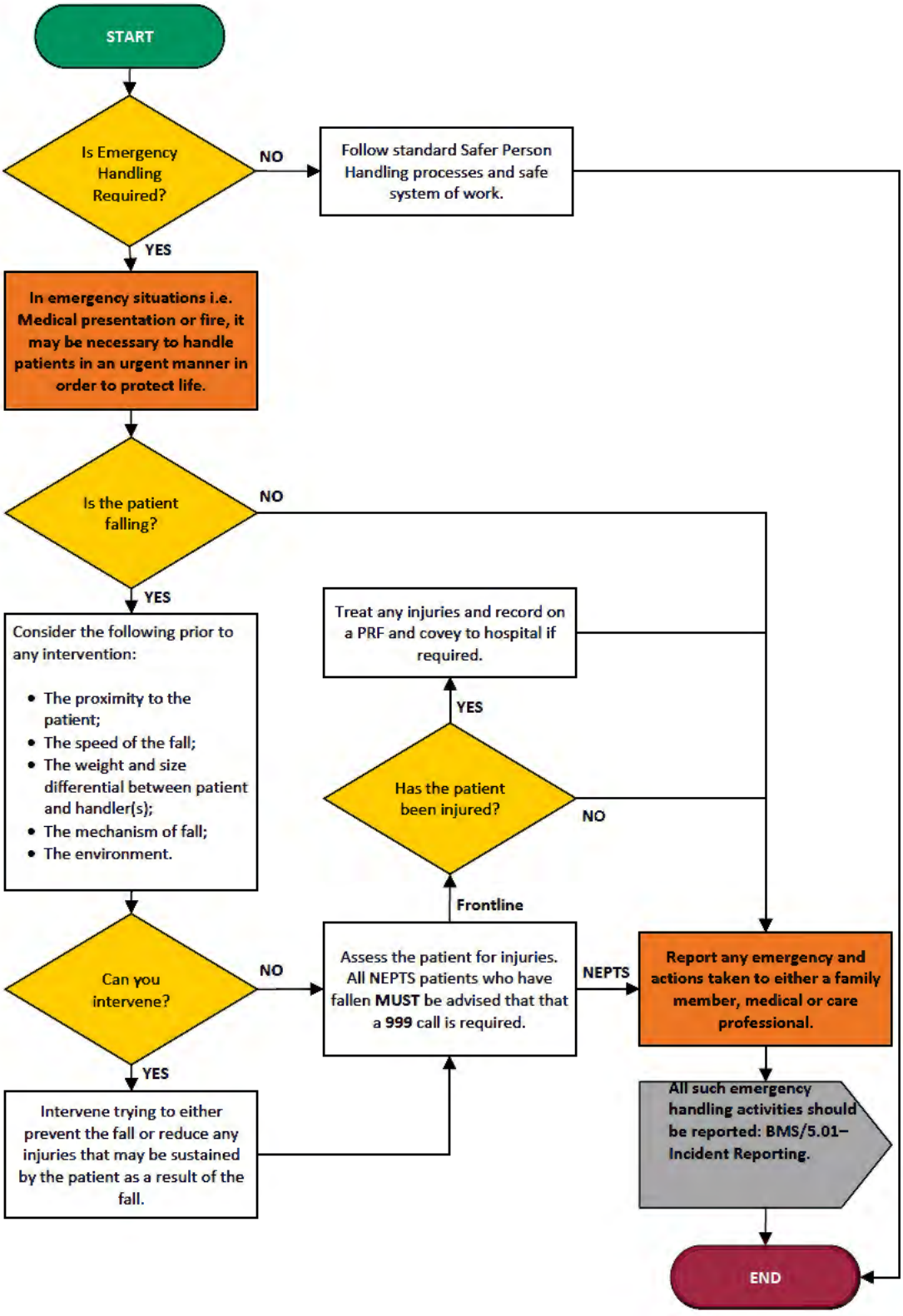
18.13 Following all emergency situations or incidents, employees are required to report the incident following the process defined in **BMS/5.01 – Incident Reporting and Investigation.**

18.14 An additional resource available for emergency handling is available from the UK Resuscitation Council at:

https://www.resus.org.uk/publications/guidance-for-safer-handling-during-cpr-in-healthcare-settings/

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19. Key Steps



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Question 1.19.14.1

Patient / Service User safety

Please detail the service user safety systems you have or intend to have in place to ensure risks are assessed and managed safely and appropriately in an emergency.

Word count 1000

Total Word Count: 997

To ensure the safety of patients during transportation we have in place several policies and working practices in place including, but not limited to:

- Care to Care policy
- Infection Prevention and Control
- Safer Person Handling and Dynamic Risk Assessments
- Patients who deteriorate in transport

We have attached each of these policies and work instruction and provided an overview of them below:

Care to Care (BMS/6.01)

The purpose of this procedure is to establish and define actions, responsibilities and standards that ERS, our contractual partners, the Care Quality Commission and our patient's, require and have an expectation of when receiving care, treatment and transportation.

Its purpose is to give guidance on the care expected and required by ERS to deliver, but not limited to:

- Operational Ambulance Crews
- Operational Managers
- CCO Call Handlers
- CCO Despatchers
- CCO Planners
- CCO Helpdesk Team
- Care Standards Team (Clinical)
- Care Standards Team (Health and Safety)
- Complaints Administrator

This procedure applies to all ERS staff, facilities and to all documents that form the BMS.

Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with ERS's Capability and Disciplinary procedures.

Infection Prevention and Control (BMS/6.03)

The purpose of this procedure is to establish and define actions, responsibilities and standards that ERS, our contractual partners are required to have in place for the prevention and control of possible cause of infections.

Safer Person Handling and Dynamic Risk Assessments

This procedure has been established to ensure ERS has a consistent process for all safer person handling and the dynamic risk assessment of any work activities that requires either direct or indirect support in the handling or assistance to patients:

- To reduce the risk of injury from all patient moving and handling operations and activities undertaken by or on behalf of ERS
- To define the responsibilities of Company personnel in relation to completing safer person manual handling and dynamic risk assessments conducted ensuring consistency is achieved
- To ensure all Company personnel are aware of their responsibilities with regard to undertaking safer person manual handling activities

The Manual Handling Operations Regulations 1992, as amended 2004 and Part 2, Chapter 4 of the Health and Welfare at Work (General Application) Regulations 2007, apply to a wide range of manual handling activities.

Whilst it is desirable to avoid the need for the manual handing of patient's by stimulating their functional mobility, if appropriate, it is recognised that due to the nature of their work, Company personnel may have no alternative but to move, handle or assist patient's with their mobility.

This work activity places significant force and stresses upon the musculoskeletal systems of handlers and patients alike and it is for this reason that ERS has adopted a minimal lifting policy.

ERS is required to follow the hierarchy of controls for manual handling operations, which are:

- Avoid the need for hazardous manual handling, so far as reasonably practicable
- Assess the risk of injury from any manual handling that can't be avoided
- Reduce the risk of injury from manual handling, so far as reasonably practicable

For the purposes of this procedure assessments will be dynamic in nature. Formal safer person manual handling risk assessments are conducted and recorded in accordance with the requirements of our procedure – Safer Person Handling Risk Assessment.

This procedure applies to all ERS staff, facilities and to all documents that form the BMS.

Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with ERS's Capability and Disciplinary procedures.

Patients who deteriorate in transport

Patients transported by the NEPTS, Mental Health and HDU services have the potential for deterioration during both planned and urgent journeys.

The service supports patients of all ages with a wide range of medical conditions and post traumatic injury.

All staff are trained to universal standards to manage patients that deteriorate on route.

The purpose of this procedure is to outline the actions to be taken should a patient deteriorate during a journey.

This procedure applies to all ERS staff, facilities and to all documents that form the BMS.

Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with ERS's Capability and Disciplinary procedures.

Incidents

All incidents that occur within ERS's operations are reported and investigated including:

- Health and Safety incidents
- Clinical/Safeguarding incidents
- Transport incidents
- Information Governance/Data Security incidents
- Environmental incidents
- Near misses

All incidents, including patient and staff safety and near misses are managed using our compliance system Radar. Each event is given a unique identifying reference number which is prefixed with a code to identify the type of incident.

All vehicle incidents are reported to the site management team immediately. All of our vehicles are equipped with CrystalBall, which provides 360 camera coverage of our vehicles. All incident data is automatically collated and sent to our senior management team and insurers to assist with investigations into the incident.

Each event is broken down into 5 workflow stages, with designated workflow leads as below:

Initial Investigation	Site Operations Manager
Compliance Team Investigation	Care Standard Team SME
Technical Review	Care Standard Team SME
Action Plan	Care Standard Team
Risk Score	Care Standard Team

All incidents reported to ERS are formally reviewed during the regional Governance and Performance Review committee meetings, which is chaired by the regions CQC Registered Manager.

Lessons learnt and shared learning are an integral part of our incident and compliance system Radar. This information is used as an essential part of developing our business allowing us to continually learn from incidents and patient feedback, combining it with our experience, innovation and best practices. This is disseminated to our employees through Clinical Memos, Notice Boards and Team Meetings.

Following a vehicle incident whilst transporting a patient our crews ensure that they prioritise the needs of the patient and ensure that they receive the required care following the incident whether this is onward transport using an alternative ERS vehicle or if emergency 999 transport is required.

Where the vehicle transporting the patient is unable to continue, we will dispatch our contingency vehicles to continue the patients transport ensuring minimal delay to the patient.

ERS Medical

BMS/5.02 Serious Untoward Incident (SUI) Investigations

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
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3.0	All	All	All	11.03.19	[redacted]	Annual Review
3.1	8	.12	11	24.09.10	[redacted]	Change to STEIS reporting period
3.2	All	All	All	14.10.19	[redacted]	Update for new Norfolk contract
4.0	All	All	All	24.03.20	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Incident Reporting and Investigation	BMS/5.01
Statutory Notifications	BMS/5.03
Business Continuity Plans	BMS/5.04
Operations and Environmental Management (all versions)	BMS/6.01
Serious Incident Report	F5.02.01
Site Visit Record	F1.03.02
Accident / Incident Statement	F5.01.03
Shared Learning	F5.01.09

NHS Serious Incident Framework
NHS Improvements – Never Event List 2018

3. Introduction

3.1 To define the process for the management, investigation, reporting and review of Serious Untoward Incidents (SUI).

3.2 To define the responsibilities of personnel for the management, investigation, reporting and review of Serious Untoward Incidents (SUI).

3.3 This procedure covers the process of responding to and investigating Serious Untoward Incidents (SUI). Guidance is provided on every stage in the Serious Untoward Incident management process, with the provision of detailed supplementary advice on incident investigation techniques.

3.4 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.5 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

3.6 The NHS Serious Incident Framework will be replaced by the Patient Safety Response Framework (PSIRF), which is due to be rolled out by Autumn 2021.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing ERS Medical's Quality, Environmental, Safety & Health, Business Continuity, Information Security and HR policies. Additionally, responsible for approving all press and social media statements prior to release.
5.2	**Head of Care Standards**	Hold ultimate responsibility for ensuring the investigation is completed and for informing all relevant senior Company personnel.
5.3	**Legal Council**	Provides legal advice to the SUIIT at all stages of the investigation.
5.4	**Regional and Operations Managers**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.5	**Serious Untoward Incident Investigations Team (SUIIT)**	Are appointed by ERS Medical to undertake the investigation on behalf of the Head of Care Standards.
5.6	**Health and Safety / Care Quality / Fleet Compliance Teams**	Provide support to the SUIIT by undertaking investigations within their specialist areas.
5.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **Serious Untoward Incident (SUI)** – A SUI in health care is an event, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that heightened levels of response are justified.

SUI's includes acts and omissions in care that result in:

- Unexpected Death;
- Unexpected or avoidable injury resulting in serious harm, including those where an injury required treatment to prevent death or serious harm;
- Abuse;
- Never Events.

These can be further defined within the NHS to include:

- Acts and/or omissions as part of NHS-funded healthcare, that result in:
  - Unexpected or avoidable death of one or more people. This includes:
    - Suicide;
    - Self-inflicted death;
    - Homicide by a person in receipt of mental health care within the recent past.
  - Unexpected or avoidable injury to one of more people that resulted in serious harm;
  - Unexpected or avoidable injury to one of more people that requires further treatment by a healthcare professional in order to prevent:
    - The death of the service user;
    - Serious harm.
  - Actual or alleged abuse, sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern-day slavery where:
    - Healthcare did not take appropriate action / intervention to safeguard against such abuse occurring;
    - Where abuse occurred during the provision of NHS-funded care.

    This includes abuse that resulted in (or was identified through) a Serious Case Review (SAR). Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused / contributed towards the incident.
- A Never Event (see 6.5 of this section) – All Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm to death.

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- An incident (or series of incidents) that prevents, or threatens to prevent an organisations ability to continue to deliver acceptable quality of healthcare services, including but not limited to the following:
  - Failures in security, integrity, accuracy or availability of information often described as Data Loss and/or Information Governance related issues;
  - Property damage;
  - Security breach/concern;
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS) - (Liberty Protection Safeguards LPS as of April 2020);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or a series of incidents, which necessitate ward/unit closure or suspension of services);
  - Activation of Serious Untoward Incident Plan (BC / EPRR) (by provider, commissioner or relevant agency).

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

6.2 **Legal Representative** – For the purposes of enacting professional legal privilege, a legal representative must be a formally qualified professional legal adviser. In England, Wales, Northern Ireland and the Republic of Ireland this is either a Solicitor or Barrister. In Scotland this is either a Solicitor or Advocate.

6.3 **Strategic Executive Information System (STIES)** – National reporting tool used for the reporting of SUI's to commissioners of NHS funded work.

6.4 **Root Cause Analysis (RCA)** – The systematic approach to identify the primary and contributory factors which lead to incidents and from which learning can be identified, taken and shared.

6.5 **Never Events** – Are events that meet the below criteria:

- Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic barriers are available at a national level and have been implemented by healthcare providers;
- An event has the potential to cause serious patient /service user harm or death. However, serious harm to death does not need to have happened as a result of a specific incident for the incident to be categorised as a Never Event;
- For each type of Never Event, there is evidence that Never Event has occurred in the past – for example, through reports to the National Reporting and Learning System (NRLS) - and the risk or recurrence remains;
- Each Never Event type must be clearly defined, and its occurrence easily recognised.

A full list of Never Events can be found in the NHS Improvements publication 'Never Events List 2018'. This is available on the BMS.

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7. Process Overview

7.1 The procedure covers, in approximate chronological order, the following stages of the incident management process:

- Declaring a Radar event as a SUI;
- Convening a Serious Untoward Incident investigation team (SUIIT);
- Attending the incident / securing and controlling the scene;
- Commencing and undertaking the investigation;
- Recording of information and report writing, this includes notifications to CCG's, if applicable using STEIS (initial report to be submitted within 2 working days);
- Incident review and recommendations.

7.2 The procedure also provides detailed supplementary advice on other important aspects of the Serious Untoward Incident investigation process. An overview of subjects covered is as follows:

- Terms of reference and remit for the Serious Untoward Incident investigation team (SUIIT);
- Legal considerations including implementation of legal privilege;
- Interviewing personnel;
- Managing emergency services and regulatory agencies;
- Managing the customer relationship;
- Managing the media and the general public;
- Evidence gathering;
- Report format and headings.

8. SUI Notification and Declaration

Internal

8.1 Immediately after an incident has occurred or has been identified, it is the responsibility of the first line manager involved with the incident to make an assessment as to the level of significance of the incident.

8.2 Incidents that are identified as serious or significant must be reported immediately by telephone to the either the Head of Care Standards or the Care Standards Manager.

8.3 Immediately in this context means as soon as it is safe and practicable to do so, in most circumstances this will be within minutes of the incident occurring or having been identified.

8.4 The Head of Care Standards and or Care Standards Manager will discuss the incident with the reporting person to determine the initial facts of the matter and will then make a judgement as to whether to declare a Serious Untoward Incident.

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8.5 In the event that a decision is made to declare a Serious Untoward Incident, the following process should be followed:

- The Head of Care Standards and or Care Standards Manager will make contact with the Managing Director informing him/her that the incident has occurred. The Managing Director will then decide if the legal council should be brought in;
- Consideration must be given to the potential legal ramifications of the incident – refer to section 9 of this procedure.
- The Head of Care Standards and or Care Standards Manager must make a decision on whether immediate attendance at the site where the incident occurred is necessary – refer to section 10 of this procedure.
- Members of the Serious Untoward Incident Investigation Team (SUIIT) must be identified and notified – refer to section 10 of this procedure.
- Consideration must be given to the requirement to notify any regulatory agencies (as required by site permits / licences or legislation) – refer to section 13 of this procedure.

8.6 Once the decision to declare a Serious Untoward Incident has been taken the following team members must be notified immediately by the most appropriate means (phone, text email) by the Head of Care Standards and or Care Standards Manager:

- Senior Leadership Team;
- Human Resources Provider.

8.7 After declaration of a Serious Untoward Incident it will be the responsibility of the Head of Care Standards and or Care Standards Manager to ensure that the incident is reported into the online incident reporting system.

External (Contract Specific)

8.8 In certain geographical and contractual areas, such as but not limited to Norfolk, ERS Medical has an additional reporting requirement.

8.9 Where an on the Radar system incident has been categorised as a SUI and meets the requirements of SUI or Never Event as defined by the NHS, it must also be reported to commissioners of the service affected by the incident.

8.10 This reporting is achieved by initially telephoning the relevant CCG manager responsible for the contract and or quality and providing them with as much as reasonably practicable a verbal briefing on the incident and what is known at the time.

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8.11 In addition to the incident must be recorded on STEIS. Specific login details for this can be obtained from the Head of Care Standards and or The Care Standards Manager. The web address for STEIS is:

https://steis.improvement.nhs.uk/

8.12 Once this has been recorded on STEIS (2 working days) a condensed Initial Report need to be submitted within 3 working days. This should be sent direct to the relevant department of the CCG o CSU. In the case of the Norfolk contract this should be to:

agemcsu.sui@nhs.net

8.13 This report should be generated from Radar as much as possible and should be redacted of all PI, prior to sending. It should also include the STEIS reference so that it can be easily matched with the report within STEIS.

8.14 For more specific requirements of submitting reports please refer to Section 22 of this procedure.

9. Legal Considerations

9.1 All Serious Untoward Incidents (SUI) have potentially serious legal implications for the Company, the individuals, and any other organisations involved.

9.2 At the earliest opportunity after declaration of a Serious Untoward Incident, the legal implications of the incident should be given due consideration.

9.3 Legal considerations are likely to be discussed, in the first instance, between the lead H&S Manager, the Head of Care Standards and the Legal Counsel.

9.4 During such discussions a decision will be made on the following key issues:

- Whether to enact legal privilege for matters pertaining to the incident.
- Whether to engage external legal counsel regarding the incident.

9.5 The purpose of legal privilege is to facilitate confidential communication between a professional legal representative (a solicitor or barrister) and their client, for the purposes of receiving legal advice. Communications made under legal privilege cannot be disclosed to a court of law without the permission of the client.

9.6 Legal privilege can be enacted between the client and any professional legal representative, so it is possible to enact this for communications between the Company and an external legal representative, and between the Company and its legal representative.

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9.7 If legal privilege is to be enacted between the Company and an external legal representative, the following process should be followed:

- The H&S Manager shall make contact, by telephone, with the nominated solicitor to notify them of the incident.
- The H&S Manager shall send an email to the nominated solicitor, providing the basic facts of the incident as understood at the time of writing.
- The email must also request that the nominated solicitor is engaged to represent the Company in legal matters relating to the incident.
- This email must contain the words 'Legally Privileged' in the subject heading.
- This email must be copied to the Head of Care Standards but to no other persons.

9.8 A template form of words for the email notification to the legal representative is provided in the following table:

Subject:	LEGALLY PRIVILEGED – engagement to represent – <Incident Reference>
Content:	Dear <Solicitor Name>, Please accept this email as confirmation that Stericycle UK and Ireland wish to engage <Law Firm Name> to provide legal representation for the Company in matters relating to the following incident. <Short paragraph providing basic facts of the incident.> I will be in contact to provide further information and to seek legal advice in due course. Yours sincerely, <H&S Manager Name>

9.9 The nominated solicitor chosen to represent the Company will be determined through discussions between the H&S Manager, the Head of Care Standards and the Legal Counsel.

9.10 If legal privilege is to be enacted between the Company and its in legal representative, the following process should be followed:

- The H&S Manager shall send an email to the Legal Counsel, providing the basic facts of the incident as understood at the time of writing.
- This email must contain the words 'Legally Privileged' in the subject heading.
- This email must be copied to the Head of Care Standards but to no other persons.

9.11 In the event that legal privilege has been enacted a secure electronic storage location must be set up for storage of all records related to the incident that may be communicated to the legal representatives for the purposes of obtaining legal advice.

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10. Investigation Team and Terms of Reference

Convening the Serious Untoward Incident Investigation Team

10.1 After declaration of a Serious Untoward Incident the H&S Manager, with support from the Head of Care Standards, will determine the following:

- The persons comprising the Serious Untoward Incident Investigation Team (SUIIT).
- Which members of the SUIIT should attend the location, and when.

10.2 The SUIIT should comprise at least one members of the H&S Team and one member of the Care Quality Team.

10.3 The SUIIT should, where practicable include support managers who are not responsible for the site or activity to which the incident relates.

10.4 The following table provides examples of possible SUIIT configurations for a range of potential incidents:

Type of Serious Untoward Incident	Serious Untoward Incident Investigation Team
Site employee involved in an accident resulting in a potentially life changing injury	Care Standards Manager Health and Safety Advisor Care Quality Advisor
Road traffic accident resulting in potential loss or escape of dangerous goods and over £50,000 damage, but no injury to persons	Care Standards Manager Health and Safety Advisor Fleet Compliance member
Significant loss of patient personal data resulting in potential for injury to individuals, adverse media coverage and financial penalties	Head of Care Standards H&S Manager
Major fire at a waste management facility, potential impacts as yet unknown	Care Standards Manager Health and Safety Advisor
Report of a patient having been incorrectly treated in a Company ambulance, resulting in an extended stay in hospital (over 28 days)	Head of Care Standards / Care Standards Manager Care Quality Advisor Health and Safety Advisor Operations Manager

Attending the Scene

10.5 When determining when to attend the incident, the following factors should be taken into consideration:

- Is the incident on-going? (for example a fire);
- If the incident is on-going will immediate attendance hamper the incident response? (i.e. may obstruct or impede the work of the emergency services);

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- If the incident is on-going will immediate attendance assist the incident response? (i.e. may be able to provide valuable information to the emergency services);
- If the incident has concluded, does the scene need to be controlled? (i.e. might viewing the scene as it happened be valuable to the investigation or may evidence need to be protected).

10.6 If the incident is on-going, and immediate attendance will not hamper or may assist the incident response, the incident should be attended as soon as is reasonably practicable.

10.7 If the incident is on-going, and immediate attendance may hamper the incident response, the H&S Manager should wait until the incident has concluded, and then re-assess the situation.

10.8 If the incident has concluded and the scene needs to be controlled, the incident should be attended without delay.

10.9 If the incident has concluded and the scene does not need to be controlled, the SUIIT should convene without delay, either at a physical location or by telephone. The SUIIT will then assess the requirement to attend the scene.

10.10 In the event that the Serious Untoward Incident is declared with a significant time delay after the event (for example the report of an injury to a patient previously in the Company's care, reported some days after the initial event), attendance at the incident shall be taken to mean the convening of the SUIIT, either at a physical location or by telephone. This should happen as is reasonably practicable.

10.11 In the event that the Serious Untoward Incident does not relate to a physical location (for example the report of a loss of data), attendance at the incident shall be taken to mean the convening of the SUIIT, either at a physical location or by telephone. This should happen without delay.

Who Should Attend

10.12 When the scene must be attended without delay, the nearest available H&S team member (on the SUIIT) should be nominated to attend.

10.13 In the event that none of the H&S team members on the SUIIT are available to attend without delay (either due to other work or outside work commitments, or due to geographical location), another member of the H&S team may be nominated to attend without delay.

10.14 In the circumstances specified in 10.15, the stand-in member should act as a member of the SUIIT until such time as the full member can replace them.

10.15 All members of the SUIIT should make arrangements to convene as soon as possible after the incident, at the Company location where the incident occurred.

10.16 In the event that the incident does not relate to a physical location the SUIIT should convene at any Company location or via teleconference.

10.17 In the event that the incident occurred away from a Company location, the SUIIT should convene at the Company location which is the operating base for the persons involved in the incident.

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Terms of Reference

10.18 The SUIIT shall conduct the investigation in accordance with the following terms of reference:

Purpose of the SUIIT
• Support the immediate response to on-going Serious Untoward Incidents (SUI) through the provision of H&S support and advice. • Conduct investigations to establish the facts pertaining to Serious Untoward Incidents (SUI). • Establish the root cause of and contributory factors to Serious Untoward Incidents (SUI). • Make recommendations for actions and improvements designed to prevent a recurrence and to secure legal compliance. • Create and issue Serious Untoward Incident investigation reports.
Remit of the SUIIT
• The Company invests the SUIIT with the authority to undertake any activities it deems necessary to facilitate a thorough investigation • This includes, but is not limited to: o Taking of witness statements from Company employees. o Interviewing of Company employees (of which an audio record may be made subject to agreement by the participants). o Recording of evidence through note-taking and taking of photographs. o Removal and retention, when appropriate, of any Company property (including online or intellectual property such as emails). o Commissioning of third-party organisations to assist in the investigation (e.g. forensic fire investigators). o Liaison with and gathering of information from other stakeholders (e.g. employees of contractors, equipment suppliers). • Such activities should be limited to those deemed necessary to establish the facts pertaining to the incident and ultimately the root cause. • In the event of a disagreement regarding the remit of the SUIIT (e.g. a refusal to co-operate with an interview, or refusal to hand over relevant Company property), the SUIIT should alert the Head of Care Standards and the Legal Counsel to the situation. The Head of Care Standards and/or the Legal Counsel will determine whether or not the request or proposed activities are within the remit of the SUIIT and will advise all relevant parties of their decision.
Functioning of the SUIIT
• The SUIIT members for an incident will be determined as soon as possible after declaration of the Serious Untoward Incident, in accordance with steps 9.1 – 9.6 of this procedure. • The H&S Manager with lead responsibility for the incident will lead the SUIIT. • The SUIIT lead shall be responsible for convening and co-ordinating the work of the SUIIT. • The SUIIT members shall be responsible for undertaking the work of the SUIIT. • The SUIIT lead shall be responsible for liaison with the Head of Care Standards and the Legal Counsel regarding legal considerations. • The SUIIT lead shall be responsible for drafting the Serious Untoward Incident investigation report (see section 16 of this procedure). • The SUIIT members shall review the draft reports prior to issue at each stage of the investigation process (see section 16 of this procedure).

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- The SUIIT shall be disbanded only after issue of the final Serious Untoward Incident investigation report.

Team Roles

10.19 When convening the SUIIT, attending the scene and commencing the investigation it is important to consider allocation of roles to members of the SUIIT and other employees who may be in attendance.

10.20 Team roles should be allocated by the SUIIT lead on the basis of experience, qualifications and suitability for the role. The SUIIT lead should consider the resources at his disposal and allocate activities to the team accordingly.

10.21 In allocating team roles, the SUIIT lead's primary focus is in ensuring the incident can be successfully investigated, however the SUIIT lead must also consider the needs of the individuals involved, particularly in the case of incidents that have resulted in harm or injury (including both physical and mental trauma) to individuals.

10.22 In the case of incidents involving harm or injury to individuals the SUIIT lead must therefore consider the welfare of the individuals involved. Whenever possible a member of the SUIIT or another appropriate person should be assigned the task of providing support to those individuals.

11. Securing and Controlling the Scene

11.1 Depending on the size and scale of the incident, several members of the SUIIT may be required to conduct interviews; however, where possible this task should be given to one member of the team to encourage consistency throughout the process.

11.2 The nature of the incident will have a significant bearing on the extent of the incident scene and the actions and resources required controlling it.

Type of Incident	Potential Control Requirements
Environmental	• Potential for emissions in the environment • Fire or risk of explosion • Unstable buildings
Health and Safety (Injury)	• Injured individuals – Crowd control, prevent further injury • Faulty equipment – secure equipment where possible • Accident site – secure site to preserve evidence • Loss of life

Transport	• Injured individuals – Crowd control, prevent further injury • Accident site – secure site to preserve evidence • Traffic and vehicles management – controlling the scene, traffic and access • Loss of life
Data Security	• Quarantine of equipment that may have been infected by a virus or may have been used contrary to • Suspension of access rights • Denial of service

11.3 Should medical aid be necessary, this should always be provided in the first instance. Once this has been done or if this stage has not been necessary, the immediate focus will be on securing and controlling the scene of the incident.

11.4 In the event that emergency services have been asked to attend the scene, they should take precedence and all SUIIT members should take their guidance from the Commanding Officer.

11.5 There are three key elements of incident containment:

- Controlling the scene;
- Limiting the impact;
- Preserving evidence.

Controlling the Scene

11.6 Ensure that the scene has been appropriately cordoned off to prevent any further risk. This may involve an inner cordon to which emergency services and other experts may have access and an outer cordon to ensure the safety of any bystanders or crowds that have gathered.

11.7 Some scenes may have significant control areas e.g. chemical spills or fires, whereas there may be no physical control areas for some incidents e.g. virus infection of Company devices.

11.8 Crowds may be attracted to Serious Untoward Incidents (SUI), especially those involving a visual impact. Whilst it is important to control the crowd, it must be considered that members of the crowd could be valuable eye witnesses.

11.9 Whilst the incident area is being cordoned off, bystanders should be informed that if they have any information to share they should make themselves known and wait until they can be interviewed.

11.10 Certain types of incident such as a fire, bomb or fatality have the potential to cause panic if not controlled properly. Any communications regarding the incident should, where possible be properly considered and approved by the SUIIT. For media communications see section 17 of this procedure.

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Limiting the Impact

11.11 Actions taken to limit the impact of any incident will rely heavily on expertise of those attending the incident.

11.12 If a fatality or serious injury has occurred, or the scene has been deemed to be hazardous, authorisation from the appropriate authority must be granted before the incident scene can be entered.

11.13 Ensure that any equipment that may have the ability to cause further damage or injury is turned off where possible or power is stopped at the incident site if it presents a risk. Additionally, all utilities should be shut off where necessary.

Preserving Evidence

11.14 All individuals attending the scene must be warned not to disturb evidence that may be found at the scene unless not doing so may result in further injury or unnecessary damage.

11.15 Photographs should be taken as soon as possible to be able to view the incident before any outside involvement has occurred.

11.16 Evidence may need to be covered or isolated to be protected from the elements.

11.17 Areas may need to be cordoned off or locked down.

11.18 Equipment or personal belonging may be taken from witnesses or individuals involved in the incident as evidence.

11.19 All electronic records relating to or with the potential to relate to the incident must be retained in a secure location. If the incident is subject to legal privilege the secure location must be a folder in the H&S secure SharePoint file location (see section 9 of this procedure).

12. Managing Emergency Services

12.1 In the event that an incident is on-going, and the emergency services are in attendance, all Company employees in attendance should defer to their authority.

12.2 Depending on the type of incident, any combination of the following services may be involved:

- Police ;
- Ambulance Service;
- Fire and Rescue Service;
- Others (for example the army may attend an incident involving explosive materials).

12.3 In the event that the emergency services have secured the scene and restricted access, no attempt should be made to access the restricted area without the express permission of the emergency services.

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12.4 On arrival at a scene controlled by the emergency services, the first H&S team member to attend should make themselves known to the person commanding the response, in most circumstances this is likely to be the police or fire officer nominated as the Commanding Officer.

12.5 The H&S team member, (this should be the SUIIT Lead if they are present) should provide the Commanding Officer with their contact details and confirm that they are leading the investigation on behalf of the Company. The contact details of the Commanding Officer should be obtained.

12.6 When the situation allows the SUIIT Lead should seek to obtain the basic facts of the incident from the Commanding Officer.

12.7 The SUIIT Lead should seek confirmation from the Commanding Officer as to whether any injuries have been sustained to any persons, and if so any information that is available as to the number of people involved, who they are, their relationship to the incident and the extent of their injuries.

12.8 In the event that Company employees have been injured and transferred to hospital, the SUIIT should nominate an appropriate person to attend the hospital to provide welfare support to the employee and to ascertain the severity of their injuries.

12.9 The SUIIT Lead should seek confirmation from the Commanding Officer as to whether any other regulatory agencies have been notified of the incident.

12.10 When the incident has occurred on Company property and has been controlled by the Fire and Rescue Service (for example a fire or chemical spill), the Fire and Rescue Service will formally return control of the premises to the Company after conclusion of the incident. This will be provided in written format, may make specific recommendations and will require review and signature by a Company representative. The SUIIT lead should be engaged with this process and should retain records.

12.11 The Emergency Services may be able to provide written reports of their response to the incident, and any investigations that have been undertaken. Such reports should be requested, when appropriate before the service has departed the scene, or by making contact with the Commanding Officer at a later date.

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13. Managing Regulatory Agencies

13.1 All Serious Untoward Incidents (SUI) are likely to have an actual or potential impact that may be of material interest to a regulatory agency in their area of responsibility.

13.2 The following table provides a reference guide to the regulatory agencies most likely to be involved in the response to, and investigation of, a Serious Untoward Incident. Please note that the table is not fully comprehensive and other agencies may be involved.

Type of Incident / Potential Impact	Regulatory Agencies
Environmental Any incident with an actual or potential environmental impact (fire, spill, emission etc). Any incident at a permitted waste management facility	Environment Agency – England Scottish Environmental Protection Agency (SEPA) – Scotland Northern Ireland Environment Agency (NIEA) – Northern Ireland Natural Resources Wales (NRW) – Wales Environmental Protection Agency (EPA) – Republic of Ireland
Health and Safety (including Transport) Any incident involving a serious injury or fatality Any incident involving a dangerous occurrence with the potential to cause serious injury or fatality Any incident involving the carriage of dangerous goods with the potential to cause serious injury or fatality	Health and Safety Executive (HSE) – England, Wales & Scotland Health and Safety Executive for Northern Ireland (HSENI) – Northern Ireland Health and Safety Authority (HSA) – Republic of Ireland
Care Provision Any incident involving a serious injury or fatality to a person under the care of the Company	Care Quality Commission (CQC) – England Healthcare Improvement Scotland (HIS) – Scotland Healthcare Inspectorate Wales (HIW) – Wales The Regulation and Quality Improvement Authority (RQIA) – Northern Ireland Health Services Executive (HSE) – Republic of Ireland
Information Governance Any incident involving the loss of personal information	Information Commissioner's Office (ICO) – all United Kingdom countries Data Protection Commissioner (DPC) – Republic of Ireland

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Notification

13.3 At the earliest opportunity in the response and investigation process the SUIIT must give consideration to the requirements of interested regulatory agencies. The following factors must be considered:

- Which, if any regulatory agencies may need to be involved in the response to, and investigation of the incident?
- Who is responsible for notifying the relevant agencies that the incident has occurred?
- Is there are any specific legal or other requirement to notify any agencies that the incident has occurred?
- If yes, is the timeframe in which the notification must be made, and the method of notification specified?
- Has any other party already notified any agencies that the incident has occurred?
- Will the relevant agencies wish to attend the scene of the incident?
- If yes, will they attend while the incident is still on-going, in the immediate aftermath or at a later date (unannounced or subject to prior arrangement)?

13.4 After it has been determined which regulatory agencies need to be involved and the required method and timeframe for notification have been confirmed, the relevant notifications should be made at the earliest opportunity.

13.5 Guidance on notification of reportable incidents to the Health and Safety, Care and Information regulators is provided in **BMS/5.01 – Incident Reporting and Investigation**.

13.6 After the notifications have been made to the relevant agencies, the SUIIT should seek to verify the contact details for the agency representatives responsible for the incident. Provided that the necessary notifications have been made it is acceptable to await contact from the agency, however dependent on the circumstances of the incident it may be prudent to initiate contact with any regulatory officers known to have responsibility for a site or activity (for example the site officer for a permitted waste facility).

13.7 In the event that an agency representative confirms their intention to attend an incident while it is on-going or in the immediate aftermath, every effort should be made to accommodate their visit, provided that their activities do not in any way impede the response to the incident.

13.8 When agency representatives attend the scene, the SUIIT should seek to confirm the status, nature and purpose of their visit. They may wish to attend the scene for either one or both of the following reasons:

- Are they attending to assist in the on-going response to the incident? (i.e. to offer advice or guidance to the Company or emergency services in their area of expertise)
- Are they attending to commence an investigation into the incident?

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Incident Attendance for Advice / Guidance

13.9 In the event that any legal statements are made, notices served, or intentions to serve notices stated, the SUIIT should seek advice from the Head of Care Standards and/or the Legal Counsel before the visit proceeds further. The making of any such statements would not be normal practice during a visit to offer advice or guidance and should be interpreted as meaning that the purpose of the visit has changed and an investigation may be under way.

13.10 Prior to the departure from the scene of the agency representatives, the SUIIT should seek to confirm the findings of their visit and their proposed next steps. Written confirmation should be requested as a follow-up to the visit.

13.11 When a regulatory agency requests to meet with the Company regarding an incident at a time after the incident and its immediate aftermath have concluded (i.e. more than 2 working days after the incident has concluded), a suitable location (at the scene or otherwise) and time should be agreed.

13.12 In such circumstances the matters stated in steps 13.9 – 13.12 are still relevant and should be given due consideration, but the pre-planned nature of the meeting should enable forward preparation and attendance of all relevant persons.

Incident Attendance to Commence an Investigation

13.13 In some circumstances the relevant regulatory agencies may have the legal power to commence an investigation and, subject to liaison where appropriate with the emergency services, to access the scene and to gather evidence. In the event that the SUIIT is unsure as to the powers of the regulatory agency, the SUIIT should seek advice from the Head of Care Standards and/or the Legal Counsel before the visit proceeds further.

13.14 In the event that any legal statements are made, notices served, or intentions to serve notices stated, the SUIIT should seek advice from the Head of Care Standards and/or the Legal Counsel before the visit proceeds further.

13.15 Prior to the departure from the scene of the agency representatives, the SUIIT should seek to confirm the findings of their visit and their proposed next steps. Written confirmation should be requested as a follow-up to the visit.

13.16 When a regulatory agency requests to meet with the Company regarding an incident at a time after the incident and its immediate aftermath have concluded (i.e. more than 2 working days after the incident has concluded), a suitable location (at the scene or otherwise) and time should be agreed.

13.17 In such circumstances the matters stated in steps 13.14 – 13.17 are still relevant and should be given due consideration, but the pre-planned nature of the meeting should enable forward preparation and attendance of all relevant persons.

14. Managing the Customer Relationship

14.1 The SUIIT must determine if necessary at which stage during the incident, customer involvement may be required.

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14.2 If the incident has occurred on ERS Medical property and effects ERS Medical personnel and will not have any business continuity implications, it may be determined that there is no requirement for customer involvement.

14.3 However, the incident has occurred on customer property, affects an individual outwith Company personnel whilst carrying out services for a customer e.g. a hospital transport booking, or involves waste produced by a customer then the customer should be contacted at the earliest opportunity. This is to ensure that the customer has the information first hand and the ERS Medcial can control the manner that the information is released.

14.4 It may be necessary on occasions to work with a customer when there is an instance of an incident at a customer premises, or when the incident relates to customer data or items belonging to that customer. At such time, the customer must be contacted without due delay.

14.5 Where customer contact is required, the SUIIT must establish the most appropriate method of contact. Where possible this should be through the appropriate customer contact e.g. Account Manager or Project Sponsor. Working with this named person the SUIIT should draft/agree communication to go to the customer with approval from the Legal Counsel and the Director of Operations and ERS Medical Managing Director.

14.6 Attempts should be made to agree a communication plan with the customer where necessary. For example, it may be decided to provide the customer with progress updates at agreed intervals throughout the incident timeline. The SUIIT should be careful that this communication plan is realistic and does not inhibit any investigatory activity. It should not be excessive; nor should updates be kept from the customer for significant periods of time without due cause.

14.7 Where possible, communications should be done in letter or email form to allow for an audit trail of the communication. Any communications should be held within the incident report and kept as evidence.

14.8 The following table provides guidance on the probably relevant customer contact depending on the type of incident.

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Type of Incident / Potential Impact	Suggested Customer Contact
Environmental or Transport where property, premises or waste belongs to a customer	• Nominated customer contact.
Health and Safety (involving transport of a patient)	• Clinical lead. • Head of Care. • Trust project sponsor.
Information Security	• Trust Information Governance Lead. • Trust Caldicott Guardian. • Trust project sponsor.

15. Managing the Media and the General Public

15.1 During the course of a Serious Untoward Incident, it is normal for a crowd to gather or for media to attend the scene. However, lack of suitable control over this may result in panic.

15.2 As per 11.17-11.18, the incident scene should be physically cordoned off where this is necessary, and crowds controlled in a calm and safe manner.

15.3 It may be necessary to provide shelter or a communication station for members of the public if the secure area is particularly large or the incident is wide reaching. If this is necessary the SUIIT should secure a safe area for members of the public can await interview, remain in a safe place or await transport or medical attention.

15.4 It may also be necessary to provide updates and information to the public in instances where family members may be involved in an on-going incident. In such cases, the SUIIT should liaise with the Director of Operations to establish the most appropriate method of communication. Care must be taken to communicate only the information necessary and to reduce any panic or further harm which may be cause by ineffective communication.

15.5 Where there is a requirement to manage any media attention the SUIIT must liaise with the Director of Operations and the Commercial Team to draft an appropriate communication.

15.6 At no time should any member of staff, SUIIT or otherwise liaise with the media without prior consent. All communication should, where possible be approved by the Head of Marketing and Legal Counsel prior to release.

15.7 In the event that media representatives or members of the public request additional information they should be asked to send their queries via email to the Director of Operation.

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15.8 It is critical to remember that sensitivity issues must be considered during any investigation. Maintaining confidentiality must form part of any communication considerations. It may be the case that some of the information regarding the incident may be commercially sensitive or may involve legal privilege. Similarly, it may be sensitive from a regulatory perspective. Communications must always be sensitive to any information which may cause undue harm or embarrassment to the Company, its customers or any individual to which the information refers.

15.9 Confidentiality considerations should always take second place to the safety of staff and resolving the immediate impacts of the incident, however care must be taken to ensure that no information is shared that could potentially result in a negative impact at any later stage.

15.10 Further guidance on the release of information and communication in general is provided in **BMS/1.06 – Communication** and **BMS/1.08 – Media Interactions**.

16. Commencing the Investigation

16.1 After the immediate response to the incident has concluded the SUIIT should commence the investigation into the incident.

16.2 The purpose of the investigation is to establish the facts pertaining to the incident. The SUIIT must focus solely on establishing the facts and should not allow attention to be diverted away from this onto other matters. Care should be taken to avoid drawing premature conclusions as to the root cause of or contributory factors to the incident.

16.3 In obtaining the facts the SUIIT must take care to ensure that the investigation techniques are objective and not subjective.

16.4 It is recommended that the investigation should be commenced by means of a meeting of the SUIIT, either at the scene in the immediate aftermath of the incident or at an agreed location or by teleconference after the event.

16.5 The SUIIT lead should chair the meeting and should take notes to record agreed actions. An outline programme of investigatory work should be defined, with tasks being allocated to SUIIT members in accordance with their specialisms.

16.6 Only the members of the SUIIT should be in attendance at this meeting. If necessary steps should be taken to ensure others are not present, in particular where they may become the subject of the investigation. Follow-up meetings with other relevant personnel should be arranged to take place after the SUIIT planning meeting.

16.7 The meeting should be concluded by agreeing timescales for completion of the initial packages of work, and a time and date for the next SUIIT meeting.

16.8 Depending on the specific circumstances of the incident the frequency of meeting may be anything from hourly through daily to weekly. The SUIIT Lead must assess the situation and determine what is appropriate.

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16.9 In undertaking the investigatory work, SUIIT members may use a range of techniques including, but not limited to:

- Investigation techniques (see section 17 for guidance)
- Taking of witness statements from Company employees (see section 18 for guidance)
- Interviewing of Company employees (see section 20 for guidance);
- Recording of evidence through note-taking and taking of photographs (see section 19 for guidance);
- Removal and retention, when appropriate, of any Company property (see section 19 for guidance);
- Commissioning of third party organisations to assist in the investigation (e.g. forensic fire investigators, see section 21);
- Liaison with and gathering of information from other stakeholders (e.g. employees of contractors, equipment suppliers).

16.10 All records created during the investigation should be made using the appropriate BMS form if one is available for the specific purpose (for example **F5.01.03** for recording witness statements). Where no specific form is available notes and general incident commentary should be recorded using the site visit record form (**F1.03.02**).

16.11 The SUIIT should continue to convene regularly until such time as the incident investigation has been concluded. The conclusion of the investigation is considered to be the submission of the final investigation report.

17. Investigation Techniques

17.1 The purpose of the Serious Untoward Incident investigation is to establish the root and contributory causes of the incident.

17.2 A range of investigation techniques should be used in the course of the investigation, including the following:

- The taking of witness statements;
- Note taking from informal discussions and observations;
- Physical and visual review of the scene and equipment, including photography;
- Interviewing of personnel;
- Analysis of equipment and samples.

17.3 All investigatory techniques and subsequent analysis of the facts should maintain a focus on the purpose of the investigation. Investigation teams are encouraged to use the 'Five Why's' approach to assist with this.

17.4 The 'Five Why's' technique is an iterative process for establishing the causes and root causes of any event. The basic principle is that asking five 'Why?' questions following on from one another will ultimately determine the root cause.

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17.5 An example of this is provided in the following table:

Five Why's in Practice – An Example	
1. Why was the worker's finger crushed?	*The workers finger was caught between a moving pulley and belt.*
2. Why was the finger caught between the pulley and the belt?	*The guard on the pulley was missing.*
3. Why was the guard missing?	*A mechanic had forgotten to replace it after performing maintenance.*
4. Why was it overlooked?	*There is no written maintenance schedule for the equipment.*
5. Why is there no maintenance schedule?	*The maintenance procedure has not been effectively implemented at the facility by site management.*

17.6 In practice it may take more than 'five why's' to reach the root cause, investigators should keep questioning until they are confident it has been reached.

18. Witness Statements

18.1 Witness statements should be obtained from all employees involved in the incident or the response to the incident as soon as it is reasonably practicable to do so. In most circumstances this will be immediately after the incident has been concluded and the person involved is no longer dealing with the immediate response.

18.2 Whenever possible witness statements should be recorded on **F5.01.03 - Accident / Incident Statement** form. Where these forms are not available, the statements must be written on any available paper and transcribed as soon as reasonably possible without making any change to the content. In such circumstances the original versions must be retained.

18.3 The SUIIT should seek to ensure that witnesses write their statements independently and without prior collaboration with other witnesses. If at all possible a room or area should be designated for individuals to write their witness statements away from distractions or the influence of others.

18.4 Witnesses should be encouraged to record their version of events in accordance with the following key questions:

- What happened?
- What time was it?
- What did you see?
- How were you involved?
- Who else was involved?
- Who else saw it?
- When did you realise something was wrong?
- Where were you at the time?
- Where was the injured person?
- What treatment was received?
- Where exactly on the body did the injury occur?

- Where exactly did the incident occur?

19. Recording of Information and Gathering of Evidence

19.1 SUIIT members should take detailed contemporaneous notes of all investigatory activities undertaken. Detailed in this context is taken to mean as comprehensive as the circumstances of the incident allow, and contemporaneous means that the notes should be recorded at the time whenever possible, and only from memory as soon as possible after the event when absolutely necessary.

19.2 It is recommended that notes are recorded in chronological order to assist in later interpretation through provision of a narrative of events.

19.3 Handwritten notes should be transcribed onto a site visit record (**F1.03.02**) at the earliest opportunity after the event. Notes should be transcribed as originally written and not amended.

19.4 It is important that notes are taken and evidence gathered as soon as reasonably possible. This reduces the risk of information or evidence being corrupted, moved or destroyed.

19.5 The amount of time given to recording information and gathering evidence should be proportionate to the level of investigation.

19.6 Photographs should be taken when possible and should be taken from all available angles and vantage points in order to gather as much information as necessary.

19.7 It should always be remembered that the direct/initial cause of the incident may not always be the root cause, therefore it is important not to discount any evidence or information from the records as it may be of use at a later stage within the investigation.

19.8 Listed below are some suggestions of evidence or information that should be gathered following an incident:

- Gather detailed information from eye witnesses or those involved in the incident
- Seek information on events immediately before the incident occurred. Where were people standing? What equipment was running? Did anything unusual happen?
- Observe the site – was any equipment involved? Record make and model numbers and take pictures of any equipment that may be involved with the incident? Has anything been changed recently? Equipment moved?
- What safe working procedures were in place and were they being followed at the time of the incident?
- Gather records of any relevant procedures or work instructions pertinent to the incident.
- Take full notes of any injuries or ill effects caused by the incident. This may not always be physical, nor present at the time of the incident. Therefore any potential injury or damage should also be noted.
- Capture information on any previous occurrences of a similar incident and establish if there were any known risks surrounding the circumstances. If risks were present, had they been treated?

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- Capture information regarding the any maintenance implications e.g. were vehicles serviced correctly, machinery appropriately tested or anti-virus software up to date?
- Assess competency of individuals directly involved. Was staff trained to complete the task? Gather any training records relevant for these purposes.

19.9 Where forensic evidence is to be gathered, the SUIIT must liaise with the appropriate person before touching any evidence. This may be police, fire service, ambulance/medical assistance or an externally engaged 3rd party.

19.10 Examples of evidence that may be gathered is listed below and is not considered exhaustive:

- Clothing;
- Medical paraphernalia e.g. syringes, medication packaging;
- Spills or discarded waste;
- Electronic devices or server locations;
- Equipment or vehicles.

20. Interviewing Personnel

20.1 Witness statements should be gathered in the immediate aftermath of the incident (refer to section 18 of this procedure) and can be used to obtain information to assist in determining potential interviewees.

20.2 Interviews should then be conducted as soon as reasonably possible after the event, or as and when required as the investigation develops.

20.3 Depending on the size and scale of the incident, several members of the SUIIT may be required to conduct interviews; however, where possible this task should be given to one member of the team to encourage consistency throughout the process.

20.4 Interview questions must be agreed by the SUIIT prior to commencing interviews to ensure consistency.

20.5 It is critical that SUIIT control their emotions or opinions during any interview. The interviewee must not see the interview situation as a process for blame, rather it should be explained that it is vital in identifying the reasons why the incident occurred and establishing new processes to ensure that it does not happen again.

20.6 As soon as possible, interviewees should be separated from one another to ensure individual recollection instead of a group understanding of the events.

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20.7 Prior to commencement of the interview, it must be confirmed that the interviewee is in an appropriate condition to be interviewed. Where emergency services are involved, confirmation should be sought from the appropriate personnel that the interviewee can be released for questioning.

20.8 The interviewees should be put at ease without fear of blame or recrimination.

20.9 The interviewee should be asked to describe what they seen, heard, felt without being subject to leading questions. They must reach their own conclusions.

20.10 Open ended questioning should be used to ensure the maximum information available is gathered. Information should be repeated back to the witness to ensure accuracy.

20.11 Ensure that the witness understands the process and clarify any stages or questions where appropriate.

20.12 Prior to completing the interview, encourage the interviewee to make contact if they think of any further information to add.

20.13 Whenever possible two members of the SUIIT should conduct each interview. When this is not possible interviews may be conducted by a single member of the SUIIT. It is recommended that audio recordings are made of all interviews conducted by a single member of the SUIIT, and audio recordings may be made of any interview irrespective of the number of the participants.

20.14 Audio recordings can only be made if the interviewers and interviewee agree to this prior to the start of the interview.

21. Use of Internal Resources

21.1 Depending on the nature of the incident and investigation it may be necessary to use external resources to assist in the conduct of the investigation.

21.2 It is the responsibility of the SUIIT to source and engage such resources as are necessary to complete the investigation.

21.3 The SUIIT should seek to engage resources from ERS Medical's existing approved supplier list, however on occasion it may be necessary to seek alternative or specialist providers to assist with an investigation. In the event that the likely expenditure is likely to exceed £1000 the SUIIT should seek approval from the Managing Director to engage the resource.

21.4 External resources are likely to be engaged to provide either:

- Direct support to and/or involvement with the investigation (i.e. forensic fire investigators or road traffic accident investigators).
- Ancillary services (i.e. laboratory analysis of equipment or environmental samples).

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21.5 In the event of resources engaged to work directly on an investigation (i.e. a fire investigator) the policy on confidentiality and disclosure of information to regulatory agencies should be reviewed prior to engagement. Any concerns identified should be brought to the attention of the Head of Care Standards and/or the Legal Counsel.

22. Report Writing

22.1 A SUI investigation report will be written for every Serious Untoward Incident. The report will be written by the H&S Manager leading the SUIIT and will be reviewed by the other members of the SUIIT prior to submission.

22.2 Reports will be completed and circulated in accordance with the timescales and requirements set out in the following table:

Report	Purpose	Format	Timescales*
Initial Progress Report	To advise: - On the immediate incident response, - On the progress of the investigation, and - On any immediate steps to be taken to reduce the risk of a reoccurrence.	Short document (1-2 pages). Does not need to be in formal template. Redacted version from Radar if possible.	Within 3 working days of the incident occurring
Interim Report	To provide detailed information on: - The nature of the investigation - The facts of the matter - Initial analysis and findings - Work still to be completed	Formal written report	Within 10 calendar days of the incident occurring
Final Report	To provide detailed information on: - The nature of the investigation - The facts of the matter - Comprehensive analysis - Conclusions (findings, root cause and contributory factors) - Recommendations	Formal written report	Within 21 calendar days of the incident occurring Final RCA Report for CCG's and CSU's has a 60 working day schedule for submission.

***These timescales may only be extended with the approval of the SVP EMEAA.**

22.3 All will be marked as 'LEGALLY PRIVILEGED' and 'STRICTLY CONFIDENTIAL' and will be circulated only to the Head of Care Standards and the Legal Counsel. Decisions on wider circulation will only be made by either the Head of Care Standards and the Legal Counsel.

22.4 Formal written reports will be set out in accordance with the headings in the following table. Sub-headings that are not relevant to a specific incident may be omitted.

LEGALLY PRIVILEGED AND STRICTLY CONFIDENTIAL: Serious Untoward Incident Investigation Report	
Title Page Contents Page Glossary of abbreviations and terms used in this report Status of this report	
• Executive Summary	
• Investigation:	• Investigation Terms of Reference • Investigation Team (including training and qualifications) • Investigation Techniques / Methodology • Involvement of Regulatory Agencies • Involvement of Affected / Injured Persons, Relatives , Staff • Involvement of Other Interested Parties • Legal and regulatory context
• Factual Information:	• Incident Description, Background and Context • Chronology of Events • Injuries to persons (including harm or potential harm both physical and mental) • Support provided to injured persons, relatives and staff • Damage to plant, equipment or property • Environmental Damage • Personnel Information and Training • Equipment Information • Weather Information (where relevant) • Site / Location Information and Layout • Recorded Data / Records (automatic systems, completed forms etc) • Organisational Information: ▪ Staffing ▪ Management ▪ WTD Compliance (fatigue) ▪ Audits, Inspections and Corrective Actions ▪ Previous Incidents ▪ Risk Assessments ▪ Operating Procedures / Method Statements ▪ Maintenance • Additional Information
• Analysis:	• Organisational aspects • Design Aspects • Human-Engineering Interactions • Fire Analysis (where relevant) • Preparation for Activity

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	• Effectiveness Emergency Procedures • Culture
• Conclusions:	• Findings • Root Cause • Contributory Factors
• Recommendations	
• Appendices	

23. Agreeing the level and type of SI/RCA Investigation

23.1 The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident.

23.2 The appropriate level of investigation should be undertaken by ERS Medical as informed by the initial review. The investigations team and, where applicable, other stakeholders will use the information obtained through the initial review to inform the level of investigation.

23.3 The level of investigation may need to be reviewed and changed as new information or evidence emerges as part of the investigation process. Within ERS Medical and the NHS there are three recognised levels of systems-based investigation (currently referred to as RCA investigation). These are described in the table on the next page.

Level	Application	Product Outcome	Owner	Timescale for Completion
Level 1 – Concise and Initial Investigation\	Suited to less complex incidents which can be managed by individuals or a small group at a local level.	The concise report is typically managed entirely with the ERS Medical Radar compliance system.	ERS Medical Operations and the Care Standards Team.	All initial Operations investigations have a 7-day completion window. Technical reviews, Action Plans and Risk Review has 14 days from the date of completion of the initial investigation

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Level 2 – Comprehensive Internal Investigation	Suited to more complex incidents which could be managed by multiple teams involving experts and or specialist. These reports are also typically shared and signed off by NHS contract commissioners.	Comprehensive investigation which is captured initially on the Radar compliance system, but which also generated a F5.02.01 – SI / RCA Final Report.	ERS Medical Operations, Care Standards Team, specialist team, experts and NHS Commissioners	This level of report must be completed within 60 working days.
Level 3 – Independent Investigation	Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved.	Comprehensive investigation report including all elements of a credible investigation	The investigator and all members of the investigation team must be independent of ERS Medical. To fulfil independency the investigation must be commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated.	6 months from the date the investigation is commissioned

24. Analysis of the Findings

24.1 Once the all of the information has been recorded and the SUIIT is confident that no further evidence is required; a meeting should be scheduling to review the findings. Where possible, all members should attend in person to allow for a thorough review of the incident investigation.

24.2 Members of the SUIIT should convene with the SUIIT lead chairing the meeting. The team should review the incident chronologically, asking for members input as the scene progresses.

24.3 The purpose of the review meeting should be to establish the root cause of the incident and to put steps in place to learn lessons and reduce the likelihood of recurrence.

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24.4 Agreed consensus should be reached to the following questions:

- What is agreed to have been the cause of the incident?
- Were there any specific threats or weaknesses that allowed the situation to worsen or caused it?
- How quickly was the incident reported/detected?
- Was the flow of communication during the incident sufficient for its purposes?
- Is there any negative impact of the communication that was released that requires mitigation?
- Was the incident controlled as quickly and effectively as possible? If not, why?
- Was there any loss as a result in the incident e.g. loss of life, data, technology, commercial advantage, equipment, revenue?
- Any other important issues raised throughout the course of investigation that need to be addressed.
- Is there a requirement for additional/expert resource in order to recover from the incident or reduce the likelihood of recurrence?

24.5 In undertaking the analysis, the SUIIT should review the findings of the investigation in accordance with the 'Five Why's' principle (see section 17of this procedure).

24.6 Once the SUIIT have been fully debriefed and discussed the incident in full, conclusions and recommendations should be formally documented.

24.7 The SUIIT lead should determine if any further communication is required to interested parties regarding the findings of the incident e.g. Regulatory Bodies, emergency services, customers, injured parties.

24.8 Any communication should be formal and in writing with a record kept within the incident file for evidence.

25. Recommendations for Action Plans

25.1 The making of recommendations for corrective and preventative action are within the remit of the SUIIT.

25.2 The SUIIT should make recommendations based on the review of findings undertaken at the end of the investigation.

25.3 Such recommendations will be included in the final Serious Untoward Incident investigation report.

25.4 With the exception of corrective actions taken during the immediate response to the incident, the setting and completion of corrective and preventative actions is not within the remit of the SUIIT, but rests with Senior Company Management.

25.5 The Head of Care Standards, the Legal Counsel and other key stakeholders will review the recommendations in the final report and will make a decision on which recommendations to enact.

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25.6 The setting and completion of corrective and preventative actions will be undertaken in accordance with **BMS/1.04 – Action Plans**.

25.7 Action Plans arising from Serious Untoward Incident investigation recommendations will be issued and monitored by the appropriate Care Standards Team Manager / Member.

Shared Learning

25.8 Whenever possible / relevant the Company will circulate information relating to events and incidents to the wider business enabling shared learning.

25.9 All such information will be generated by the relevant H&S Manager and be circulated using **F5.01.09**, having first sought approval from the appropriate Company Director or Head of Department.

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BMS/5.03 CQC Statutory Notifications – A Guide for Registered Managers

Document Author:	[redacted]		Head of Care Standards		
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2. Related Documents & Legal References

Human Resources	BMS/2.01
Personal Development and Training (Healthcare)	BMS/2.02
Employee Health and Wellbeing	BMS/2.03
Disclosure & Barring Service (DBS) Checks	BMS/2.06
Incident Reporting and Investigation	BMS/5.01
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Appendix A – CQC Statutory Notifications Process Maps
The Health and Social Care Act 2008
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
The Care Quality Commission (Registration) Regulations 2009

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3. Introduction

3.1 Under the requirements of the '**Health and Social Care Act 2008**' and specifically the '**Care Quality Commission (Registration) Regulations 2009**', are detailed the legal responsibilities of providers of care, who are registered with the CQC, for the making statutory notifications.

3.2 The CQC provides guidance which is contained within the their publication called 'Statutory Notifications – Guidance for Registered Providers and Managers of:

- Independent healthcare;
- Adult social care;
- Primary dental care;
- Private ambulances.

3.3 This publication is available to all ERS Medical Registered Managers and compliance team members from the 'company's BMS which is available through the HR system.

3.4 There are specific regulations contained within the '**Care Quality Commission (Registration) Regulations 2009**', which require notification to the CQC, these are:

- **Regulation 12**: Change of statement of purpose;
- **Regulation 14**: Absence of the Registered Person;
- **Regulation 15**: Change of Registration Details;
- **Regulation 16**: Death of a person who uses the service;
- **Regulation 17**: Death and unauthorised absence of people who are detained or liable to be detained under the **Mental Health Act 1983**;
- **Regulation 18**: Notifications about other types of incidents;

Regulation 20: Duty of candour (**Regulated Activities Regulations 2014**).

3.5 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.6 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Health and Safety Team**	Are responsible for reviewing incident reports that have the potential to or have: impacted the environment, injured a member of staff or the public and caused an information security breach. Additionally responsible for liaising with any regulatory or legal bodies. Are responsible for providing training on ERS Medical requirements for incident reporting and investigation. Are responsible for writing to customers (as appropriate), requesting an investigation to be conducted and subsequently reviewing the customer's response to ensure they are satisfactory. Responsible for making the respective CQC Registered Manager aware of any CQC statutory notifications.
5.4	**Clinical Team**	Are responsible for reviewing incident reports that have the potential to or have caused injury to patients. Additionally responsible for liaising with any regulatory or legal bodies. Are responsible for providing training on ERS Medical requirements for incident reporting and investigation. Responsible for making the respective CQC Registered Manager aware of any CQC statutory notifications and assisting them in the notification process.
5.5	**Transport Compliance Team**	Are responsible for reviewing incident reports that involve Company vehicles. Additionally responsible for liaising with any regulatory or legal bodies.
5.6	**General and Operations Managers / Team Leaders**	Have day to day responsibility for ensuring that this procedure is put into practice within their areas of control and are responsible for ensuring that all incidents are reported and investigated.
5.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **Apology** – an expression of sorrow or regret in relation to an unexpected incident that resulted in patient harm. Apology does not imply acceptance of responsibility for the incident and the resulting harm. In some cases, however, where harm is linked to an error in the care of the patient, then an apology should also include an acknowledgement and acceptance of responsibility.

6.2 **Notifiable Safety Incident** for health service bodies – any unintended or unexpected incident that occurred in respect of a patient's care that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

- The patient's death;
- Severe harm;
- Moderate harm;
- Prolonged psychological harm.

This definition (and the whole duty of candour) refers to harm directly caused by the incident, and not by the natural course of the patient's illness or underlying condition.

Identifying something as a notifiable safety incident does not automatically imply error, negligence or poor quality care. It simply indicates that an unexpected and undesirable clinical outcome resulted from some aspect of the patient's care, rather than their underlying condition.

6.3 **Moderate Harm**:

- significant harm which is defined as the temporary lessening of bodily, sensory, motor, physiologic or intellectual functions that is directly related to the incident and not to the natural course of the patient's illness or underlying condition;
- moderate increase in treatment, which is an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another treatment area (such as intensive care).

6.4 **Prolonged Pain** - pain which a patient has experienced, or is likely to experience, for a continuous period of at least 28 days.

6.5 **Prolonged Psychological Harm** – psychological harm which a patient has experienced or is likely to experience, for a continuous period of at least 28 days.

6.6 **Relevant Person** - means the service user or, in the following circumstances a person acting on their behalf:

- On the death of the service user;
- Where the service user is under 16, and not competent to make a decision in relation to their care and treatment, or;
- Where the service user is 16 or over and lacks the capacity in relation to the matter.

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6.7 **Severe Harm** – a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb, or organ or brain damage which is directly related to the incident and not to the natural course of the patient's illness or underlying condition.

6.8 **Written Notification** – one given or sent to the relevant person in written form containing the information provided in any initial notification made in person, details of any enquiries to be undertaken, advice of any appropriate enquiries to be undertaken, the results of any further enquiries, and an apology.

6.9 **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

6.10 **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

6.11 **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

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7. Regulation 12

7.1 Any provider who seeks to carry out regulated activity must submit a statement of purpose to the CQC as part of their registration application.

7.2 This must include:

- The aims and objectives;
- The service you provide;
- The needs your service meets;
- Your contact details;
- Your services legal entity;
- The places where services are provided.

7.3 Any changes in the details contained within the original statement of purpose, must be notified to the CQC as a statutory notification within 28 days.

7.4 The template for making this notification to the CQC is available via a hyperlink from the Care Quality Team's, CQC Registered Managers Portal on their SteriPoint page;

CQC Registered Managers Portal

Or direct from the CQC's website at:

http://www.cqc.org.uk/guidance-providers/registration-notifications/notifications

7.5 Prior to making any change to the statement of purpose the Registered Manager should seek the guidance and advice of the Head of Care Standards.

7.6 Once the changes have been agreed, the Registered Manager should access the Regulation 12 notification template through the links detailed above.

7.7 Once the template has been completed and the notification is sent to the CQC the Registered Manager should save a copy for their records and send a copy to the Head of Care Standards for central retention.

7.8 A detailed process map for this notification is available at Appendix A of this document, which is available from the ERS Medical CQC Registered Managers Portal and or on request to the Head of Care Standards.

8. Regulation 14

8.1 Any absence of 28 days or more planned or as a result of an emergency of the registered manager must be notified to the CQC.

8.2 If the absence is planned this notification must be sent to the CQC 28 days prior to the first planned day of absence.

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8.3 If the absence is of an emergency nature, this notification must be sent to the CQC within 5 working days of the start of the absence.

8.4 All returns of registered managers after a period of notified absence must be notified to the CQC within 7 days of the return.

8.5 Individual registered managers can agree shorter timescales with the CQC, but these must be agreed with CQC beforehand.

8.6 Prior to notifying the CQC of an absence the Registered Manager should seek the guidance and advice of the Head of Care Standards.

8.7 The Registered Manager should access the Regulation 14 notification template through the links detailed at section 5 of this document.

8.8 Once the template has been completed and the notification is sent to the CQC the Registered Manager should save a copy for their records and send a copy to the Head of Care Standards for central retention.

8.9 A detailed process map for this notification is available at Appendix A of this document, which is available from the ERS Medical CQC Registered Managers Portal and or on request to the Head of Care Standards.

9. Regulation 15

9.1 Changes to provider registration details, either significant or routine, must be made to the CQC under the requirements of Regulation 15.

9.2 These changes are:

- Changes of provider activity;
- Changes of registered manager for activity;
- Changes to a registered individual's name;
- Changes to the membership of a partnership;
- Changes to an organisation's name and address;
- The appointment of a new nominated individual;
- Changes to an organisation's officers or directors;
- Changes of main contact email address and telephone number;
- The appointment of a trustee in bankruptcy, receiver or liquidator;
- The sequestration of a registered person's estate.

9.3 Prior to notifying changes to registration the Registered Manager should seek the guidance and advice of the Head of Care Standards.

9.4 The Registered Manager should access the Regulation 15 notification template through the links detailed at section 5 of this document.

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9.5 Once the template has been completed and the notification is sent to the CQC the Registered Manager should save a copy for their records and send a copy to the Head of Care Standards for central retention.

9.6 A detailed process map for this notification is available at Appendix A of this document, which is available from the ERS Medical CQC Registered Managers Portal and or on request to the Head of Care Standards.

10. Regulation 16

10.1 The death of a service user in our care requires a statutory notification to the CQC, under Regulation 16 without delay.

10.2 Without delay is defined by the CQC as meaning exactly what it says. ERS Medical Registered Managers MUST submit their notifications as soon as possible after the incident.

10.3 Prior to notifying the CQC about the death of a service user the Registered Manager should seek the guidance and advice of the Head of Care Standards.

10.4 The Registered Manager should access the Regulation 16 notification template through the links detailed at section 5 of this document.

10.5 Once the template has been completed and the notification is sent to the CQC the Registered Manager should save a copy for their records and send a copy to the Head of Care Standards for central retention.

10.6 A detailed process map for this notification is available at Appendix A of this document, which is available from the ERS Medical CQC Registered Managers Portal and or on request to the Head of Care Standards.

10.7 A Regulation 16 notification will also require a Regulation 20 – Duty of Candour to be conducted. Please refer to Section 11 of this document for more details on this requirement.

11. Regulation 17

11.1 The death and unauthorised absence of people who are detained or liable to be detained under the Mental Health Act 1983, requires a statutory notification under Regulation 17 without delay.

11.2 Without delay is defined by the CQC as meaning exactly what it says. ERS Medical Registered Managers **MUST** submit their notifications as soon as possible after the incident.

11.3 Prior to notifying the CQC about the death and unauthorised absence of people who are detained or liable to be detained under the Mental Health Act 1983, the Registered Manager should seek the guidance and advice of the Head of Care Standards.

11.4 The Registered Manager should access the Regulation 17 notification template through the links detailed at section 5 of this document.

11.5 Once the template has been completed and the notification is sent to the CQC the Registered Manager should save a copy for their records and send a copy to the Head of Care Standards for central retention.

11.6 A detailed process map for this notification is available at Appendix A of this document, which is available from the ERS Medical CQC Registered Managers Portal and or on request to the Head of Care Standards.

11.7 A Regulation 17 notification will also require a **Regulation 20 – Duty of Candour** to be conducted. Please refer to Section 11 of this document for more details on this requirement.

12. Regulation 18

12.1 Regulation 18 requires statutory notifications to be made for other incidents. These incidents are:

- Serious Injuries;
- Deprivation of Liberty (DoLS) applications and their outcomes (unlikely to be an ERS Medical notification);
- Abuse and allegations of abuse;
- Incidents reported to, or investigated by, the Police;
- Events that stop, or may stop, the registered person from running the service safely and properly;
- The admission of a child or young person under the age of 18 to an adult psychiatric ward or unit (unlikely to be an ERS Medical notification).

12.2 These notifications must be made without delay.

12.3 Without delay is defined by the CQC as meaning exactly what it says. ERS Medical Registered Managers **MUST** submit their notifications as soon as possible after the incident.

12.4 Prior to notifying the CQC about other incidents the Registered Manager should seek the guidance and advice of the Head of Care Standards.

12.5 The Registered Manager should access the Regulation 18 notification template through the links detailed at section 5 of this document.

12.6 Once the template has been completed and the notification is sent to the CQC the Registered Manager should save a copy for their records and send a copy to the Head of Care Standards for central retention.

12.7 A detailed process map for this notification is available at Appendix A of this document, which is available from the ERS Medical CQC Registered Managers Portal and or on request to the Head of Care Standards.

12.8 A Regulation 18 notification will also require a **Regulation 20 – Duty of Candour** to be conducted. Please refer to Section 11 of this document for more details on this requirement.

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13. Regulation 20

13.1 The requirement to discharge a 'Duty of Candour' is to ensure that ERS Medical as a CQC registered provider is open and transparent with people who use the service and other 'relevant persons' (people acting lawfully on behalf of them) in general relation to their care and treatment.

13.2 It also sets out specific requirements that ERS Medical must follow when things go wrong with care and treatment, this would include:

- Inform the service user or relevant person of the incident;
- Provide reasonable support to the service user or relevant person;
- Be truthful in all information provided to the service user or relevant person;
- Provide an apology to the service user or relevant person.

13.3 The meeting between the Compliance Team and the Relevant Person, will be recorded on **F5.03.01 – Duty of Candour Record**. This form will then be added as an attachment to the Radar incident log.

Initial Assessment to Determine the Level of Response

13.4 All incidents will be initially be assessed by the Health and Safety Team and Care Quality Team to determine the level of response required.

13.5 Incidents deemed to require a higher level response should be escalated to the Health and Safety Manager and the Head of Care Standards.

13.6 If it requires a high level of response again, then it will be escalated to the Head of Care Standards and Director of Operations.

13.7 Following this escalation process it will be determined if a notifiable safety incident has occurred. The Head of Care Standards will assume responsibility for reporting to the UK Leadership Team and the Managing Director.

Notifiable Safety Incidents and the CQC Registered Manager

13.8 When a notifiable safety incident has deemed to have taken place the CQC Registered Manager for the location of the incident will take responsibility for communication with the Patient, family and Care Quality Commission.

13.9 Any communication with the Patient, family and Care Quality Commission will be recorded and detailed within the Company incident log.

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13.10 The Registered Manager for the location will in regards to the patient, family or carer:

- Inform of the incident with an accurate, evidenced explanation of all known facts;
- Offer a sincere apology, an apology is not an admission of liability;
- Explain the possible consequences to the patient, if not already evident;
- Explain any immediate steps that will be taken to minimise or prevent the same incident recurring and that a more detailed investigation will take place;
- Inform them that they will be the point of contact for the incident and will follow up this initial discussion with more information after further investigation;
- Document this discussion on the incident log and follow it up with a letter to the patient, family or carer detailing what was discussed.

13.11 The Registered Manager for the location will in regards to the Regulatory Authorities:

- Inform the Care Quality Commission of the incident with an accurate, evidenced explanation of all known facts by way of notification through the registered managers portal available on the Care Quality page of Steripoint;
- Ensure other regulatory bodies have necessary notifications submitted, such as, an example, RIDDOR to the Health and Safety Executive should this be appropriate.

13.12 The Registered Manager for the location will Arrange follow up discussions with the patient, family or carer as necessary to discuss:

- The final outcome of the investigation and the actions taken to prevent or limit recurrence;
- Explain any further steps which are planned;
- Answer any further questions;
- Provide a copy of the final report to the patient, family or carer with a covering letter.

14. Training

14.1 All CQC Registered Managers, Care Quality Team and Health and Safety Team members must receive CQC Statutory notification training as part of their initial induction into the company or on appointment from other areas of the Company.

14.2 This training should be requested through the Training Team and will be provided by the Care Quality Team and recorded in compliance with the requirements of **BMS/2.02 – Personal Development and Training (Healthcare)**.

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Question 1.19.14.2

Patient / Service User safety - Incidents

Please provide the relevant policies and procedures, and set out arrangements in place for recognising, recording, reporting, investigating, learning lessons and implementing improvements in response to adverse events including:

• Serious clinical incidents

• All other clinical incidents

• Near misses

• Non-clinical incidents

• Complaints

• Informal concerns (PALS type queries).

Word count 1000

Total Word Count: 995

All incidents, complaints and compliments are recorded on [redacted] allowing us to monitor the quality and clinical governance of our service. It is ERS's policy to ensure that all complaints, accidents, incidents and near misses are reported and investigated fully to identify immediate, underlying and root causes. These include:

- Complaints
- Non-clinical incidents
- Health and safety incidents
- Serious Clinical/Safeguarding/Prevent incidents
- Informal concerns (PALS)
- Transport incidents and occurrences
- Information Governance/Data Security incidents
- Environmental incidents
- Near misses

All incidents, including patient and staff safety and near misses are managed using our compliance system [redacted] Each event is given a unique identifying reference number which is prefixed with a code to identify the type of incident.

Each event is broken down into 5 workflow stages, with designated workflow leads as below:

Initial Investigation	Site Operations Manager
Compliance Team Investigation	Care Standard Team SME
Technical Review	Care Standard Team SME
Action Plan	Care Standard Team
Risk Score	Care Standard Team

In support of the telephone reporting system ERS operates an on-line incident reporting system, [redacted] is a software system, which has been specifically developed to assist healthcare providers report, track, manage and feedback on governance matters, such as incidents, complaints, audits, action plans and risks. ERS Medical has worked with the developers, on their beta development team, to drive the product forward and have innovative practices within the system such as auto notifications of transport incidents to our fleet insurers. The CQC have inspected ERS and recognised this as truly unique to ERS Medical.

[redacted]

A typical [redacted] employee dashboard: This details any company and compliance 'Notices' which need to be read and acknowledged, Audits that are due, Assigned 'Actions' to complete, Incidents (events) which need to investigated and managed, Documents which require reviewing and any employees who have overdue items in their [redacted] dashboard.

[redacted]

A site-specific dashboard, which provides a quick reference oversight of compliance within the [redacted] system, for audits that have been undertaken.

[redacted]

A Regional Trend analysis for all events. It can also be configured as below to drill down into specific incident types to provide more clarity on issues and drive forward improvements and highlight areas of concern.



This shows Regional complaints which have been received and can show surges in complaints linked to specific times of the year.

Our real-time tracking and telematics system, Crystal Ball, delivers real-time reporting to our insurers following transport incidents or complaints including HD video recording.

Once completed any electronic/paper incident documentation is submitted as soon as possible to the responsible Manager who will add the incident to the [redacted] system. Following this, our Standard Investigation Process will commence.

We will report all incidents to the CCGs as soon as practically possible, but always within 24 hours. We will then continually inform the CCGs of the investigation and provide a full report upon completion of the investigation.

All events are then reviewed by the Regional Governance Committee on a monthly basis and then the Patient Safety Committee, which is chaired by our Medical Director. Significant events will be escalated in advance of any scheduled review based on severity and risk.

Lessons learnt and shared learning are an integral part of our incident and compliance system [redacted] This information is used as an essential part of developing our business allowing us to continually learn from incidents and patient feedback, combining it with our experience, innovation and best practices. This is disseminated to our employees through GaPS meetings, Clinical Memos, Notice Boards and Team Meetings.

We have included our Incident management policy to provide a full overview of how we report, investigate and feedback on all incidents.

Example of incident management

Below we have provided a real-life example of how our incident management system works:

How was this identified?

We identified that our processes were not meeting the patient's needs and expectations due to the fact that she raised similar complaints on a number of occasions regarding our Booking Process and the Planning and allocation of her bookings.

How was this investigated?

Her Booking Data was reviewed regarding the vehicle allocation of each of her complaints. All of our booking calls are recorded which allowed our investigator to listen and critique each of her calls to establish what changes could be made to improve the service. Due to the difficulties with the patient we engaged with the CCG for assistance in finding a suitable solution.

What was the learning?

We established that our booking process was not suitable to the patient due to her suffering from memory loss and as such our booking process (preventing patients from booking more than 28 days before their appointment) was causing her issues. Also, the patient was not suited to traveling on all vehicle types as some lead to severe pain and discomfort.

What actions were implemented?

The patient was permitted to book with more notice due to her memory loss. This enables her to book all of her appointments as soon as she is made aware of them regardless of their destination or date. This provided her with peace of mind that all of her transport requirements are arranged as soon as she is made aware of the appointment reducing the risk of transport not being booked.

The patient's bookings now all go directly through to her local Operations Manager. This prevents her from having to go through the booking process and eligibility criteria that has caused her distress. Furthermore, specialised knowledge of the patient's case means that the Operations Manager is able to ensure that the patient is treated with the sensitivity that is required.

We have changed her transport preference within her booking record to ensure she only travels in a WAV.

Following discussions with the CCG and the patient our Operations Manager has been trying to assist by liaising with the patient's GP to arrange more effective pain management as it was raised as a serious concern for her.

How were you assured that changes were effective?

No further complaints reported, and the patient communicated satisfaction with actions taken by the Operations Manager

We have attached our policies and processes that act as out governance framework for all incidents.

WI/6.08.15 Service User Behavioural Process

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.0	**Date Active:**	10.06.2020	**Review Date:**	30.06.2021

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1.1	All	All	All	13.04.18	[redacted]	Name change and the addition of a review date
2.0	All	All	All	23.07.18	[redacted]	Annual review and with feedback from Norfolk CCG.
2.1	2	All	4	10.08.18	[redacted]	Addition of BMS/1.10 to related documents.
3.0	All	All	All	10.06.19	[redacted]	Annual Review
4.0	All	All	All	10.06.20	[redacted]	Annual Review

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2. Related Documents

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Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
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Language Translation Services (CCO)	WI/6.08.03
ADHOC Journey Quotes and Bookings	WI/6.08.04
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3. Purpose of Work Instruction

3.1 To ensure that there is a single process defined and utilised for ERS Medical's Contact Centre of Operations (CCO) team, local control / dispatch members and Operations staff, for the management of service users with behavioural challenges.

3.2 To define the responsibilities of personnel in relation to CCO, local control / dispatch activities and operations, ensuring consistency is achieved throughout ERS Medical.

3.3 **ERS Medical has a zero tolerance for all forms of violence and aggressions,** which may come under the wider team of service user with behavioural problems.

4. Scope and Application

4.1 This work instruction applies to all ERS Medical CCO, local control / dispatch team members and Operations personnel.

4.2 Failure to comply with the requirements of this work instruction may result in investigation and subsequent formal action in line with the Company's Capability and Disciplinary procedures.

5. Policy Statement

5.1 Please refer to the Company's Health, Safety, Quality and Environmental Policy.

5.2 Please refer to the Company's Business Continuity Policy.

5.3 Please refer to the Company's Information Governance Policy.

5.4 Please refer to the Company's Care and Treatment Policy.

5.5 Please refer to the Company's Corporate Social Responsibility Policy.

5.6 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations. Additionally, to ensure that all possible measures have been taken to minimise the risk to staff, patients and the Company from violence and aggression arising in the course of ERS Medical's business.
6.3	**Medical Director**	Is responsible for providing clinical support and guidance to the Managing Director and Head of Care Standards in any decision to withdraw ERS Medical transport from a patient. In addition to this the Medical Director is responsible when required to liaise with lead clinicians and nurses from NHS Trust, CCG's and other healthcare providers where behavioural issues may or could be attributed to their medical condition, either suspected or diagnosed.
6.4	**Head of Care Standards**	Is responsible for the prioritisation of resources in relation to control measures and have the responsibility for bringing to the attention of the Senior Leadership Team all cases of physical and verbal assault against staff including where weapons are used.
6.5	**Care Standards Manager**	Is responsible for writing and documenting a risk assessment for violence and aggression within the workplace. Ensure that the reporting and, where necessary the investigation, of acts of violence and aggression against our staff to outside agencies are completed as required.
6.6	**Head of HR and Training**	Is responsible for the development and deployment of suitable and sufficient training for the management of violence and aggression.
6.7	**CCO & Contact Centre, local Control / Dispatch Managers**	Have day to day responsibility for ensuring that this procedure is put into practice within the CCO and all locations controlled by the CCO, including local dispatches.
6.8	**Senior Operations Managers and Operations Managers**	Have the responsibility to ensure that this work instruction is followed in the management of violence and aggression within the work place.
6.9	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Behavioural Problems** – For the purpose of this work instruction the term 'Behavioural Problems' will also encompass the use and definition of 'Violence and Aggression' as defined at points 7.2 and 7.3.

7.2 **NHS Defines Violence and Aggression** –as; 'Any incident where staff are abused, threatened or assaulted in circumstances related to work, involving an explicit or implicit challenge to their safety, well-being or health'.

7.3 **The Health and Safety Executive define Violence and Aggression** – as; 'Any incident in which the employee is abused, threatened or assaulted' by a member of the public or other ERS Medical employees in the circumstances arising out of his/her employment.

7.4 **Accident** – For the purpose of the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995, the term 'accident' has been extended to include 'an act of non-consensual violence done to a person at work'.

8. Telephone: Abusive and Threatening Calls

8.1 All staff operating telephones, having applied the correct procedures, have the right to 'terminate' calls where abusive, obscene or threatening language is directed towards them.

8.2 In the CCO / Regional Control / Dispatch rooms, this may not always be the case as a patients' medical condition may affect their behaviour and therefore termination of the call may be delayed where appropriate or if the caller's behaviour is being directly affected by their emotional state.

8.3 CCO / Regional Control / Dispatch staff receiving calls should adopt the following procedure when dealing with abusive, obscene or threatening language that is directed towards them as an individual:

- Warn the caller that the call will be terminated if they continue to use abusive, obscene, threatening language – **FIRST WARNING**;
- If the behaviour persists, to remind the caller that the warning has been given – **SECOND WARNING**;
- If the behaviour continues despite the two previous warnings to remind the caller that the two warnings have been given – **THIRD WARNING**. If the caller continues to use abusive, obscene or threatening language the CCO agent / Dispatch room staff may terminate the call;
- The incident must be reported as an abusive/hostile call using the ERS Medical incident reporting system - [redacted]
- If threats to kill, harm or cause damage are received anonymously or otherwise, whether at home or in the workplace the Police must be notified.

8.4 Where the recipient is a lone worker e.g. CCO / Regional Control / Dispatch and their line manager / supervisor is not immediately available, the staff member shall terminate the call as detailed at paragraph 8.3.

8.5 The lone worker is then required to inform their supervisor and or line manager at their earliest opportunity and raise an incident on the [redacted] compliance system.

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9. Management: Abusive and Threatening Behaviour

9.1 In general, all acts of violence and aggression will be treated on a case by case basis, taking all variables into account. With patients' additional factors will also be considered, such as, but not limited to:

- The patients' capacity;
- The patients' medical condition i.e. are they suffering from some medical / mental conditions that can affect their ability to control and be accountable for their actions either on a temporary or permanent basis;
- The medication that they are currently taking and its effects on their ability to make what would be considered by a sensible decision.

9.2 Where a patient / caller does not comply with the requests from ERS Medical staff to stop using either threatening or abusive language further steps will be taken.

9.3 In the first instance the ERS Medical Complaints Administrator will draft a letter to be signed by the Head of Care Standards, detailing the specific occasions that have been recorded and logged as 'violence and aggression' on the [redacted] compliance system.

9.4 Further to this the letter will formally request that the patient / caller does not continue with any further communication that ERS Medical staff would deem to be inappropriate.

9.5 If after receiving the letter there is a re-occurrence of this behaviour then ERS Medical reserves the right to take more punitive action in order to provide a safe working environment for its staff as required by the Health and Safety at Work Act etc 1974. This action may include any of the following:

- A request for a face to face meeting with the patient / caller to further discuss their behaviour, if deemed appropriate by ERS Medical;
- Refer the issue to the patients' / callers CCG / NHS Trust if the services is commissioned by them;
- Refuse any further transport requests if the service is funded privately;
- Refuse further transport for CCG / NHS Trust funded patients' and inform the CCG / NHS Trust that they will have to make alternative arrangements for this patients' continued transport needs.

9.6 Any decision to withdraw ERS Medical transport for a patient can only be made by either the Managing Director in consultation with the Head of Care Standards / ERS Medical Director and or the ERS Medical Director liaising with the NHS Trust / CCG lead Nurse.

9.7 Under **NO** circumstances are Regional Managers and or local Operations Manager to exclude patients from Transport.

9.8 It is important to note that ERS Medical is **NOT** refusing the patient care, as this is beyond the scope of ERS Medical's responsibilities.

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10. Risk Assessment

10.1 This work instruction requires that a risk assessment be undertaken, in order:

- To prevent, wherever possible, risks to staff from violence and aggression;
- To ensure that staff are involved in this risk assessment process and are kept fully informed of the outcomes and control measures put in place to reduce the risk;
- To fulfil legal and obligations by ensuring that all ERS Medical team members are aware of the safety issues from incidents of violence and aggression;
- To protect ERS Medical team members from all forms of violence and aggression;
- Provide training to team members to enable them to avoid and/or deal with actual potential violence and aggression.

11. Training

11.1 ERS Medical's expectations in relation to training around the management of violence and aggression will be covered in more detail within the annual Training Prospectus and **BMS/2.02 – Training and Personal Development**.

12. Monitoring and Review

12.1 The Care Standards Team will hold the responsibility of monitoring the frequency and actions of all incidents and complaints on [redacted] healthcare which relate to violence and aggression.

12.2 It will also be the responsibility of the Care Standards Team to communicate the decisions taken in relation to any actions which arise from such an incident to the relevant Operations and the management team of the CCO.

12.3 The decision to review a decision to withdraw transport can only be authorised by a member of the ERS Medical SLT and must be coordinated through the Head of Care Standards.

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Question 1.19.14.3

Patient / Service User safety – Safe use of equipment Patient / Service User safety – Safe use of equipment

Please provide policies and procedures and set out arrangements in place for ensuring equipment (including all clinical and patient transport equipment) is used safely and in accordance with manufacturer's instructions.

Word count 500

Total Word Count: 409

Manual handling forms an integral part of our induction training and all staff are provided with regular refresher training. We also provide detailed bespoke training on all of the equipment that our crews will utilise to deliver the service to the CCGs. This ensures that all equipment is used safely and effectively. All training on equipment is certified by the manufacturer.

Our HR system [redacted] records and stores all training each employee has received and sets up notifications for when refresher training is required. Specific equipment training will be delivered during the induction process and refresher training will be provided annually. If the manufacturer recommends more frequent refresher training, then this will be put in place.

Further to training in the use of equipment to ensure service user and staff safety we also maintain all of the equipment to the highest standard. Our latest CQC report recognised that we have effective systems and processes in place to ensure our vehicles and equipment are maintained to the highest standard.



Our staff conduct a visual check of vehicle and equipment cleanliness before their shift to ensure vehicles and equipment are maintained in a clean and hygienic condition. These checks are retained for reporting and auditing purposes. Regular daily checks are made of the vehicles by the Management team to ensure compliance.

Cleaning and decontamination have been broken down into 5 distinct levels for ease of understanding and measurement. These levels are:

- Level 1: Pre-Shift
- Level 2: Patient Handover – After every patient
- Level 3: Risk of contamination i.e. where there has been an exposure to bodily fluids
- level 4: Post shift
- level 5: Scheduled deep cleans – every 90 days for NEPTS vehicle and 45 days for HDU vehicles

These checks also include ensuring that all equipment is in good working order and cleaned to IPC standards. At the end of each shift it is the crew's responsibility to ensure that the vehicle is left in a clean and hygienic condition ready for the following shift.

All of our equipment is registered on our FleetCheck system. Within the system we outline the maintenance requirements for all equipment and a schedule is created. The system alerts the managers when maintenance is required and once it has been completed this is logged in the system ensuring all equipment used within our service is in a good, safe working order. Further to this all of our equipment is audited annually by external maintenance company, Clinical Engineering.

Question 1.19.14.4

Patient / Service User safety – safety during a journey

Please provide policies and procedures and set out the arrangements in place to respond to the deterioration of patient health or a clinical emergency during a journey.

Word count 500

Total Word Count: 482

We have attached our policy to provide full details on how we respond to patients who deteriorate during transport.

Patients transported by the NEPTS, Mental Health and HDU services have the potential for deterioration during both planned and urgent journeys. All of our staff are trained to universal standards to manage patients that deteriorate on route.

The key objectives of our process and policy to respond to the deterioration of patients is to ensure that appropriate advice is given to personnel regarding the management and transfer of these patients.

Priorities when a patient deteriorates in transit:

- To ensure the safety of the patient and crew
- To prioritise and initiate lifesaving treatment where required
- To access assistance at the earliest opportunity
- To ensure the patient is conveyed to an appropriate receiving facility

Our policy provides a full overview of our how staff should deal with patients who:

- Suffer Cardio/Respiratory arrest in transit
- Become unwell during transit
- Suffer a fall or injury during transit

It also provides details on how crews should manage others onboard to minimise their exposure.

Patients Who Suffer Cardio / Respiratory Arrest in Transit

- The crew will stop as soon as possible in a safe place and attend to the patient
- Resuscitation should commence immediately in line with the training guidelines including the use of equipment such as oxygen and defibrillator.
- Unless the vehicle is within the hospital grounds or expected arrival at an Emergency Department is imminent the crew should stop the vehicle and undertake full resuscitative efforts

- 999 must be called for paramedic assistance as soon as possible.
- All assistance requested by the emergency crew will be given.
- Patients with a valid DNAR order in place should be managed in accordance with the resuscitation procedure.
- The crew will report the incident.

Patients Who Become Unwell In Transit

- The crew should stop as soon as possible in a safe place and attend the patient.
- The crew should begin to administer treatment in accordance with their training
- IHCD Tech and Paramedic HDU crews are free to use their own clinical judgement in making a decision to continue to the planned destination or divert to ED or other appropriate destination such as a Cath Lab for example.

Patients Who Suffer a Fall or Injury in Transit

- IHCD Tech and Paramedic HDU crews are free to use their own clinical judgement in making a decision to continue to the planned destination or divert to ED.
- ACA, Mental Health and ECA staff should not continue transportation as a matter of course.
- Treatment should be initiated and call 999 for assistance.

In all cases the crew must call the incident reporting line on [redacted] and seek guidance from the Care Quality on call service if required.

The on-call team may make recommendations for treatment or transport options, in such cases the crew should follow the advice given by the on-call clinical team.

ERS Medical

BMS/6.11 Renal Patient Services

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version No:	3.0	**Date Active:**	23.12.2019	**Review Date:**	31.12.2020

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3.0	All	All	All	23.12.19	[redacted]	Annual Review

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3. Introduction

3.1 ERS Medical has designed and implemented its patient centred renal transport service, as an integral part of its Non-Emergency Patient Transport Service, to be both flexible and reliable.

3.2 ERS Medical acknowledges the need to provide this service in a consistent and efficient manner, rapidly being able to identify service delivery issues, so they can be resolved with the minimum impact to our patients, thus reducing the stress and anxiety for all concerned and causing minimum disruption to their lives and routines.

3.3 ERS Medical will ensure that we provide robust communications between all concerned parties so that they are aware of any problems and issues which may arise and how they may impact on the delivery of the service to patients, carers, healthcare providers and NHS Renal Dialysis Units.

3.4 In the identification of a service delivery issue ERS Medical will implement at site level, through the Operations Manager responsible a 'Care Improvement Plan. Details for the use, application and reporting on 'Care Improvement Plans' can be found detailed within **BMS/1.04** – **Corrective and Preventive Actions**.

3.5 ERS Medical will also try to ensure that renal patient transport travelling and waiting times are kept to a minimum, whilst utilising its resources to provide a cost efficient service for the relevant CCG.

3.6 The provision of renal NEPTS services does not cover patients whose clinical presentation or diagnoses is categorised as:

- Emergency;
- GP Urgent;
- Mental Health.

3.7 This procedure, although extensive, will not provide specific details on how ERS Medical manages of categories of non-emergency patient transport, such as:

- Non-Emergency Patient Transport Services (NEPTS);
- High Dependency Patients (HDU).

For detailed information on these categories of NEPTS please refer to either **BMS/6.10(ERS)** – **NEPTS Operations** or **BMS/6.12(ERS)** – **HDU Patient Services respective**ly.

3.8 Renal patient journeys typically occur 3 times a week and NHS Renal Dialysis Units typically provide 3 treatment windows over this 6 day period (see tables on the next page).

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Daily Pick Routine

Group	Mon	Tues	Wed	Thur	Fri	Sat	Sun
A	✓		✓		✓		
B		✓		✓		✓	

Journeys In (all times are approximate and at NHS Renal Dialysis Units)

Early Journeys	Mid Journeys	Lates Journeys
07:00 – 07:30	12:30 – 13:00	17:30 – 18:00

Journeys Out (all times are approximate and from NHS Renal Dialysis Units)

Mid Journeys	Lates Journeys	Twilight Journeys
12:30 -13:00	17:30 – 18:00	21:30 – 22:00

3.9 ERS Medical will, when contractually required, provide a renal NEPTS service to cover all of these days and treatment windows.

3.10 To ensure a single procedure is defined and utilised at all locations within ERS Medical that provides instruction and guidance to all Non-Emergency Patient Transport Services personnel, who are tasked to provide Renal Services for ERS Medical.

3.11 To define the responsibilities of personnel in relation to the Renal Service activities and operations, ensuring consistency is achieved throughout ERS Medical.

3.12 To recognise and document any regional or contractual differences and obligations that may be in place across different CCG or NHS Trust areas in relation to carrying out NEPTS Renal services.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

4.4 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
5.3	**Medical Director**	Has the strategic responsibility for setting, directing and monitoring clinical standards, scope of practice and ensuring that patient safety remains the primary focus of all patient facing services within ERS Medical.
5.4	**Head of Operations**	Is responsible for the implementation, resourcing and strategic delivery of all Non-Emergency Patient Transport Services.
5.5	**Head of Care Standards**	Is responsible for the development, implementation and co-ordination of consistent, quality, efficient and a clinically based approach to the Non-Emergency Patient Transport Service process across ERS Medical.
5.6	**Senior Operations & Operations Managers**	Have day to day responsibility for ensuring Non-Emergency Patient Transport Services procedures are adhered to at all times. In addition to this they are also responsible for ensuring CQC Essential Care Standards are in place and adhered to at all times.
5.7	**Team Leaders**	Are responsible for ensuring all personnel are guided through ERS Medical procedures and that they record, accurately, all records relating directly or indirectly to the transportation, care and treatment of patients by ERS Medical.
5.8	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **At Work** – All activities that are carried out off site which includes all operational personnel across all company facilities.

6.2 **Bariatric Patient** – Bariatric service users are defined by NICE 2004 as being a patient whose weight is 40kg above their ideal weight and or who has a body mass index(BMI) of >30kg/m2. However, for pre-hospital care the accepted criteria are 160kg / 25 stone or a BMI > 35. The realistic model should however be the impact the patient's weight, BMI and body shape has on the crew's ability to care for them with the equipment to hand.

6.3 **Basic Life Support (BLS)** – Is the level of medical care which is used for victims of life-threatening illnesses or injuries until they can be given full medical care at a hospital. It can be provided by trained medical personnel, including Ambulance Care Assistants (ACA's), Emergency Care Assistants (ECA's), Ambulance Technicians, Paramedics and by laypersons (non clinical staff) who have received BLS training. BLS is generally used in the pre-hospital setting, and can, if required be provided without medical equipment.

6.4 **Blood Borne Disease (BBD)** – Sometimes referred to as a Blood Borne Virus (BBV) is a disease or pathogen that can be spread through contamination by blood and other body fluids.

6.5 **Capacity** – Is defined as having sufficient understanding and memory to comprehend in a general way the situation and circumstances that an individual finds themself and the nature, consequences and purpose of any act into which they may enter.

6.6 **Carer** – A family member, friend or someone from an outside company employed to look after the welfare and day to day support of the service user which without support would not be able to attend to basic daily living functions alone.

6.7 **CCG** – Clinical Commissioning Group that is responsible for funding individual patients transport.

6.8 **Computer Aided Dispatch (CAD)** – Computer aided dispatch is a method of dispatching Company assets in customer focused, economical and expedient manner.

6.9 **Compressed Oxygen (02)** – Is Oxygen compressed and stored within a pressurised receptacle (normally a cylinder). Oxygen is an odourless gas that is present in the air and is essential to maintain life.

6.10 **Confidential Information** – Any data or information in whatever form that is disclosed to any ERS Medical staff member which by its nature is confidential or to which the disclosing party acting reasonably states in writing to the received party is to be regarded as confidential.

6.11 **Consent** – Is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of purpose, nature, likely affects and risks of that intervention; including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

6.12 **CCO** – Contact Centre of Operations.

6.13 **DEFIB (AED)** – Automated external defibrillator which is used in the event of cardiac arrest, which consist of delivering a therapeutic dose of electrical energy to the heart.

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6.14 **DNAR Status** – A service users with an active DNAR Status must not be given active CPR in the event a cardiac arrest.

6.15 **Do Not Attempt Resuscitation (DNAR)** – Is a service user who is not for active resuscitation and has a form completed by the attending doctor or register which may have been made with or without the close immediate family.

6.16 **Functional Mobility** – The degree of an individual's ability to move and mobilise independently within their environment.

6.17 **Healthcare Associated Infections (HCAI)** – Infection resulting from treatment in hospital (in or out-patient), nursing homes, or even the patient's own home.

6.18 **Infection Prevention and Control (IPC)** – IPC has been defined as the clinical application of microbiology in practice (RCN 2010). In a more simplistic term, it is the collective term for those activities and resources intended to protect people from infections.

6.19 **Medical Records** – A chronological written account of a patient's examinations and treatments that include the patient's history and complaints, the physician's physical findings, the results of diagnostic tests and procedures, and medications and therapeutic procedures. Medical records can cover a wide range of materials including:

- Hand written notes;
- Computerised records;
- Correspondence between health professionals;
- Laboratory reports;
- Imaging records, including x-rays;
- Photographs;
- Video and other recordings;
- Printouts from monitoring equipment;
- Patient Report Forms (PRF's) and associated documents.

6.20 **Safeguarding** – Is the multi-disciplinary work we do to minimise and manage risk to adults and children who may be vulnerable. It employs a framework which brings together all aspects of an investigation into an allegation of abuse against a vulnerable adult or child.

6.21 **Renal Patient** – For the purposes of this procedure a renal patient will be a person that has been clinically diagnosed with Chronic Kidney Disease (CKD) with such a reduced Glomerular Filtration Rate (GFR) that they are receiving renal replacement therapy.

6.22 **Vulnerable Adult** –As defined in the Department of Health 2000, is someone who aged 18 or over:

- Who is, or may be, in need of community services due to age, illness or a mental or physical disability;
- Who is, or may be, unable to take care of himself / herself, or unable to protect himself / herself against significant harm or exploitation.

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7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a particular decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions for themselves in the future.

7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

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7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

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7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

8. NEPTS Eligibility

8.1 ERS Medical does not engage in the routine checking for renal patient eligibility for transport. Instead we will work to the renal patient lists (RPL), provided by the relevant NHS Trust Renal Dialysis Unit.

8.2 It will be the responsibility, as defined in Section 6 of this procedure, that Operations Managers and his/her team will liaise with the specific NHS Renal Dialysis Units for their contractual area of responsibility, on a regular basis. This should be a minimum of once per week, to ensure that these renal lists are kept up to date.

8.3 If ERS Medical staff arrive at a renal patient's address, as they are still on the RPL provided by the NHS Renal Dialysis Unit and are subsequently informed, the patient died unexpectedly. They should initially apologise for this obviously upsetting situation, withdraw from the address as sensitively as possible and immediately inform the CCO / Control Room / Despatch / Helpdesk as applicable.

8.4 The CCO / Control Room / Despatch / Helpdesk should initially contact the relevant NHS Renal Dialysis Unit providing treatment for the patient and inform them of the situation.

8.5 After informing and confirming with the NHS Renal Dialysis Unit, the deceased patient is removed from any additionally planned transport requirements.

9. Safe Working Practices

Health and Safety

9.1 ERS Medical has made a commitment to ensure that it delivers a service to its patients and customers in a timely, effective and safe manner. It recognises the importance of patients attending their appointments on time and the consequences to both the individual and the healthcare provided when this is not realised.

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9.2 Crews must ensure that all passengers wear seatbelts or other safety restraints/devices appropriate to their mobility/medical classification. Patient who are exempt from wearing such devices should be able to produce valid documentation, on request by ERS Medical employees as proof. Failure to comply shall result in the insistence of the wearing of seatbelts or their transportation being refused.

9.3 Crew must ensure that the correct, issued PPE is worn at all times when required (as per **BMS/9.03 – Uniform and PPE** issue and Use) any defects with PPE must be reported to Line Manager or Team Leader immediately.

9.4 Crew must ensure they are familiar with the risk assessments for all work undertaken and have access to and utilise the driver Hazard Identification process as defined in **BMS/1.07** – **Risk Management**.

9.5 Wherever possible drivers must select the most appropriate equipment and mobility aids, based upon the patients functional mobility and their dynamic scene risk assessment, in order to reduce the amount of manual handing, when assisting a patient.

9.6 When Safer Person Manual Handling cannot be avoided they must refer to and follow their training, which is based on best practice as defined within' The Guide to the Handling of People, Edition 6' (HOP6), and the procedures and risk assessments that are defined within **BMS/6.07** – **Safer Person Handling and Dynamic Risk Assessment**.

9.7 When working as part of a 2 person crew, with patients on board, the attending crew members must travel seated and suitably restrained in the clinical area of the vehicle.

9.8 They must, unless seating space allows, utilise the rear facing attendant seat at all times. Patients, carers, escorts and next of kin should not be permitted to use the attendant's seat.



9.9 Crew rest periods will be determined locally at the discretion of Operations Managers and in accordance with any TUPE terms and conditions for staff. ERS Medical will endeavour to allocate a 30 minute rest period during a shift period.

9.10 Control room staff will try to schedule crew rest periods at the midpoint in their shift, but the needs of the patient will be given priority and rest periods, may on occasion be allocated early or late.

9.11 Under **NO** circumstance will crews be permitted to hold their rest period to the end of their shift and leave early.

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Clinical

9.12 ERS Medical employees must adhere to 'Renal Patient Services' procedures and any other applicable procedural or clinical instructions given by ERS Medical, to avoid and reduce the possibility of injury or harm to service users.

9.13 ERS Medical acknowledges that on some renal patient service / NEPTS platforms, namely singled crewed vehicles, patients will at times be left unattended, to allow for the collection, loading and unloading of other patients. For safety and continuation of care, this is to be kept to the absolute minimum wherever and whenever reasonably practicable.

9.14 Patients should be closely monitored during all journeys in order for the crew to be aware of any changes to the patient's clinical presentation, in both the negative and positive. It is important to know that renal patients can experience some side effects as a result of their dialysis, such as:

- **Fatigue** – feeling tired and exhausted all the time is a very common side effect and is attributed;
  - The loss of normal kidney function;
  - The effects that dialysis can have on the body;
  - The dietary restrictions associated with dialysis;
  - The overall stress and anxiety that people with kidney failure experience.
- **Hypotension** - (Low blood pressure) with can cause;
  - Nausea;
  - Dizziness (this may also cause some mobility issues for the patient).
- **Staphylococcal Infections** –dialysis can cause an increased risk of invasive staphylococcal infections. These infections are caused by the 'staphylococcus aureus bacteria, which are usually responsible for minor skin infections such as boils. These increased susceptibility can cause;
- **Blood Poisoning or Sepsis** – serious infections which can lead to multiple organ failure and death. (High temperature 38°C / 100.4^{o}F or above, dizziness & increased hypotension);
- **Muscle Cramps –** These can be experienced by some patients' undergoing dialysis and are usually in their lower legs, which can also cause patient mobility issues;
- **Itchy Skin –** Possible due to an increased level of potassium in the body;
- **Insomnia –** Difficulties in falling asleep;
- **General Bone and Joint Pains;**
- **Dry Mouth;**
- **Anxiety.**

9.15 Patients diagnosed with Chronic Kidney Disease (CKD) can also be suffering from co-morbidities that can either be related or unrelated to their CKD, such as:

- Diabetes;
- Acute Kidney Injury;
- Hypertension (High Blood Pressure);
- Cardiovascular Diseases;
  - Ischemic Heart Disease;
  - Chronic Heart Failure;
  - Peripheral Vascular Disease;
  - Cerebral Vascular Disease;

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- Structural Renal Tract Disease;
- Haematuria (Blood in the urine) – Opportunistic detection;
- Increased risk of Bleeding normally due to medication to manage their condition;
- Increased risk of bruising normally due to medication to manage their condition;
- Reduced mobility and a proportional increase in assistance to mobilise.

9.16 Patients with a valid DNAR order in place who are well enough and whom are not expected to die imminently can travel alongside other patients. This situation is very different from those patients who are terminally ill/ palliative and are being transported at the end stages of life and who must travel alone. For more detailed information please refer to **BMS/6.06** – **End of Life** Care Pathway.

9.17 In the event of cardiac arrest full BLS will take place, unless a valid DNAR order is in place.

9.18 When death is suspected in transit, please refer to the end of life work instructions within **BMS/6.06 – End of Life**.

9.19 Patient care, safety and comfort should be paramount at all times.

9.20 All 'Renal Patient Services/NEPTS' vehicles are provided with a folder containing driver information sheets, clinical information sheets and other information that is deemed useful or required as part of a contractual obligation.

9.21 All issues that could affect and do affect the quality of the service provided by the company should be recorded and summated to the crews Line Manager or Team Leader on **F6.10.05** – **NEPTS Daily Issues Log**. This form does not negate drivers from their responsibilities to report incidents and near misses in accordance with the procedures at **BMS/5.01** – **Incident Reporting and Investigation**.

9.22 The ERS Medical Clinical Team will publish 'Clinical Memo's' and Toolbox Talks, twice annually (May and November), for guidance and advice for Line Managers and Clinical Staff on the dangers of high and cold temperatures, for patients who find it difficult to regulate their internal body temperature, such as the young, elderly and those who have medical conditions that are exacerbated by extremes of temperature.

10. Scheduling and Crewing

10.1 ERS Medical has 4 separate types of staff who work and provide services on behalf of the Company:

- **Full Time Employees** – Contracted staff that work to a set rota and hours (i.e. 37.5hrs / week);
- **Part Time Employees** (Relief) – Contracted staff that work on a relief / part-time basis and are assigned shifts in priority over zero hours staff;
- **Zero Hour Employees** – Contracted staff who do not work to a set rota or number of hours, but who summit their availability and receive shifts based on this declaration;
- **Volunteers** – Volunteer staff that declare their availability to ERS Medical and are assigned work based on their availability.

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10.2 ERS Medical will schedule and roster 'Renal Patient Services/NEPTS' staff at a local level, to ensure that appropriate staffing levels are maintained to satisfy Company operational and contractual requirements.

10.3 ERS Medical will, wherever and whenever reasonably practicable, staff renal transport in a manner, (i.e. use the same team for specific renal patients) to allow our staff become familiar with the individual needs and concerns of our patients and just as important, that our patients become familiar and comfortable with our staff.

10.4 ERS Medical will, wherever and whenever possible, ensure the crewing of differing clinical grades is appropriate to the requirements of the operational need, contractual requirements and the experience levels of the individual crew members.

	ACA	ECA	Student Technician	Technician
ACA	✓	✓	X	X
ECA	✓	✓	X	✓
Student Technician	X	X	X	✓
Technician	X	✓	✓	✓

10.5 The above NEPTS Crewing Guide, taken from **BMS/6.10 – Non-Emergency Patient Transport Services**, is intended for use only when the clinical grades are working at the identified clinical level *i.e. a student technician may well be considered an ECA when not working with a qualified technician and therefore would work as per the ECA guideline.*

10.6 For the purposes of renal NEPTS transport, ERS Medical would normally assign either a single or double crewed ACA vehicle. This crewing would be tailored to the clinical and mobility needs of the patient. If a higher level of clinical crew were required, (up to Technician level), this would be resourced as appropriate (although this level of transfer would normally be categorised as High Dependency and would be covered by **BMS/6.12 – High Dependency Services**.

10.7 In order to publicise staff rotas at site level, managers can use **F6.10.04 – Staff Rota**. Other locations within ERS Medical may utilise a web based staff rota solution, such as 'GoAssign' to meet this requirement.



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11. Renal NEPTS Platforms

11.1 ERS Medical utilises a number of different platforms to provide a safe, reliable and flexible service to all of our customers. Each platform can also denote a grading of clinical staff assigned to it. In this way ERS Medical can assure its service users that they are being cared for and treated by appropriately qualified staff.

11.2 These platforms and their selection are tailored to the clinical, cognitive and mobility needs of the patients. These platforms are (please see the next page);



Volunteer Car Drivers



Taxis



Wheelchair Access Vehicle (WAV)



Ambulance (seated & stretcher variants)

11.3 Typically these Renal NEPTS platforms would be staffed as follows:

- **Volunteer Car Drivers** – Volunteers will no formal clinical training;
- **Taxis** – Local authority taxi drivers often with no formal clinical training;
- **WAV's** – Ambulance Care Assistant (ACA) / Emergency Care Assistant (ECA);
- **Ambulance (seated)** – ACA & ECA;
- **Ambulance (stretcher)** – including bariatric variant – ACA & ECA.

11.4 ERS Medical will wherever and whenever possible, provide a WAV or appropriate ambulance for renal patients'.

12. Patient Mobility

12.1 Patient mobility classifications are vitally important to allow ERS Medical to assign the correct resource for the requirements of the patient and therefore protect the health, safety and wellbeing of both patients and ambulance crews providing mobility support.

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12.2 These mobility classifications can vary a great deal from contract, CCG, hospital, ward, department and healthcare professional to another. Therefore in response to this ERS Medical as formalised, through interactions with existing customers, a single patient mobility classification to be applied for 'Renal Patient Services / NEPTS' requests.

Mobility Type	Description
	C1 - Driver only The patient can walk unaided to, and travel in a saloon car with the assistance of a driver for walking.
	C1 - Ambulance with driver and vehicle ramp The patient is a minimal falls risk and can walk with assistance of the x1 crew. The patient can manage the step or ramp onto the vehicle with steadying assistance only. The patient may require assistance to the vehicle in a wheelchair but can transfer to the seat of the ambulance. The destination location in known to have easy access (no multiple steps or stairs) and access can still be achieved with the assistance of x1 crew
	C1(W) - Ambulance with driver and vehicle ramp; travelling in own wheelchair The patient has their own wheelchair, been assessed as immobile and unable to transfer out of the wheelchair. The patient will transfer in their wheelchair (secured using WTORS). The destination location in known to have easy access (no multiple steps or stairs) and access can still be achieved with the assistance of x1 crew.
	C2 - Ambulance with driver and attendant plus vehicle ramp The patient cannot walk and requires either a wheelchair (secured using WTORS) or carry chair with the assistance of two ambulance staff to be transfer to and from the ambulance and / or the patients mental, physical condition requires the attention of two staff and or the patient requires oxygen whilst travelling to and from hospital.
	C2 - Ambulance with driver and attendant plus tail-Lift Patient Travelling In Own Wheelchair The Patient is required to travel in their wheelchair (secured using WTORS) and cannot transfer. There are steps at home and / or their condition requires a two person crew.

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Mobility Type	Description
	C2 (Str) - Stretcher Crew The patient has no independent mobility or must remain, for medical reasons, lying down for the duration of the journey, and/or has a full leg cast or patient is unable to bend their leg and cannot sit.
	C3 (Str) - 3 Man Crew Requires x3 Crew members to transport the patient safely due to patient mobility and or access and egress to either the collection or delivery destination or both.
	C4 (Str) - 4 Man Crew Require x4 crew members to transport patients due to mobility, weight and size in the case of bariatric patients or due to known access and egress issues to collection or delivery destination or both.
	C-Para - Paramedic Crew Due to the patient's presenting medical condition a paramedic intervention or monitoring crew is or may be required on route to safely convey the patient.

Escort Type	Description
	C+(E) - Elative or Medical Escort A nurse, clinical team or carer is required to travel due to the needs of the patient during the journey. Or a parent or relative is deemed necessary due to the needs of the patient either 1 or 2 relative may travel.
	C+ (CE) - Child Escort All children under 16 must travel with an escort.

12.3 For detailed and specific information relating to patient mobility types and suitability for transportation please refer to **BMS/6.07 – Safer Person Handling and Dynamic Risk Assessment** and **F6.10.03 – Mobility Assessment Flowchart.**

13. Pre-Shift Routine

13.1 Crews should arrive at the ERS Medical sites in good time before the start of their allocated shift, allowing sufficient time to conduct their pre-shift routine.

13.2 Staff should check their rota / allocated shift noting the correct resource assignments, vehicle & crew partner and the duration of their shift.

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13.3 It is vital to the efficient running of the ERS Medical 'Renal Patient Service / NEPTS service and the CAD system, that crews are matched with the correct resource i.e. ***N27 (NEPTS Stretcher Ambulance) crewed with John Smith (ACA) with Jane Smith (ACA).***

13.4 They should notify their control room immediately if they encounter a resource issue so that these can be resolved the minimum effect on service delivery. They should under **NO CIRCUMSTANCES** take upon themselves to change their assigned vehicle or crew partner without the prior approval of their control room.

13.5 They should then collect their CAD Tablet (if this system is being used), ensuring that it has been fully charged, undamaged and functioning correctly or if the site is recording data manually complete the start information on **F6.10.01 – Daily Running Sheet.**



CAD Tablet

13.6 The crew should then log onto the tablet (if used) and select the correct resource and wait for their task allocations to be sent to them. For manually managed renal journeys please refer to S16 of this procedure.

13.7 They should then complete a physical check on the serviceability of their assigned vehicle as required by **BMS/8.01** – **Transport – Common Tasks for Line Managers**.

13.8 All vehicle issues should be reported immediately to their control room and if necessary and available another vehicle will be assigned to them. This check should be recorded on the pre-printed and numbered 'Drivers' Daily Vehicle Inspection' sheet and handed in their line manager prior to departing their site.



Renal Patient Services / NEPTS staff checking the vehicle

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Drivers' Daily Vehicle Inspection

Report No. 39404

Driver 1:	Vehicle Reg.	Date	Time	Mileage Start	Mileage Finish
Driver 2:	Vehicle Reg.	Date	Time	Mileage Start	Mileage Finish

Driver to check all items. Tick if okay.
All safety related faults to be reported immediately.

Fuel / Oil / Water	Number plate	Body / livery / eqpt
Battery	Wipers / washers	Tax
Steering / Tyres / Wheels	Horn / reverse warning	Engine / excessive exhaust smoke
Lamps & Gauges	Seat belts straps	Cleanliness
Brakes	Tail lift operable	Fire ext / 1st aid kit
Lights / Indicators	Infection control	Mirrors
Stretcher	Wheel chair	Carry chair

Vehicle left clean	Fuel added (litres)	Mileage at refuelling

Write all defects below.

Reported to:

Rectified by:

Mark all damage.
S = Scratch
D = Dent
B = Broken

Pre-Printed Drivers Daily Vehicle Inspection Form

13.9 The crew should then complete a thorough check of their clinical equipment, consumables and ambulance equipment and record this on the relevant **F6.10.02 – Vehicle Loading List**. All discrepancies should be immediately reported to their line manager and replaced prior to the commencement of the duty shift.



Renal Patient Services / NEPTS staff checking clinical stores and equipment

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13.10 As part of their vehicle checks they should also check and verify the contents of the Ambulance Information Pack. It should contain:

- An Information Pack Contents List;
- Locality Introduction and ERS Medical Useful Telephone Numbers List;
- Recent and Relevant Clinical and IPC Memos;
- ERS Medical Safeguarding Procedure **WI/6.05.01 – Safeguarding of Vulnerable Adults & Children Reporting**;
- Local Useful NHS Telephone Numbers and Site Maps;
- ERS Medical Patient Report Forms;
- ERS Medical Dynamic Bariatric Risk Assessment (Bariatric Capable Vehicles Only);
- Capacity and Consent Assessment Form;
- DNAR Orders and Forms;
- NEPTS Daily Running Sheets **F6.10.01**;
- CAD Tablet Overview;
- Accident / Incident Report Form **F5.01.02**;
- Accident / Incident Statement **F5.01.03**;
- Vehicle Accident Bump Card **F5.01.06**;
- Drivers Handbook.

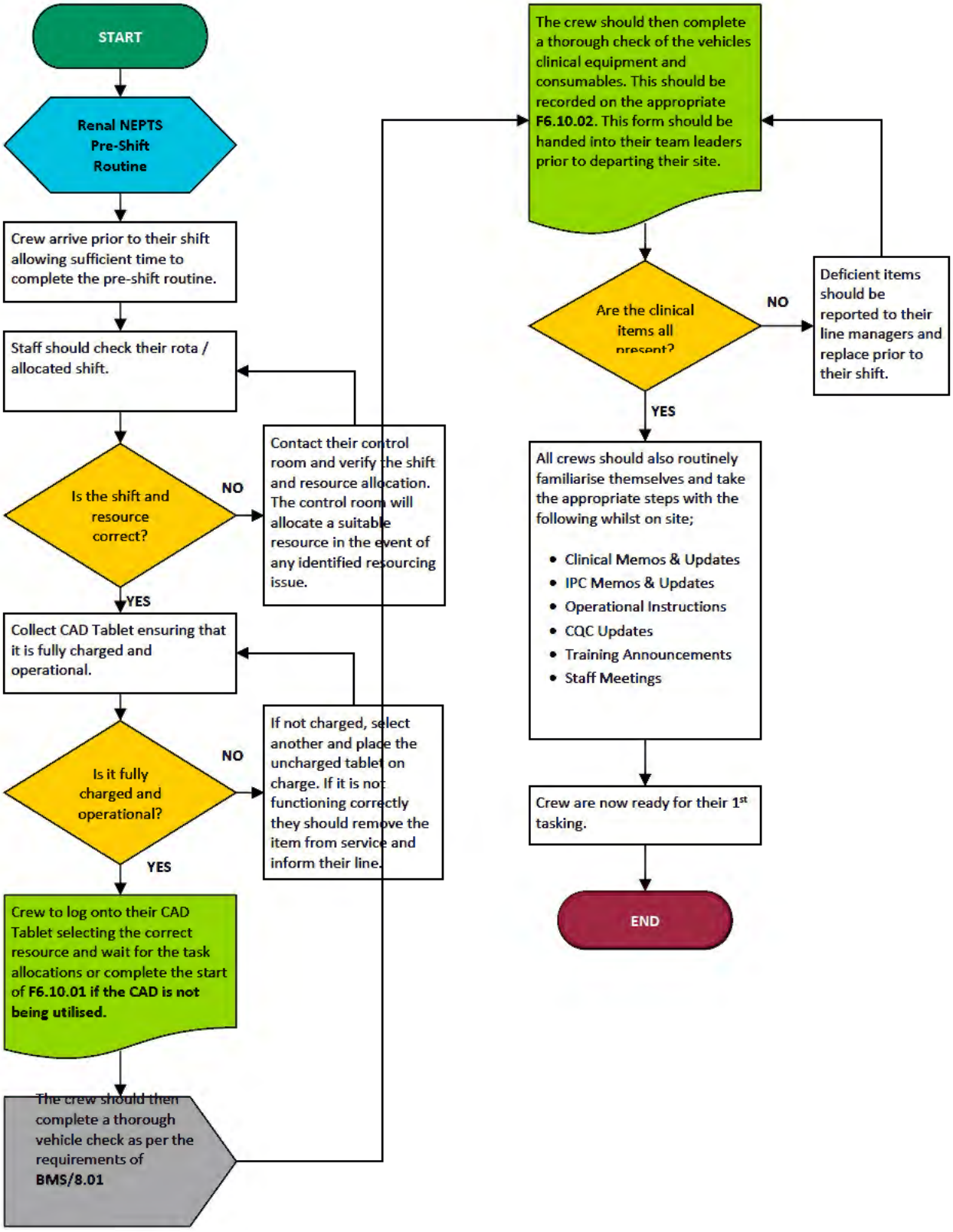
Routine Checks

13.11 Staff should also ensure that they routinely check and familiarise themselves with the following:

- Clinical Memos, updates and Instructions;
- Infection Prevention and Control Memos, Updates and Instructions;
- CQC Notifications and Information Posters;
- Operational Instructions and Changes;
- Company Training Announcements and Notifications;
- Site Notice Boards, for staff meetings, team talks and toolbox talks.

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14. Key Steps



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15. Renal Patient Services Task Process

15.1 The CC) / Local Control Room / Helpdesk receives the initial or updated renal patient transport list, from the NHS Renal Dialysis Unit (NHS RDU). This should include:

- Patient Name;
- Date of Birth;
- Hospital / NHS number;
- Collection Address and possibly telephone number;
- Days, times & Location for their dialysis;
- Collection days, times;
- Delivery Address if different from the collection address;
- Mobility classification for the patient;
- Additional information such as;
- Any significant co-morbidities such as;
  - Dementia or other cognitive impairments;
  - Physical disabilities such as blindness, deaf or amputated lower limb;
- Escorts travelling with the patient.

15.2 ERS Medical will use the renal patient lists provided, as the verification for eligibility for transport, as it would unrealistic and inappropriate to continually check individual patient eligibility.

15.3 The CCO / Local Control Room / Helpdesk will then check to ensure that all required information fields are present. If there are missing data fields a call will be made to the relevant NHS Renal Dialysis Unit to obtain this information.

15.4 Depending on how renal transport is resourced and controlled at ERS Medical operational locations, this information is either entered into the secure CAD system or the secure local renal patient spreadsheet, to be planned and resourced appropriately.

15.5 There are numerous reasons for theses variations in renal patient data handling such as:

- Contractual requirements placed on ERS Medical;
- Individual preference stipulated by a specific NHS Renal Dialysis Unit;
- Connectivity issue for the CAD and CAD tablets in certain geographical areas;
- Volume and frequency (both positive and negative) of renal patient transport requirements.

15.6 Once details are checked and entered, the process moves to planning to rationalise and match the transport requirements of patients' to available resources, taking into account:

- The distance and travel times for patients' in relation to their NHS Renal Dialysis Unit;
- The times of their booked treatment (earlys', mids' or lates');
- The geographical grouping of renal patients attending the same NHS RDU;
- The clinical and mobility needs of individual patients;
- The return transport destination (home or care facility address) post treatment (mids', lates' and twilights').

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15.7 If the CAD system is being utilised the booking is then stored within the unplanned section of the CAD, until such time as the planners can allocate a suitable resource (ambulance and crew).

15.8 None CAD journeys will be manually planned and resourced, normally 24 hours in advance from the renal patient spreadsheet.

15.9 Once manually planned the CCO / Local Control Room / Helpdesk will telephone the crew members assigned to the renal transport and pass the next day's booking details to them. (This information is not emailed as this would breach patient and data security requirements).

15.10 Having completed their pre-shift routine (section 16) the crew should sign into the CAD system as an available resource (ambulance and crew). The CAD should then auto despatch the first planned task for that resource to their CAD Tablet.

15.11 Once the crew receive the first task on the CAD Tablet they should confirm receipt of the task and at then change their status on the tablet to 'On-Route'. Crews using the manual system should start completing **F6.10.01** – **NEPTS Daily Running Sheet** from the information provided by telephone the day before and enter their departure time in the 'Time Allocation' box.

15.12 Once they have arrived at the patient collection location, they should change their CAD status to 'Pick-up Started' or enter the time in the box 'Arrived on Scene' on the **F6.10.01** – **NEPTS Daily Running Sheet.**

15.13 If for some reason the patient is not ready they should inform either the patient, carer, next of kin or healthcare professional that they will wait for a maximum period of 15 minutes, after which time the task will be aborted and they or the booking agent will have to rebook the transport through the CCO.

15.14 In addition to this the crew should send a message via the tablet or telephone, as soon as they are aware of a delay the CCO / Local Control Room / Helpdesk and wait for a further guidance and instructions as there may be sufficient time available before their next task to extend this waiting period. This decision should be balanced against the needs of the delayed patient and those of any patients' that are already on the ambulance or still require picking up.

15.15 Once the patient has been picked up made comfortable and safely secured on the ambulance, the crew should change their CAD Tablet status to 'Driving to Destination' or enter the time of departure in the box 'Depart / Clear Location', on **F6.10.01** – **NEPTS Daily Running Sheet** and proceed on their way.

15.16 Crews should always try to position patients on their ambulances to take into account the order of the patients' getting off. This should be balance against the clinical and mobility needs of the patient and their safety and comfort. These principles should never be compromised for what is deemed easier and quicker for the crew.

15.17 The crew should contact the CCO / Local Control Room / Helpdesk and inform them of any delays they encounter on route, that will or has the potential to cause a late arrival for their patient(s) or make them late for the next planned journey for them.

15.18 The crew should continue to monitor all patients in on route, to ensure that they are safe, comfortable and that their clinical presentation does not deteriorate. If this does occur they should follow the procedure for clinical escalation at Section 18 of this procedure.

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15.19 Once they have arrived at the NHS Renal dialysis Unit, the crew should change the CAD tablet status to 'Delivering at Destination' or enter the time in the 'Arrive Destination' box of the **F6.10.01 – NEPTS Daily Running Sheet** More detailed information and guidance for patient arrival procedures can be found at **WI/6.11.01 – Renal Patient Arrival Process**.

15.20 They should then begin to unload their patients in a safe and professional manner and ensure that each patient arrives at NHS Renal Dialysis Unit.

15.21 Once all patients' have been safely dropped off at their respective locations the crew should change the CAD tablet status to 'Finished' or enter the time in the 'Time Available' box of the **F6.10.01 – NEPTS Daily Running Sheet**.

15.22 They should then either wait for the next task to be assigned, or continue to work already manually programmed for them from the CCO / Local Control Room / Helpdesk.

15.23 Crews must report any problems or customer related issues they encounter, that may affect service delivery, to their Team Leader / Line Manager as soon as possible to allow remedial action(s) to be implemented as needed.

15.24 In the event that the CAD system is down or inaccessible by the crew due to poor data signal reception, the crew should in the first instance attempt to contact their CCO / Local Control Room / Helpdesk for guidance, by use of the CAD tablets built in mobile phone system. It is important to note that this function may still work even when there is no data signal.

15.25 They should record all tasks undertaken whilst the CAD system is unavailable on the **F6.10.01 – NEPTS Daily Running Sheet**. This should then be handed into their line manager on return to the site for retrospective data entry into the CAD system. Crews should understand this data capture and input is essential to ERS Medicals ability to accurately record and report on Key Performance Indicators (KPI's).

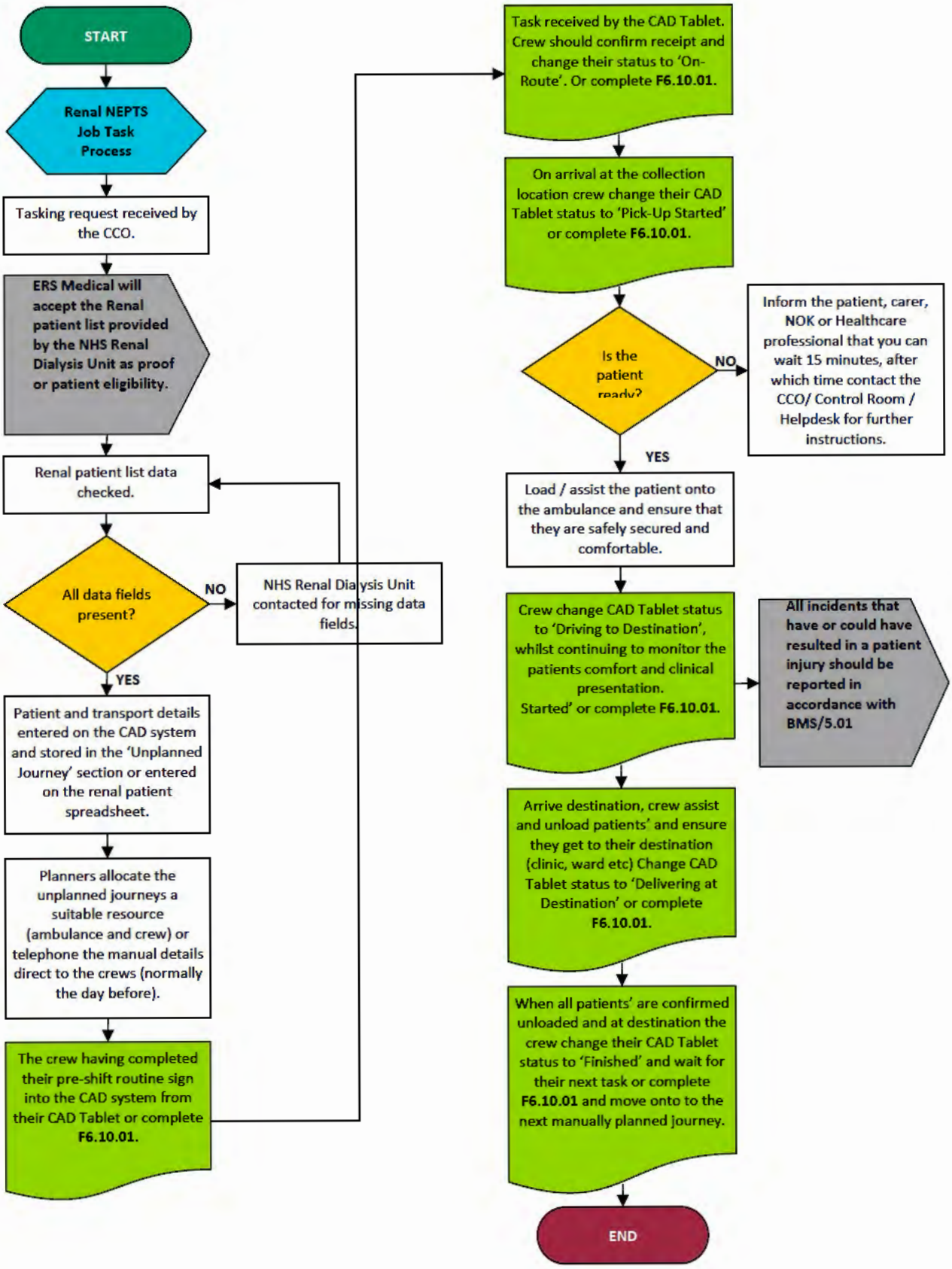
15.26 All return journeys from the NHS Renal Dialysis Unit that are either controlled by the CAD or manually booked should have all their timings and status changes recorded and logged on the **F6.10.01 – NEPTS Daily Running Sheet** as per the inward journey.

15.27 Staff should also be mindful of any clinical impacts as a result of the dialysis treatment and expect their patients to require additional assistance with mobility.

15.28 The **F6.10.01 – NEPTS Daily Running Sheet** should be handed into their line managers, completed in full at the end of their working shift to allow the journey data to be reported back to the CCO / Local Control Room / Helpdesk for contractual and KPI reporting purposes.

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16. Key Steps



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17. Clinical Escalation

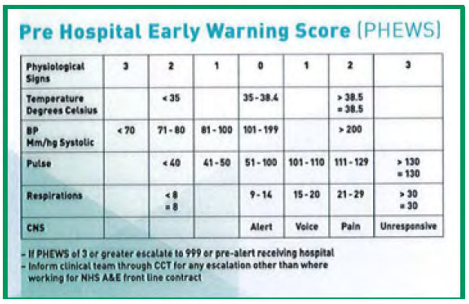
17.1 When NEPTS patients clinical presentation becomes a concern, crews should follow the protocols and guidance contained within;

- Ambulance Care Assistant (ACA) – Emergency Medical Aide-Memoire.



ACA Emergency Aide-Memoir

- Emergency Care Assistant (ECA) – Pre-Hospital Early Warning Score (PHEWS).



Pre Hospital Early Warning Score (PHEWS)

Physiological Signs	3	2	1	0	1	2	3
Temperature Degrees Celsius		< 35		35 - 38.4		> 38.5 = 38.5	
BP Mm/hg Systolic	< 70	71 - 80	81 - 100	101 - 199		> 200	
Pulse		< 40	41 - 50	51 - 100	101 - 110	111 - 129	> 130 = 130
Respirations		< 8 = 8		9 - 14	15 - 20	21 - 29	> 30 = 30
CNS				Alert	Voice	Pain	Unresponsive

- If PHEWS of 3 or greater escalate to 999 or pre-alert receiving hospital
- Inform clinical team through CCT for any escalation other than where working for NHS A&E front line contract

ECA – Pre-Hospital Early Warning Score (PHEWS)

- Ambulance Technician – are expected to use their clinical knowledge, training and experience in caring and treating both acute and chronically ill patients, using more advanced diagnostic protocols such as; Glasgow Coma Score (GCS).

17.2 ERS Medical ambulance crews should not delay any call for the emergency services, in the event of any medical emergency. They should initiate the 999 call and then follow the clinical protocols, up to the level of their scope of practice, until such time as help arrives.

17.3 They should then provide the emergency services with a detailed handover or what they have observed, actions they have taken and any relevant information relating to the emergency i.e. timings, mechanism (if known), previous medical & medication history and any known allergies.

17.4 For more details on how to manage patients who deteriorate please refer to **BMS/6.02 – Patients Who Deteriorate in Transit**.

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18. Clinical Scope of Practice

18.1 All clinical grades within ERS Medical have a defined clinical scope of practice to which they are permitted to operate. For specific clinical grade scope of practices see:

- ACA – Appendix A;
- UCA – Appendix B;
- ECA – Appendix C;
- Technician – Appendix D.

19. Safeguarding of Vulnerable Adults and Children

19.1 For guidance and advice on dealing with safeguarding issues staff should consult the procedural guidelines detailed within **BMS/6.05 – Safeguarding of Vulnerable Adults and Children** and its associated work instruction and forms. They should also complete the competency matrix within the work instruction prior to undertaking NEPTS work activity.

20. Infection Prevention and Control (Deep Clean)

20.1 For guidance and advice on Infection Prevention and Control (IPC), including post exposure procedures and vehicle and equipment 'Deep Clean' protocols and schedules, staff should consult the procedural guidelines detailed within **BMS/6.03 – Infection Prevention and Control** and its associated work instruction and forms.

21. Conflict Resolution

21.1 ERS Medical acknowledges that although most NEPTS journeys will be completed without incidents involving verbal or physical abuse, there will be small percentage of patients who will, due to varying reasons, behave in a manner that may make staff feel uncomfortable or threatened.

21.2 For guidance and advice on dealing with violence and aggression staff should consult the procedural guidelines detailed within **WI/6.13.02 – Conflict Resolution**. They should also complete the competency matrix within the work instruction prior to undertaking NEPTS work activity.

21.3 ERS Medical staff should report all incidents of verbal and physical abuse immediately to the line mangers or the CCO and complete and incident report at the earliest opportunity using the procedures within **BMS/5.01 – Incident Reporting and Investigation**.

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22. Patients Incidents and Near Misses

22.1 For guidance and advice on dealing with any incidents that have or had the potential to cause harm, injury or ill health to our patients, service users or members of the public, staff should consult the procedural guidelines detailed within **BMS/5.01 – Incident Reporting and Investigation**.

22.2 It is imperative that all near misses and incidents that either did or had the potential to cause a patient injury are reported. Proactive reporting allows ERS Medical to identify trends for near misses and put measures in place to either reduce eliminate the risk.

23. Vehicle Breakdowns and Incidents

23.1 For guidance and advice on dealing with vehicle breakdowns and accidents staff should consult the procedural guidelines detailed within **BMS Section 8 – Transport**.

23.2 Patient safety, care and comfort should be paramount and staff should inform the CCO / control room immediately if they have a breakdown or accident, and declare when they a patient or patients travelling on their ambulance.

23.3 Operations Managers should take appropriate steps to ensure that patients' are not kept at the roadside any longer than necessary and never exceeding a 60 minute period. Additional resources should be mobilised to minimise the impact of medical appointment late arrivals and communications must be made to healthcare facilities advising of them of the potential delay.

23.4 The Managing Director and Operations Director should put in place suitable breakdown and recovery services, on a national basis, ensuring an arrival of service at the ERS Medical vehicles location, within 60 minutes of receipt of the initial call.

24. Patient Experience Survey

24.1 ERS Medical recognises that it has a duty and responsibility, not only under regulation (CQC) but also from a moral stand, to monitor and measure the effectiveness, care, safety and general wellbeing of the patients, service users and carers who use our service.

24.2 To measure how our service is perceived, from these patients, service users and carers, we offer them the opportunity to complete one of our 'On Board Ambulance Surveys', and return it to us Freepost at their convenience.

24.3 Our crews are instructed to offer these to all patients, service users and carers and allow them to take them away and complete with no pressure or timeframes set. We will also assist those, who request, in the completion of the surveys and return them on their behalf.

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24.4 The completed surveys will be processed on receipt by the staff of the CCO based in Leeds, who issues a report on a monthly basis, which is sent to each area General Manager or site Operations Manager for review. This report will be available from the Patient Client Experience Team and the CCO.

24.5 General Managers and site Operations Managers will at all-time hold the responsibility to monitor and act upon the findings of the monthly patient survey report. This will include and not be limited by the implementation of Remedial Action Plans (RAPs) as required by **BMS/1.04 – Corrective and Preventive Actions**.

25. Post Shift Routine

25.1 Prior to the completion of shift all ambulance crews will ensure that their vehicle has at least ½ a tank of fuel. This is to ensure that on the commencement of that vehicles next shift it has sufficient fuel to start its allocated tasking, without the initial need to refuel.

25.2 Any vehicle found, during the pre-shift routine (see section 13 of this procedure) not having at least ½ a tank of fuel should be initially recorded on the (Drivers' Daily Vehicle Inspection' form) and their line manager informed.

25.3 Crews should then start completing the ERS Medical 'Vehicle Closing Down' closing down procedure as detailed on the pre-printed closing down form (see fig below).

25.4 In addition to the post shift requirements, stipulated by the ' Vehicle Closing Down' form, staff should ensure that the following are also completed:

- Replenish Medical Gases as required;
- Replenish any clinical consumable that were used during the course of their shift;
- Replace any paperwork i.e. safeguarding referral forms, dynamic bariatric risk assessment forms or patient report forms.

25.5 The crew should then log out of their CAD Tablet and secure it within the site building and place it on charge, so that it is ready for the next shift.

25.6 All CAD Tablets should be left **ON CHARGE**, so that their software can be updated overnight or whilst not in use.

25.7 Staff should then ensure that the vehicle exterior is washed. All ERS Medical vehicles should, weather conditions permitting, be have their exteriors washed at the end of every operational day, or at some point during this period, depending on operational pressures.

25.8 Staff should remember that the exterior condition of ERS Medical vehicles is often one of the first impressions patients', other healthcare professionals and the public have of the Company.

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DATE: TIME: LOCATION: ERS CALL SIGN:

OFF GOING CREW:

NAME 1:	SIGNATURE 1:
NAME 2:	SIGNATURE 2:

TASKS TO BE COMPLETED BY OFF GOING CREW AND A ✓ WHEN COMPLETED: X IF NOT COMPLETED

SEC.	DESCRIPTION:	✓/X	REMARKS:
1	SAT NAV & PHONE SECURED IN GLOVE BOX		
2	TERRAFIX SECURED IN GLOVE BOX		
3	ISOLATORS SWITCHED OFF		
4	ALL ELECTRICAL EQUIPMENT UNPLUGGED		
5	ANY EVIDENCE OF DRINKS AND FOOD REMOVED FROM CREW CAB		
6	CLINICAL WASTE REMOVED AND NEW WASTE BAG FITTED		
7	SHARPS SECURED AND CONTAINER CLOSED		
8	CONTACT AREAS WIPED DOWN		
9	EQUIPMENT USED DURING SHIFT RESTOCKED		
10	PATIENT COMPARTMENT MOPPED OUT		
11	CONTROLLED DRUGS SECURED		
	CD REGISTER COMPLETED & CORRECT		

ON GOING CREW:

NAME 1:	SIGNATURE 1:
NAME 2:	SIGNATURE 2:

ON COMING CREW: IF CORRECT PLACE ✓ IN BOX

VEHICLE FOUND TO HAVE BEEN CLOSED DOWN CORRECTLY BY PREVIOUS CREW?

IF THIS IS NOT THE CASE PLEASE LIST COMMENTS BELOW:

ERS OPERATIONAL MANAGERS DATE: ON CALL LOG REFERENCE:

OBSERVATION:

ACTION TAKEN:

ERS Medical Vehicles Closing Down Form

25.9 In inclement weather conditions i.e. snow and ice, where washing the vehicles becomes impracticable because of frozen water pipes and because of the increased slip trip risk from residual water left after the washing process, staff should ensure that as a minimum the following are kept clean and clear;

- Windscreen;
- Cab Side Windows;
- Side Mirrors;
- Front lights and indicators;
- Rear Lights;
- Front and Rear Number Plates.

25.10 The decision to put an operational site on a cold weather cleaning footing will be made the sites Operations Manager or deputy in his/her absence. This decision should be notified to staff by a clear instruction and signage.

25.11 Interior cleaning protocols are covered in the 'Vehicle Closing Down' form, but for more specific IPC guidance and information staff should refer to **BMS/6.03(ERS) – Infection Prevention and Control (IPC)** but in general the following should be adhered to:

- All clinical waste removed and placed in a clinical waste bin;
- All rubbish removed from all areas of the vehicle;
- All floor surfaces cleaned and mopped with disinfectant;
- All flat surfaces wiped clean;
- All medicines PODs removed and secured;
- All monitors removed and secured.

25.12 Depending on the site and its available resources the cleaning of the exterior and interiors of ERS Medical ambulances will be conducted by the 'Make Ready' staff.

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25.13 On completion of all or the previous actions, the vehicle should be parked in a safe manner with the handbrake applied; all personal effects should be removed from the vehicles and crews should ensure that all doors and windows are fully secured.

25.14 The vehicle keys and vehicle fuel card should be returned and secured within the site, ready for the next crew to man the vehicle.

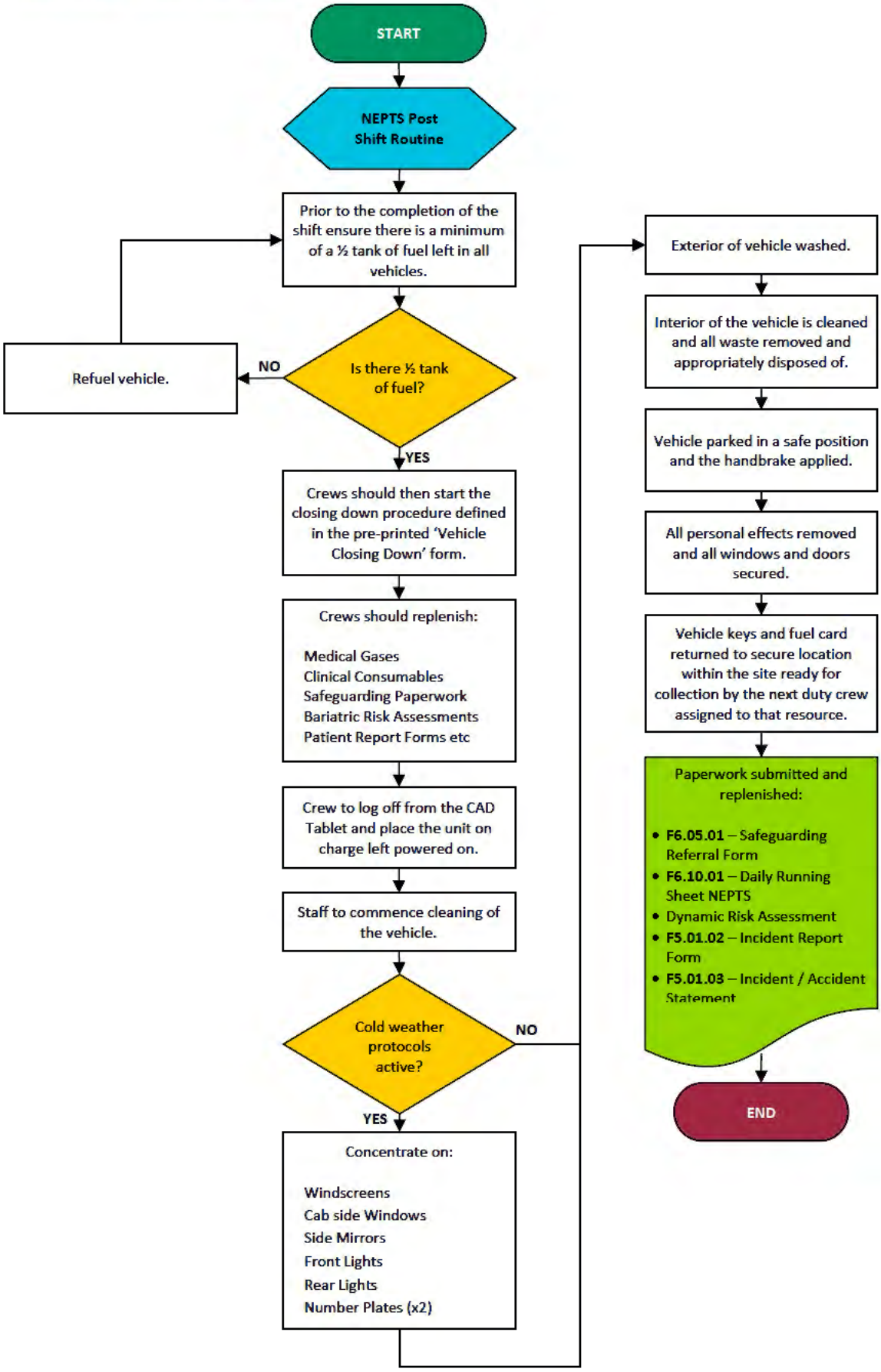
25.15 Prior to leaving staff should submit any manual paperwork that was completed during their shift;

- **F6.05.01** – Safeguarding Referral Form (Road Staff);
- **F6.07.01** – Dynamic Bariatric risk assessments;
- **F6.10.01** – Daily Running Sheets (NEPTS);
- ERS Medical Patient Report Form;
- **F5.01.01** – Incident Report Form;
- **F5.01.02** – Incident / Accident Statement.

This list is not exhaustive.

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26. Keys Steps – Post Shift Routine



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28. Hospital Based Staff (Concierge and Hospital Liaison Officers)

27.1 ERS Medical has taken an innovative decision to embed with NHS hospitals, where it has a contractual obligation to provide NEPTS services, staff to act as a face to face liaison between the Company, NHS customer and patients.

27.2 These staff members will be able to react and interface, in real time, with wards and departments, within the NHS Trusts to providing updates to NEPTS related questions and enquiries, by means of interrogating the ERS Medical CAD and vehicle tracking systems.

27.3 Additionally they can deal with on the day discharges from the Trusts and allocate the most suitable resource for the tasking, ensuring a prompt efficient service to both the customer and patient.

27.4 The liaison staff will also have a proactive role within these facilities to attend bed meetings and pre-warn ERS Medical of any known bedding issues, such as black alert bed status or the declaration of a major incident within the Trust.

27.5 This proactive step will then enable ERS Medical, time in which to mobilise suitable resources to manage the expected increase in NEPTS demand.

27.6 The liaison staff will also serve as a point of contact within the NHS Trust for ERS Medical staff to initially contact, if appropriate to do so, if they encounter any issues that may affect the delivery of service to our customer and patients.

29. Observer Shift

28.1 In the event of a site receiving a request for an individual to ride out on an ERS Medical Ambulance as an observers, **F6.10.11 – Observers Indemnity Form** must be completed prior to any such observer shift being undertaken.

28.2 **F6.10.11 – Observers Indemnity Forms** can only be authorised by a General Manager or above. All completed and authorised forms will be retained for a period of 3 years from the date of the observation shift.

28.3 All ERS Medical crews selected to have an observer ride out with them will be briefed by their Operations Manager on the requirements of and limitations to an observer, whilst out with the crew.

28.4 For the purpose of this procedure an ‘ambulance observer’ means; an authorised person suitably dressed, may accompany ERS Medical ambulance staff solely to observe operational activities and crew actions without interference or assisting in any way with patient care or treatment.

28.5 Under NO circumstances should an observer be left unattended with any patient transported, cared for or treated by ERS Medical.

28.6 Any incident / complaint that results from any actions of an observer, during the course of their shift will be handled in accordance with the requirements of **BMS/5.01 – Incident Reporting and Investigation** and **WI/6.08.01 – Dispute and Complaint Resolution (CCO**).

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30. Useful Hints & Tips

29.1 Ambulance work is dynamic, unpredictable, fluid and rewarding. For the less experienced staff it can often prove to be challenging, demanding and riddled with pitfalls and the potential for things to just go wrong.

29.2 ERS Medical recognises this fact and in conjunction with more experienced ambulance crew, it has compiled a short hints and tips section for this procedure. This list is not designed to act as procedure in itself, but merely to help staff feel more confident in their work environment.

- What does the patient look like when you first meet them? Has their mobility been correctly categorised and can you verify this;
- Have they been sitting for a prolonged period;
- Do they require the assistance of a stick or frame;
- Ask how they have been mobilising to the bathroom or in general;
- What was their mobility prior to admission to hospital;
- Are they going home or to a care / nursing home;
- Have they and do they have the capacity to consent;
- Expect a handover from a qualified member of staff (Nurse);
- Don't assume that everyone in uniform is a qualified member of staff;
- Is the patient continent and if not how is their incontinence managed;
- Check any urine bags and if necessary ask staff to empty them prior to transportation;
- If the patient is immobile ensure that the hospital, care or nursing home provides staff to assist you with the handling of the patient;
- Prior to moving a patient, ensure they consent, if they can and that they participate in any decision on how to move them;
- Protect their dignity and ensure that curtains or blinds are drawn;
- Ask the staff if there is someone to receive them at the destination and are they likely going to be there when you arrive;
- Check the address that the patient is going to;
- Does the patient have a key to the address? If the staff say it is in their personal effects, don't take their word as them to verify this;
- If the key is secured within a wall key safe, ensure that you know the number of the safe before you leave the ward. If you write this number down ensure that you treat it with and dispose of it securely;
- Is the patient dressed appropriately for their discharge? Remember some patients may have been an emergency admission and therefore may not have what is deemed suitable clothing available. Preserve their dignity, comfort and warmth at all times;
- Is access to the property known i.e. steps, access ramp can an ambulance trolley fit in the property;
- Ensure that all cannula are removed from the patient prior to discharge. (These are often overlooked);
- Is there a valid DNAR order in place;
- Do you have the right and appropriate medical notes if the transfer is intra-hospital;
- Do you have the right medications and discharge letter for the patient;
- **DO YOU HAVE THE RIGHT PATIENT!**

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Question 1.19.14.5

Health and wellbeing of regular users.

Please set out the arrangements in-place to support the health and wellbeing of patients requiring regular journeys including haemodialysis, chemotherapy etc.

Word count 750

Total Word Count: 499

Attending regular appointments for chemotherapy and haemodialysis forms an integral part of a patient's day to day routine which may also impact on family members. We consider regular service users to be essential patients with a service tailored to their specific needs.

The chemotherapy and haemodialysis services will have dedicated vehicles that will not be diverted to any other service. Providing regular service users with a regular driver enables a rapport to be developed between our staff and the patients which helps us to deliver a tailored service to best meet each patient's needs. From our experience assigning regular drivers to transport regular service users builds trust and understanding and provides positive benefits to the health and wellbeing of the patient. We also believe that a regular driver/crew may well notice those small differences in patient presentation that can be invaluable.

To provide an efficient service, we will look to implement our shuttle bus service but will also have a variety of additional vehicles to provide a dedicated service dependent on the patients' mobility and clinical needs:

- Ambulance (stretcher) – including bariatric variant
- Ambulance (seated)
- WAV's
- Volunteer Car Drivers
- Taxis



Wheelchair Access Vehicle (WAV)



Renal & Ambulance (seated & stretcher variants)

ERS Medical



Volunteer Car Drivers



Taxis

Co-ordinated Service

ERS Medical will provide a fulltime dedicated regular service user Co-ordinator focused on patient care and journey efficiency. This fulltime role will deliver a quality service to ensure we are 'on time every time'.

Due to the nature of regular service users we do not engage in the routine checking of eligibility for each and every transport. This streamlines their service booking experience and minimises any inconvenience. We will conduct eligibility checks every 3 months or as and when appropriate.

We have made a commitment to ensure we deliver a service to our patients and customers in a timely, effective and safe manner. We acknowledge the need to rapidly identify service delivery issues, so they can be resolved with the minimum impact to our patients.

Renal Bus

As part of our dynamic approach to renal and chemotherapy transport, to maximise efficiency and patient comfort, we would investigate the potential for implementing our renal bus service. It utilises an innovative patient grouping system to maximise the effectiveness of the service.

Booking system

The booking system allows for block bookings for Renal and Oncology Patients up to three months in advance. Individual bookings can also be made on a regular basis.

The ERS Patient Zone allows renal patients to view current and future transport bookings, giving peace of mind.





Service Developments

Through actively encouraging feedback from renal patients and by working in partnership with independent groups such as Healthwatch we will identify and implement service developments.

We have reviewed the Insight reports prepared by Healthwatch Staffordshire, where they identified areas for service improvement relating to communication, journey planning and the need for a Renal Transport Coordinator.

ERS is confident that the recommendations published by Healthwatch are all addressed as part of our contract service offering.

ERS Medical

WI/6.11.01 Renal Patient Arrival Process

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version No:	3.0	**Date Active:**	23.12.2019	**Review Date:**	31.12.2020

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	03.12.18	[redacted]	Annual Review
3.0	All	All	All	23.12.19	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
Information Governance	BMS/1.09
GDPR	BMS/1.10
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02
Whistleblowing (Raising Concerns at Work)	BMS/2.05
Disclosure & Barring Service (DBS) Checks	BMS/2.06
Alcohol, Drugs and Substance Misuse	BMS/2.07
Incident Reporting and Investigation	BMS/5.01
Serious Untoward Incident Investigation	BMS/5.02
Statutory Notifications	BMS/5.03
Business Continuity	BMS/5.04
Care to Care	BMS/6.01
Patients Who Deteriorate in Transit	BMS/6.02
Infection Prevention and Control	BMS/6.03
Medicines Management	BMS/6.04
Safeguarding of Vulnerable Adults and Children	BMS/6.05
End of Life Care	BMS/6.06
Safer Person Manual Handling and Dynamic Risk Assessment	BMS/6.07
Patient Communications and Control	BMS/6.08
Non-Emergency Patient Transport Services (NEPTS)	BMS/6.10
HDU NEPTS Operations	BMS/6.12
Transport - Common Tasks for Line Managers	BMS/8.01
Transport - Vehicle Management	BMS/8.02
Transport - Managing Drivers	BMS/8.03
Health and Safety Management (Common Tasks for Line Managers)	BMS/9.01
ADHOC Journey Quotes and Bookings (CCO)	WI/6.08.04
CAD Bookings	WI/6.08.07
NEPTS Eligibility	WI/6.10.01
NEPTS Arrival Process	WI/6.10.02
Renal Patient Arrival Process	WI/6.11.01
Conflict Resolution	WI/6.13.02
Daily Running Sheet NEPTS	F6.10.01

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3. Introduction

3.1 The work instruction that ERS Medical ambulance crews follow when they have arrived at their assigned destination is essential in assuring that CAD patient arrival data is accurate, the disembarkation of patients is safe and efficient and that the ambulance in parked and left in a safe and secure manner.

3.2 To ensure a single procedure is defined and utilised at all locations within ERS Medical that provides instruction and guidance to all Renal Patient Transport Service personnel on the arrival at hospital and other locations with patients.

3.3 To define the responsibilities of personnel in relation to the service activities and operations, ensuring consistency is achieved throughout ERS Medical.

3.4 To recognise and document any regional or contractual differences and obligations that may be in place across different CCG or NHS Trust areas in relation to carrying out renal patient services.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

4.4 It is the policy of ERS Medical to ensure that all communications with customers are undertaken in accordance with the 'Equality and Diversity Policy' and all legal and regulatory requirements.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
5.3	**Medical Director**	Has the strategic responsibility for setting, directing and monitoring clinical standards, scope of practice and ensuring that patient safety remains the primary focus of all patient facing services within ERS Medical.
5.4	**Head of Operations**	Is responsible for the implementation, resourcing and strategic delivery of all Non-Emergency Patient Transport Services.
5.5	**Head of Care Standards**	Is responsible for the development, implementation and co-ordination of consistent, quality, efficient and a clinically based approach to the Non-Emergency Patient Transport Service process across ERS Medical.
5.6	**Senior Operations & Operations Managers**	Have day to day responsibility for ensuring Non-Emergency Patient Transport Services procedures are adhered to at all times. In addition to this they are also responsible for ensuring CQC Essential Care Standards are in place and adhered to at all times.
5.7	**Team Leaders**	Are responsible for ensuring all personnel are guided through ERS Medical procedures and that they record, accurately, all records relating directly or indirectly to the transportation, care and treatment of patients by ERS Medical.
5.8	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **Arrive Hospital / Destination** – For the purposes of this work instruction 'Arrive Hospital / Destination will be deemed as when the ambulance arrives and is parked in a safe position to disembark patients.

6.2 **At Work**- All activities that are carried out off site which includes all operational personnel across all company facilities.

6.3 **Computer Aided Dispatch (CAD) –** Computer aided dispatch is a method of dispatching Company assets in customer focused, economical and expedient manner.

6.4 **Confidential Information** - Any data or information in whatever form that is disclosed to any ERS Medical staff member which by its nature is confidential or to which the disclosing party acting reasonably states in writing to the received party is to be regarded as confidential.

6.5 **CCT / Helpdesk** – Communications and Control Team.

6.6 **Functional Mobility** – The degree of an individual's ability to move and mobilise independently within their environment.

7. Capacity and Consent

Capacity

7.1 Mental capacity means being able to make your own decisions. When someone is said to lack capacity, because of an illness or disability as a mental health problem, dementia, or severe leaning disability, they are deemed to lack the ability to do one or more of the following:

- Understand information given to them about a decision;
- Retain the information long enough to be able to make the decision;
- Weigh up the information available to make the decision;
- Be able to communicate their decision.

7.2 The Mental Health Act 2005 states that people and organisations providing health treatment and social support to people have to take into consideration that and these people may have difficulties making some or all decisions about their lives.

7.3 If the person is aged over 16 years of age and lives in England and Wales, then the Mental Capacity Act 2019 applies to how professionals and other paid carers work with them. (Scotland has its own law – The Adults Incapacity (Scotland) Act 2000).

7.4 The Mental Capacity Act 2019 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan in case they are unable to make important decisions for themselves in the future.

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7.5 These decisions can be, but not be limited to:

- Major decisions such as decisions about personal finance, social care or medical treatment;
- Every day decisions, such as what to wear and what to eat.

7.6 A lack of mental capacity could be due to, but not limited to:

- A stroke or brain injury;
- A mental health problem;
- Dementia;
- A significant learning difficulty;
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it;
- Substance or alcohol abuse.

7.7 Loss of capacity can be either temporary in the case of substance or alcohol abuse and or some illnesses, including mental health illness and or medical treatments for these illnesses.

7.8 It can also be a permanent loss in cases of dementia and severe learning disabilities.

7.9 Capacity should be presumed for everyone unless it has been documented that they do not have capacity.

7.10 Healthcare professionals can assess an individual as lacking capacity, under Section 2(4) of the Mental Health Act, if they can provide proof that on the balance of probabilities that an individual lacks the capacity to make a particular decision, at the time it is needed to be made.

7.11 These types of decisions by healthcare professionals are supported within the Mental Capacity Act 2019.

7.12 This is typically a 2-stage process which requires being able to prove;

- **Stage 1** - The individual has an impairment of, or a disturbance in the functioning of, their mind or brain;
- **Stage 2** – The impairment or disturbance mean that the person is unable to make a specific decision when they need to.

7.13 To provide clear guidance for healthcare professionals, carers, social workers, attorneys of law and others the Department of Constitutional Affairs has written a Mental Health Act 2005 – Code of Practice. This is available from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent

7.14 Consent is an informed decision taken by and in certain circumstances on behalf of the patient, for medical treatment and or assessment to take place.

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7.15 In order for consent to be given and deemed valid it must have some specific criteria met, which are detailed below.

7.16 **The patient must be competent**; that is the must have mental capacity, which is decision specific, to make any decision that is required at the time or in advance of any medical treatment or care.

7.17 **The patient must have sufficient information to make a choice**; without adequate information patients are unable to make a decision about their treatment or care.

7.18 Any information provided to a patient should contain an explanation of any investigation, diagnosis, treatment and care. It should also contain an explanation of the possibilities for success, any associated risks and complications / side effects that may result from any medical treatment or care.

7.19 Staff who give this type of information verbally, must ensure that they take the time to document all the information they have discussed with the patient carefully in their ambulance notes / PRF.

7.20 **Patients must be able to give their consent freely**; pressuring patients into consenting to any treatment of care plan invalidates any consent given.

7.21 To ensure that any consent is given freely, patients should, where possible, be given time to consider their options before deciding on any specific treatment or care plan.

7.22 Be aware that patients' friends and family may also try and exert and influence any decision that is taken, and this can be a powerful but often subtle powerful influence.

7.23 In all of our Operational services (NEPTS, HDU, Front Line and Mental Health) consent will be required for, but not limited to:

- In the formation of any plans that affect their care or treatment, where possible **INCLUDE THEM**;
- Prior to any medical observations being taken;
- Prior to any patient manual handling that is required in assisting the patient;
- Prior to entering a patient's home address.

8. Process

10.1 On arrival at the designated hospital or destination, ERS Medical crews should ensure that they park their ambulance in a safe and legally compliant manner, whilst showing due care and consideration to the distance patient's may have to mobilise into the facility and their level of functional mobility.

10.2 Crews should also consider environmental factors, such as the local weather and lighting conditions.

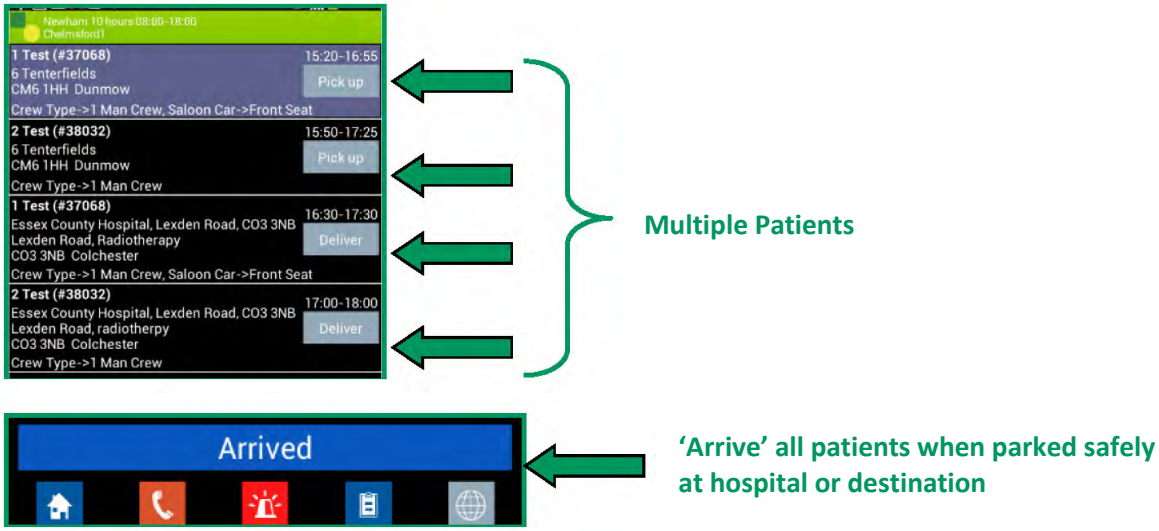
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10.3 They should also show consideration when selecting their parking location to others, such as:

- Other ambulances and vehicles requiring access;
- The deployment of the vehicle ramp;
- Trolley and wheelchair access to the vehicle ramp;
- Other vehicular traffic;
- Other patient's, staff and members of the public, who may or may not have mobility issues.

10.4 Once they have safely parked their vehicle if a safe and considerate manner, they must record their arrival time on either the CAD tablet or on **F6.10.01** – **NEPTS Daily Running Sheet**.

10.5 It is **VITAL**, for the accuracy and validity of this data, that all patients on board their ambulance are '**Arrived**' immediately after the vehicle becomes safely parked at the hospital or destination. This means that multiple transfers are all recorded within the CAD as arrived at the same time.



10.6 Once all patients have been 'Arrived' at either the hospital or destination, the crew should begin to assist their patients, depending upon their functional mobility, to their medical appointments.

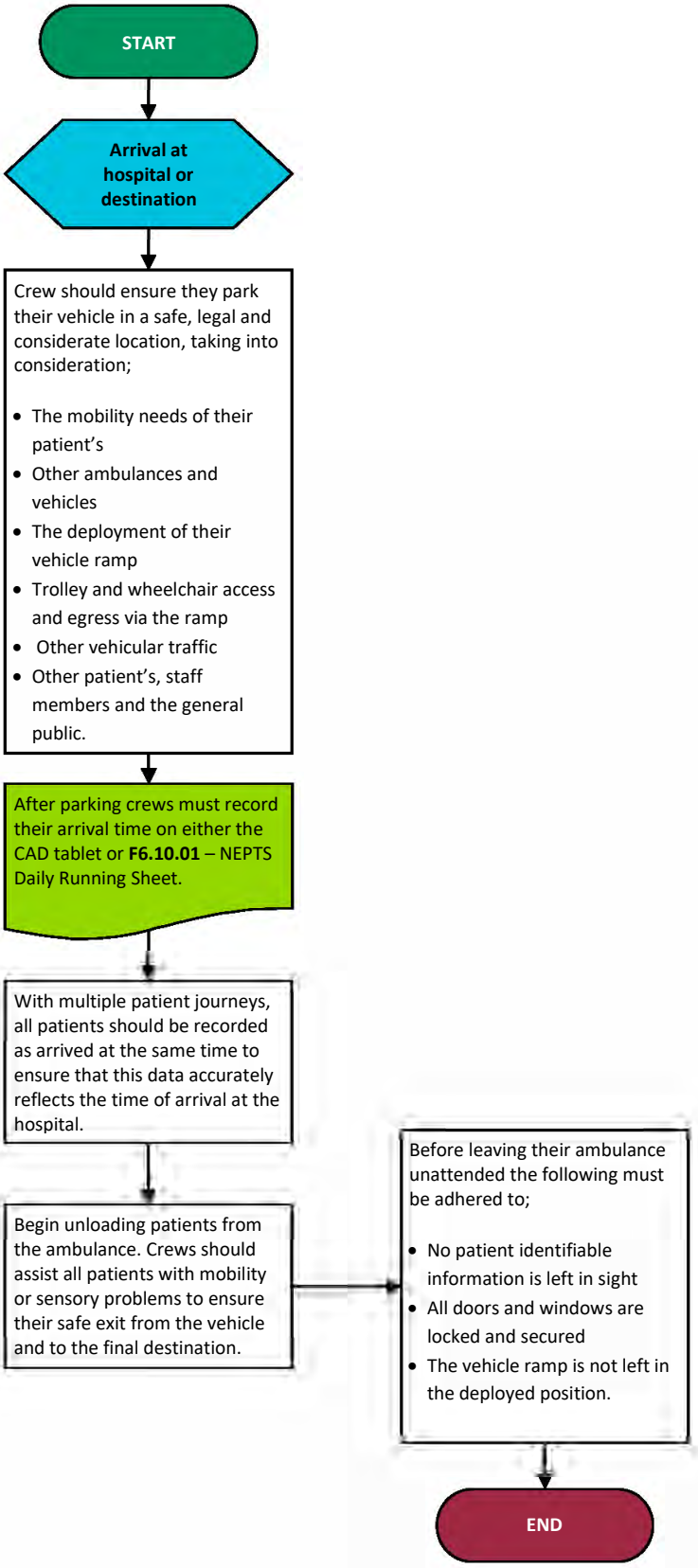
10.7 Before leaving their ambulance unattended the must ensure the following is adhered to:

- Not patient identifiable information is left in sight within the vehicle;
- All doors and windows are locked and secured;
- The vehicle ramp is not left in the deployed position.



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9. Key Steps



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Question 1.19.14.6

Patient / Service User safety – safety from point of collection.

Please set out the arrangements in-place at the point of collection for ensuring the patient is fit, and that all essential medical items (drugs and equipment), patient held records and records to be transferred, items required for daily living (including appropriate amount of clothing, dentures, spectacles, hearing aids, mobility aids, appropriate continence supplies etc) are available for the journey.

Word count 500

Total Word Count: 500

We have a formal process that is to be followed when collecting a patient for transport. We have provided a full overview below and attached our care to care policy (section 10 addresses patient collection).

Collection of the Patient

When arriving at the address to collect the Patient, the three most important things to remember are:

- Identification
- Introduction
- Information

Crews will always work from and to the information provided at the time of booking. For example, if a patient is booked as a wheelchair patient, a wheelchair will be taken to the patient.

Identification & Introduction

The crew will liaise with hospital staff to identify which patient they are to collect. It remains the responsibility of the patient's current care provider, i.e. the staff on the ward, department, care or nursing home to correctly identify the patient of the ambulance crew who have arrived to provide transport.

The Crew will introduce themselves to the patient 'Hello, my name is……. . What is your name please? I'm from ERS Medical, I will be taking you to…… address', it is useful to add context here by verifying if the address is their home, care home, relatives etc. It is also good practice to ask the patient what they like to be known as, not just assume that all patients will want or be happy with you calling them by their first name.

Information

Our crews will make sure they have all the relevant information they require to transport the patient safely to their destination. The check list includes:

- Has the person who has been responsible for the Patients care given a handover?
- Does the Patient have any cognitive issues such as Dementia or Alzheimer's?
- Does the Patient have their keys or key safe code if being taken home?
- What is the access like to their property? Any challenges or difficulties?
- What is the Patient's mobility like, how best can we assist them?
- Is the Patient dressed appropriately for their dignity, the weather conditions and mobility requirements? Especially checking their footwear and its appropriateness
- Do we have all of their belongings?
- Does the Patient have a DNAR order in place? Does the Patient have it with them?
- Does the Patient have medications to take with them? (TTO's)?
- Is there a care package/plan in place for the Patient? Are the Family aware?
- Is the destination on the booking safe to leave the Patient and are they expecting them?

Belongings within the 'Care to Care' guidelines are deemed to be, but not necessarily limited to:

- The patient's personal effects, such as clothing, toiletries, jewellery, money, mobile phones etc
- Medical notes
- Appointment letters
- DNAR documentation
- Discharge summary letters
- Non-prescription medication
- Prescription medication including hospital TTO's

If our crews have answers to all the questions above, they will proceed with the transport. If for any reason we are unable to gain answers to the questions above, this will be documented, either with the incident hotline or control. A Patient Referral Form or statement will also be completed.

Question 1.19.14.7

Patient / Service User safety – Drop off with clinical team.

Please set out the arrangements in-place at the point of collection for drop off with clinical team or care home (with professional carers or clinical staff). This will include arrangements for verifying that the patient is expected, the drop off location is correct and what to do if there is any issue.

Word count 500

Total Word Count: 450

Our thorough, detailed and comprehensive booking of patient's details, prior to any ambulance journey, is an essential part in ensuring that the requested journey is undertaken in a safe, effective and caring manner.

The initial contact at the point of booking should be used to determine essential information such as, but not limited to:

- Confirmation of the collection address i.e. home address, ward or outpatient's department etc
- Confirmation of the destination address; i.e. home address, ward or outpatient's department etc
- Escort details, if required, the name of any NOK, specialist carer / worker
- Are there any access or egress issues at the collection of destination points
- Confirmation of the patient's mobility at the time of booking and if there have been any changes i.e. walks with a stick or frame, history of mechanical falls
- Confirmation of the booking requirements, notification to change the booking if the circumstances have changed
- The infectious status of the patient and any additional IPC precautions that may be required
- Reason for the admission / transport
- Any on-going medical treatments, i.e. O2 therapy
- Are there any cognitive issues such as dementia
- Has the patient been known to be violent or aggressive, especially in the last 48hrs
- Confirmation of the address the patient is to be taken to, and the name of any specialist carer / worker
- Journeys for patients with a mental illness should also be processed through the mental health risk assessment tool
- Any additional, relevant information should also be taken at this point

Following the capture of all relevant information the transport will be booked.

As part of our initial patient collection process our crews will identify the patient's destination and if required call ahead to ensure that any requirements for their arrival are in place and the destination is expecting them prior to setting off. Should there be any issues with contacting the destination or the destination not being ready for the patient our crews will liaise with the Healthcare Professional and our control room to agree the best way to proceed whether this be to delay the patients transport or to try any alternative contact at the destination.

Once confirmation that the destination is ready for our patient, we will commence the journey.

Under no circumstances will the patients be allowed to attend the ward/department independently of the ambulance service and be expected to provide their own handover.

The crew will escort patients to the ward and department, making sure they arrive safely, and that hospital staff are aware of their arrival and are provided with a full handover of the patient.

We have attached our Care to Care policy which provides full details of our patient collection and drop off process.

Question 1.19.14.8

Patient / Service User safety – Drop off at domiciliary setting.

Please set out the arrangements in-place at the point of collection for drop off at a domiciliary setting (including safe arrival checklist).

Word count 500

Total Word Count: 466

Within our Care to Care policy we set out a full process on how to safely drop a patient off at a domiciliary setting. We have provided an extract from the policy below and attached the full policy for completeness.

On arrival at the destination the ambulance will be parked safely. When working as a two person crew the attendant should remain in the vehicle whilst the driver opens the doors and prepares the exit. The crew will assist the patient at all times.

When taking patients out of hospital it is essential that all patients and especially those who have any cognitive impairment due to conditions such as Alzheimers or Dementia, are taken to the exact address as per their booking and that they are assisted safely inside in a manner that is appropriate to their booked and observed mobility.

It is not acceptible for crews to drop patients at any other locations other than those booked.

When dealing with patients who have been booked or dynamically assessed as having mobility issues or require the use of mobility aids such as, but not limited to:

- Walking Sticks
- Frames
- Wheelchairs

Ambulance crews should encourage patients to mobilise as booked. However, in the real world and given the patients right to make choices, patients may insist on self mobilising to and from the ambulance.

If patients do decide to self mobilise, attending crews should manage the risks by dynamically assessing the situation and providing an assisted walk for all patients. This decision by the patient will be communicated and recorded to despatch. Decisions made by a patient to self mobilise does not absolve the crew from their responsibilities of ensuring the patient gets to their destination without incident.

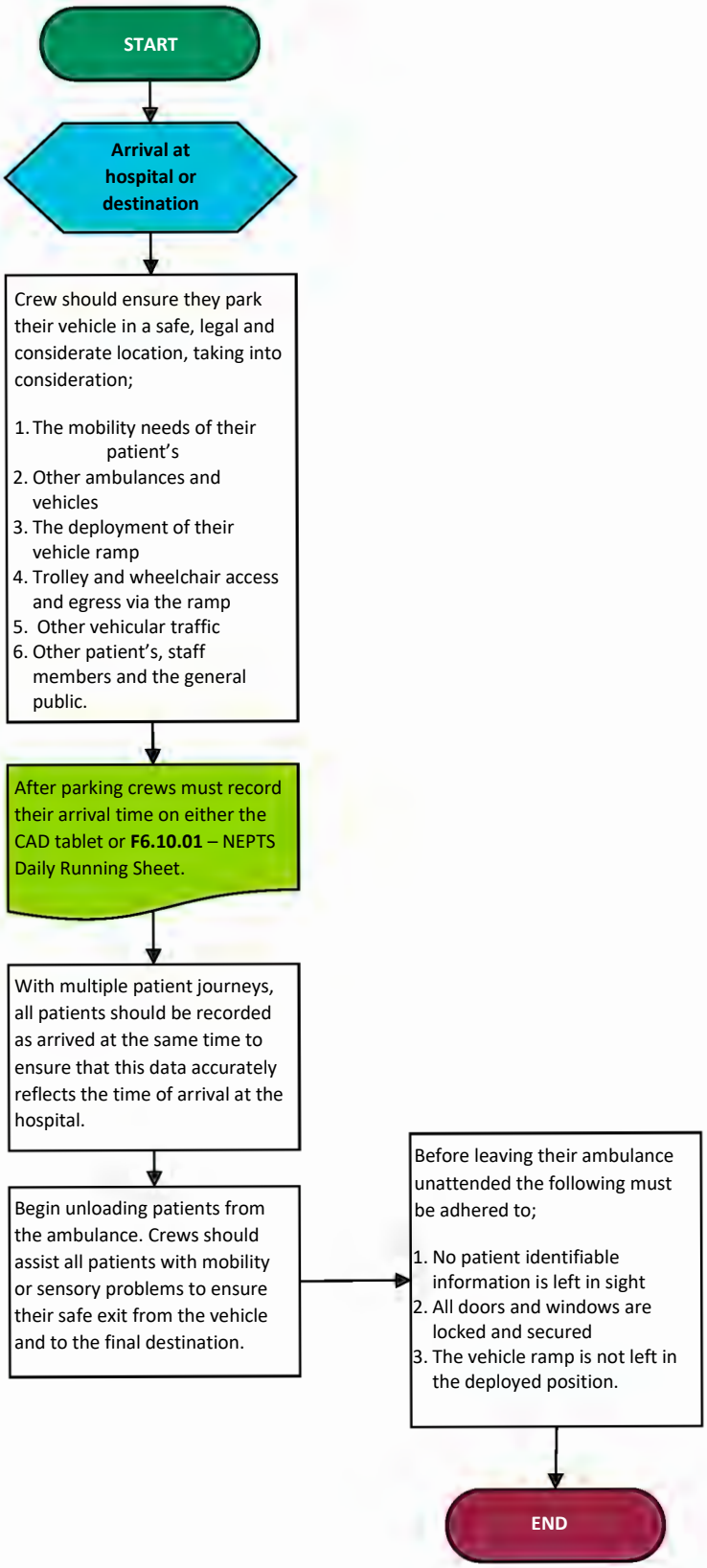
Crews should always prioritise assisting patients with mobility issues above the personal effects or TTO's. These can be secured on the ambulance and given to the patient after they are safely in their care location

As part of the crews process in delivering a patient to a domicillary setting they will have to conduct the following checks, which will be signed off within the PDA prior to the patient being left:

- Patient condition on arrival
- Basic safety in the home
- Food, light and warmth
- Water and sanitary
- Safe means of access and egress which can be secured
- Patient will be able to access sanitary facilities
- Patient can access medication, medical equipment etc
- Patient access to items required for daily living
- Patient has been given and knows how to access any patient held records or they have been given to an appropriate person.
- Patient has ability to access help in an emergency
- Anyone who needs to know the patient has been returned home has been notified
- Are there any safeguarding concerns?

We have processes in place for the following scenarios:

Someone else is present	The crew will ensure the patient is safely taken int the house and settled in prior to leaving.
The only person present is a child, a vulnerable adult or otherwise dependent upon the patient	Our crews may raise a safeguarding concern about the child, vulnerable adult or dependant being left alone.
The patient doesn't have capacity	We will ensure that the patient is handed over to a suitable individual prior to leaving the patient. If there isn't a suitable individual at the patient destination, we will contact the Trust and work with them to find a safe solution. If our crews feel the circumstances require it, they may raise a safeguarding concern.
The patient will be home alone	If the patient has capacity the crew will ensure the patient is safely taken into their home and settled in. They will then conduct their checks to ensure the home is safe prior to leaving the patient.


START
Arrival at hospital or destination
Crew should ensure they park their vehicle in a safe, legal and considerate location, taking into consideration;
1. The mobility needs of their patient's
2. Other ambulances and vehicles
3. The deployment of their vehicle ramp
4. Trolley and wheelchair access and egress via the ramp
5. Other vehicular traffic
6. Other patient's, staff members and the general public.
After parking crews must record their arrival time on either the CAD tablet or F6.10.01 – NEPTS Daily Running Sheet.
With multiple patient journeys, all patients should be recorded as arrived at the same time to ensure that this data accurately reflects the time of arrival at the hospital.
Begin unloading patients from the ambulance. Crews should assist all patients with mobility or sensory problems to ensure their safe exit from the vehicle and to the final destination.
Before leaving their ambulance unattended the following must be adhered to;
1. No patient identifiable information is left in sight
2. All doors and windows are locked and secured
3. The vehicle ramp is not left in the deployed position.
END

ERS Transition Limited

ERS Medical East

Quality Report

Quality report
Unit 2, Sapphire Estate, Sapphire House, Roundtree Way, **Norwich**, Norfolk, NR7 8SQ
Tel:Tel: 0333 240 4999
Website:http://www.ersmedical.co.uk

Date of inspection visit: 2 October to 3 October and 16 October
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Good
Patient transport services (PTS)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

ERS Medical East is an independent ambulance service in East Anglia operated by ERS Transition Ltd. The service primarily serves the communities in East Anglia. ERS Transition Ltd took over the services and became the registered provider with CQC in October 2017. The service is registered for patient transport service (PTS).

ERS Medical East primary service transports non-emergency patients within Norfolk, Suffolk and Essex. The service can transport patients detained under the Mental Health Act 2007 in a formal and informal context.

The service has had a registered manager in post since October 2017. At the time of the inspection, a temporary registered manager was registered with the CQC. A permanent registered manager had been appointed and their application was being processed.

We inspected this service using our next phase inspection methodology. We carried out a short notice announced inspection on 2 and 3 October 2018, followed by an unannounced inspection on 16 October 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated the service as good overall because:

- There were effective systems to monitor vehicles and equipment maintenance.
- There were systems in place to safeguard vulnerable adults and children. Staff could identify safeguarding concerns and knew how to report them.
- Policies and procedures were in line with national guidelines and were version controlled and within date. There was an audit programme in place to monitor compliance with policies and procedures.
- Staff received annual competency update training.
- Staff treated patients with dignity and respect. They were kind and caring. Staff told us that caring for their patients was the best part of their role.
- The service had good oversight of the booking process and monitored drop off and pick up times and kept patients informed about delays.
- There were systems of governance at management level to monitor performance and risk.
- The service had effective, integrated business management systems which gave them up to date information and oversight of the service.

However, we also found the following:

- Processes for incident reporting were not fully embedded. Staff described different processes for reporting incidents. Staff could not tell us how learning from incidents was shared. Some members of staff were unclear as to what constituted an incident.
- Staff had not received an annual appraisal.

Summary of findings

- Staff did not always document on the patient record forms that verbal consent had been obtained.
- Staff did not have access to translation sheets for patients whose first language was not English. Staff did not have access to communication prompts for patients who were hearing or visually impaired.
- The process for shared learning from complaints was not embedded. Staff could not tell us how learning from complaints was shared.
- Staff felt that there was not effective communication between managers and staff, team meetings were not embedded. There was low morale amongst the staff and staff told us that they did not feel valued by managers.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals, on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Good 	We rated this service as good because safe effective, caring and responsive were good. Staff received mandatory training and annual competency updates, there was effective processes in place for infection prevention and control and vehicle and equipment maintenance. Policies were up to date and reflected national guidelines, staff treated patients with kindness, dignity and respect. Well led was rated as requires improvement. Staff were not clear as to what constituted an incident and learning from incidents was not shared. There was a lack of staff engagement and staff reported low morale. Staff had not received annual appraisals.

ERS Medical East

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to ERS Medical East

ERS Medical East is operated by ERS Transition Ltd. It is an independent ambulance service in East Anglia that primarily serves the communities in East Anglia. The service has been registered with CQC as ERS Transition Ltd since October 2017.

ERS Medical East is registered for patient transport service (PTS).

ERS Medical East primary service transports non-emergency patients within Norfolk, Suffolk and Essex. The service can transport patients detained under the Mental Health Act 2007 in a formal and informal context.

The service has had a registered manager in post since October 2017. A temporary registered manager was in place at the time of inspection however a permanent registered manager had been appointed and their application was in train.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our next phase inspection methodology. We carried out a short notice announced inspection on 2 and 3 October 2018, followed by an unannounced inspection on 16 October 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Detailed findings

Facts and data about ERS Medical East

ERS Medical East operates from stations located in Norwich, Kings Lynn, Snetterton and Chelmsford.

They operate a total of 64 vehicles in Norfolk, 23 in Chelmsford and operate two vehicles to transport patients with mental health issues. They employ 172 members of staff in Norfolk and 23 in Chelmsford, supported by a central support staff of 30 from Head Office in Leeds and a dedicated call centre team.

The service is registered to provide the following regulated activities:

- Patient transport service (PTS)

During the inspection, we visited Norwich and Kings Lynn stations. We spoke with 33 staff including; patient transport drivers, dispatch and planning staff, trainers, volunteer driver and managers. We spoke with five patients. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (January 2018 to July 2018)

- There were 203,748 patient transport journeys undertaken.
- Seven ambulance technicians, 176 patient transport drivers and 33 administration and clerical staff worked at the service.

Track record on safety:

- No never events.
- Incidents: 69 no harm, 39 moderate harm, seven serious harm. No deaths had been reported.
- 115 complaints.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Patient transport services (PTS)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

ERS Medical East is an independent ambulance service in East Anglia operated by ERS Transition Ltd. The service primarily serves the communities in East Anglia. ERS Transition Ltd took over the services and became the registered provider with CQC in October 2017. The service is registered for patient transport service (PTS).

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Summary of findings

Are services safe?

We rated safe as good because:

- Mandatory training compliance rates for staff was 96%.
- There were effective processes to ensure vehicle and equipment maintenance was up to date.
- There were effective processes to prevent the risk of infection.
- Medicines were managed well, in line with policy and national guidelines.
- Risk assessment and monitoring of patients was carried out to ensure patient safety during transport.

However:

- The process for incident reporting was not fully embedded. Staff described different processes for reporting incidents. Staff could not tell us how learning from incidents was shared. Some members of staff were unclear as to what constituted an incident.
- The service had staff vacancies which meant that they were not able to crew all vehicles.
- Five out of six vehicle record folders we checked did not contain a copy of the up to date MOT certificate, according to the provider policy. Information provided on site demonstrated that all vehicles were in date for MOT testing.

Are services effective?

Patient transport services (PTS)

We rated effective as good because:

- Policies and procedures were up to date and in line with national guidance.
- The service was performing well against the key performance indicators outlined in the non-emergency transport service contract.
- The service worked well with other health care providers to provide the best care for patients.
- Staff received annual competency update training to maintain their skills to deliver care to service users.

However:

- No staff had received an annual appraisal.
- Although we observed that staff acquired verbal consent from patients, staff did not consistently record verbal consent had been obtained on the patient record forms.

Are services caring?

We rated caring as good because:

- We observed staff treating patients with kindness, dignity and respect.
- Staff told us that delivering good care was what they enjoyed most about their job.
- Patient survey results showed that 89% of service users felt staff were kind and treated them with dignity and respect.

Are services responsive?

We rated responsive as good because:

- The service was planned and managed in line with the commissioning agreement in place.
- There was information available to service users about how to make a complaint. Complaints were handled in line with the service complaints policy.
- The service had good oversight of the booking process. Pick up and drop off times were monitored and patients were informed about delays.

However:

- Although the provider had tools for communicating with patients whose first language was not English they were not in the vehicle folders and staff were not aware of them.
- Staff were not aware of shared learning from complaints.

Are services well-led?

We rated well-led as requires improvement because:

- Staff felt that managers were not visible and that communication between staff and management was ineffective. Staff reported low morale.
- Although there were systems of governance in place these needed to be embedded and strengthened. For example, learning from incidents and complaints were not shared with staff effectively and MOT documentation was not filed correctly.
- There was a lack of engagement with staff. Staff meetings were not embedded and staff were not always notified of meetings in a timely way. Although the service had a clear vision and strategy staff were not aware of it.

However:

- A new local management team had recently been appointed and were implementing processes for better communication with staff.
- Senior leaders were aware of the risks facing the business. They were aware that morale amongst staff was low and were taking steps to improve engagement with staff.
- The service had effective, integrated business management systems which gave them up to date information and oversight of the service.

Patient transport services (PTS)

Are patient transport services safe?

Good

We rated safe as **good.**

Mandatory training

- Staff completed annual update training which contained 14 core elements including manual handling, basic life support, health and safety and safeguarding adults and children. Data provided by the service showed that 94% of staff in Essex were compliant with their mandatory training against a target of 98%. Compliance was 98% for staff in Norfolk.
- The training programme identified the training needs of each staff group which meant that each member of staff completed the relevant training for their role for example driver training.
- The training team had a system in place to monitor mandatory training compliance against the target of 98%. We saw a spreadsheet identifying all staff members which indicated their training compliance status, when training was due to expire and whether they were booked onto a course to receive their update training.
- Training was delivered face to face and staff were notified via email when their training was booked.
- All the staff were positive about the training they received and felt that they received the appropriate training to carry out their role.

Safeguarding

- There were processes in place to protect people from abuse and neglect.
- The service had a safeguarding policy. We reviewed the policy and saw that it was version controlled and within review date. The policy referred to the intercollegiate document, Safeguarding: Roles and Competencies for Health Care Staff.
- The medical director was the safeguarding lead and there was a deputy safeguarding lead in post. Both had completed safeguarding level four training. In addition, the head of care standards had also trained to level four safeguarding.
- Patient transport service (PTS) staff were trained in safeguarding adults and children level 2. They received safeguarding update training every three years and an annual refresher as part of their mandatory training. The provider was contracted to transport children when required but the operations manager told us that this occurred very rarely. Any child that was transported was accompanied by a parent or carer.
- There were processes in place to support frontline staff to report a safeguarding concern. The service provided staff with a single phone number to use to contact the ERS control room located in Leeds to make a safeguarding referral.
- When a safeguarding referral was recorded on the system the regional manager and the head of care standards were alerted via email. This meant that they could assess the type of referral that had been reported and whether any immediate action was required.
- We reviewed the computer system and saw that there were drop down boxes which had to be completed as part of the safeguarding referral. If any were answered “no” the system automatically generated an action plan which the person allocated to investigate had to complete before the referral could be closed. We reviewed one safeguarding incident which was recorded using the online system. Information recorded included the nature of the incident and actions taken which included completing a safeguarding referral to the local authority.
- Staff we spoke with demonstrated a good understanding of safeguarding concerns. Staff knew how to make a safeguarding alert. Two staff members gave us recent examples of when they had made a safeguarding referral. Staff received an email thanking them for making the referral and confirmation that the referral had been made to the local authority.

Cleanliness, infection control and hygiene

- There were systems and processes in place to protect people from health care associated infection.

Patient transport services (PTS)

- The service had an infection prevention and control policy and guidance document. We reviewed the document and saw that it was version controlled and within review date.
- All the areas we visited were visibly clean and tidy.
- We inspected five vehicles and the equipment carried on them. All the vehicles and equipment were visibly clean and tidy. All the vehicles inspected contained hand sanitising gel and sterile wipes which were in date.
- Staff received infection prevention and control (IPC) training as part of their annual mandatory training update. Data provided by the service showed that staff training compliance was 96%.
- There was a vehicle deep cleaning programme in place. Vehicles were deep cleaned every 90 days. This process was monitored using the fleet computer system which highlighted when a vehicle was due a deep clean. We reviewed the records for six vehicles and saw that all were deep cleaned in accordance with the programme.
- Staff were compliant with being bare below the elbow. We observed staff sanitising their hands after patient contact. We observed staff clean equipment on the vehicle after patient contact. Personal protective equipment (PPE) was available in all the vehicles we inspected and we observed staff using it when in contact with patients.
- Staff told us that they were responsible for laundering their own uniform and had been given guidance to wash their uniform on a sixty-degree wash. Washing at this temperature is in line with the Department of Health guidance and is sufficient to remove all micro-organisms
- We saw that monthly infection prevention control audits were completed by the head of care standards at both locations we inspected. Audit data showed that in the most recent audit in Norwich compliance was 100%, at Kings Lynn it was 98%. The head of quality told us that where there was noncompliance an action plan was completed and allocated to a manager for delivery.
- Spillage kits were available on four of the five vehicles we inspected. Staff told us that if the vehicle became contaminated they would return to the station to clean it. Staff told us that spare uniforms were available at the station if a staff member's uniform became soiled during the shift.
- The depots at Norwich and Kings Lynn had a designated area for mops and cleaning products. Mops were colour coded; yellow for ambulance interiors, black for vehicle exteriors green for kitchen and dining areas, blue for general areas and red for toilet and shower areas. All mops were single use and we saw that there were unused mops ready for use. Mop checks were completed weekly. We reviewed records which showed that the check had been completed consistently from 22 August 2018.

Environment and equipment

- The service used an electronic system to schedule and monitor vehicle servicing and MOT.Both the stations at Norwich and Kings Lynn had a board in the office which recorded all the vehicles, with their service date and MOT. Vehicle status was also noted, for example if the vehicle was at the garage, off the road or due to be taken to the garage. This meant that the team leaders had easy access to information relating to all vehicles in the fleet.
- We reviewed six vehicle folders and found that the MOT certificates were not in the files for five of the vehicles checked. The service policy is that hard copies should be stored in vehicle files. The lead driver showed us on the government website that all five vehicles had up to date MOTs and the dates reconciled with the dates on the electronic system and the vehicle board in the office. We raised this at the time of inspection and the manager told us that they would ensure that the files were audited to ensure that they contained the correct documentation.
- Paper vehicle check sheets were completed by crews at the start of each shift before the vehicle left the station. Any faults identified were recorded on this form. The forms were collated by the team leader and faults on the vehicle were addressed. In the case where a fault was identified that meant the vehicle was not road worthy, this was escalated to the team leader and the vehicle would be taken off the road and an alternative vehicle provided for the crew.

Patient transport services (PTS)

- We found that there was no process in place to ensure that daily vehicle checks were completed for all vehicles. We raised this at the time of inspection. When we returned for our unannounced inspection we saw that the team leader had implemented a system to collate the sheets, ensure all had been completed and escalated any concerns with the vehicle that needed repair. We saw that a fault with a light on a vehicle was reported on the vehicle check form. We observed that this was noted and the vehicle was taken for appropriate repair before going back on the road. The managing director told us that there were plans to roll out electronic vehicle checks which would enable monitoring of the completion of vehicle checks.
- Both stations had an area where staff could leave broken equipment. Staff placed a red label on the equipment to indicate that it was not in working order and could not be used. We observed that all equipment in this area was clearly labelled.
- Equipment servicing was provided by an external supplier. All the equipment we checked during inspection was within service date. We checked the equipment service schedule and saw that all equipment service checks were up to date.
- We checked 25 consumable items. All were within expiration date. We checked 20 pieces of clinical equipment. Most were within expiration date. We found 2 out of 20 items we checked had expired. We bought this to the attention of a staff member who removed the items and disposed of them appropriately.
- There was equipment available that was suitable for different patient groups including heavy patients and children.
- All vehicles had a satellite navigation system and a vehicle tracker system so the dispatchers could identify the location of the vehicles. The vehicles had a 'dash cam' system. Should an accident occur, this emailed a video clip of a vehicle incident to the driver's line manager, allowing immediate action to be taken.

Assessing and responding to patient risk

- There were processes in place to ensure that risks to patients were assessed and their safety was monitored and managed to keep people safe.
- Staff carried out risk assessments prior to transporting patients to keep people safe. Staff told us that if a risk was identified, the appropriate action to address the risk were undertaken. For example, crews requested the support of additional staff, obtained additional equipment, adapted the number of patients transported at one time, or made the decision not to transport the patient if the risk was too high.
- The service had a specialised vehicle to transport morbidly obese patients. Staff told us that there was a specific risk assessment form that was completed when transporting a such patients to keep them and the staff transporting them, safe.
- We reviewed two policies relating to the use and application of handcuffs and the use and application of spit hoods when dealing with patients suffering from conditions that resulted in disturbed or violent behaviour. The document was version control and within review date. Both policies contained detailed information for staff about when to use handcuffs and spit hoods, risk assessments to be completed and safe application. We spoke to three members of staff from the mental health transport crew. They told us that they had received training in the use of handcuffs and spit hoods and knew when and how to use them.
- High dependency vehicle staff (HDU) used national early warning scoring (NEWS) to assess deteriorating patients. Staff told us if a patient became ill while being transported crews would deal with the patient in line with their qualifications and training. If the patient was seriously unwell staff told us they would call 999 for an emergency ambulance to attend.
- Staff ensured that if the patient had a do not attempt cardiopulmonary resuscitation (DNACPR) order the form travelled with the patient. Where the patient had a DNACPR but the document was not carried with the patient then the staff completed an ERS medical form which was signed by the healthcare professional responsible for the persons care.

Staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times.

- The service used an electronic system to generate the staff rota which involved allocating crews to available vehicles. This rota was generated weekly. Staff who did not work a set shift pattern were notified of their weeks work pattern at short notice meaning it was difficult to manage work life balance.
- Senior staff told us that there were numerous different shifts and individual working patterns which meant that it could be complicated to effectively allocate staff. To attempt to address this a new shift pattern was out to staff consultation.
- At the time of our inspection there were road crew vacancies for 13 full time staff. These vacancies were in the process of being recruited to and we saw that interviews were taking place. A senior manager told us that they covered gaps in the rota by offering additional shifts to existing staff. If a shift could not be covered this meant that not all the vehicles would be utilised. This meant that there were not always enough PTS vehicles to fulfil all the bookings.If this occurred the regional manager told us that additional patients who were able, would be transported by taxi or in a volunteer driver vehicle as per the service delivery agreement. The volunteer drivers were coordinated by the service.
- The service was not able to provide information about the number of unfilled shifts.
- The local dispatch team had two vacancies which were in the process of being recruited to. Vacant shifts were covered by staff in the central control room in Leeds.

Records

- Staff had the information they needed to provide patients with safe care and treatment.
- Crews received job information via a hand-held tablet before conveying the patient. Staff told us that they received information about the patient's name, date of birth, and if they required any equipment.
- Transport bookings were made through a central control room based in Leeds. Staff recorded information provided on an electronic system. The system had a number of required fields to be completed, to assess the patient's eligibility, before the booking could be confirmed. This included information about the booking, the patient's mobility and additional relevant information. Staff received this information on their tablet. Staff told us that the information provided was not always accurate and this caused delay in the patient being transported and in some cases meant that the transport could not go ahead because staff would not transport a patient if it was not safe to do so. We raised this with the management team at the time of inspection. They told us that they were aware of the situation but the process was dependent on information given by the person making the booking. The provider monitored the number of aborted journeys and told us that they were working with services that booked transport to reinforce the importance of providing correct information at the time of booking.
- If the information provided about the patient was not accurate staff told us they would contact the control room to update the record with additional information. This was used to decide whether to complete the transfer or not.
- Patient record forms (PRFs) were completed by staff for patients transported on the high dependency vehicle. We reviewed 10 PRFs and saw that they were completed appropriately and contained patient details, patient observation and pain assessments.
- The PRFs were audited monthly. We saw that the patient record audits had been completed every month by the head of care standards dating back to January 2018. We reviewed three audits completed in June 2018, August 2018 and September 2018. In each audit all PRFs completed during the month had been reviewed. We saw that for each month no issues or concerns were identified.

Medicines

- The provider had systems and processes in place to ensure the proper and safe use of medicines.
- The provider had a medicines management and medicines administration policy document. The document was version control and was within review date. At the time of the inspection the provider did not store controlled drugs or prescription drugs.
- The provider had a medicines formulary in place which indicated which drugs could be used by paramedics,

institute of health care development (IHCD) technicians, emergency care assistants (ECA) urgent care administrators (UCAs) and student paramedics with an IHCD technician certificate.

- Ambulance technicians carried medicine pods which were sealed with colour coded tags. They were stored securely at the base behind a locked door. The pods were signed out by technicians at the start of their shift. At Kings Lynn, we reviewed the sign out sheets and saw that they had been signed. However, there were two different sheets to sign and it was not clear which had been completed by staff. At the unannounced inspection we reviewed the sign out sheets for August, September and October 2018. We saw that a standardised form was used. We also saw that the alternative form had been removed and replaced with the correct sign in sheet. The data from the form had been recorded and stored electronically for audit purposes.
- Weekly medicines inspections and a monthly medicines audit were carried out. Data provided showed that the weekly checks had been completed for the previous three months and the monthly audit had been completed for the previous six months. Compliance had been 100% for each audit at Norwich and Kings Lynn.
- Medical gases at Norwich and Kings Lynn were stored in cages in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders. Full and empty cylinders were kept separate and were clearly marked. Piped oxygen in ambulances we inspected had been serviced and were in date.

Incidents

- There were processes in place where by incidents were identified and reported. However, this was not fully embedded.
- The service had an incident reporting policy. We reviewed the document and saw that it contained definitions of incidents, reporting and investigation process, and detailed different types of incidents such as clinical incidents, information governance, security incidents and transport and road traffic incidents. Two out of six staff we asked could tell us what constituted an incident. However, four members of staff were unclear what constituted an incident and referred to incidents relating to vehicles. Therefore, we were not assured that all staff recognised and reported all incidents.
- The service had reported 115 incidents in the six months prior to our inspection. Of these 69 were risk scored as no harm, 39 were reported as moderate harm, seven were reported as serious and zero were reported as catastrophic.
- We reviewed the process for frontline PTS crews to report an incident. The head of care standards told us that the incident reporting process required staff to use a single telephone number to call the control room in Leeds to report incidents. However, four staff members that we asked, told us that they would call dispatch to report any incidents. Two other staff members told us that they would complete an incident form. Therefore, we were not assured that the incident reporting process was fully embedded.
- Incidents were recorded on an electronic system. When an incident was recorded an email, alert was sent the regional manager and the head of care standards as well as the staff member's line manager.
- We reviewed the system and saw that incidents were colour coded red, amber and green (RAG rated). Incidents were allocated an investigation owner and timescales were included to ensure the investigation was completed in line with policy. If required an action plan was developed because of concerns identified.
- The head of care standards was responsible for overseeing the investigation into serious incidents. This included a route cause analysis investigation led by the care standards compliance team.
- We saw three sets of minutes from the monthly Governance and Patient Safety Committee (GaPS) meeting which showed that incidents were a regular agenda item.
- The head of care standards told us that learning from incidents was shared with staff through a computer business system. Individual learning from incidents was delivered by the regional manager or operations manager to the crew or individual concerned. Wider learning was shared with staff via team meetings, email

and tool box talks. However, none of the staff we spoke with could not tell us how learning from incidents were shared. Therefore, we were not assured that learning from incidents was shared with staff.

Are patient transport services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The service had policies and procedure in place which were in line with legislation and evidence based care. We reviewed the infection, prevention and control policy, the manual handling policy and the safeguarding policy. We saw that policies included joint Royal Ambulance Colleges Liaison Committee (JRCALC) guidance and control of substances hazardous to health (COSHH).
- There was a document control policy. Review of policies was managed by the care standards team. Policies were grouped on the electronic system according to the guidelines referenced meaning that policies could be easily accessed and updated when there was an update to national guidelines.
- Office based staff could access policies and procedures via their desk top computer. Road crew staff could access these through their hand-held devices.
- There were eligibility criteria applied before patients were referred to ERS Medical East as part of the non-emergency patient transport services (NEPTS) contract. There was a process in place to assess a patient's eligibility to use the service. At the time of booking staff in the central booking team located in Leeds used an electronic booking system that prompted a number of questions that had to be answered in order to complete the booking process. Only those patients that met the eligibility criteria could be booked onto the system. Data provided by the service showed that between May 2017 and July 2018 100% of bookings were assessed for eligibility.

Nutrition and hydration

- All vehicles had a supply of water available for patients during transport. Staff were aware that patients who were being transferred for renal dialysis had their fluid intake restricted.

Patient outcomes

- The service utilised key performance indicators to monitor their performance against, this was in line with NEPTS contract requirements. Data provided showed that between May 2017 and July 2018, 98% of patients arrived between 0 and 45 minutes before their appointment time against a target of 99%. The percentage of aborted journeys was 4% against a target of 2%. 98% of patients were collected within 60 minutes of notification and the patient ready time against a target of 99%.
- Response times were monitored through an electronic system on staff hand held devices. Staff would notify dispatch when they had arrived at a location to collect the patient, when the patient was on the vehicle, when the vehicle left the location, when they arrived at the destination and when they had finished the transport.
- The contract in place did not indicate a maximum number of transports. A senior manager told us that where demand outstripped capacity, a taxi or volunteer car would be arranged for patients that did not require ambulance transport.

Competent staff

- The service had processes in place to ensure that staff had the skills, knowledge and experience to deliver effective care, support and treatment.
- All staff that we spoke with told us they had received a comprehensive induction when they joined the organisation. The training was classroom based and lasted either four or five days, depending on the nature of their role. We reviewed the induction training and saw that it included basic life support, health and safety, fire safety, infection control, and manual handling. Staff told us that the training was comprehensive and provided them with the skills they needed for their role. Once staff had completed the induction training they initially worked in a two-person crew with an experienced member of staff.
- Staff received annual update training which included assessments of driving, knowledge and practical

competence. Training was scheduled by the training associate and staff were notified two to three weeks in advance as to when they were to attend training. We reviewed the training schedule and saw that staff update training status was rated, green, amber and red indicating when training was due. We saw that training dates were scheduled for staff to ensure that their update training was completed within the timeframe.

- The service had plans in place for staff to receive FutureQuals training in the future. This is a nationally recognised qualification. Trainers had completed the course to deliver the training and there was a plan in place to deliver training under the new programme to new starters as well a conversion training for existing staff to be delivered at the annual update training.
- Staff provided authorisation for an annual driver's license check to be completed. The provider recorded the driving licence details of the staff on a spreadsheet. The spreadsheet recorded staff names, date of birth, driving licence details, date licence expired, date when the licence was checked and the date when the next check needed to be carried out. There was an alert in place to notify managers when checks were due to be completed.
- Eleven members of staff had received additional mental health training to support secure patients transfers. Training included restraint and self-protection. Three members of staff from the mental health team told us that the training was comprehensive and provided them with the skills required to fulfil their role and support people with challenging behaviour.
- None of the staff we spoke with had received an annual appraisal. A senior manager told us that they were aware that staff had not been appraised. The provider had an online appraisal system that was due to be rolled out across the service. Therefore, the senior leadership team had taken the decision to start the annual appraisal programme once the system was in place so that all staff appraisals were completed on the new system. However, staff we spoke with were not aware of this decision.

Multidisciplinary working

- The service worked within and across organisations to deliver effective care to patients.
- Team leaders across the five stations held a morning call to discuss the needs of the day and coordinate the daily workload across the different locations.
- The operations manager at Kings Lynn attended the daily regional multiagency call coordinating between the local NHS Trusts, the acute ambulance trust and clinical commissioning group to discuss capacity issues and work load priorities so service could be coordinated and prioritised according to need.
- There was a member of staff located at two NHS trusts. These staff worked with the staff at the trust to coordinate discharges and ensure that patients were waiting in the correct areas to be collected by the ambulance crews.

Seven-day services

- The service operated between 5am to 3am seven days a week in line with the requirements of the non-emergency patient transport contract requirements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with confirmed they had received training in consent and Mental Capacity Act. Staff training data showed that staff had received training on consent, Mental Capacity Act, and Deprivation of Liberty Safeguards. Staff we asked, demonstrated a good understanding of mental capacity assessments and how this affected their work transporting patients.
- Staff told us that they would gain consent from patients to transport them. We observed staff gaining verbal consent from patients when transferring them in to the vehicle, securing them safely and when transferring from the vehicle.
- We observed staff from the mental health team supporting a patient living with dementia who was on a deprivation of liberty order. The patient was not willing to get into the vehicle. The ambulance staff did not touch the patient and had a clear understanding that they were not allowed to as the patient was not detained under the mental health act. Staff were kind and supportive to the patient but respected that they did not want to get into the vehicle and the transfer was abandoned.

Patient transport services (PTS)

- The provider had a Deprivation of Liberty Safeguards (DoLS) policy which contained related documents and legal references, an introduction, policy statements, responsibilities, levels of restriction and restraint, ERS medical responsibilities and death of a person subject to a DoLs order.
- The service had a policy and procedure in place around the use of restraint. Staff confirmed that they received annual prevention and management of aggression training which involved training in restraint in the secure car. However, staff expressed concerns that they did not feel confident in transferring these skills for use in an ambulance due to the position of the seats a member of staff was not able to sit either side of the patient. Staff told us that they had escalated their concerns to the management team but were waiting for a response.
- Training included the use of cuffs and spit hoods. Staff knew when they would use them and processes they needed to follow. There was also picture guidance in the vehicle demonstrating their appropriate use. Staff told us that if restraint was used this was reported as an incident and was investigated following the service incident investigation process.

Patient record forms (PRF's) were completed for patients transferred on the high dependency vehicle. Patient observations were recorded and a record kept of any medication administered. The form had a section to record consent but this was not routinely completed. Of the 10 forms we reviewed the consent section was completed on two forms. We raised this with the head of care standards and they confirmed that this was not required to be completed. These inconsistencies meant it was unclear from the record whether verbal consent to care had been given.

Are patient transport services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff treated patients with kindness, respect and compassion. We observed several episodes of care and saw that staff were kind and respectful in all interactions with patients.
- Staff told us that delivering good care was what they enjoyed most about their job. Staff were caring toward the patients asking if they were comfortable and engaging in friendly conversation.
- We observed one patient who was unable to support themselves fully in the chair. Staff adjusted pillows and blankets to ensure they were comfortable and continued to check their comfort throughout the journey.
- Staff showed an encouraging, sensitive and supportive attitude to people who used the services and to those close to them. For example, we observed members of the mental health team encourage and support a patient living with dementia and ultimately respect the individual's decision.
- Staff ensured patients' dignity was respected. They ensured that patients were appropriately covered during transfer. Patient feedback showed that between January 2018 and July 2018 98% of 6756 service users who completed the patient survey felt they had been treated with dignity and respect.
- All the patients we spoke with told us that staff were kind and caring. One person told us "that staff are always friendly."

Emotional support

- Staff offered emotional support to patients. They recognised that patients may have been feeling vulnerable and uncertain and ensured that they offered support. One member of staff told us, "imagine how you would like a member of your family treated."
- Patients told us that staff were very supportive and reassured them if they were worried. Patient feedback showed that between January 2018 and July 2018 98% of service users felt that staff were confident and polite.

Understanding and involvement of patients and those close to them

Patient transport services (PTS)

- Staff told us they would talk to the patient when they were going home and keep patients informed about the journey. They told us they would phone a relative or carer who was expecting the patient to keep them updated of their progress.

Are patient transport services responsive to people's needs?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- The service was planned and managed in line with the commissioning agreement in place with the clinical commissioning group (CCG). Managers told us the planning of the service was done through the contract agreements between themselves and commissioners. The service had regular meetings with commissioners to review progress against the contract and to raise and address any issues or concerns.
- At times the service could not meet the capacity demand required due to staff vacancies. Steps were being taken at the time of inspection to attempt to address this through recruitment and review of shift patterns. The provider was in the process of consulting with staff to implement a new shift system which mangers felt would improve the services ability to meet demand. Where demand could not be met, arrangements were in place to transfer appropriate patients by alternative methods (taxi or volunteer driver cars.)
- There was a hospital liaison assistant based at two NHS trusts to support the safe discharge of patients from the hospital to avoid delays for patients leaving the hospital.

Meeting people's individual needs

- Crews were made aware, through the booking process, of patients with complex needs including those living with dementia, a learning disability and patients with complex needs.
- Staff received training in dementia, equality and diversity, bariatric patients and paediatric care during induction and during their annual update training. We observed staff supporting a patient living with learning difficulties and saw that they were supportive and understanding of the patient's condition.
- Many patients used the service frequently. We observed that patients were familiar with staff and there was a degree of continuity of staff for patients who used the service regularly.
- Staff told us that when they were transporting a vulnerable patient they would call ahead to the persons family member or carer to advise them when the patient was due to arrive at their destination to ensure that there was someone there to meet them.
- All staff we asked could tell us how they would support a patient that was visually impaired. They told us that they would use verbal instructions and offer support to the patient to ensure that they were transported on and off the vehicle safely.
- Staff told us that if a patient had hearing difficulties they would use writing and gestures to explain and support the patient during their transport.
- Staff told us they could access interpreters via a telephone translation service if required. In some instances, staff said that family members might accompany patients and interpret if required. The service provided us with examples of basic instruction sheets that were available in multiple languages to support staff to provide patients with simple instructions to patients whose first language was not English. We did not see evidence of these in three vehicle packs that we checked. We asked five members of staff about the sheets. Only one was aware of the sheet although the sheets were not in the vehicle pack. We asked a manager about this at our unannounced inspection and they confirmed the sheets should be available. At the Norwich station we saw that the sheets were being printed at the time of our unannounced inspection.

Access and flow

- There were processes in place to ensure that patients had access to the service in a timely way.
- Bookings were managed through a central booking system. Response rates to calls made into the central

booking system were monitored. Data provided showed that between January 2018 and July 2018, 96% of calls were answered within 60 seconds against a target of 95%.

- Due to the nature of the contractual arrangements the service did not have control over the number of requests for patient transport. A senior manager told us that the monthly number of patient journeys varied between 11,500 and 12,500.
- There was an ability to track where the patient transports service (PTS) vehicles were and when crews had completed a job and were ready for another to be allocated. Dispatch staff told us that crews updated them on their location and availability.
- A member of dispatch staff told us that if a patient was going to be collected late they called the patient and advised them that there was a delay and gave them a revised time of when their transport was expected.
- We saw evidence that the service had worked with commissioners and local NHS trusts to provide two vehicles directly controlled by the trust's operations team, which supported the management of on the day, non-contractual work.
- There was a hospital liaison assistant, employed by the provider, in two acute hospitals to improve communication between the hospital and the crews. This helped reduce the instances of abandoned journeys by checking the eligibility booking, that the patient was ready for discharge and equipment required to transport the patient was correct.

Learning from complaints and concerns

- The service had a process in place for handling patient complaints. They told us that there was a patient and client experience team who were responsible for documenting and coordinating all patient enquires.
- The experience team referred complaints to the local operations manager, who was responsible for investigating it. Findings were fed back to the experience team. The experience team responded to the complainant. The response contained details on the next steps of the complaints process and what to do if the complainant was still not happy with the response.
- We saw that there were forms available on the vehicles for patients to provide feedback and explained how to make a complaint. There was also information on the company website telling service users how they could make a complaint.

Complaints were discussed at the regional monthly gap meeting and where required learning was identified. Managers told us that learning was shared via team meetings, staff email or via company tool box talks. We reviewed three sets of team meeting and did not see that learning from complaints was an agenda item. Staff we spoke with were not able to tell us how learning from complaints were shared so we were not assured that this was fully embedded.

Are patient transport services well-led?

Requires improvement

We rated well led as **requires improvement.**

Leadership

- Leadership of the service had the capability to deliver high quality and sustainable care. However there had been recent changes in the local management structure and this had impacted on the visibility of the leadership team.
- The senior leadership team consisted of the managing director, group finance director, head of care standards, head of human resources (HR) and training, an executive director and a medical director.
- There were defined managerial roles in place. There was a regional manager who had responsibility for ERS Medical East including the Norwich and Kings Lynn stations. There were two operational managers who reported into the regional manager. They had responsibility for the Norfolk stations, one was based in Norwich and one based in Kings Lynn. There were two team leaders based at Norwich, two lead drivers based at Kings Lynn and a lead driver based at Snetterton and Kelling. They were responsible for the supervision of road crews. At the time of our inspection there had been a change of ` local leadership in the service. The

regional manager had been in post for two months, one operations manager had been in post for one month and the team leaders had been in post two weeks and one day respectively.

- Staff we spoke with in Norwich felt that some leaders were not visible. They told us that they had not had regular team meetings. Team meetings had started since the new management team had been in post. On the day of our unannounced inspection we observed that a meeting had been scheduled to discuss the new rota system.
- Staff at Kings Lynn told us that the operations manager was approachable. Team meetings were held and staff attended where possible although due to the nature of the work it was difficult to get teams together. Staff told us that the team leader and lead driver were very supportive. The operations manager held a weekly clinic where staff could come to discuss any issues and concerns.
- There was a company directors fit and proper persons policy in place, which contained references to related documents and legal references, and requirements of the Health and Social Care Act Regulations 2008 (Regulated Activities) Regulations 2014: fit and proper person, unfit person test, and management and monitoring.

Vision and strategy

- The service's vision was "to provide a reliable caring service that puts people at the heart of everything we do". Alongside the vision were seven values which were; integrity, compassion, respect, professionalism, patient focus, innovation and working in partnership.
- Senior leaders told us that business vision was to be recognised as the leading provider of health care transport services in the United Kingdom by 2022.
- Staff we spoke with could not tell us what the service vision and strategy was.

Culture

- There was a culture of high quality, sustainable care amongst staff. The service was very patient focused. All staff when asked stated that the best thing about their job was providing a good service for their patients. Staff were proud of the service they offered to patients.
- Processes were not in place to provide all staff with career development as there had not previously been an effective appraisal programme in place. The managing director told us that an appraisal programme using an online appraisal tool which was in use in other areas of the business was due to be rolled out from November 2018. However, communication to staff had not been effective as staff we spoke with were unaware of this.
- The service had been through significant change in the 12 months prior to our inspection. Staff told us that moral amongst staff was low. They told us that they did not feel that there had been effective communication from the senior management team. Senior managers told us that they were aware that morale amongst the staff was low and were in the process of implementing processes for better communication with staff.
- There had been several new management appointments prior to our inspection. All positions within the local management team at Norwich had only been filled weeks before our inspection. Staff told us that the transition period had been very unsettling.

Governance

- There was a governance structure in place. A weekly operational meeting took place where team leaders reported to the operational managers. This meeting fed into a monthly regional governance and performance review where operations managers reported to the regional manager. This meeting fed into a monthly governance and performance review where the regional manager reported to the business directors. The outcome of this meeting was reviewed and fed into a monthly executive committee meeting.
- The governance and performance review committee met monthly on a regional basis. We reviewed three sets of meeting minutes and saw that regular agenda items included audits, incidents and serious incidents, risk register, safeguarding referrals raised by ERS Medical, complaints, compliments and vehicle deep clean compliance.
- Whilst there was governance process in place we found that these were not fully embedded or effective. The recent change in local management may have impacted on this. However, we were not assured that there was effective oversight of the governance. For example, we

found that vehicle MOT certificates were not held according to the policy, vehicle daily checks were not being monitored, although this had been implemented on our second unannounced inspection. Monitoring of gaps in the rota was not possible with the system in place and this had potential impact on patients having to be transported by taxi when all vehicles were not on the road due to staff shortages.

- Regular staff meetings had not been taking place at all sites and therefore frontline staff did not feel involved in the governance process. Staff felt that there was a disconnect with the flow of information and did not feel that their concerns were escalated or that they received information effectively form the management team.
- Staff were clear about their roles and their scope of practice. We saw comprehensive scope of practice outlined for each job role.
- The registered manager told us that they held monthly meetings with commissioners to monitor the contract. We received feedback from two commissioning groups who confirmed that there was effective communication with the service around the delivery of the contract.

Managing risks, issues and performance

- There was a process in place for incidents to be reported but this was not embedded. Staff we spoke with were not clear about the correct process for reporting incidents. We did not see evidence that learning from incidents was shared and staff could not describe any recent learnings or changes to practice following incidents or complaints.
- There was good oversight of staff training and competencies. The service had an online HR system that tracked staff training compliance. At the time of inspection 98% of staff had completed mandatory training and 100% of staff were up to date with their annual update training. However, staff appraisals had not been completed. There were plans in place to commence an appraisal programme at the time of our inspection.
- During inspection we reviewed the service risk register. Each risk had a date when it was added to the register, with a risk rating, a review date and who the owner was. We saw that the risks register was reviewed and discussed regularly at the governance and performance review meetings. Individual risk owners were responsible for devising actions to mitigate the risk.
- There was a monthly audit programme in place. We saw that where audit compliance was below expected standard, an action plan was put in place to improve compliance. For example, we saw that the infection prevention and control (IPC) audit carried out in December 2017 at the Kings Lynn station was only 57% compliant. We saw that an action plan was generated with a person nominated to deliver the action plan. The following IPC audit at this station showed improvement with compliance at 98%.

Information Management

- Appropriate and accurate information was effectively processed and acted upon. The service had integrated computer based business management systems in place to support the business. The systems produced accurate real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.

Engagement

- Staff were not actively engaged so that their views were reflected in the planning and delivery of services. There was a disconnect between the staff and the management at the time of our inspection. All the local management team at Norwich were new in post. Staff felt that communication was not effective between the management team and the staff.
- We saw evidence that team meetings had taken place in Norwich although staff told us that these had started to happen very recently. We saw meeting minutes for Norwich dated 26 June 2018 and 21 August 2018. The meetings did not follow a standard agenda but offered staff the opportunity to voice concerns. Staff in Kings Lynn told us that team meetings did happen but did not always take place monthly. The operations manager told us that they tried to run two meetings to allow as many staff to attend as possible. We saw meeting minutes dated 24 July and 27 July 2018.The meeting did not follow a set agenda. The new management team in place told us that there were plans to embed regular staff meetings and improve staff engagement.

Patient transport services (PTS)

- We saw evidence that the proposed change to the staff shift pattern was managed through staff consultation. We observed a staff meeting, attended by the operations manager, where staff had the opportunity to raise questions. The regional manager told us that staff members would have an individual meeting to discuss the impact of the shift pattern on their individual work schedule.
- There was a secure social media communication group available for road crew which enabled staff to share information. They told us that it was used to share information about road closures and other information that impacted work flow.
- The service received patient feedback through patient feedback forms which were available in the vehicles. Data showed that between January 2018 and July 2018, 83% of service users were extremely satisfied with the service and 10% were satisfied. Of those that were dissatisfied they noted delays as the reason for their dissatisfaction.

Learning, continuous improvement and innovation

- Evidence of this was limited due to the change in ownership of the provider and the recent changes in leadership at the locations we visited during our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should ensure that all staff are following the incident reporting process and that learning from incidents is shared with all staff.
- The provider should ensure that all staff have received incident training.
- The provider should ensure that all staff have an annual appraisal.
- The provider should ensure that communication aids are available to staff when transporting patients whose first language is not English or are hearing impaired
- The provider should ensure that learning from incidents and complaints are shared with staff.
- The provider should ensure that there is clear oversight of the local governance processes.
- The provider should ensure that communication with staff is improved with regular staff meetings and staff engagement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...

ERS Medical North

Quality Report

Unit 5, Severnside Trading Estate,
Textilose Road, Trafford Park,
Manchester,
Lancashire,
M17 1WA
Tel: 07985 333303
Website: www.ersmedical.co.uk

Date of inspection visit: 18 to 20 September 2018, and 12 February 2019
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

ERS Medical North is operated by ERS Medical, which in turn is owned by ERS Transition Ltd. The service provides a patient transport service throughout the north of England from five bases: Manchester, Mansfield, Leeds, Crewe and Speke (the crew and vehicles are based within a hospital in Merseyside). There are 38 patient transport vehicles split (by demand) across all five sites. The registered location address is in Trafford, Manchester.

ERS Medical was previously owned by another company which sold the business towards the end of 2017. The new company, ERS Transition Ltd has been registered with the CQC since October 2017.

ERS Medical North provides support to the North West Ambulance Service as required. It also supports several acute hospital trusts across the north of England and provides support for a GP urgent care contract to a GP federation in Leeds.

Summary of findings

ERS Medical North can transport patients detained under the Mental Health Act 2007 in a formal and informal context.

ERS Medical North is registered to provide treatment of disease, disorder or injury, and transport services, triage and medical advice provided remotely. We carried out our inspection between the 18 and 20 September 2018, and 12 February 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We found the following areas of good practice:

- The service protected patients from abuse and harm.
- The service used suitable vehicles and ensured equipment was stored on these safely and securely.
- The service had updated its running sheets to allow clinical handover information to be recorded.
- Patient records were securely stored.
- Disclosure and barring service checks were completed for all staff.
- Staff ensured appropriate paperwork was available when transporting patients detained under the Mental Health Act.
- The service had introduced an updated national training programme for road crews, as well as an updated observational audit to assess the competency of staff.
- The service's policies were up to date.
- The service had introduced systems to monitor the quality and safety of the services provided.
- All staff had completed training that was required to undertake their roles safely. In addition, records indicated that most staff were up to date with mandatory training.
- The service had a clear policy for staff to follow in the event of an emergency. Staff were aware of this and knew what actions to take if needed.
- Staff delivered patient care in a caring and compassionate way. Staff demonstrated an awareness of the need to protect the privacy and dignity of patients.
- Sites had specific business continuity plans.
- Patient feedback was very positive.
- There was a good culture in the organisation, staff felt engaged, and they praised the regional manager.

However, we also found the following issues the service provider needs to improve:

- Patient review forms were inconsistently completed.
- Not all the running sheets we reviewed contained clinical handover information.
- The service did not always record that staff returned uniforms or badges when they left the service.
- The Leeds site did not hold regular staff meetings (albeit that new manager had plans to reintroduce meetings and to increase attendance).

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Patient transport services	Good	ERS Medical North provided patient transport service from five bases throughout the north of England. We found the following areas of good practice: • The service protected patients from abuse and harm. • The service had appropriate vehicles for transporting patients and these were well equipped. • The service had updated its running sheets to include a section for staff to record clinical handover information, albeit that this information was not consistently completed • Patient records were securely stored. • Staff ensured appropriate paperwork was available when transporting patients detained under the Mental Health Act. • The service had introduced an updated national training programme for road crews. • The service's policies were up to date. • The service had introduced an updated observational audit to assess the competency of staff. • The service had introduced systems to monitor the risk, quality and safety of the services provided. However, we found the following issues the service provider needs to improve: • Patient review forms were inconsistently completed. • The service did not always record that staff returned uniforms or badges when they left the service. • There were no regular staff meetings at the Leeds site (albeit that new manager had plans to reintroduce meetings and to increase attendance).

Summary of findings

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Good

ERS Medical North

Services we looked at:
Patient transport services

Summary of this inspection

Background to ERS Medical North

ERS Medical North is operated by ERS Medical. The business was sold to ERS Transition Ltd in the autumn of 2017. It is an independent ambulance service with five ambulance bases throughout the north of England. The service has 38 patient transport vehicles, one of which serviced the GP urgent care contract, and approximately 111 operational staff.

The service has had a registered manager in post since October 2017. The current registered manager was in post from August 2018.

Our inspection team

Across the two visits, the teams that inspected the service comprised a CQC lead inspector, four other inspectors including two mental health inspectors, and a specialist advisor with expertise in patient transport services. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about ERS Medical North

The service is registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

During the inspection, we visited three stations; Mansfield, Leeds and Manchester. Manchester was the registered location address; it contained a crew room, office, welfare facilities and an internal storage area for the vehicles. Leeds was the head office address for ERS Medical and contained the control room staff as well as being a base for the crews. This was a three storey building with staff operating out of the top floor. Mansfield operated from a leased unit in a business park with welfare facilities available in a council run building near to the unit. All sites had secure access to the units, but some vehicles, including those at Mansfield, were parked in an open car park. Vehicles could be driven into an internal bay to be loaded and checked.

The Crewe and Speke sites are located on industrial units and have secure vehicle parking, training rooms and staff welfare facilities.

In total we spoke with 23 staff including; the regional manager, care quality manager, team leaders, human resource manager, ambulance crews, control centre staff and hospital staff. We also spoke with four patients. We received 42 'tell us about your care' comment cards which patients had completed before and during our inspection. We reviewed over 310 sets of patient records including running logs and patient review forms. We also accompanied a crew on one patient journey for the GP urgent care contract.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since it registered with the CQC.

Activity (January 2018 to September 2018)

- There were approximately 40,000 patient transport journeys undertaken, including 180 paediatric transfers.
- The service did not use controlled drugs.

Track record on safety

- Zero Never events.

Summary of this inspection

- Clinical incidents: two no harm, four low harm, seven moderate harm, two severe harm, one death.
- Zero serious incidents.
- 50 complaints reported from February to June 2018.

Good

Patient transport services

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are patient transport services safe?

Good

We rated safe as **good.**

Mandatory training

- Staff who worked as mental health crew received training in de-escalation and management of violence and aggression. Staff had received training in the application of handcuffs, but training had not been provided in the use of spit hoods which were in use.
- ERS Medical North had a training prospectus that set out the statutory and mandatory training that all staff had to complete. This included modules in safeguarding adults and children (to level two), "PREVENT" (a government strategy to identify and prevent terrorism), health and safety, infection prevention and control, moving and handling and equality and diversity. All staff that had patient contact also had to undergo mental capacity and consent training.
- At the time of the inspection most staff (80%) were up to date with their mandatory training. The service had introduced mandatory training cards which staff were required to keep so that they were able to evidence that they were up to date with relevant mandatory training modules.
- Staff who worked on the urgent care contract were required to complete modules such as basic life support for adults and children as well as other modules such as information security and moving and handling. Records indicated that both members of staff employed directly by the service were up to date with these.

Safeguarding

- The service had a safeguarding adults and children policy which was available for all staff to access. Staff we spoke with were aware of this policy and knew how to locate it. Staff we spoke with could articulate what a safeguarding incident was and how to report it (via a dedicated incident reporting number).Staff would also call the incident line for advice including what action to take.
- Over 85% of eligible staff had received appropriate safeguarding children training.
- There was a named safeguarding lead for the service (the medical director) who was trained to level four.
- We reviewed how the service dealt with safeguarding incidents. Most of these were dealt with appropriately and a safeguarding referral made to the local authority the same day.
- We saw evidence that one incident had not been recorded as a safeguarding incident when it should have been (albeit that the patient was "safety netted" at the time and returned to a place of safety).This was investigated, and action taken including speaking to the relevant staff member and a making the safeguarding referral. ERS Medical North told us that it had identified a system issue at the time (December 2017) which meant that the operations manager had not been alerted to the incident. We saw evidence that the system had been changed to allow easier recognition of safeguarding alerts.
- Handcuffs and spit hoods were stored in the glove boxes of locked vehicles when not in use. Vehicle keys were also stored securely.

- The provider's policy detailed the need for prior authorisation for use of handcuffs and situations where these may be applied during transport in an emergency. Staff should have completed an authorisation form for this, but we were told these were not being used and use of handcuffs was documented on an incident form post transfer instead.
- The service transported patients sectioned under the Mental Health Act. There had been 181 journeys carried under the Act from April to September 2018.Of these journeys, 14patients were transported whilst restrained. National Institute for Health and Care Excellence guidance 10 stated that ambulance staff should "ensure that the techniques and methods used to restrict a service user: are proportionate to the risk and potential seriousness of harm; are the least restrictive option to meet the need; are used for no longer than necessary".
- ERS Medical North provided training to staff that included reference to considering the least restrictive option. However, during out initial inspection, its policies and procedures were not consistent with this training as they did not refer to the conditions of the National Institute for Health and Care Excellence guidance. However, during a follow up visit, we found that the service had updated its Mental Health Services policy (in November 2018) to include additional details about mechanical restraint. This highlighted that handcuffs should only be used as a last resort and for the minimum time necessary for patients' protection and those around them. This was in accordance with National Institute for Health and Care Excellence guidance 10 which stated that ambulance staff should "ensure that the techniques and methods used to restrict a service user: are proportionate to the risk and potential seriousness of harm; are the least restrictive option to meet the need; are used for no longer than necessary". The policy did not previously reference this national guidance.

Cleanliness, infection control and hygiene

- The service monitored compliance with hand hygiene audits across its sites. Monthly head office infection audits showed a lack compliance across ERS Medical North. In February and March 2018, some sites had poor compliance with infection prevention and control audits at between 45% and 50%.However, these issues were discussed in the monthly Governance and Patient Safety meeting and compliance had improved to over 80%.Most sites were complying with the audit at the time of the inspection.
- Infection and prevention control training was delivered to all staff. Staff who we spoke with were aware of their roles and responsibilities for infection and prevention control. We found that staff had an awareness of 'bare below the elbow' when delivering care to patients.
- All sites we visited were visibly clean and tidy.
- Sites used colour coded mops for use in specific areas: toilets; general areas; kitchen and vehicles.
- The vehicles we inspected were visibly clean.
- ERS Medical North had a comprehensive Infection Prevention and Control policy, which included details of how staff should decontaminate uniforms, when to wear personal protective equipment, and the use of aseptic non-touch techniques.
- The service had an Infection Prevention and Control – Environmental Management policy. This stated that "the clinical waste bin in one of the stations was located outside in a carpark used by other businesses. Whilst it was behind a locked gate, the bag itself was open. Staff told us that they added to the waste bag when necessary and it was only cost effective to seal it at the end. Another site tied clinical waste bags closed because staff did not always have access to tags to seal them.
- For the GP urgent care contract, patient information was passed to the crew verbally by the provider whom work was being undertaken for, rather than booking forms being completed in the control room. Ambulance staff we spoke with informed us that information about infectious patients, for example, those with Clostridium difficile or meticillin-resistant Staphylococcus aureus, was not routinely provided as part of this process. This meant that there was an increased risk that infection would be spread if the appropriate personal protective equipment was not worn.
- Most vehicles carried appropriate infection, prevention and control equipment including clinical waste bags, vomit bowls and gloves. During our first visit we saw that there were no spill kits available on the vehicles at Mansfield, or the vehicle used for the GP urgent care

contract at Leeds. However, during the follow up visit we checked three further vehicles and found that they all contained spill kits, gloves and wipes. They were also clean and tidy.

- Following our last inspection, the service updated its Quality Audit – Observation Shift form. This form included questions about whether staff followed correct infection control procedures including hand hygiene and vehicle cleaning.

Environment and equipment

- The service had one ambulance equipped with blue lights which was routinely used for the GP urgent care contract. This vehicle had been off the road since the 7 September due to a mechanical failure, therefore we were unable to inspect this vehicle during the inspection. However, we reviewed records between August and September 2018, finding that daily vehicle and equipment checks had been completed for the vehicle on all occasions. In addition, we found that the vehicle had been serviced on a regular basis as well as having an up to date MOT.
- Prior to our follow up visit, the service had implemented a revised contract with the GP federation in November 2018 (for the GP urgent care service) which stated that ERS Medical North must use stretcher equipped vehicles for patient journeys. Staff told us that this happened.
- Each vehicle had a file in the crew room that would then be taken to each vehicle when it was used.This file contained, amongst other details, a driver's handbook, certificate of motor insurance, incident reporting form, end of life care information and capacity to consent forms.
- ERS Medical North used a third party provider to monitor vehicles including servicing, tax, MOT, or whether vehicles were off road. The reports produced by the provider showed that vehicles were up to date with these requirements. We checked 12 of these vehicles against the Government's tax and MOT database which supported the data supplied by ERS Medical North. ERS Medical North used another provider to manage the deep clean of vehicles.
- A traffic light system was used to alert operations managers about upcoming vehicle servicing requirements and MOTs. We saw evidence that vehicles were being monitored appropriately, and those not up to date with servicing were placed off road.
- Vehicle Off Road reports were generated every night which helped operations managers to plan and schedule resources.
- We saw that bases displayed their group vehicle insurance policy and medical malpractice policy and had clear details of the fire assembly points.
- We saw evidence that vehicles keys were stored securely.
- Sites had access to a system that allowed children to be transported on adult stretchers. We saw evidence that staff had received training on the use of the equipment and had signed to say this had been completed. This equipment was not available at all sites (for example, Mansfield) but staff told us that they could contact a neighbouring site to use their equipment. The Mansfield site had not completed any paediatric transfers since it opened in April 2018. There had been a total of 180 paediatric transfers across ERS Medical North in the nine months prior to the inspection.
- Each site had secure oxygen storage. ERS Medical North's storage policy was in accordance with the manufacturers Medical Gases Data Sheet – oxygen cylinders were clearly segregated between full and empty. Oxygen cylinders were regularly checked and those nearing empty (approaching the red line) were moved to the empty side of the container with clear separation (crews could not mistakenly pick up an empty cylinder).
- During our first visit we observed the ambulance crew transferring a response bag (which included equipment such as a defibrillator) and monitoring equipment to an ambulance. However, we found that there was no facility on the patient transport vehicle to store the monitoring equipment safely. This meant that in the event of a road traffic accident, there was an increased risk that it could cause staff or patient injury. However, during our follow up visit, staff showed us how the equipment could be safely stored on the vehicle.

- There was a daily vehicle checklist which crews should complete to ensure vehicles were appropriately stocked and safe for use. Checks included medical equipment, restraint (where appropriate) and fuel cards. However, the checklists were not always used consistently. One vehicle at the Mansfield site had not had a daily checklist completed on four out of the previous 11 occasions the vehicle was used. There was also one occasion were a defect was reported but there was no log of what action was taken to remedy it. Vehicles at the Leeds site had been checked daily. Staff recorded, on four occasions, that equipment was missing, but there was no record of what action they took to remedy this.
- However, during our follow up visit we found that the service had used daily vehicle checklists. We saw evidence that where a vehicle had not been used, the daily checklist either stated that the vehicle was "not in use" or was "off road". The Leeds base also contained a whiteboard detailing which vehicles were off road. The service also had an electronic system that monitored this. We also saw evidence that the team leader conducted local checks of vehicles. They told us that they tried to do this once a week and would check the condition of the vehicle, including whether it had been appropriately cleaned, and the state of the equipment.
- We observed that one secure patient transfer vehicle in Leeds contained no decontamination wipes. In addition, we found a box of paracetamol in an unlocked glove compartment, and cleaning granules used for spillages were out of date. Another vehicle did not have any clean linen available.

  ERS Medical North had several older vehicles that required increasing maintenance – this was recorded on the corporate risk register.

Assessing and responding to patient risk

- Although the service did not routinely record patient review forms, staff were required to complete them for all patients who required clinical assessment or monitoring. We reviewed five patient review forms that had been completed, finding that patient observations such as blood pressure and pulse rate had been documented on all occasions.
- The service used a numerical pain scoring system (between one and 10) to document how much pain a patient was in. Also, following the inspection we were informed that there was a pain scoring tool available for staff to use when assessing pain for children. However, during the inspection this was not available to staff and staff were unaware of it.
- Bookings were taken by control room staff who completed a patient transfer request form. Information recorded included patient requirements (for example - wheelchair, stretcher, medical escort – for those patients requiring medicines to be administered during the journey) and would indicate if a patient was not for resuscitation (the booking form clearly highlighted that this documentation would be required by the collecting crew).The computerised booking system asked control room staff to record infection, oxygen and mobility status, and whether the patient had any disabilities.
- A 24 hour bookings team took telephone bookings for mental health transfers. They worked through a comprehensive assessment of the patient's needs during transfer, including the patient's diagnoses, whether they were detained under the Mental Health Act, current presentation, behavioural triggers, absconsion risk and whether restrictive interventions were needed. The information generated a risk summary and level of staffing needed.
- Crews knew to call 999 should a patient deteriorate and there was a policy in place for this. Staff could give examples of when they had followed it.
- Staff had access to an automated external defibrillator (equipment that is used to diagnose and treat life threatening irregular heartbeats). We found that defibrillator pads were present, sealed and in date.
- The patient risk summary generated by control room staff was available to mental health crew undertaking the transfer. This information was sent electronically as a read only file to the hand held mobile devices used by the crews. Whilst some crew told us that they did not complete a further risk assessment at the time of transfer, others confirmed that they did and would contact the management team for advice if required.
- ERS Medical North transported renal patients requiring dialysis. Its policy relating to these transfers was in line with relevant guidance issued by the national Institute for Health and Care Excellence. Job bookings went

directly to road crews' electronic device and clearly identified that the booking was for a renal patient. Transfer times were in accordance with guidance issued by National Institute for Health and Care Excellence.

- During our initial inspection, we found the provider had not acted in accordance with an alert issued by the National Institute for Health and Care Excellence in 2015, The importance of checking vital signs during and after restrictive interventions/manual restraint (which applied to all organisations providing NHS-funded care). There was no evidence that of the 14 journeys involving restrained patients, crews took observations during and after restraint. In addition, in accordance with National Institute for Health and Care Excellence guidance 10 - Violence and aggression: short-term management in mental health, health and community settings, there was no evidence that staff were completing an immediate post-incident debrief. Therefore, there was a risk that staff might not identify a deteriorating patient.
- The policies for restrictive interventions, including the restraint policy and a policy outlining the use of spit hoods, included reference to dynamic risk assessments being undertaken. These risk assessments were not documented for any of the 14 journeys involving restrained patients as there were no journey records.
- However, the service's restrictive interventions policies had been updated during our last visit to reference the National Institute for Health and Care Excellence 2015 alert: The importance of checking vital signs during and after restrictive interventions/manual restraint (which applied to all organisations providing NHS-funded care). They set out that any patient under mechanical restraint required continued observation in line with the national guidance, and that these observations should be recorded on a patient review form. No patients had been transferred using mechanical restraint in the five months prior to the follow-up visit.
- The restrictive intervention policies also referenced National Institute for Health and Care Excellence guidance 10 - Violence and aggression: short-term management in mental health, health and community settings. The national guidance highlighted that staff should use the least restrictive option and for no longer than necessary. The service's application of spit hoods guidance stated that they should only be used as a last resort.
- The policies included reference to dynamic risk assessments being undertaken, and the use of a risk matrix. Risk areas included patient behaviour, triggers, self-harm history, physical or medical restraint. Each transfer would be given a risk rating and the score identified the number of road crew required. If the risk rating was three or more than a registered mental health nurse was required to accompany the patient. The risk assessment included a question about whether patients' "behaviour was consistent with presentation of dementia".
- During our follow-up visit we saw that risk assessments were appropriately completed for two mental health transfers completed in the three months prior to visit. They detailed the number of staff required and what to do if the road crew experienced difficulties. The relevant section paperwork had been completed by a health practitioner from the NHS who accompanied the patients. In one incident, which was recorded, consideration was given for use of mechanical restraint, but this was not needed.
- The service had a Conflict Resolution and Physical Restraint policy that had been updated in November 2018 to reflect national guidance. The policy included amongst other things, guidance for staff about what to do if a patient became unmanageable (call 999).It also highlighted what staff should do regarding positional asphyxia; it gave an overview of warning signs, and if there were concerns, to immediately release or change the method of restraint. Conflict resolution and de-escalation training was provided to staff on induction.
- Road crew told us that for those patients being transferred to the emergency department under the GP urgent care contract, hospital staff required up to date observations on a patient review form prior to handover (blood pressure, blood oxygen levels, temperature and blood monitoring results).However, this was not consistently done. Of the 142 running sheets we reviewed between October 2018 and December 2019, there were four transfers to the emergency department where patient review forms had not been completed (one each in October and November, and two in December 2018).

- In addition, the service completed running sheets for all booked patients under the GP urgent care contract, and these had been recently updated to include details of the clinical handover from the GP service.

Staffing

- One operations manager told us that staff rotas had changed to better meet the demands of the organisations they provided services for.
- The Leeds base managed staff rotas using a software application which all relevant staff had access to. The software enabled the operations manager to easily view weekly timesheets, and managed financial reports and budgets. The system had a noticeboard function which allowed the manager to relay information to staff. This system was not universal across all ERS Medical North sites and other bases managed rotas on a shared drive. We saw staff rotas in the crew rooms.
- Most shifts were fully crewed. There had been some issues with short term staff sickness that had impacted on one of the contracts operated from the Leeds base. However, additional staff had been recruited and minutes from the contract meeting suggested that performance had improved – albeit that we could not see the level of improvement.
- Whilst most staff had had disclosure and barring service checks completed, a minority were waiting for their applications to be processed. Operations managers had completed risks assessments and restricted these staff members to driving duties only until their application had been processed. They could also not work alone.
- ERS Medical North's human resource function was outsourced to a third party. Operations managers could manage staff via an online computer system. Staff we spoke to told us that the system was easy to use.
- Driving licence checks were carried out on all employees. The computer system would generate an alert when these were due to be renewed.
- We reviewed correspondence from the NHS Trust who had commissioned the GP urgent care contract, which determined that a minimum of one emergency care assistant should be available on every shift to deliver the urgent care service safely. Emergency care assistants had received training in assessing patients through examination and undertaking diagnostics such as blood pressure, oxygen saturations or an electrocardiogram (a picture taken to assess the electrical activity of the heart).

Records

- The service's record management policy stated that staff were required to complete a patient review form for all patients who required clinical assessment or monitoring during the journey (a patient review form documented important information such as a patient's vital signs, mental capacity and pain score, as well as having space to document a patient's main complaint and any medicines that the patient had).Crews did not complete patient review forms unless there had been a problem during patient transfer. This include mental health transfers.
- During our initial inspection, we reviewed five patient review forms completed for journeys between July and September2018.There were inconsistencies in how these were completed. Two patient review forms were completed fully apart from recording whether staff needed to take any action during the journey. One patient report form included details of a safeguarding concern. Whilst the patient report form recorded that an appropriate safeguarding referral had been made, it did not document what immediate action staff had taken to keep the patient safe. That said, ERS Medical's own incident tracking system contained this information. One patient report form was incomplete - it contained no patient information and did not document what happened during the journey. We raised this with management at the time who acknowledged that this was not good practice and that staff would be spoken with. One patient report form showed that a patient had collapsed at home and was unconscious for three minutes. Staff eventually completed the patient journey but there was no evidence that they escalated the patient (sought clinical advice), considered calling 999 or took any other action to stabilise or monitor them.
- Managers told us that crews checked the Mental Health Act documentation at the start of transfer. One crew member told us that a "focus for all [ambulance care assistants] … is to ensure paperwork is fully completed. If paperwork [had] any mistakes it can be disastrous". However, at the time of our initial inspection, there had been two recent incidents where patients had needed

to return to their original hospital as detention papers were incorrect. In one case there was no Mental Health Act H4 form (which authorises the transfer of a patient detained under the Mental Health Act to move from one hospital to another). In the other case, the crew were given copied papers rather than the original detention papers.Failing to ensure the correct documentation was in order meant that staff could not say that the correct legal processes had been followed, exposing them to risk.

- However, during the follow up visit we saw that relevant road crews carried a Mental Health Act section papers checklist.This set out the forms that were required for the transfer of a patient detained under the Mental Health Act; confirmation that the papers were lawful; and what to do if the papers were not completed correctly. The correct paperwork was in place for two mental health journeys that had taken place in the three months prior to this visit.
- We reviewed five patient review forms for the GP urgent care contract that had been completed by staff between July and September 2018. Although patient observations and presenting complaints had been clearly documented on all occasions, the job reference number and ambulance call sign had not been documented on any.
- During our initial inspection, we reviewed 160 running logs (from April to September 2018) relating to the informal contract between the Leeds site and a local hospital. The sheets were not designed to make a contemporaneous record of the journeys undertaken. On three occasions we noted comments on the running logs such as “TTO missing”, or “could not find patient”. There was no record of what action staff had taken to resolve these issues. We also saw evidence of one journey when a mental health patient was transferred in a patient transport bus. There was no evidence that a risk assessment had been carried before transporting the patient in this vehicle.
- During our follow-up visit we reviewed a further 142 sets of patient records including running sheets and patient review forms. Most of these had been appropriately completed.
- Staff did not complete patient review forms for routine patient transfers. They told us that forms would only be completed if a patient deteriorated, there was any incident or accident, concerns about safeguarding, or a capacity assessment required. We saw that these forms were stored on the vehicles we checked. We saw one patient review form completed for a patient transferred to an acute medical unit; there was no indication on patient review form that they had deteriorated
- We noted one incident where a patient review form should have been completed but was not. This was identified following a technical review of the incident (incidents were automatically sent to and reviewed by the care quality manager).Learning was shared with the crew who were reminded of their responsibility to complete the forms in these circumstances.
- The operations manager told us that due to a shortage of staff trained in undertaking the transfer of mental health patients, these transfers were not currently taking place in ERS Medical North locations.
- The running sheets for each day were posted to a locked box in the office (within a locked room).The sheets contained sections to record the patient’s name, address, pick up time and clinical handover information. There was nowhere on the running sheet to indicate whether a patient review form had been completed.
- There was no standardised approach to documenting the administration of oxygen. The running sheets were not designed to capture such information.
- Staff we spoke with were aware of do not attempt cardiopulmonary resuscitation orders and the requirement to carry relevant paperwork with patients at all times.
- Crews told us that do not attempt cardio-pulmonary resuscitation orders were recorded in the special notes section on the patient booking form and that they would review the validity of these forms prior to collecting the patient.
- Staff reduced the risk of patient identifiable information being lost by keeping completed records with them at all times. We reviewed all incidents reported between January and September 2018, finding that there had been no reported breaches of patient confidentiality. In addition, all paper records were stored securely at the ambulance station.

Good

Patient transport services

Medicines

- Patient transport vehicles did not carry any medicines. If a patient required sedation during a secure transfer, ERS Medical North would request a medical escort (a registered mental health nurse).Nurses were provided via an agency.
- Oxygen cylinders were stored securely on vehicles.
- ERS Medical North had produced several standard operating procedures including the Administration of oxygen by PTS crews.This guidance supplemented the training given to all patient transport service crews and was developed in line with UK Ambulance Service Clinical Practice Guidelines 2016.The guidance set out how much oxygen therapy an ambulance care assistant could provide (up to four litres per minute) and stated that its use must be documented in the patient review form. The guidance also stated that if there was to be a continuation of oxygen therapy (from a unit and during transfer) staff must record details of the healthcare professional that had made that assessment.
- Staff had access to guidance that set out what to do in emergency situations and the types of oxygen masks that could be used. Staff had access to an on-call care quality member of staff via the control centre if they had concerns about administering oxygen therapy.
- The service had a medicines management policy, but this did not include details about the reconciliation of patients' own medicines.
- The service had a controlled drugs policy that included a form for the reconciliation of those drugs, but this form was not being used at the sites. We informed senior management of this point and they immediately put the appropriate paperwork on the vehicles at the site we were inspecting at that time. During our inspection we saw evidence that this new process had been rolled out to other sites.
- Staff were required to complete a controlled drugs reconciliation form on occasions when patient's own controlled drugs were transported as part of a journey. However, staff who we spoke with informed us that they had not been aware of this requirement prior to the inspection and that this form had not been routinely used. This was important as there would be a clear record of controlled drugs being transported and being safely handed over to other healthcare providers.

Incidents

- Staff we spoke with knew how to report incidents. There was a dedicated incident reporting telephone line which staff called and the incidents details would be logged onto a dedicated computer system. An email alert would be sent to relevant team leaders and operations manager to review the incident and complete any actions. The alert would also be sent to the regional manager. The incident would also be sent to the clinical manager or health and safety manager for technical review. Any actions developed from the technical review would be assigned to a specific person.
- The regional manager was alerted to every incident and copied into any technical feedback (which also went to the operations manager).
- Staff told us that incidents had not always reported as quickly as they should have been (company policy stated within 24 hours).However, they also told us that reporting was much better and we saw evidence that this was monitored via monthly Governance and Patient Safety meetings.
- We saw examples of where changes had been made following incident reporting. For example, staff used to wait until oxygen cylinders were empty before changing them. After this issue was raised as an incident following an audit, the company policy was changed, and cylinders are now replaced sooner, reducing the risk of oxygen running out during a patient journey. We saw evidence of a clinical memo sent to every site and attached to the oxygen storage areas.
- We saw examples of incidents being discussed at team meetings. For example, following an injury to a crew member the incident was discussed in the team meeting along with how to avoid recurrence. This information was also kept in the crew room.
- Also saw evidence that ERS Medical North monitored incidents to identify trends, which included an increase

Good

Patient transport services

in falls. A joint memo was issued to remind staff about patient handling, particularly that patients should not be mobilised differently to the original booking requirements.

- Incidents were graded by technical leads who decided whether an incident was notifiable to the relevant regulatory body. The Duty of Candour responsibility sat with the regional manager who would action these as "soon as is practically possible".Whilst ERS Medical North did not have a separate Duty of Candour policy, details of when the Duty of Candour would be applicable was contained within its policy CQC Statutory Notifications – A Guide for Registered Managers. A flow chart clearly described how and when to use Duty of Candour.
- There was no joint policy to manage incidents that occurred involving some NHS organisations. Management staff told us they had attempted to investigate one incident with the support of an NHS organisation, but that organisation had refused to share information, including patient outcome.

Are patient transport services effective? (for example, treatment is effective)

Good

We rated effective as **good.**

Evidence-based care and treatment

- Staff could access policies via the intranet, and we saw a crew room displaying a sign that highlighted changes to policies.
- Standard operating procedures, including the administration of oxygen, was based on appropriate guidance.
- The restrictive interventions policies, including use of restraint, handcuffs and spit hoods were appropriate.
- The management team had some regard to best practice guidance. This included guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) and the UK Ambulance Service Clinical Practice Guidelines (2016). However, we found that there was limited reference made to best practice guidance in clinical policies that were available to staff. This meant it was unclear if all clinical guidelines reflected the most up to date best practice.
- The service had a 'Language Translation Services' policy that set out steps for how the ensure the service was accessible for patients that did not speak English as a First Language. Staff were required to read the policy and take a test at the end to ensure the understood it and confirm that that they understood that the service did not discriminate against groups or individuals. The service had a mental health services policy in place for staff. During our initial inspection, we saw the policy included some relevant guidance for staff but did not reference key parts of the Mental Health Act including relevant guidance about conveying or transporting patients detained under the Act. An appendix outlining Mental Health Act documentation was incomplete and did not include H4 forms (which allow the transfer of a detained patient from one hospital to another).
- However, during the follow up visit we saw that relevant road crews carried a Mental Health Act section papers checklist. This set out the forms that were required for the transfer of a patient detained under the Mental Health Act; confirmation that the papers were lawful; and what to do if the papers were not completed correctly. The correct paperwork was in place for two mental health journeys that had taken place in the three months prior to this visit.
- The restraint policy included guidance indicating the circumstances where a single member of staff could undertake restraint. However, this put patients and staff at risk of injury as staff were trained in team restraint techniques.

Nutrition and hydration

- Guidance was issued to staff to ensure that there was sufficient water for patients was on each vehicle prior to transporting them. Drinking water was part of the daily vehicle check.
- We also spoke to several patients who confirmed that water was available on journeys if needed.

Response times / Patient outcomes

- ERS Medical North sent us key performance indicator data for one of the patient transport service contracts it

operates.From October 2017 to August 2018 the service carried out 4,517 journeys. Crews arrival times (within 60 minutes of booking) fluctuated between 79% and 81%. Late arrivals fluctuated between 8% and 21%.We saw evidence that waiting times were discussed in meetings between ERS Medical North and the commissioning organisation.

- ERS Medical North transported renal patients requiring dialysis. Its policy relating to these transfers was in line with relevant guidance issued by the national Institute for Health and Care Excellence.
- During our initial inspection, we found the Leeds site had an informal contract with a hospital in the region. As there was no official contract, calls did not go through the call centre but were taken by the crew directly. This meant the ERS Medical North, via the control centre, did not have oversight of the types of patients being transported. The lack of records for these patient journeys meant it was unclear if inappropriate patients were being transported.
- At our initial inspection, we found there were contracts and key performance indicators in place for some patient transport services provided to organisations, but this was not universal. We found that some commissioners of the service did not require performance measures, but ERS Medical North did not always consider it necessary to always have internal measurements in place. The lack of performance indicators meant that the service could not readily review its effectiveness.
- However, during the follow up inspection, we saw the service had contracts in place. Even where the commissioning organisation did not require performance statistics, the service set its own internal targets and monitored these to ensure that patient journeys were undertaken in a timely manner. For one contract, data showed that on average, in the three months prior to the inspection, road crews attended over 86% of appointments within 60 minutes.

Competent staff

- The service used a centralised electronic system to store and access training resources.
- The service had updated its observational audits form in January 2019.Senior road crew from each site acted as observers. They completed an observational audit form (a set of structured measures staff could be assessed against). The programme was applicable across all ERS Transition Limited locations. We saw evidence of a completed audit form, saved to the employees electronic file, which highlighted an issue and how it was addressed.
- Clinical training managers met weekly (via skype) and quarterly (face to face) to review staff training requirements.
- Managers could easily access training records to see whether staff had completed relevant training.
- The service employed two emergency care assistants who had received additional training to what an ambulance care practitioner would be expected to complete. This included training to monitor patients' vital signs, such as blood pressure, oxygen levels or an electrocardiogram (used to monitor the electrical activity of the heart).
- The training prospectus covered details of control and communication operator initial training.
- A personal development policy set out how competencies would be assessed, including via work activity observation.
- The service provided training that offered regulated qualifications. Training provision was developed in partnership with the NHS National Education Network for Ambulance Services.
- Most staff had completed allocated training and had been booked onto a conversion training course provided by a third party.We identified one member of staff who was not up to date with all their training requirements (including infection prevention and control), nor were they on the list of staff to attend the conversion training course. The operations manager added the staff member to the training schedule during the inspection.
- Staff received refresher training every 12 months and the majority were up to date.
- ERS Medical North were not required to provide major incident support for the local area.

- Staff had undertaken additional mental health training to support secure patients transfers. Training included restraint and self-protection.
- Staff told us that they had had opportunities to undertake additional training. For example, one crew member told us that they had requested additional mental health training, and this had been provided.
- The data sent to us by ERS Medical North showed that prior to the inspection, most operational staff (about 75%) had not had appraisals – this included three sites where no appraisals had taken place. The service told us that it was rolling out a new appraisal system (which would go live in December 2018) which managers would be trained on. All staff were targeted to have appraisals completed by the end of February 2019.
- At the time of the initial inspection the service had one member of staff that was self-employed. However, there were no arrangements for this staff member to have an appraisal. This meant that it was unclear how their performance was reviewed.ERS Medical North had induction training for new starters which included clinical training (first aid), driving assessment and observations. An updated training prospectus had recently been introduced that set out details of the Ambulance Care Assistant Initial Training Course – an eight day course (five days clinical training and three days driver training).There was a minimum of 20 hours of observation by an experienced ambulance care assistant. There was site specific training such as vehicle familiarisation and kitting list.

Multi-disciplinary working

- Staff told us that they provided support to other sites to help with holiday cover.
- Staff were being cross-trained in secure patient transfers to provide additional cover.
- We observed one patient journey during the inspection. The crew worked well with other members of clinical staff from a local hospital when handing over the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a policy outlining guidance in relation to the Deprivation of Liberty Safeguards and the service had reviewed this in 2018. However, during our initial inspection, we saw this contained out of date information in relation to deaths and involvement of the police which had changed over a year before this inspection. The policy also gave guidance to staff to check deprivation of liberty authorisations, but these were location specific and there was no power to convey as part of the safeguards. However, during our follow-up visit, we found that the service had updated its policy (in November2018) to reflect national guidance in relation to patient deaths and the involvement of the police. The policy also confirmed that there was no power to convey patients as part of the safeguards; staff could encourage cooperation from patients, but not force them to be transferred.
- On the day of the initial inspection, inspectors asked if there was a policy outlining the Mental Capacity Act. Managers explained that they had printed a summarised copy of the guidance for staff to read, but then provided the inspection team with a copy of the Mental Health Act code of practice. This was the easy read pictorial version which would not give sufficient guidance to staff to follow. However, ERS Medical North told us that staff had access to the medical care quality team and the clinical on call team should they have any queries regarding capacity. The service also had a Care to Care policy that provided staff with guidance on assessing a patient's capacity and consent".
- Prior to our follow-up visit, the service had updated its Mental Health Services policy. This now referenced up to date national guidance and included details about capacity and consent, and the health, safety and wellbeing of patients, drivers, escorts and others. The policy set out the initial process for transferring patients detained under the Mental Health Act which included obtaining a brief about the patient; checking section papers were correct; introducing themselves to the patient; and explaining details about the journey.
- At our initial inspection, we found most staff were up to date with up to date with statutory and mandatory training which include training in the Mental Capacity Act and consent. However, staff operating on the GP urgent care contract had a mixed knowledge of consent,

mental capacity, best interest decisions and deprivation of liberty safeguards. Not all staff were aware of the differences between the Mental Health Act and the Mental Capacity Act.

- In addition, staff on the GP urgent care contract did not have an understanding of Gillick competence. This was important as there was a potential for the service to transport children of a variety of ages. Gillick competent is a term used to describe if a child under 16 years of age can consent to their own medical treatment without the need for parental permission or knowledge.
- However, during our follow up visit we saw that staff had received updated training in consent and underwent a multiple-choice question test at the end to test understanding. They were also assessed, via the updated observational audit form, to see whether they were competent in this area. We spoke with a member of staff who could demonstrate their knowledge of the Mental Health Act and how to apply this to their role.
- Staff told us that they would speak to their operations manager for advice regarding the Mental Health Act if required.
- Staff demonstrated an awareness of the importance of obtaining consent prior to providing patient care. We observed staff seeking verbal consent from a patient when helping them from their home address to the ambulance.

Are patient transport services caring?

Good

We rated caring as **good.**

Compassionate care

- Staff we spoke with could provide examples of where they had provided compassionate care. This included a patient at the end of their life who they ensured was transferred so they could spend their last days at home.
- We observed an ambulance crew delivering caring and compassionate care to a patient during the inspection. Staff who we spoke with demonstrated a commitment to provide the best care possible to all patients.
- We found that patients' privacy and dignity was maintained, particularly when transferring a patient to the ambulance, as well as when transferring the patient from the ambulance into hospital.
- Staff told us that they would ensure that patients were comfortable and warm prior to journeys. Patients told us that staff had offered them drinks.
- We had feedback from 42 patients via comments cards and spoke to four patients who completed the cards. They told us that staff were "reliable, friendly [and] efficient".

Emotional support

- A patient told us that the crew that collected them "were really understanding of my needs" and helped them into their home and made them a drink.
- A patient told us that they had complex medical needs but that crews listened to make sure their needs were met.
- Staff could give us some examples of when patients or relatives had required reassuring during their journey, informing us that they had done their best to alleviate any anxieties or concerns that a patient or a relative had.
- Crews undertaking mental health transfers told us that they felt it was important to understand that patients were "poorly".

Understanding and involvement of patients and those close to them

- Staff could articulate examples of remaining with patients until their carers arrived to ensure they were not left alone.
- A services user told us that "staff were very professional and caring, got me to my appointment on time and were there waiting for me when I finished". Another patient told us that as they no longer had use of a car and would find it impossible to attend hospital appointments within the help of ERS Medical North staff who they praised for being "very friendly, helpful and caring".
- Another patient told us that crew members were "really respectful of my needs".

Good

Patient transport services

- We observed one occasion when the staff communicated with a patient clearly when helping them into a wheelchair. This meant that the patient understood what was happening and they were given the opportunity to say how they wanted the staff to support them.

Are patient transport services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

- Operations managers met with local commissioners to understand how they could meet the needs of the local population.Meetings would include a review of performance and discussions about any complaints or compliments. However, there were not always formal contracts in place and so it could be difficult for the service to reliably know whether it was meeting the needs of local people. There were a number of commissioned services were there was limited business oversight.
- Whilst staffing levels had compromised the service to some commissioners, these issues had been raised as part of the regular meetings and steps put in place to remedy them, including recruiting three additional staff.

Meeting people's individual needs

- ERS Medical North had a 'Language Translation Services' policy that set out the steps staff should take to ensure that patients that spoke different languages could access the service.
- Control centre operators have access to language line if callers do not speak English as a first language. In addition, the system control centre operators use to book patient transport requires them to ask whether the patient requires "additional help with understanding or communicating with others".
- Staff informed us that they sometimes transferred patients who were living with dementia as part of the work that was undertaken. Members of the management team informed us that all staff received dementia awareness training. Staff could provide examples of caring for patients living with dementia. For example, they explained how they reassured and calmed a patient and stayed with them until carers arrived.
- Staff could access interpreters if required. In addition, vehicles contain language cards that can help crews convey basic information. These cards were in 41 different languages. There was also access to language line if needed.
- Crews had access to an emergency phrase book which they could use for patients who were deaf. This would allow patients to consent for examination, describe their pain level and location, and communicate their current symptoms. It also had a modified section for deaf patients who were pregnant.
- Crews had access to pictorial cards to help relay information to patients that had communication difficulties. For those patients that had additional needs, the service would recommend that the commissioner of the service provided a healthcare escort.
- ERS Medical North had wheelchair accessible and bariatric vehicles. The vehicles were adapted to take larger stretchers and wheelchairs. The was a clear policy in place to ensure the safer handling of bariatric patients to avoid aggravating pre-existing medical conditions.
- Control room staff recorded any special notes that need to be relayed to the crew about a patient needs, for example, patients living with dementia or learning disabilities, or approaching the end of their life. The special note would be reviewed prior to the transport to ensure that enough crew attend to help the patient.
- We spoke to the carer of a patient (the patient was blind) who told that the crew were attentive to their needs.
- Additional information was requested at the booking stage for mental health transfers to ensure that individual needs could be taken into consideration. For example, patients could request a preferred gender of the crew, although this could not always be guaranteed.
- Vehicles used for transporting mental health patients were unmarked and had mirrored privacy glass, which

protected the privacy and dignity of patients. The provider only used people carrier type vehicles for mental health transfers which allowed for greater legroom and headroom for patients and accompanying staff. The provider did not use caged vehicles.

Access and flow

- During our first visit we saw that ERS Medical North did not have service level agreements in place for all commissioned services. This meant that there was no central oversight of the service and it could not quickly monitor response times or see whether there had been delays. It also meant it was difficult to monitor resources levels or excess demand. For example, taking on an additional contract affected the performance of an existing one. This was highlighted to the service by the commissioner rather than being proactively identified and remedied. During our follow up visit, we saw evidence that ERS Medical North had introduced service level agreements.
- ERS Medical North had a policy in place to manage ad hoc booking requests. These bookings were managed via a central control room.
- Bookings could be received via email, telephone or fax and control room staff should ensure that suitable vehicles and qualified staff are used.
- ERS Medical North used technology to track the location of vehicles which helped with the allocation of resources.
- We saw that one of the bases had had issues with picking up patients in a satisfactory timescale and that this had been raised as a concern in meetings with two different commissioners. We saw evidence that additional staff had been recruited but it was too early to say for certain whether this had helped reduce waiting times.

Learning from complaints and concerns

- The service had an up to date complaints policy which set out a clear pathway for how complaints should be managed depending on the type of complaint received. All complaints were reviewed by the appropriate manager, and then passed to the relevant head of department. The complaints pathway referenced the Parliamentary and Health Service Ombudsman when the complaint was about NHS services.
- ERS Medical North's policy stated that a written response should be sent to complainants within 25 working days, a target it was generally meeting at the time of the inspection (the average response time was 26 days).
- We saw that complaint forms were kept on vehicles.
- We reviewed two complaint investigations. In one instance ERS Medical North identified that crews should have acted differently, and it apologised to the patient. Lessons learnt were sent to the operations manager to discuss with staff. The complaint was investigated and resolved quickly. A second complaint related to delays in collecting a patient. The issue was investigated quickly, and the service identified that winter pressures had affected the service. ERS Medical North apologised to the commissioning service who had raised the complaint.
- Complaint investigations were recorded electronically. We saw evidence of staff statements, technical reviews and learning saved to individual complaint files and that learning had been shared with individuals involved in the complaint.
- The contracts in place for the provision of services to NHS providers set out ERS Medical North's obligations for managing and reporting on complaints in line with NHS complaint regulations.
- Complaints were discussed as monthly Governance and Patient Safety meetings. The data showed that 50 complaints had been made between February and June 2018.
- ERS Medical North had recently begun to record the compliments it received from patients. Compliments were discussed at the monthly Governance and Patient Safety meetings.

Are patient transport services well-led?

Good

We rated well-led as **good.**

Leadership of service

- ERS Medical North had a clearly defined leadership structure. The regional manager had operational

responsibility for sites in Speke, Crewe, Manchester, Leeds and Mansfield (ERS Medical North).The operations managers at each of these sites oversaw local operations and managed the team leaders.

- Staff told us that the leadership team were visible and that heads of departments, and the regional manager, regularly visited sites. Staff described senior managers, including the managing director, as approachable.
- The regional manager had recently been brought into the region to provide stability and continuity across sites. This included ensuring that operations managers used the various computer systems to manage HR, vehicles and billing. The regional manager told us that the change in ownership at the end of 2017 had been a springboard to make changes. The regional manager acknowledged that standardisation was still an issue, but there was continual improvement.
- The regional manager told us that a key challenge was ensuring that staff at individual sites were aware of policies. Other key challenges included maintaining contracts, and commissioners trying to drive down costs. Incident management had also been an issue, but they had begun to educate operations managers to ensure their staff reported them immediately. The data sent to us by ERS Medical North demonstrated that most incidents were being reported in a timely manner.
- The regional manager, who was relatively new to the role in ERS Medical North (albeit they had been the manager of another region and had worked for the organisation for over four years), told us they were supported to carry out his duties and responsibilities.
- There was no leadership management programme, but staff could give us examples of how they had progressed in the company, including the regional manager.
- During our first visit we found that the leadership of ERS Medical North did not ensure that there were always formal contracts in place for the services it provided, and they did not always recognise the risk associated with the lack of these contracts. This meant that it could be difficult for the service to assure itself it was managing services effectively.In those circumstances where there was no contract in place, ERS Medical North was largely reliant on the operational managers meeting with commissioners and escalating concerns where appropriate. Whilst we saw some evidence in the monthly performance review meeting notes that contract issues were discussed, there were no actions assigned or deadlines given for completion.
- During our initial inspection, we also found leaders did not always understand the challenges to the quality and sustainability of services ERS Medical North provided. Leaders did not proactively assess the risk of taking on additional work or the impact this would have on operational performance. For example, ERS Medical North acknowledged to a commissioner that performance had deteriorated due to taking on additional work. Whilst additional staff had been taken on to resolve the issue, there was no evidence that leaders had assessed the risk or impact to other contracts prior to taking on the work.
- However, during our follow-up visit we found that a new operations manager had been appointed at the Leeds site. There was greater emphasis on reviewing performance across commissioned contracts, and a recognition of the risks associated with the lack of formal contracts. We saw examples of where the operations manager had considered the risk of taking on new business and the potential impact to other contracts.
- The operational manager at Leeds planned to improve consistency across the two sites they managed, including introducing a standardised meeting agenda.

Vision and strategy for this service

- Managers we spoke with could articulate the strategy and vision for the service; a five year plan (ending 2022) to become the leading independent ambulance provider in the area they operated.
- ERS Medical North had a clear set of values which it considered were important to its business and employees. These values included, integrity, compassion, patient focus, working partnership, innovation, professionalism and respect. Staffs' appraisals took account of these values.
- Each regional manager had their own directives based around 12 key measures they were measured against.

These measures included reference to performance of the business against financial targets. Importantly, the directive also highlighted that managers were responsible for delivering a "patient focused service".

- Staff told us that they had had the opportunity to visit the head office to speak with the managing director about the vision, strategy and values of the organisation.

Culture within the service

- The service had a freedom to speak up guardian and staff could articulate their role. We saw posters of the guardian's role in staff rooms.
- The regional manager praised the operational managers and crews for embracing the changes to the service since it was sold last year, including cross-site working.
- The operations managers we spoke with were spoke positively about the new regional manager who had only recently started managing sites within ERS Medical North.
- The staff we spoke to felt supported in their roles. One member of staff said that there had been uncertainty when the business was sold at the end of 2017, but they felt that the new managing director had "refocused" the business and they were now "much happier". Another member of staff told that that it was a "great place to work" and they "loved it". One member of staff told us that they felt informed and valued. A member of staff praised the operations manager at Mansfield base saying they were a "breath of fresh air".

Governance

- During our initial inspection, we found that whilst ERS Medical North had a process to review internal policies, several policies were outside of their review date. This meant that ERS Medical North could not be assured that they referenced up to date guidance. We found that the Deprivation of Liberty Safeguards policy, which had been reviewed by the provider in 2018, referenced out of date standards. In addition, the restraint policies did not reference appropriate guidelines. This meant that service users were not protected from abuse and improper treatment. The provider told us they would review these policies.
- During the follow up inspection, we found that the service had reviewed its policies and those that we checked had been updated and referenced appropriate guidelines. Copies of policies were kept in the staff room. However, a staff member told us that they were not aware that any policies, including mental health policies, had been updated recently and that they were not aware of any process for informing staff of updates. This issue was mitigated by the training they had received which occurred on the day of the visit.
- The GP urgent care service had provided support to a local NHS trust since November2017.The contract was initially set up for a two week trial period. We saw no evidence that the management team had reviewed the service provision following this period. In addition, because of there being no written agreement between the service and the NHS trust, it was unclear about other minimum requirements for the provision of the service. For example, what equipment was required and what records staff were required to complete.
- After our first visit, ERS Medical North had agreed a formal contract with the GP urgent care service (in November 2018).The contract highlighted that the service was for the "hospital managed transport booking for GPs referring 'urgent non-emergency' patients to [an acute medical unit] for assessment/ admission". It set out how bookings would be made, and that the clinical team at the GP federation were responsible for triaging patients to ensure they were suitable for transfer.
- ERS Medical North had an audit policy (amended in August 2018) that defined the audit process, and the roles of staff and their responsibilities for specific audits. Audits included, but were not limited to, health and safety, infection prevention and control, roller door safety, and patient review forms. We saw evidence that, where patient review forms were used, these had been audited. Where a technical review had identified the patient review forms had not been fully completed, feedback was recorded in the incident management system. However, during the first visit we found several examples of patient review forms that had not been completed correctly. We were not assured that the audit process was sufficiently robust to improve record keeping.

Good

Patient transport services

- The service completed patient review forms for any journey where there had been an incident, including the clinical deterioration of a patient. Despite not being set out as a requirement in the new GP urgent care contract, staff also told us that they completed patient review forms for those patients being transferred to the emergency department. However, during our follow up visit, we saw evidence that this process was not consistently followed by staff.
- ERS Medical North had a process whereby operations managers should collect uniforms and identification badges from staff when left the business, and this information recorded on the employee file. However, information about staff uniforms was not always recorded. This meant that there was no audit trail if this information subsequently needed to be checked which exposed the business to risk. This remained an issue during our follow up inspection.
- Operations managers at each base held crew meetings to discuss progression of the business, health and safety minutes, and training requirements. During our first visit we found that there were inconsistencies in how often the meetings were held at sites. One site held staff meetings regularly every quarter and had good staff attendance. Another site did not have set dates for meetings and those they did have were not well attended – the operations manager at Leeds told us that about 20% of staff had attended the meetings. However, the ad hoc nature of the work undertaken, and staffing rotas, meant that it was not always possible for staff to attend meetings. In addition, the Leeds site had access to technology to share information with all staff (a "notice board" on a software application).We saw minutes from some of these meetings which showed evidence of learning being shared.
- There was a change in operational managers at the Leeds site prior to our follow-up visit, and as a consequence, there had been no recent staff meetings. The operations manager had placed a poster in the communal areas advising staff that they could have a one to one with them to discuss any immediate concerns. The manager told us they planned to hold monthly meetings and have two sessions to coincide with shift times to reach as many staff as possible.
- Operations managers had different tools for managing shifts patterns and timesheets. One member of staff told us that they had concerns about the hours they worked and that they "often" worked long hours. Minutes from a regional meeting showed that managers were aware of the issue albeit there were no actions in place to address it.
- The Governance and Performance Review committee met once a month. There were clear terms of reference for the committee which set out the attendees, the chair, and the function of the committee. The scope was defined as "All patient care, quality and clinical issues arising from and related to CQC regulated activity within the CQC registration locations and pertaining to ERS Medical, its subsidiary companies and business activities in the UK."
- A Governance and Patient Safety committee met once a month to discuss complaints, compliments, safeguarding concerns or incidents across the entirety of the regions represented by ERS Medical. Relevant operations managers attended, as did the regional manager and clinical and health and safety managers.
- In June 2018, the new regional manager introduced a North Governance and Patient Safety committee meetings to discuss issues specific to the sites they managed. The committee was attended by the operations managers and the technical leads. The minutes of these meetings highlighted that incidents were discussed and learning shared – for example, following an incident with a wheelchair, an action was generated to produce a clinical memo and share with all sites. The action included an owner and a deadline date.
- Minutes from the monthly committees were sent to the head of care to review and the outputs of these reported to the quarterly patient safety meeting chaired by the medical director. They were also reported to the managing director via the monthly performance review meeting.
- Prior to the appointment of the new regional manager there had been no cross-region meetings. This changed in June 2018 when the regional manager brought together the North team and the North East region for monthly meetings. Prior to his appointment there had been little standardisation across regions and teams, and little guidance for operations managers about expectations. They had begun to introduce this

standardisation, including site presentation (see decontamination areas) and staff engagement - albeit that there were still some inconsistencies – for example, regularity of site specific crew meetings.

- Infection prevention and control audits highlighted poor compliance at the beginning of 2018.The data showed that the compliance for infection prevention and control audits improved and was over 80%.
- The sites we visited had had regular health and safety audits completed by the health and safety manager. These identified what the risks were, what the risk score was, what control measures were in place, and what the revised risk rating was. Hardcopies of the audit results were kept on site and recorded within the risk management system.
- ERS Medical North carried out a number of audits including uniforms, hand hygiene, mop, care quality and governance, and driver audits.
- Contracts were commissioned and managed at site level but could be escalated through the Governance and Performance Review committee if there were any issues.
- The service undertook enhanced disclosure and barring service checks for all staff who were employed. Checks were completed every three years unless there had been a clear break in employment with the service.
- The service reviewed all disclosure barring checks to review any issues or convictions. We saw evidence of risk assessments being conducted on those staff who had not had a disclosure and barring service check returned. This included a member of staff who had not been provided with a uniform until their certificate had been returned.

Management of risk, issues and performance

- During our first visit we had concerns about the management of organisational risks, including the lack of contracts in place for some commissioned services and the lack of performance monitoring. ERS Medical North had taken a number of steps to improve its service in this area.
- We spoke with the service's business relationship manager. They confirmed that there were performance indicators in place for contracts. Whilst some of these had previously been monitored centrally, a new process was being introduced whereby the local operations managers would take responsibility for reviewing, understanding contractual performance, and identifying and remedying issues.
- The business relationship manager explained that where some contracts had previously required manual input to produce performance reports, this had been automated to make analysis easier. This automation also allowed the commissioner of one service to view the performance reports remotely.
- At our follow-up inspection, we found the service had introduced performance monitoring into one of contracts even though the contract did not specify such monitoring. For example, the service now had a colour coded system used to easily identify how long it was taking road crews to attend appointments. Performance monitoring of this contract started in October 2018.It showed that, on average, in the three months prior to the inspection, road crews attended over 86% of appointments within 60 minutes.
- The operations manager at Leeds had also put steps in place to review contracts prior to taking them on to ensure they had the required resources in place to support them. For example, a hospital trust wanted the service to provide patient transport support over winter (a 24 hour per day service utilising two shifts).The service reviewed the contract and concluded that it required three shifts to provide effective support. It also identified that it did not have enough staff to achieve this and therefore recruited and trained more in advance of the contract starting.
- We also saw that the service was proactively reviewing the performance and trends in contracts. For example, it identified a trend for patient discharges from a hospital in the afternoon. The service had then introduced a double crew during this increasingly busy period to respond to the demand.
- The care quality manager conducted audits of patient review forms to ensure they had been completed appropriately. There was only one incident in the previous five months where a patient review form was required for the patient transport service.The audit

identified that the staff member had not completed a patient review form when they should have. They were reminded that this was a requirement and completed it retrospectively.

- Following the visit in September 2018, the service had introduced an updated process to monitor the performance of road crews; a Quality Audit – Observation Shift form was used. Questions included, amongst other things, how staff communicated with professionals, whether they understood the handover details, their communication with the patients and whether they obtained consent. Staff were also assessed on adherence to infection control procedures and the completion of relevant paperwork.
- The running sheets did not contain a section to record whether a patient review form had been completed. Staff told us that patient review forms completed should be stored with the corresponding running sheet. However, there were four occasions where there were no patient review forms completed for journeys to the emergency department, and one occasion when a review form was completed for a transfer to an acute medical unit, but there was no indication that the patient had deteriorated or there had been an incident. The evidence demonstrated that there was inconsistency in the completion of patient review forms.
- ERS Medical had a corporate risk register which detailed the risk, action needed to mitigate the risk and the original and current risk score. The register also included planned review dates and risk owner. Risks were graded based on the consequence of the risk and the likelihood of recurrence.
- Operations managers managed their own site specific risks and the managers we spoke with could tell us what these were.Within the minutes of regional site meetings we saw an example of risks being discussed; after a commissioner raised concerns regarding performance, ERS Medical North had committed to recruiting additional staff (which they told us they had done).
- The corporate risk register highlighted four levels of risk, low, moderate, high and extreme. No staff member below regional manager could record a risk. Examples of current risks included the absence of a permanent registered manager in another registered location.
- We saw evidence of ERS Medical working with software developers to improve the reporting abilities, including trend analysis, of its risk management system.
- The operations managers we spoke with could articulate the risks specific to their site. We could see that some of these risks were discussed at the Governance and Patients Safety committee, including staff leaving to work for NHS providers. However, there was no local register of these risks, other than the minutes from meetings. Therefore, if a risk was not considered serious enough to be recorded on the corporate risk register, it could be difficult to keep a track of progress towards mitigating these local risks.
- ERS Medical North had site specific business continuity plans that highlighted the actions staff needed to carry out in certain circumstances. These were readily available for site staff to review.
- Prior to the first visit, ERS Medical North sent us data that showed they had transferred at least one patient detained under the Mental Health Act from England to Scotland. Two different Mental Health Acts apply to England and Scotland.Therefore, once a formally detained patient crossed the border into Scotland, they become an informal patient unless a warrant from the secretary of state was in place. ERS Medical North's policies did not advise staff to check the paperwork for cross border transfers. Whilst there was no evidence that a warrant was not in place for the transfer(s) ERS Medical North carried out, the lack of clear guidance on this issue placed staff at risk of detaining patients without the required paperwork. However, as previously noted, the service had amended its policy and during our follow up visit, we were satisfied that staff were acting in accordance with this.
- During our initial inspection, we found evidence of policies that did not reflect current guidelines which resulted in patients and staff being placed at risk. However, during our follow up visit, we saw evidence that this issue had been resolved.

Information Management

- Staff we spoke with had sufficient access to computers. They could easily access training records, staff rotas and relevant policies.

Good

Patient transport services

- Operations managers could readily access the incident tracking system.
- Software used by ERS Medical North helped operations managers keep track of vehicles more efficiently then a paper based system.
- ERS Medical North had a Caldicott Guardian (the Head of Care Quality).We saw evidence that detail of the General Data Protection Regulation was circulated in the staff magazine, along with details of who the guardian was and what the Caldicott principles were. The corporate risk register also included an ongoing risk of systems being compromised by a virus. We saw that no threats had been detected but this would be monitored on an ongoing basis.
- All staff information, including references and disclosure and barring service checks were kept on an electronic system. However, we found that information for a self-employed technician was not held on this system, meaning that there was a risk that not all members of the management team would have access to this information if needed. The service told us that the disclosure and barring service check had been carried out within the last three years and there had not been a break in service. They were satisfied that that the checks they had conducted were appropriate.

Public and staff engagement

- There was a commitment for the senior management team to be represented at team meetings.
- A staff recognition scheme had been introduced and would be awarded each quarter. Nominated staff had the opportunity to win extra annual leave entitlement. All staff nominated also received a letter of thanks from the managing director.
- Patients could provide feedback via a questionnaire. The provider identified that there was only a small percentage (2%) of journeys generated patient feedback. However, it recognised that this feedback was important to improve service responsiveness and we saw evidence that sites had been reminded to ask patients to complete feedback forms. Data provided by ERS Medical North showed an increase in the feedback forms being returned from 14 in March 2018, to 150 in July 2018.
- Staff had free access to health and wellbeing services and we saw details of these displayed in crew rooms.
- ERS Medical produced a quarterly staff magazine, with the first issue being produced in Spring 2018.The magazine highlighted business developments, celebrated staff successes and patient stories.
- ERS Medical North analysed patient feedback forms in July 2018.Of the 31 responses received, over 85% of patients were highly likely to recommend the service to family and friends.

Innovation, improvement and sustainability

- Crews used hand held electronic devices to which they received patient transport instructions. Information included any special notes about the patients they were transporting, including do not attempt cardio-pulmonary resuscitation.
- ERS Medical North was working with a software provider to increase the functionality of the incident reporting system.Meetings had taken place prior to our inspection to look at additional reporting functions to allow benchmarking site performance and trend analysis. There were no timescales for this improvement project.
- The service used several online software packages to track vehicles and their speed (for resource planning and to monitor driver performance), and record and store training certificates, driving licence checks and disclosure and baring service certificates. Packages were also used to monitor and report on vehicle maintenance.
- Staff felt encouraged to share good practice. For example, an operations manager had redesigned the decontamination area within their base. This example was shared with other sites and was being adopted across the region (the Leeds site was developing their decontamination area and were waiting for an outside sink to be installed).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure appropriate documentation is completed on occasions when patient's own controlled drugs are transported as part of a patient journey.
- The service should ensure that all staff have appraisals.
- The service should consider steps to improve the consistency of recording when uniforms and badges are collected from staff leaving the organisation.
- The service should consider steps to help the Leeds site re-introduce team meetings.
- The service should consider how it reviews patient review forms to ensure that they are consistently completed when appropriate.

ERS Transition Limited

ERS Medical North East

Quality Report

Unit 6
Bowburn North Industrial Estate,
Bowburn,
Durham,
County Durham
DH6 5PF
Tel:07917647923
Website:www. http://ersmedical.co.uk/

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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information known to CQC and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

ERS Transition Ltd, trading as ERS Medical provides a range of patient transport services (PTS) to the NHS within the North-East Region. The registered location is in Bowburn, Durham which was established on 1 September 2014 when SRCL Ltd, trading as ERS Medical, acquired what was Medical Services North East (MSNE).

ERS Medical was recently sold by SRCL and a new provider had been registered with CQC as ERS Transition Ltd since October 2017.

ERS Medical North East is registered for emergency and urgent care and a patient transport service (PTS). As the provider had not undertaken any regulated activity in the last 12 months in respect of emergency and urgent care the focus of this inspection was in relation to PTS.

ERS provides support to the North East Ambulance Service as required but predominately support specific Trusts and Clinical Commissioning Groups (CCGs) within the north eastern geographical boundaries. The primary service is transporting non-emergency patients. ERS also provides PTS for GPs in the North Yorkshire and East Riding area of Yorkshire.

ERS can transport patients detained under the Mental Health Act 2007 in a formal and informal context.

The provider has an additional operating base in Blyth, Northumberland that provides similar services to the Bowburn site. This is not a registered location.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 and 22 May 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we do not rate

We regulate independent ambulance services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- All the PTS staff compliance in mandatory training and safeguarding training.
- The provider had a robust incident reporting procedure which all staff understood and alerted managers in real time if an incident had occurred, which allowed managers to make an early assessment.
- The provider's key performance indicators were consistently met.
- Staff received a comprehensive induction at the start of their employment.
- There was evidence that all PTS staff were up to date with the Mental Capacity Act (MCA), including consent training.
- There was evidence from 101 staff files including, two staff that worked in accounts and admin, which showed all staff had DBS checks within the past three years and 99 PTS staff had their driving licenses checked within 12 months of this inspection.
- There was evidence of high levels of satisfaction from a patient/carer/relative survey.

Summary of findings

- There was regular staff engagement through staff meetings.
- The provider had invested in six computer based business management systems to support various parts of their business. These provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.

However, we also found the following issues that the service provider needs to improve:

- There were no visual communication aids in any of the PTS ambulances.
- The provider did not have an effective system in place to identify out of date consumable items. Two automated external defibrillator (AED) pads and the electrocardiogram (ECG) dots on one ambulance were found to be out of date.
- There were no complaints forms carried on PTS ambulances.

Following this inspection, we told the provider they should make three improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Name of signatory

Ellen Armistead

Deputy Chief Inspector of Hospitals (area of responsibility), on behalf of the Chief Inspector of Hospitals

ERS Medical North East

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to ERS Medical North East

ERS Medical North East is operated by ERS Transition Limited. The background to the service is that on 1 September 2014 SRCL Ltd trading as ERS Medical acquired Medical Services North East (MSNE). ERS Medical was sold by SRCL Ltd in the autumn of 2017 creating ERS Transition Ltd. The service registered with CQC October 2017.

It is an independent ambulance service with a main base in Bowburn, Durham and a smaller base in Blyth, Northumberland providing PTS for NHS trusts and general practitioners.

The service has had a registered manager in post since October 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, a CQC Assistant Inspector and a specialist advisor with expertise in PTS. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Facts and data about ERS Medical North East

The service was registered to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we visited Bowburn and Blyth bases. Eleven PTS vehicles were inspected across each of the stations.

The station at Bowburn was leased privately and was a single story building situated on an industrial estate. The front of the building had signage indicating the premises was operated by ERS. There was car parking to the front of the building and a large gated car park on the eastern side which led to a large parking area at the rear of the building where ambulances were located. The site was surrounded by a secure metal fence. The exterior of the building had security lights, CCTV and an alarm system. The CCTV was monitored by ERS staff and the recordings were stored on the company`s computer hard drive.

The front door of the building leads to a lobby which has a visitors' signing in book. There was a short corridor with the dispatcher`s office leading off it. The office had seven work stations for dispatching staff to use. There was a large training room/ meeting room, two offices for managers to use and a crew room with welfare facilities. There was a large garage with access to the rear car park

via a roller shutter door. Inside the garage there was a store room with consumable items. The garage also contained a clinical waste bin, staff lockers, oxygen cylinder storage and welfare facilities.

The station at Blyth was a single story privately leased building on an industrial estate. The front of the building had signage indicating the premises was operated by ERS. There was a gated carpark at the front with room to park ambulances. The entry through the entrance was via a key pad lock and the front door was alarmed. There was access to the internal garage through a roller shutter door.

There was a ground floor lobby with a signing in book. There was a porta cabin inside the garage area which had a manager's office and crew room. There were male and female toilets and a small cupboard with consumable items which was locked within the garage area. There was a large walk in cupboard which contained additional consumable products and other items such as replacement wheel chairs. Near the entrance to the garage there was a colour coded cleaning station. The garage also contained a clinical waste bin, staff lockers, oxygen cylinder storage and welfare facilities.

We spoke with the Head of care, Regional Manager, Care Quality Manager, two Operations Managers, two team leaders, Health and safety advisor, 10 crew members and two dispatchers.

During our inspection, we reviewed 10 sets of patient records.

This was the service's first inspection since registration with CQC.

Activity (October 2017 to April 2018)

In the reporting period October 2017 to April 2018 the following PTS journeys undertaken;

- PTS 23,956 transfers
- GP transfers 1,595

Track record on safety

- No Never events
- Clinical incidents were reported where no harm occurred, twelve with low harm, six with moderate harm, one with severe harm and no deaths had been reported.
- There were no serious incidents reported.
- 15 complaints had been received.

Patient transport services (PTS)

Safe

Effective

Caring

Responsive

Well-led

Overall

Information about the service

ERS provided support to North East Ambulance Service when and where required but predominately in support of specific Trusts and CCG's within the North Eastern geographical boundaries. In addition, they provided a PTS for General Practitioners in the North Yorkshire and East Riding area of York. The primary service was transporting non-emergency patients to destinations across the North-East Region.

Summary of findings

We found the following areas of good practice:

- All the PTS staff compliance in mandatory training and safeguarding training.
- The provider had a robust incident reporting procedure which all staff understood and alerted managers in real time if an incident had occurred, which allowed managers to make an early assessment.
- The provider's key performance indicators were consistently met.
- Staff received a comprehensive induction at the start of their employment.
- There was evidence that all PTS staff were up to date with the Mental Capacity Act (MCA), including consent training.
- There was evidence from 101 staff files including, two staff that worked in accounts and admin, which showed all staff had DBS checks within the past three years and 99 PTS staff had their driving licenses checked within 12 months of this inspection.
- There was evidence of high levels of satisfaction from a patient/carer/relative survey.
- There was regular staff engagement through staff meetings.
- The provider had invested in six computer based business management systems to support various

parts of their business. These provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.

However, we also found the following issues that the service provider needs to improve:

- There were no visual communication aids in any of the PTS ambulances.
- Some consumable items on the PTS ambulances were out of date.
- There were no complaints forms carried on PTS ambulances.

Are patient transport services safe?

Incidents

Incidents

- Due the type of service provided none of the incidents recorded fell into the category of a never event; the service had therefore not recorded any never events during the past 12 months. Never events are incidents of serious patient harm that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- During inspection the provider's incident reporting policy was reviewed. The document contained sections on related documents and legal references, policy statements, responsibilities, definitions of incidents, reporting and investigation process, health and safety incidents, clinical incidents, information governance / security incidents, transport / road traffic incidents and environmental incidents.
- We saw evidence in the incident reports we reviewed that staff were adhering to the providers reporting policy.
- The document had an owner, a review date and a version control number.
- Incidents were recorded on an electronic system, which was colour coded (RAG rated) the incident had timescales included to ensure the investigation was completed on time by the identified investigation owner.
- PTS crews used a single telephone number to call the ERS control room in Leeds. Staff there followed a script to ensure all relevant information was obtained when recording an incident.
- When an incident was recorded an automatic notification was sent to the provider's insurers to give them early notification to consider if an insurance claim was likely. The notification contained basic information as to the type of incident. No patient identifiable information was included. An alert was also immediately sent to an app on the work phones of the regional manager and the head of care. This allowed

them the opportunity to make an early assessment of the type of incident that had been reported and whether or not any statutory notifications needed to be made.

- The health and safety adviser told us they monitored incidents through the incident recording system to collect information and investigate if there were any health and safety issues to ensure any required notifications were made. They were involved in local governance meetings where incidents were discussed.
- Any use of mechanical restraint or the spit hood reported by staff would automatically create an incident for the operations manager to review and investigate. We saw evidence of this during inspection.
- The incident reporting system had several drop-down boxes to complete as part of the incident investigation process. If any were answered "no" the system automatically generated an action plan, which the person allocated to investigate had to complete before the incident could be closed.
- We saw minutes from the monthly Governance and Patient Safety Committee (GaPS) meeting which showed that incidents were an agenda item and had been discussed. There was evidence each incident had a reference number, event type, identified region, location, event date, owner, work flow status and submission date.
- We saw evidence that wider organisational learning from incidents was shared with staff through a computer business system which they had access to. Individual learning from incidents was delivered by the regional manager or operations manager to the crew or individual concerned.
- During inspection we reviewed two incidents. Both had been recorded on the same day as the incident had occurred. One related to a patient displaying challenging behaviour towards staff and being restrained and another where the crew stopped and provided assistance at a road traffic accident. Appropriate information was recorded about the incidents, the staff members involved, and the timescale of the events.
- We saw an example of an occasion in October 2017 where a safeguarding referral was recorded, but not submitted due to the introduction of a new computer system that week. Staff had made an error recording it on the training computer system. This was reviewed as an incident and investigated, leading to a re-referral being made. Managers told us a review of the incident had led to additional training being completed by staff on the new computer system.
- Staff we spoke with told us they received feedback from incidents. Feedback was provided to individual staff members where appropriate. Broader learning points from incidents were shared with staff teams in anonymised form to further staff knowledge and promote good practice.
- Staff told us learning from incidents was shared at staff meetings and in hard copy format in a folder on the staff notice boards, which we were able to review during the inspection.
- We spoke with ambulance crew members. All stated that they had received training in incident reporting, which was confirmed in the mandatory training records, and all could explain the incident reporting procedures.
- Managers we spoke with could explain what the application of duty of candour was and provided examples of when this had been used.
- The definition of duty of candour is that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

Mandatory training

- We viewed the provider's spreadsheet which contained the details of all 99 PTS staff based at Bowburn and Blyth. The spreadsheet had staff names, where they worked, their role, date of induction training, date of provider driving test, driving qualification, clinical skill set, date of clinical skill set refresher, dates of the one day statutory and mandatory training, dates for statutory and mandatory training refresher, dates of DoLs/MCA training and MCA consent training. The spreadsheet showed all staff training was up to date.
- The training spreadsheet showed all PTS were up to date with their mandatory training.

Patient transport services (PTS)

- Frontline staff were informed when they were required to do statutory and mandatory training and training to maintain their professional qualifications through an app on their work phones.
- We reviewed 10 staff training files. These all demonstrated that staff had undertaken comprehensive inductions and mandatory and statutory training. For example, induction training included basic life support, health and safety, fire safety, infection control, and manual handling.
- Staff told us they received annual training which included assessments of knowledge and practical competence. They told us they were scheduled to undertake training updates automatically and would receive notification of training dates two to three weeks in advance.
- Staff told us they had undertaken driver training. This did not include driving under blue lights. Managers told us they would travel with staff in the ambulance and observe and assess staff driving ability which was recorded in staff personal files. We saw evidence of this in three personal files of staff who had undertaken driver training.

Safeguarding

- The medical director was the safeguarding lead and the care quality manager was the deputy for safeguarding. They had completed safeguarding level four training in the previous 12 months with an external training company. In addition, the head of care standards had been trained to level four safeguarding.
- Staff based in the Leeds call centre were trained to safeguarding Level 2.
- Safeguarding training for ambulance crews was delivered face-to-face for four hours duration every three years, plus annual refresher face to face supported by e-learning.
- We saw evidence of safeguarding information being available for staff. In the crew room there was an A3 laminated information poster titled “Adult and child safeguarding referral for ambulance crews”. There was an A4 version of same information located in the PTS crew information pack held on ambulances.
- During inspection we saw posters displayed on staff notice boards titled “Prevent referral process “which provided staff with information to make a referral in relation to any concerns related to terrorism. There was evidence the information had been updated in April 2018.
- The care quality manager told us the Monthly Governance and Patient Safety Committee (GaPR) meeting included any lessons learned from safeguarding incidents and specific information for the region is discussed.
- We saw evidence that all 99 PTS staff were compliant with their safeguarding training.
- PTS staff were trained to safeguarding level two.
- ERS Medical North East had adopted a single phone number to use to contact the ERS control room in Leeds to make a safeguarding referral.
- Staff we spoke with could explain the referral procedure.
- We saw evidence of when staff had called the ERS control centre in Leeds to make a safeguarding referral. Staff who received the call would record the referral on an ERS computer system and inform the appropriate safeguarding authority.
- The computer system was set up so that when a safeguarding referral was recorded an alert would be immediately sent to an app on the work phones of the regional manager and the head of care. This would allow them the opportunity to make an early assessment of the type of referral that had been reported and whether any immediate action was required.
- The ERS computer system had drop down boxes to complete as part of the safeguarding referral. If any were answered “no” the system automatically generated an action plan which the person allocated to investigate had to complete before the referral could be closed.
- We reviewed one safeguarding incident which was recorded using the online system. Information was provided about the nature of the incident and actions taken which included promptly making a safeguarding referral and contacting the police.

Cleanliness, infection control and hygiene

Patient transport services (PTS)

- During inspection the infection prevention and control policy and guidance document was reviewed. The document had version control, and a review date.
- An infection prevention and control annual statement summarised the systems and procedures that were in place covering three areas; people, ambulances and equipment, and environment and included daily, monthly and quarterly protocols and audit procedures, and equipment and guidance available for ERS staff. The statement confirmed the infection prevention and control lead was available as a "champion" to provide guidance and support to staff. The annual statement was signed off by the medical director who was the infection, prevention and control lead.
- The provider had a document titled "Specific infection IPC guidance 2018" which was a lookup matrix of guidance available for ambulance crews to use.
- The care quality manager told us infection, prevention and control training for ambulance crews was done at induction and then updated annually. This was confirmed during inspection in the staff training records.
- During inspection we reviewed the hand hygiene inspection forms and the uniform inspection forms which showed both areas were regularly audited.
- The care quality manager told us ERS had taken part in World Hand Hygiene Day. We saw evidence the care quality team had submitted an entry, which included the ERS care quality team visiting the Bowburn site on 5th May 2018 with hand hygiene training equipment to demonstrate the World Health Organisation's FIVE moments of hand hygiene. The submission included photographs taken at the event as evidence of compliance.
- The care quality manager told us daily housekeeping records were completed by contracted cleaning staff which were reviewed during inspection. The care quality advisors did monthly inspections of sites and a full infection, prevention and control audit was completed at each site every six months.
- We saw evidence of two infection prevention control audits carried out. Both audits covered 49 areas. The audit carried out at Blyth on 29 November 2017 showed a 100% compliance and the audit carried out at Bowburn showed a 98% compliance.
- The care quality manager confirmed the scheduled deep clean for each vehicle was completed every 90 days and checked during the audit process. Any action plans from the audit were generated by the provider's computer recording system which was seen during inspection. Managers had an app with the same audit information on their work phones with completed and in-progress actions reported in one daily report daily.
- Each manager had a 'My dashboard' which showed pending items and others if overdue and not completed. Any overdue or not completed action plans were automatically escalated to the ERS Managing Directors dashboard who contacted managers direct to ask when the required actions would be finalised.
- During the inspection 10 vehicles and the equipment carried in them were inspected. All the vehicles and equipment were visibly clean. All the vehicles inspected carried hand sanitising gel and sterile wipes which were in date. Vehicles carried infection, prevention and control cleaning level information on a laminated sheet for crews to use.
- Ten vehicle document files were checked; all contained evidence of vehicle deep cleans in accordance with the providers' policy.
- The garages as Bowburn and Blyth had a designated area for mops and cleaning products. The mops were single use and colour coded; red for toilet and shower areas, yellow for ambulance interiors, green for kitchen and dining areas, blue for general areas and black for vehicle exteriors. Mops that had clearly not been used were observed to be hanging on the wall ready for use.
- Beside the mops were notices advising which colour bag to use when disposing of rubbish, black for general rubbish and orange for clinical waste.
- Staff at both stations were observed using the correct colour coded mop for the cleaning they were undertaking.
- Staff we spoke with could explain the daily vehicle cleaning regime and that if the vehicle became contaminated they would return to the station to clean it.

Patient transport services (PTS)

- Vehicle deep cleans were carried out by an external company. Vehicles were deep cleaned every 90 days. A checklist was supplied by the contractor's company which had a set list of tasks and identified areas to clean.
- After each deep clean a report was prepared for the vehicle which included a checklist of what had been cleaned, any problems found, vehicle registration details and vehicle mileage. A blue log book in each vehicle had the dates when next deep clean was due and if any decontamination has been done. Although the report provided a lot of information in addition the senior manager present was updated verbally as to what had been done and if any issues had been identified.
- Managers told us that the external company provided regular training for ERS Medical North-East staff which included how to use various cleaning products and how to physically clean vehicles and the station environment.
- During the inspection we saw in both garages there was a designated clean and dirty area which was used during the vehicle deep clean. We observed a vehicle deep clean being carried out and saw the equipment and vehicle being cleaned in the dirty area before being moved to the clean area.
- During inspection a crew was observed during a patient transport. The crew followed hand hygiene practices cleaning their hands before and after transferring the patient as well as at the hospital and they wore personal protective equipment (PPE). The crew were also observed to clean the stretcher after use.
- During inspection we observed good practice in hand washing. There were signs displayed beside every sink with instructions how to clean hands. Next to the sinks were suitable cleaning products.
- We observed numerous staff and saw their uniforms were visibly clean. We saw posters displayed on staff notice boards which outlined how a clean uniform should look and where equipment should be carried. Managers told us the reason for this was to have a corporate image.

Environment and equipment

- Both stations were well maintained and laid out.
- We saw evidence the provider used a computer system to record all vehicle Ministry of Transport (MoT) test dates for the PTS vehicles with an alert on the anniversary date. The system also recorded the date of the vehicle service and the anniversary date.
- During inspection 10 vehicle files that contained original documents were checked. There was evidence all 10 vehicles had been serviced in accordance with the serving schedule and had a current Ministry of Transport (MoT) test certificate.
- We saw evidence of a CQC Compliance audit and an Annual CQC Compliance audit carried out by the provider. The audit templates showed that the consumables replenishment check was completed as part of audit.
- The Health and Safety adviser told us they received information in relation to vehicle checks on an app on their phone. We saw evidence of completed responses to daily checks undertaken, monthly visits and vehicle pre-visits.
- We spoke with operational staff who told us they had access to specialist equipment for adults and children. Relevant equipment was available for both adults and children including age related child restraint seats for children. One identified ambulance at each station had a bariatric stretcher and wheel chair. If a bariatric patient was booked in for transport the crew would use that ambulance that carried the specialist equipment to transport the patient.
- Staff could replenish ambulances with consumable items from stock cupboards in the garages of each station. When staff removed items, they signed a stock control sheet outlining what had been taken. The stock control sheet was checked daily by the operations managers who would replenish the store room stocks. Staff we spoke with confirmed this.
- Staff we spoke with told us that there was always sufficient stock held at the stations to restock the ambulances.
- Staff told us they carried out equipment checks at the start of each shift against a checklist. We saw evidence of this on the daily vehicle check sheets.

- Staff told us that there was always enough equipment to complete the shift and that additional equipment could be obtained from another site if required.
- Both stations had a designated quarantine area. Staff used these to leave defective equipment after applying a visible red label. Staff would also record the defective equipment on the daily vehicle running sheet.
- The running sheets and quarantine areas were checked after the start of each shift by the operations managers who would remove the defective equipment and replace it as soon as possible on the vehicles.
- There were some consumable items carried on the PTS ambulances we inspected that were out of date. When this was pointed out to the Operations Manager they ensured all the items were immediately changed.

Medicines

- The provider had an effective policy for the management and administration of patients' own medication.
- At the time of the inspection the provider did not store controlled drugs or prescription drugs.
- The provider had a medicines management policy, should they require it, with 26 areas covered in place to support this. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- There was a separate policy in relation to the management of controlled drugs. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- The provider had a medicines management and medicines administration policy document. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- We saw evidence of a medicines formulary which identified which were controlled drugs and which were not. The document also highlighted which drugs could be used by paramedics, institute of health care development (IHCD) technicians, emergency care assistant (ECA)/ urgent care administrator(UCAs) and student paramedics with an IHCD technician certificate.
- During the inspection we saw evidence of weekly medicines checks from 2017 when the provider did hold medicines. We reviewed 14 weekly checks that had been carried out at Bowburn and Blyth in November and December 2017. Every check showed 100% compliance apart from one at Blyth on 28th November and Bowburn on 29th November 2017 which showed 83% compliance.
- Medical gases in both stations were stored in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders. Full and empty cylinders were kept separate and were easily identifiable. The cage containing the cylinders in each garage were in a position whereby a vehicle could not accidentally be reversed into them. There was evidence the oxygen piping on the all the PTS ambulances inspected had been serviced and was in date.

Records

- Crews were made aware of special notes during the patient booking in process. These notes gave additional information about the needs of the patient and the crew would receive the information on tablets. Staff told us they would also confirm if there were special notes during the patient handover when ERS staff took responsibility for the patient.
- Staff reported that control room staff would request comprehensive information about patients and that available information was passed on to them before conveying the patient. Staff told us that they received information about the patient's name, date of birth, and whether or not they required any particular equipment.
- Some staff reported that external organisations requesting patient transport services did not always provide full or accurate information about patients. In such situations they would contact the control room to update the record with additional information. This would be used to decide whether to complete the transfer or not.
- Staff said they would transfer patient paper notes in a sealed bag with the patient, but they were not permitted to access these due to data protection. Staff said they

had access to information about do not attempt cardiopulmonary resuscitation orders, dementia, and mental health from the booking in process and through the person requesting the service.

- There was information displayed in staff areas providing guidance on methods of ensuring security of confidential information. For example, password protection and maintaining a clear desk.
- The provider used a computer based system for recording patient records. During inspection five records were checked and all had been completed correctly.
- We saw evidence patient records were audited and had been discussed at the monthly governance and patient safety committee meeting.

Assessing and responding to patient risk

- Staff we spoke with described assessing patient needs by reviewing information provided by the control room, seeking additional clinical advice if required, speaking with the patient, carer, and / or staff, and conducting their own clinical observations.
- Patient record forms reviewed during inspection showed staff had assessed risk and provided patient transportation in a way that aimed to ensure safety. For example, if a risk was identified, crews requested the support of additional staff, obtained additional equipment, adapted the number of patients transported at one time, or made the decision not to convey the patient if the risk was too high.
- Managers and staff we spoke with told us if a patient became ill while being transported crews would deal with the patient using their skills in accordance with their qualifications and training. If the patient was obviously seriously unwell an emergency NHS ambulance would be contacted to attend.
- We saw evidence of a policy in relation to use and application of handcuffs, and dealing with disturbed or violent patients. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- The policy document contained extensive information for staff relating to the use of and application of handcuffs.
- The provider had a safer person handling and dynamic risk assessments guidance document with links to provider policies. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- The guidance document contained extensive information for staff to use in relation to risk assessing patients.
- The provider had a policy in relation to use and application of spit hoods. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- The policy document contained extensive information for staff to use in relation use and application of spit hoods when dealing with patients who spat at them.
- Spit hoods were available for staff to use when transferring patients with mental ill health, who presented a risk of spitting or biting and transferring disease.
- Spit hoods had been used twice in the reporting period following advice from the provider who had requested the transfers and after a risk assessment had been carried out.
- Any use of mechanical restraint or the spit hood reported by staff would automatically create an incident for the operations manager to review and investigate. We saw evidence of this during inspection.
- Incidents were recorded on a business management computer system which was colour coded once the incident was recorded with timescales to ensure the investigation was completed on time by the identified investigation owner.
- The computer system was set up so that when an incident was recorded an alert would be immediately sent to an app on the work phones of the regional manager and the head of care. This would allow them the opportunity to make an early assessment of the type of incident that had been reported and whether any statutory notifications needed to be made.
- Staff we spoke with told us they had raised the need for more information prior to conveying patients with

senior managers. They told us that managers had met with external providers on several occasions to request complete patient information at the time of the booking in process.

Staffing

- The staffing at Bowburn consisted of 53 advanced care assistants, four urgent care assistants, four staff trained to deal with patients who have mental ill health, one clinical supervisor, two call handlers, one operations manager and two team leaders.
- The staffing at Blyth consisted of 26 advanced care assistants, five urgent care assistants, two dispatch operators and one manager.
- Three different types of shifts were used to maximise use of resources and to fulfil the providers contractual arrangements. These were contract shifts covering NHS trusts, floating shifts used to cover any additional contract transport requests and day and night shifts to cover any unexpected requests and to cover requests from contracted GP practices.
- The computer based shift allocation system that aligned staff to shift patterns.
- Crews allocated to contracted shifts were based at NHS hospitals. The contracted shift for one NHS trust was a double crewed ambulance staffed by two advanced care assistants working 7.45am - 6.45pm, 11.15am - 8.15pm and 1.15pm - 10.15pm.
- The contracted shifts for another NHS trust was a double crewed ambulance staffed by two advanced care assistants working 9.30am - 6.30pm, 11.30am - 8.30pm and 1pm - 10pm.
- One other NHS trust required a double crewed ambulance staffed by two advanced care assistants covering 8am - 8pm, another NHS trust required the same staffing working 11.30am - 9.30pm and another required the same staffing 10.00am - 10.15pm.
- At Bowburn there was a day shift ambulance crewed by two advanced care assistants working 7am-2.30pm and a night shift working 9pm - 9am. There was also a floating crew staffed by an urgent care assistant and an advanced care assistant which tended to cover 11am - 10pm.They picked “as required” transport requests and supported the contracted crews.
- During weekends and during bank holidays the shift coverage was to cover hospital discharge contracts supplying an ambulance crewed by two advance care assistants working 8am -10pm and two ambulances working 9am - 10pm and one working 11.30am - 8pm.
- At Blyth the shifts were two double crewed ambulances working 09.00- 22.00 staffed by two advanced care assistants, and seven crews working 10am - 9pm staffed by one UCA and one advanced care assistant. On weekdays two of these crews came from Bowburn.
- During weekends and Bank Holidays the staffing was two double crewed ambulances staffed by advanced care assistants working 9am – 8pm and five double crewed ambulances staffed by one urgent care assistant and an advanced care assistant working 10am – 9pm. All the crews came from Blyth
- The shifts to cover unexpected demand Monday to Friday were; early shift 07am – 2.30pm and a night shift covering 9pm – 9am. Both ambulances were double crewed with advanced care assistants.
- The floating shift tended to be 11am- 10pm but the start time could vary. The ambulance was doubled crewed with two ACA`s
- Managers told us they did not use agency staff.
- Staff competencies were maintained through statutory and mandatory training. Managers told us they had recently commenced supervision ride outs with staff so supervisors could observe staff operationally to confirm they carried out their duties in accordance with their role and training. We saw evidence of the supervision ride outs during the inspection.
- We spoke with four staff who all worked 11-hour shifts. They said they did not have set break times and were unsure of when and how long breaks should be for, but thought it should be 30 minutes after six hours worked. They said they set their own break times around jobs and informed control room staff of this.
- Staff told us there were always enough staff on shift to provide cover. In the event of sickness cover was provided by ERS bank staff, or supervisors. No agency staff were used.

Anticipated resource and capacity risks

Patient transport services (PTS)

- Managers told us foreseeable resource and capacity risks were managed through the service level agreements devised as part of the contractual arrangements. We saw evidence that the provider was meeting their contractual arrangements.
- We saw evidence of regular meetings between the provider and the services contracting PTS. Managers told us the meetings were used to identify if there needed to be any changes to existing service level agreements and to discuss any impact on patient safety.

Response to major incidents

- Managers told us ERS Medical North East was not part of any NHS trust major incident plan and that none of their staff had received training on major incidents as it was not required.
- The provider had a business continuity plan for the Bowburn and Blyth sites. The plan contained extensive information covering 29 areas including clear roles and responsibilities, a business continuity impact assessment summary, impact on buildings and facilities, what to do including maps to assist in relocation, establishing a business continuity control centre and notifying stakeholders.
- The plan had been tested practically when the computer based dispatch system failed so all crews and dispatchers had to revert to using paper bookings and received patient booking information through mobile phones. Managers told us there had been no reduction in service.

Are patient transport services effective?

We found the following areas of good practice:

- Crews conducted their own risk assessment through speaking with the patient, carer or staff and through clinical observation which was recorded
- The provider's key performance indicators were met.
- Staff received a comprehensive induction at the start of their employment
- The provider recorded the driving licence details of all 99 PTS staff on a spreadsheet including; staff names, date of birth, driving licence details, date licence expired, date when the licence was checked and the date when the next check needed to be carried out.
- Staff records showed all 99 PTS staff were up to date in relation to training in the Mental Capacity Act (MCA) including consent.

Evidence-based care and treatment

- Staff were able to remotely access and read company policies and procedures via an app on their tablets.
- The crew logged on to the system to access policies and procedures. We saw the infection, prevention and control folder gave access to all relevant policies which was particularly useful for newer staff. We also saw the manual handling folder which contained relevant policies and procedures. The following polices were also reviewed which followed joint royal ambulance colleges liaison committee (JRCALC) guidance; safeguarding, control of substances hazardous to health(COSHH) and end of life care.
- There was a specialised mental health trained member of staff on call Monday to Friday 12 hours per day to provide advice.
- We saw evidence managers discussed local polices and pathways which included the scope of practice for every clinical grade. Managers told us they were undertaking a review to align the clinical grades with standardised training.

Assessment and planning of care

- Staff told us they were made aware of a patient's condition including any mental health issues so that they could plan transport accordingly through the booking in process. The dispatchers obtained the information from a script which they passed to the crew on their tablet. We saw evidence of this during inspection.
- The crews conducted their own assessment through speaking with the patient, carer or staff and carrying out their own risk assessment and clinical observation. This

was recorded on the vehicle running sheet (PRFs). Staff told us they would assess how to move and transport the patient, and assess hydration, nutrition, or pain if indicated. We saw evidence of this during inspection.

Response times and patient outcomes

- Managers we spoke with told us only one of the contracted NHS trusts had key performance indicators (KPIs) for ERS Medical North East to work to. Another NHS trust had provided ERS Medical North East with KPIs in April 2018 but because they were relatively new no performance data had been collected.
- The regional manager told us the monthly mission performance review meeting included key performance indicators. KPIs were not separately audited but crews time stamped the running sheets to show when activities are completed.
- In relation to the KPI where data was collected, every patient journey was recorded each month on a spreadsheet and reviewed by management. The provider had two key performance indicators from the main commissioning provider which were; 90% of patients are to be collected within a maximum of three-hour response time from time of booking to the patient being picked up on the ward and 98% of patients will travel no longer than 1 hour 30 minutes on transport for any given transfer.
- The KPI for patients to be collected within a maximum of three-hour response time from time of booking to the patient being picked up on the ward had a target of 98% the data for December showed 97.12% achieved, January 98% achieved and February 98% achieved.
- The KPI for patients will travel no longer than 1 hour 30 minutes on transport for any given transfer from the main commissioning provider had a target of 98% the data for December showed 99.24% achieved, January 99% achieved and February 98% achieved.
- Managers told us that due to the limited KPI information collected no corporate and wider benchmarking was carried out, however, we saw evidence the data was discussed at regional governance meetings.

Competent staff

- All staff that we spoke with told us they had received a comprehensive induction at the start of their employment which had lasted at least four to five days, depending on the nature of their role and start date.
- We reviewed 10 staff training files. These all demonstrated that staff had undertaken comprehensive inductions and mandatory and statutory training. For example, induction training included basic life support, health and safety, fire safety, infection control, and manual handling.
- Staff told us they received annual training which included assessments of knowledge and practical competence. They told us training updates were automatically scheduled and notified two to three weeks in advance.
- Two of six staff we spoke with told us they had appraisals where their performance was reviewed. Four of the six staff we spoke with stated they had not had formal appraisals. Staff told us they could approach managers if there was something they wished to discuss in relation to their role.
- Managers we spoke with told us there was a staff appraisal process and we saw evidence of this; however, not all operational staff had an appraisal. Managers told us because the company had only been registered with CQC since October 2017 the priority had been to ensure all staff had been on an induction course and had received statutory and mandatory training and staff appraisals would follow that.
- Managers also told us they wanted to ensure all staff knew and worked to the company values before commencing appraising staff.
- The provider had a training prospectus for staff to refer to. This included the training team, mandatory e-learning, annual core update day, ambulance care assistant course, mental health uplift course, urgent care assistant course, emergency care assistant course, emergency medical technician, registered healthcare professionals, non-clinical staff courses, education and training staff courses, management training courses, commercial training, training administration process, training hub equipment list and feedback.
- The prospectus also covered continuing professional development.

- The provider had a performance development and review plan. A blank plan was reviewed. It contained key performance areas to consider.
- In performance quality the performance areas included; job knowledge, quality of work, adaptability, team work, dependability and attitude. In safety the areas considered included; attendance/punctuality, customer focussed, care of equipment, initiative/innovation, continuous improvement and technical skills. Personal strengths and development opportunities are identified and a plan is devised.
- The performance development and review plan was supported by a personal development review plan with individual SMART objectives, achieving personal qualities, personal qualities reflections, future objectives and development and a staff rating was reviewed before signing off by the individual and their manager.
- The provider had a personal training and development policy. There were 23 areas covered including training plans, workplace activity observations records and training compliance audits/targets. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- During inspection the policy document was reviewed and found to contain extensive information for staff to refer to in relation to their training and development needs.
- The provider recorded the driving licence details of the staff on a spreadsheet. The spreadsheet recorded staff names, date of birth, driving licence details, date licence expired, date when the licence was checked and the date when the next check needed to be carried out. The spreadsheet had an alert set up to inform managers when the checks were due.
- The service had a computer based system linked to front facing cameras in the provider's ambulances. The cameras were activated when the vehicle exceeded a certain speed. The camera footage was stored on a computer hard drive. The system also recorded harsh breaking and over-revving of the engine. This information was used by the operations managers to identify any drivers whose driving standards were below what was accepted.

Coordination with other providers

- Coordination with other providers was achieved through the booking-in system which ensured pre-alerting and capacity issues were highlighted to PTS crews.

Access to information

- Staff we spoke with told us they had access to special notes, advanced care plans(ACPs) and do not attempt cardiorespiratory resuscitation (DNACPR) orders through the patient booking-in process and during the patient handover.
- During inspection we saw evidence in patient report forms that special notes, advanced care plans (ACPs) and do not attempt cardiorespiratory resuscitation (DNACPRs) were recorded.
- All the ambulances we inspected had accurate and up-to-date satellite navigation systems. If the system failed crews could ring the dispatchers for directions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a Deprivation of Liberty Safeguards (DoLs) policy which contained related documents and legal references, an introduction, policy statements, responsibilities, levels of restriction and restraint, ERS medical responsibilities and death of a person subject to a DoLs order.
- During inspection the policy document was reviewed and found to contain extensive information for staff to refer to in relation to dealing with patients who could be subject to a DoLs order.
- The provider training spreadsheet had evidence that all 99 PTS staff were all up to date in relation to training in the Mental Capacity Act (MCA) including consent.
- Staff we spoke with confirmed they had received training in consent and Mental Capacity Act. Staff files showed that staff had received training on consent, Mental Capacity act, and Deprivation of Liberty Safeguards.
- Staff we spoke with could give examples of when DoLs would apply.
- Staff reported they would seek consent from patients, if they had capacity, before conveying them and if a

patient did not consent they would not convey them. They told us that on such occasions ERS staff would ask staff working with the patient to speak with them and further explain the rationale for transport in the hope the patient would consent. Staff said that such decisions would be documented on the running sheet. If consent was not obtained the ERS control would be contacted and advice sought.

- Staff told us they did not complete a specific form detailing whether the patient had consented and whether or not staff had completed a Mental Capacity Act assessment.
- Some of the staff we spoke with were not aware of MCA assessment process of a two-stage test and four criteria to meet to determine capacity but could explain the assessment process from the training they had received.

Are patient transport services caring?

We found the following areas of good practice:

- Staff were observed ensuring the dignity of patients.
- The provider had received several letters from providers thanking ERS staff for their caring attitude toward patients.
- Staff described providing emotional support by listening to patients and responding in a calm and empathic manner.

Compassionate care

- We observed a crew ensuring the dignity of a patient was maintained by closing the ambulance door while transferring them from a wheel chair to a stretcher.
- Other staff we spoke with told us they routinely ensured the door of the ambulance was closed when transferring patients
- Staff were observed to be respectful and caring toward the patient asking if they were comfortable and confirmed they had their belongings with them.
- Staff we spoke with told us about how they maintained patient dignity during long distance transfers. The crews ensured at least one female member of crew was present when transporting a female patient. If the crew were male and female they would switch roles, for example if a patient needed to use the toilet so that patient's dignity was preserved
- Staff told us they would ensure a patient was comfortable, warm and would ask what they could do to make the patient more comfortable. For example, adjusting the head position if transported on a stretcher. Staff told us they would offer patients drinks and if the hospital had sent the patient with a packed lunch they assisted them to eat and drink, if required, at a time which suited the patient.

  We saw a letter of thanks from staff at a NHS trust in relation to a delay accessing an inpatient bed; the crew remained with the elderly patient in the day room ensuring their comfort. They volunteered to transfer a discharged patient to ensure both patients reached their appropriate destinations.
- We saw another example where staff picked up a patient outside of the contracted area and transferred them. The family asked the commissioners to pass on their sincerest thanks as ERS Medical staff helped make a very difficult situation easier for them which allowed for some dignity to be restored to the patient in a caring and responsive way.

Understanding and involvement of patients and those close to them

- Staff told us they would explain to the patient they were going home and keep patients informed about the journey. Staff would phone a relative who was waiting for the arrival of the patient to inform them of their progress.

Emotional support

- Staff we spoke with described providing emotional support by listening to patients and responding in a calm and empathic manner. Staff had received customer care training to assist with positive communication with patients.
- Staff told us sometimes older patients would get very nervous so they held the patient's hand for the entire journey to reassure patient them and asked if they were OK.

- Staff told us when children were being transported, for example for radiotherapy, they would talk to the children to reassure them.

Are patient transport services responsive to people's needs?

We found the following areas of good practice:

- Crews were made aware of patients with complex needs including those with learning disabilities, dementia, older people with complex needs and those requiring access to translation through the booking in process.
- All PTS staff had received training in dementia, equality and diversity, care of bariatric patients and paediatric care.
- The provider had a robust complaints procedure, which all staff understood.
- Wider learning in relation to complaints was shared with staff through a computer system which they could all access.
- There was regular staff engagement through staff meetings.

However, we found the following issues that the service provider needs to improve:

- There were no visual communication aids in any of the PTS ambulances.
- There were no complaints forms carried on PTS ambulances.

Service planning and delivery to meet the needs of local people

- Managers told us the planning of the service with commissioners was done through the contract and accompanying service level agreements This was supported by regular meetings with commissioners to review progress against the contract and to discuss any issues or concerns that had arisen.
- During inspection we saw evidence the provider had a set shift system appropriately staffed with additional resources as contingency to meet additional demand.

Meeting people's individual needs

- Crews were made aware of patients with complex needs including those with learning disabilities, dementia, older people with complex needs and those requiring access to translation through the booking in process.
- All PTS staff had received training in dementia, equality and diversity, bariatric patients and paediatric care during induction.
- All staff we spoke with could described the steps they would take to support patients with visual or hearing difficulties. They said they would use writing, gesture or verbal explanation. One member of staff could use British sign language.
- Staff described being able to access interpreters if required. We saw there was information about how to request an interpreter displayed in staff areas for ease of access. Staff reported that family members might accompany patients and interpret for them additionally some patients used interpreting devices on their own mobile phones.
- We did not see any visual communication aids in any of the PTS ambulances. This is important for patients that are unable to verbally communicate and is particularly relevant in relation to recording levels of pain.

Access and flow

- Managers told us the resourcing levels were agreed with the providers requesting PTS through a service level agreement. The provider scheduled floating crews on duty each day to deal with unexpected demand or to support existing contracts.
- Managers told us the commissioners did not set KPIs for on-scene turnaround. On scene turnaround is the time taken from when a PTS ambulance arrived at its destination and being ready for allocation of another job.
- Due to the nature of the contractual arrangements the provider did not have control over the number of requests for patient transport.
- The provider had the ability to track where the PTS ambulances were. We saw evidence of crew members that had provided information and updates about their location and availability to control room staff.

Learning from complaints and concerns

Patient transport services (PTS)

- We reviewed the provider`s complaints policy. The policy contained related documents and legal references, an introduction, policy statements, responsibilities, definitions, complaints management with key steps, complaint referenced to an incident with key steps, comment and / or concern and compliments. The policy document had a flow chart which explained how a complaint would be investigated.
- The complaints policy had an owner, a review date and a version control number.
- Managers told us the procedure for making complaints was through a link on the ERS website or through a phone call to the ERS 24-hour HQ control room in Leeds. The information would be recorded on a computer based business support system overseen by the patient experience coordinator. The system generated an email to the operations manager of the site where the complaint originated from. They had five days to investigate it. The complaint was then routed to the technical lead who had 14 days to complete the investigation before it went back to the patient experience coordinator for quality assurance, who drafted a response to the complainant.
- If the complainant was unhappy and wished to appeal the outcome of the investigation the complaint was escalated to the head of care.
- We saw minutes from the monthly governance and patient safety committee meeting which showed that complaints were an agenda item and had been discussed. Each incident had a reference, event type, region, location, event date, owner, work flow status and submission date. The minutes showed there had been three complaints made in November 2017, three in December 2017, and 13 in January 2018.
- Any wider learning in relation to complaints was shared with staff through a computer system which they could all access. Any individual or crew learning was delivered to staff by the operations managers or regional manager.
- Staff we spoke with told us if a patient asked to make a complaint they would provide them with the service telephone number.
- We did not see any evidence of any forms explaining the complaints process for patients being carried on PTS ambulances. Staff we spoke with confirmed this.
- The provider had a whistle blowing (raising concerns at work) freedom to speak up policy. The document had an owner, a review date and a version control number. Staff could refer to the policy which included information on how to raise issues at work and the investigation process.
- To support the policy the provider had a raising a concerns report. The report form had various areas for the person raising the concern to fill in. The information could be anonymous. Once completed the form went to the regional manager to investigate.

Are patient transport services well-led?

We found the following areas of good practice:

- The leaders were visible and had clearly defined roles.
- The provider had a clear vision and strategy which all staff understood.
- There were monthly governance meetings with a set agenda and minutes recorded which all staff could access.
- Staff records showed 101 staff, including two that worked in accounts and admin had DBS checks within the past three years and 99 PTS staff had their driving licenses checked within 12 months of this inspection.
- There was evidence from a patient/carer/relative survey of high levels of satisfaction.
- There was regular staff engagement through staff meetings.
- The provider had invested in six computer based business management systems to support various parts of their business.
- Managers had real time reporting of information which allowed them to track business performance, staff accountability and supported decision making.

Leadership of service

Patient transport services (PTS)

- The corporate leadership consisted of the managing director, group finance director, head of care, head of HR and training, an executive director and a medical director.
- ERS Medical North East had clearly defined managerial and supervisory roles. The regional manager had overall responsibility for the Bowburn and Blyth sites. They had operational responsibility for the operations managers. The operations managers were responsible for supervising and managing the team leaders. The team leaders were responsible for the supervision of the lead drivers and road crews.
- The regional manager had regional responsibility for HR administration and financial administration.
- We saw that the corporate leadership team and regional leaders maintained their visibility by attending regular staff meetings and visiting the two stations.
- During the inspection we reviewed the provider's company directors fit and proper persons policy which contained references to related documents and legal references, an introduction, policy statements, responsibilities, definitions, requirements of the Health Social Care Act Regulations 2008 Fit and proper person, unfit person test, and management and monitoring.
- Managers told us the purpose of the policy was to define a single process in which the provider would manage and meet the requirements of CQC regulated activity, specifically under the Health and Social Care Act 2008 (regulated activities) Regulations 2014 Regulation 5 Fit and Proper Persons: Directors. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- Staff we spoke with told us that the leaders were visible and had attended staff meetings informing them about various aspects of the business including finance. Staff felt the leaders were open, transparent and accessible.
- Staff reported that managers were approachable and would listen and respond to feedback about the organisation.
- We saw there was information about the organisational structure and senior management team displayed in staff areas.

Vision and strategy for this this core service

- The provider's vision was "to provide a reliable caring service that puts people at the heart of everything we do".
- The providers vision was underpinned by seven values which were; integrity, compassion, respect, professionalism, patient focus, innovation and working in partnership.
- Staff we spoke with were able to describe what the values were.
- The provider's business vision was to be recognised as the leading provider of health care transport services in the UK by 2022.
- The provider's vision, values and business vision were displayed on posters in various prominent places around each of the stations. At Bowburn there was a screen in the foyer which played a presentation of the provider's vision, values and business vision on a continuous loop. This could be watched by staff and visitors.
- Staff we spoke with told us the service vision, values and five-year plan had been communicated at a recent staff meeting. Minutes from the meeting were available to all staff, so those not in attendance were kept informed. We saw evidence of this during the inspection.
- The providers vision, values and business vision were included in the appraisal system.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The governance and performance review committee met monthly on a regional basis. The scope of the meeting was all patient care, quality and clinical issues arising from and related to CQC regulated activity within the CQC registration locations and pertaining to ERS Medical, its subsidiary companies and business activities in the UK.
- The core committee members for each location were the registered manager; health and safety advisor / manager; care quality manager; site operations

managers within the location region; regional clinical trainer and other senior managers, heads of department and business unit managers who could be invited attend on an as required basis.

- A national governance and performance review meeting had been conducted March 2018. The review identified key areas of performance where improvements could be made. The information was shared with staff via a power point presentation.
- The provider held monthly board meetings. The minutes for the meetings held in December 2017, January 2018 and February 2018 were reviewed. The meetings had a set agenda with recorded minutes and actions with owners and completion dates.
- The provider held local monthly governance meetings. The minutes for the meetings held in December 2017, January 2018 and February 2018 were reviewed. The meetings had a set agenda with recorded minutes and actions with owners and completion dates.
- Managers told us that the governance meetings were audio recorded and the recordings were stored on a hard drive along with the minutes of the meeting. The recordings were made and kept ensuring transparency and so there could be no dispute over what had been discussed.
- We reviewed staff files for all six employees who had been recruited since registration. We saw evidence of identification, references, and job applications. Managers told us interview documentation was recorded and held at ERS headquarters. Managers told us that staff were asked about health conditions that could affect their performance or restrict which duties they could perform as part of the interview process. They told us that staff did not undertake a separate occupational health questionnaire or interview.
- We reviewed information for 101 staff including two that worked in accounts and admin and this showed that all staff had DBS checks within the past three years.
- Staff were offered hepatitis B immunisations free of charge. We reviewed a sample of records for 66 operational employees and all the staff had been offered the option to receive hepatitis B immunisations free of charge and their decision recorded whether to or not they took up the offer.
- We reviewed information for 99 PTS staff employees and saw that driving licence checks had been completed within 12 months of the inspection. Managers told us checks were carried out yearly and that when an update was due a reminder was sent to staff and results were checked by managers.
- Driving licence checks provided information about driving penalties and points and identified whether drivers were low, medium or high risk. Decisions about whether staff could drive or not were based on what the contract with other providers specified, the driver risk assessment, and the nature of any driving offence.
- We evidence staff competencies were maintained through statutory and mandatory training.
- During inspection we saw evidence of a risk register with 15 risks identified. Each had a date when it was added to the register, with a risk rating, a review date and who the owner was. There was evidence the risk register had been discussed at the governance and performance review meetings. Individual risk owners were responsible for devising actions to mitigate the risk.
- Managers told us they received alerts from external organisations relating to medical devices and health and safety. We saw an example of an alert that had been received from on 18 May 2018 relating to blood glucose test strips which had been actioned. There was a system to report back to senior managers that the alert had been received and actioned.

Culture within the service

- All managerial and operational staff we spoke with described the culture at both sites as positive. All the staff we spoke with said that since the buyout of the business the culture had changed for the better. They were kept informed regularly of significant issues in the company and the leaders were open and visible.
- We saw evidence that change in the organisation was managed through staff consultation, keeping the staff informed through forums and by leaders delivering key messages face to face with staff.
- Delivery of organisational change was done by appointing action owners with timescales for completion and holding them to account by the Managing Director through the governance meetings.

Patient transport services (PTS)

Public and staff engagement (local and service level if this is the main core service)

- The regional manager told us ERS staff attended contract review meetings to discuss with commissioners what is going well and not so well.
- The regional manager told us ERS conducted on-board patient surveys; however, the response rate was approximately 2%. Patients could respond by freepost, or could hand completed forms to crews, or submit feedback through the provider website.
- Managers we spoke with told us staff engagement was more open and transparent since the ERS 'takeover'. The provider mission performance had been shared with operational teams on site. The head of performance and the ERS managing director have done roadshows in each region in 2018 for team leaders to deliver the provider's vision and mission statement.
- There was evidence of other engagement with staff through team briefings for team leaders and quarterly staff meetings, the minutes of which were reviewed during inspection.
- Managers told us the managing director had given directions to managers to be very visible to staff. Managers told us the providers values are the result of engagement with staff and linked to their PDR.
- The regional manager told us the provider had started publishing a quarterly newsletter for staff called "In Touch Issue 1 Spring 2018". We reviewed the document and it contained information about performance and plans for the future.
- A patient/carer/relative survey from May 2018 received 107 responses where satisfaction rates were asked for. Some of the key questions were; how likely are you to recommend our service to friends and family if they needed similar care or treatment? The response was, extremely likely 72% and very likely 28%, Could you tell us how you would rate our service based on the following areas of your journey; pick up time; extremely satisfied 69.81% satisfied 25.47%, crew introduced themselves and explained what would happen during the journey extremely, satisfied 80.37% satisfied 19.81% and were you treated as an individual with dignity and respect, extremely satisfied 79.25% satisfied 19.81%
- The provider also had patient feedback forms on the PTS ambulances. During inspection staff were observed to hand a patient they had transferred a feedback form to complete.
- There was evidence that patient feedback was discussed at the monthly regional governance meetings.
- During inspection there was evidence of weekly team leader meetings and monthly staff meetings. If anyone could not attend the minutes were copied and held in folders in each station for staff to read.
- Staff told us that they received prizes as recognition for times when they went 'above and beyond' their role.
- We saw information displayed on a staff notice board about an employee assistance programme which staff could access for emotional support.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The provider had invested in six computer based business management systems to support various parts of their business. Managers told us they had been involved in the design to ensure the systems were appropriate for the services provided.
- The systems produced accurate real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.
- Managers we spoke with told us that the business was sustainable because the provider had several contracts with NHS trusts.

Outstanding practice and areas for improvement

Outstanding practice

- The provider had strong governance processes in place which confirmed all staff were up to date with their mandatory, safeguarding and Mental Capacity Act (MCA) training and all staff had current DBS and current driving licence checks which ensured the safety of patients who used the service.
- The providers key performance indicators were consistently met.
- Staff had received a comprehensive induction at the start of their employment.
- There was evidence of high levels of satisfaction from a patient/carer/relative survey.
- There was regular staff engagement through staff meetings.
- The provider had invested in six computer based business management systems to support various parts of their business which provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should have accessible information in ambulances to support communication with patients who have cognitive impairment.
- The provider should have an effective system in place which identifies out of date consumable items.
- The provider should have written information about how to complain is available to patients.

ERS Transition Limited

ERS Medical South

Quality Report

Unit 1
Barton Farm Industrial Estate
Chickenhall Lane
Eastleigh
SO50 6RP
Tel: 03302404451
Website:

Date of inspection visit: 22 and 29 March 2019
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, other information known to CQC and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this ambulance location	Good
Patient transport services (PTS)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

ERS Medical South is operated by ERS Transition Limited. It is an independent ambulance service in Hampshire. The service primarily serves the communities in South East London and Hampshire.

The provider has been registered with CQC as ERS Transition Ltd since October 2017.

ERS Transition Limited is registered with the CQC to carry out the regulated activity of transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury.

ERS Medical South primary service is transporting non-emergency patients within South East London and Hampshire.

The service has had a registered manager in post since October 2017. At the time of the inspection, a temporary registered manager was registered with the CQC.

We inspected this service using our next phase inspection methodology. We carried out a short notice announced inspection on 22 March 2019, along with an unannounced visit to the service on 29 March 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated the service as good overall because:

- The senior leadership team had created a culture where information was used to drive improvement and gain assurance. Through this process front line staff engaged in the change process. They shared their data with partner organisations for better decision making.
- The service had a clear vision and strategy and staff were fully aware of it. The strategy and supporting objectives and plans were stretching, challenging and innovative.
- There were systems of governance in place that had been embedded and strengthened. Staff worked with other organisations to improve patient care outcomes.
- There were effective and integrated business management systems which gave senior leaders up to date information and oversight of the service.
- There were systems in place to safeguard vulnerable adults and children. Staff could identify safeguarding concerns and knew how to report them.
- Policies and procedures were in line with national guidelines and were version controlled and within date. There was an audit programme in place to monitor compliance with policies and procedures.
- The service had good oversight of the booking process and monitored drop off and pick up times and kept patients informed about delays.
- There were systems of governance at management level to monitor performance and risk. Problems were identified and addressed quickly and openly.
- The process for shared learning from complaints was embedded. Staff told us how learning from complaints was shared.

However, we also found the following:

Summary of findings

- Road staff at the Mitcham location were not aware on how to exchange their oxygen cylinders if it was out of date or empty. We raised it at inspection and followed it up formally with the service following our inspection. The service submitted evidence that they had informed all staff of the process for exchanging cylinders.
- The service did not have a system to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Dr Nigel Acheson
Deputy Chief Inspector of Hospitals (South), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Patient transport services (PTS)	Good	Patient transport services were the only activity undertaken. We rated well led as outstanding because the senior leadership team had created a culture where information was used to drive improvement and gain assurance. Front-line staff were engaged in the change process. They shared their data with partner organisations for better decision making. The service had a clear vision and strategy and staff were fully aware of it. There were systems of governance in place that had been embedded and strengthened. The service had effective, integrated business management systems which gave senior leaders up to date information and oversight of the service. We rated safe, effective, caring and responsive as good because staff received mandatory training and annual competency updates. There was an effective process in place for infection prevention and control and vehicle and equipment maintenance. Policies were up to date and reflected national guidelines and staff treated patients with kindness, dignity and respect.

Good

ERS Medical South

Detailed findings

Services we looked at
Patient transport services (PTS)

Detailed findings

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Background to ERS Medical South

ERS Medical South is operated by ERS Transition Limited. It is an independent ambulance service in Hampshire. The service primarily serves the communities in South East London and Hampshire.

The provider has been registered with CQC as ERS Transition Ltd since October 2017.

ERS Transition Limited is registered with the CQC to carry out the regulated activity of transport services, triage and medical advice provided remotely and treatment of disease, disorder or injury. ERS Medical South primary service is transporting non-emergency patients within South East London and Hampshire. The service can transport patients detained under the Mental Health Act 2007.

The service has had a registered manager in post since October 2017. At the time of the inspection, a temporary registered manager was registered with the CQC. The organisation was in the process of recruiting a permanent registered manager.

Our inspection team

The team that inspected the service comprised of a CQC inspection manager, a CQC lead inspector,one other CQC inspector, and two specialist advisors with expertise in patient transport services. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Facts and data about ERS Medical South

ERS Medical South operates from stations located in Eastleigh and Mitcham.

They operate a total of seven vehicles in Mitcham, two in Eastleigh and operate two mental health vehicles. They employ seven members of staff in Mitcham and two in Eastleigh. A central control room based in Leeds supports all ERS Medical, part of ERS Transition Ltd.

The service is registered to provide the following regulated activities:

- Patient transport service (PTS)

During the inspection, we visited Mitcham and Eastleigh stations. We spoke with ten staff including; medical director, patient transport drivers, dispatch and planning staff, trainers, volunteer driver and managers. During our inspection, we reviewed 10 sets of patient records. We inspected seven vehicles.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12

Detailed findings

months before this inspection. This was the service's first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity January 2018 to February 2019:

- There were 8156 patient transport journeys undertaken.
- There were 10 patient transport drivers and two administrative and clerical staff who worked at the service.

Track record on safety:

- No never events.
- Incidents: 14 no harm, two moderate and three serious harm. No deaths had been reported because of an incident.
- 16 complaints.

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Patient transport services	Good	Good	Good	Good	☆ Outstanding	Good
Overall	Good	Good	Good	Good	☆ Outstanding	Good

Patient transport services (PTS)

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	Good

Information about the service

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Patient transport services (PTS)

Summary of findings

We found the following areas of good practice:

- The senior leadership team had created a culture where information was used to drive improvement and gained assurance. Through this process front line staff engaged in the change process.
- The service was rolling out a leadership development programme to all its front-line staff. It had started this programme for all senior and operational managers.
- The service had linked the hospital bed flow software with ERS dispatch. Good hospital bed flow allows for an efficient system to arrange the transportation of the patient to their residence. This software had created a seamless link between the hospital and the service. It also allowed patients to track their transport through a special "Patient View" on an accessible portal.
- All vehicles had a forward-facing vehicle camera that recorded continuously. The system captured 40 seconds of footage when triggered by an incident and this was sent by email automatically to the driver's line manager. It allowed for immediate investigations of any serious incident.

However, we also found the following:

- Road staff at the Mitcham location were not aware on how to exchange their oxygen cylinders if it was out of date or empty. We raised it at inspection and followed it up formally with the service following our inspection. The service submitted evidence that they had informed all staff of the process for exchanging cylinders.
- The service did not have a system to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty.

Are patient transport services safe?

Good

This was the first inspection of the service under our new methodology. We rated safe as **good.**

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated and shared lessons learned with the whole team at a local and national level.
- There was genuinely an open culture in which all safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement.
- The service had an incident reporting policy. We reviewed the document and saw that it contained definitions of incidents, reporting and investigation process, and detailed different types of incidents such as clinical incidents, information governance, security incidents and transport and road traffic incidents. All staff we asked could tell us what constituted an incident.
- The service had reported 19 incidents between January 2018 and February 2019. Of these,14 incidents were risk scored as no harm, two as moderate and three as serious harm. There were no deaths reported. All moderate and serious harm incidents were investigated by a team leader in line with policy. The incident and the investigation report was peer-reviewed by the medical director. An action plan was developed for each of concerns identified. The action plan was implemented by a team leader and progress reported to the senior leadership team (SLT).
- We reviewed the process for frontline PTS crews to report an incident. The care standard manager told us the incident reporting process required staff to use a single telephone number to call the central control room based in Leeds to report incidents. All staff were aware of this number. They told us they would call dispatch to report any incidents.

Patient transport services (PTS)

- Incidents were recorded on an electronic system. When an incident was recorded, an email alert was sent to the regional manager and the head of care standards as well as to the staff member's line manager and the member of staff who had raised the incident.
- We reviewed the system and saw that incidents were colour coded red, amber, lower amber and green (RALAG rated). Incidents were allocated an investigation owner and timescales were included to ensure the investigation was completed in line with policy.
- We saw three sets of minutes from the monthly Governance and Patient Safety Committee (GaPS) meeting which showed that incidents were a regular agenda item. This was a location based committee. The head of care standards told us that learning from incidents was shared with staff through a computer business system. Individual learning from incidents was delivered by the regional manager or operations manager to the crew or individual concerned. Wider learning was shared with staff via team meetings, email and tool box talks. Individual learning from incidents was delivered by the regional manager or operations manager to the crew or individual concerned.
- During inspection we spoke with five ambulance crew members. All staff stated that they had received training in incident reporting, which was confirmed in the mandatory training records, and all could explain the incident reporting procedures.
- Managerial staff understood their legal responsibilities under the duty of candour. We saw evidence the service applied duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014 following three applicable incidents. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide them with reasonable support.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training arrangements and policies were in place for all front-line staff, team leaders, managers and directors. Staff completed annual update training which contained 14 core elements including manual handling, basic life support, health and safety and safeguarding adults and children.
- We reviewed a spreadsheet that had staff names, where they worked, their role, date of induction training, date of provider driving test, driving qualification, clinical skill set, date of clinical skill set refresher, dates of the one day statutory and mandatory training, dates for statutory and mandatory training refresher, dates of Depravation of Liberty Safeguards (DoLS)/Mental Capacity Assessment (MCA) training and MCA consent training. The spreadsheet showed all staff training was up to date. We saw a record identifying all staff members which indicated their training compliance status, when training was due to expire and whether they were booked onto a course to receive their update training. The target set was 95% and the service exceeded this target as 98% of staff had completed their mandatory training.
- The service had adopted the Health and Safety Executive guidance on moving and handling in an ambulance. It had applied, where applicable, the same guidance to patient transport vehicles. We saw evidence of this in three personal files of staff who had undertaken driver training and manual handling.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it**
- The service had a safeguarding policy. We reviewed the policy and saw that it was version controlled and within review date. The policy referred to the intercollegiate document, Safeguarding children and young people: roles and competencies for health care staff (2019). It also contained information on how to safeguard those in vulnerable circumstances; for example, those with learning difficulties or complex needs and children under 16 accessing services without requirement of parental consent.

Patient transport services (PTS)

- The service had a safeguarding and a deputy safeguarding lead in post. The medical director was the safeguarding lead. Both had completed safeguarding level four training. In addition, the head of care standards had trained to level four safeguarding.
- Patient transport service (PTS) staff were trained in safeguarding adults and children level two. They received safeguarding update training every three years and an annual refresher as part of their mandatory training. The average safeguarding training rate for staff was 98% across both sites.
- There were processes in place to support frontline staff to report a safeguarding concern. The service provided staff with a single phone number to use to contact the ERS control room located in Leeds to make a safeguarding referral.
- When a safeguarding referral was recorded on the system the regional manager and the head of care standards were alerted via email. This meant that they could assess the type of referral that had been reported and whether any immediate action was required.
- We reviewed the computer system and saw that there were drop down boxes which had to be completed as part of the safeguarding referral. If any were answered "no" the system automatically generated an action plan which the person allocated to investigate had to complete before the referral could be closed. We reviewed three safeguarding incidents which were recorded using the online system. Information included the nature of the incident and actions taken for example completing a safeguarding referral to the local authority. To raise awareness of staff, the outcome of each safeguarding incident was shared with them monthly.
- Staff we spoke with demonstrated a good understanding of safeguarding concerns. Staff knew how to make a safeguarding alert. As part of their training, they identified and dealt with concerning situations at the locations they attended, particularly homes and care homes.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- The service had an infection control policy, which addressed all relevant aspects of infection prevention and control including environmental cleaning and laundering of uniforms. Paper copies of this were displayed on the wall at the Eastleigh and Mitcham bases. We reviewed the document and saw that it was version controlled and within review date.
- Staff were aware of how to maintain cleanliness and to reduce the risk of the spread of infection. Staff explained how they would clean their vehicle if a patient was unwell and we noted spill kits were available in all vehicles we inspected to enable staff to safety deal with spillages of body fluids.
- We were told 12 weekly deep cleans took place and these were undertaken at the Mitcham location. The deep clean schedule was not available for us to review during our inspection to confirm that these deep cleans had been completed. However, staff did confirm these were undertaken. The completed schedules were sent to us after the inspection.
- The service had a total of seven vehicles: three in Mitcham, two in Eastleigh and two mental health vehicles. As part of our inspection, we looked at three vehicles in Mitcham and two vehicles in Eastleigh. These were all uncluttered and visibly clean. All the vehicles inspected contained hand sanitising gel and sterile wipes which were in date.
- They all had clinical waste bags and staff were aware of how to dispose of this waste. We noted the clinical waste bins at Mitcham and Eastleigh were locked.
- Short sleeve uniforms were provided by the service and designed to be washed at high temperatures. These uniform assisted staff to adhere to the arms bare below the elbow protocol. Staff had access to personal protective equipment such as gloves and aprons to reduce the risk of the spread of infections between patients and staff. We saw staff use them.
- Staff received infection prevention and control training as part of their annual mandatory training update. Data provided by the service showed that staff training compliance was 100%.
- We saw that monthly infection prevention control audits were completed by the head of care standards at both sub stations we inspected. Data showed that in the

most recent audit in February 2019, compliance was 100%. Compliance in January 2019 was 98%. The head of quality told us that where there was non-compliance, an action plan was completed and allocated to a manager for delivery.

- The ambulance station at Mitcham had a designated area for mops and cleaning products. The registered location at Eastleigh also had a designated area for mops and cleaning products. Mops were colour coded and mop checks were undertaken in line with their policy. We reviewed records which showed that the check had been completed consistently from 2 January 2019. Previous records had been archived.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- There were seven ambulances used for patient transport.
- All the ambulances we inspected had four seats with seat belts and space for a wheelchair. The vehicles were also fitted with a hydraulic ramp to help with patient access to the vehicles.
- All work was allocated and managed from the Eastleigh station with staff only visiting the Mitcham location to collect consumables or bring their vehicle for a deep clean. The vehicles were parked at the staff member's home overnight and when not in use and were checked before each shift. To ensure the security of the vehicle, each ambulance had an alarm system.
- The staff were responsible for checking their vehicle prior to starting their shift. We reviewed the checklists and saw that vehicle and equipment checks were carried out daily and the forms had been completed correctly.
- We saw details of road tax, fleet insurance and, where applicable, MOT testing for the vehicles.
- The service had 24-hour breakdown cover for the vehicles. During our inspection one of the ambulances had a puncture and we saw the problem was dealt with in a timely manner and the vehicle was back on the road. No patient had their journey cancelled or delayed as the other drivers covered the journeys.
- All staff we spoke with reported that faults on the ambulances were repaired quickly and managers were responsive to any concerns raised by staff about vehicles.
- Each vehicle carried a first aid kit, high visibility jacket, wheelchair, first aid box, vomit and urine bowls and blankets. Each vehicle had a resuscitation bag that included oxygen and masks both paediatric and adults for use in the event of an emergencies. All ambulances carried a defibrillator which had been serviced and staff were aware of how to use it. The service did not use radios. There was a personal digital assistant (PDA) in the vehicles for communication. A PDA is a small electronic device that is used for storing, and organising information. The vehicles could be tracked using the PDA.
- All vehicles carried oxygen and staff were trained to use. We noted all cylinders were in date. However, staff gave us various answers when asked how they would exchange their cylinder if it was out of date or empty. Staff were unclear on the process for exchanging cylinders. They were also unclear whether medical gasses were stored at Mitcham or Eastleigh. The inspectors visited Eastleigh and saw medical gasses were stored and managed safely at that location. The Mitcham base only stored consumables and no medical gases.
- Both stations had an area where staff could leave broken equipment. Staff placed a red label on the equipment to indicate that it was not in working order and could not be used. We observed that all equipment in this area was clearly labelled.
- Equipment servicing was provided by an external supplier. All the equipment we checked was within service date. We checked the equipment service schedule and saw that all equipment service checks were up to date.
- We checked 10 consumable items. All were within expiration date. We checked 10 pieces of clinical equipment. All were within the manufacturer's recommended expiry date. There was equipment available that was suitable for different patient groups including bariatric patients and children.
- All vehicles had a satellite navigation system and a vehicle tracker system so dispatch could identify the

location of the vehicles. The vehicles had a dash cam system that emailed a video clip of a vehicle incident to the driver's line manager allowing immediate action to be taken.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- There was a triage system in place so that only appropriate patients were accepted by the dispatch team. Staff we spoke with described assessing patient needs by reviewing information provided by the control room, seeking additional clinical advice if required, speaking with the patient, carer, and / or staff, and conducting their own clinical observations.
- There was evidence on the patient record forms reviewed during inspection, showing staff had assessed risk and provided patient transportation in a way that aimed to ensure safety. For example, if a risk was identified, crews requested the support of additional staff, obtained additional equipment, adapted the number of patients transported at one time, or made the decision not to convey the patient if the risk was too high.
- Managers and staff, we spoke with told us if a patient became ill while being transported crews would deal with the patient using their skills in accordance with their qualifications and training. If the patient was obviously seriously unwell an emergency NHS ambulance would be contacted to attend.
- The service had a specialised vehicle to transport bariatric patients (severely or morbidly obese). Staff told us that there was a specific risk assessment form that was completed when transporting a bariatric patient to keep patients and the staff transporting them safe.

Staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- The service used an electronic system to generate the staff rota which involved allocating crews to available vehicles. A new shift pattern consisting of a seven-week rolling rota of 10-hour shifts had been implemented. A senior manager told us that this work pattern had been successfully established in other areas of the business.
- At the time of our inspection there were no road crew vacancies. If there were gaps in the rota, these were filled by offering additional shifts to existing staff. If a shift could not be covered, team leaders and senior managers, who had front line training PTS training stepped in. We looked at four rotas and found there were no unfilled shifts.
- The provider scheduled floating crews on duty each day to deal with unexpected demand or to support emergency cover due to illness or family emergency.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- Crews received job information via a PDA before conveying the patient. Staff told us that they received information about the patient's name, date of birth, and if they required any equipment.
- Transport bookings were made through a central control room based in Leeds. Staff recorded information provided on an electronic system. The system had required fields to be completed before the booking could be confirmed. This included information about the booking, to assess eligibility, patient's mobility and additional relevant information. Staff received this information on their tablet. Staff told us that the information provided was accurate since a new system had been introduced by the central control room. If the information provided about the patient was not accurate staff told us they would contact the control room to update the record with additional information. This would be used to decide whether to complete the transfer or not. Staff told us since this system had been introduced, delays were reduced.
- Staff said they would transfer patient paper notes in a sealed bag with the patient. They were aware they could not access these due to data protection. Records were not shared with other providers.

Patient transport services (PTS)

- Patient record forms (PRFs) were completed by staff for patients. We reviewed 10 PRFs and saw that they were completed appropriately and contained patient details, patient observation and pain assessments.
- The PRFs were audited monthly. We saw that the patient record audits had been completed every month by the head of care standards dating back to February 2018. We reviewed three audits completed in September 2018, November 2018 and January 2019. In each audit all PRFs completed during the month were reviewed. We saw that for each month no issues or concerns were identified.
- We saw that there was information displayed in staff areas providing guidance on methods of ensuring security of confidential information. For example, password protection and maintaining a clear desk.
- The provider used a computer based system for recording patient records. During inspection five records were checked and all had been completed correctly.
- Patient records were audited and were discussed at the monthly Governance and Patient Safety Committee (GaPS) meeting. This was a location based committee. The results of the last audit in January 2019 highlighted an overall compliance rate of 95% to the standard. The service had set a standard of 90% compliance.

Medicines

- **The service followed best practice when giving, recording and storing medicines.**
- At the time of the inspection, with the exception of oxygen, the provider did not store controlled drugs or any medicines including prescription only medicine (POM), pharmacy only (P) medicines and general sale lists (GSL) medicines.
- The service had a protocol in place to support oxygen administration. Staff followed the protocol on administering and recording and storing of oxygen.
- We inspected the records of three patients and found all had received oxygen based on the protocol.
- Medical gases were available at Eastleigh only. They were stored in cages in accordance with the British Compressed Gases Association Code of Practice 44: the storage of gas cylinders. Full and empty cylinders were kept separate and were clearly marked. Oxygen piping in ambulances we inspected, had been serviced and were in date. At Eastleigh staff were aware how to obtain replacement oxygen. Road staff at the Mitcham location were not aware on how to exchange their oxygen cylinders if it was out of date or empty. We raised it at inspection and followed it up formally with the service following our inspection. The service submitted evidence that they had informed all staff of the process for exchanging cylinders.

Are patient transport services effective?

Good

This was the first inspection of the service under our new methodology. We rated effective as **good.**

Evidence-based care and treatment

- **People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and technologies. This was monitored to ensure consistency of practice.**
- Staff had up to date guidance available to them on how to provide evidence based care and treatment. The following polices were reviewed and they all followed Joint Royal Ambulance Colleges Liaison Committee (JRCALC) guidance; safeguarding, oxygen administration, Control of Substances Hazardous to Health (COSHH) and end of life care. For example, senior staff told us staff followed Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines when administering oxygen. There was a local policy in place on how to administer, record and store oxygen. We inspected the records of three patients and found they all had received oxygen based on the protocol.
- We saw evidence managers discussed local polices and pathways which included the scope of practice for every clinical grade. Managers told us they were undertaking a review to align the clinical grades with standardised training.
- Staff valued the access they had to a specialised mental health trained member of staff if needed. A member of staff was always on call Monday to Friday 12 hours per day to provide advice and guidance.

Patient transport services (PTS)

Response times/patient outcomes

- **Information about people's care and treatment, and their outcomes, was routinely collected and monitored.**
- The regional manager told us the monthly Mission Performance Review meeting included key performance indicators (KPIs). KPIs were not separately audited but crews were time stamped on the running sheets to show when activities were completed.
- KPIs were recorded for every patient journey undertaken. These KPIs were reviewed by management. The provider had two key performance indicators (KPIs) from the main commissioning provider which were; 90% of patients were to be collected within a maximum of three-hour response time from time of booking to the patient being picked up on the ward and 98% of patients would travel no longer than 1 hour 30 minutes on transport for any given transfer.
- The KPI for patients to be collected within a maximum of three-hour response time from time of booking to the patient being picked up on the ward had a target of 98%. The data for December showed 98% achieved this KPI, January 99% achieved it and February 99% achieved it.
- The KPI for patients would travel no longer than 1 hour 30 minutes on transport for any given transfer from the main commissioning provider had a target of 98%. The data for December 2018 showed 99% achieved this KPI, January 2019 99% achieved it, and February 2019 98% achieved it.
- Managers told us that due to the limited KPI information collected no corporate and wider benchmarking was carried out, however, we saw evidence the data was discussed at local and regional governance meetings.

Competent staff

- **The service made sure staff were competent for their roles.** All staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was provided to meet these needs. Managers regularly appraised staff's work performance. Managers held regular supervision meetings with staff to provide support and monitor the effectiveness or the service.
- All staff that we spoke with reported they had received a comprehensive induction at the start of their employment which had lasted at least four to five days, depending on the nature of their role and start date.
- Staff reported they received annual training which included assessments of knowledge and practical competence. They told us training updates would be automatically scheduled and notified two to three weeks in advance.
- We reviewed five staff training files. These all demonstrated that staff had undertaken comprehensive inductions and mandatory and statutory training. For example, induction training included basic life support, health and safety, fire safety, infection control, and manual handling.
- Managers also told us they wanted to ensure all staff knew and worked to the company values before commencing appraisals.
- The provider had a training and continuing professional development (CPD) prospectus for staff to refer to. This included; the training team, mandatory e-learning, annual core update day, mental health uplift course, non-clinical staff courses, education and training staff courses, management training courses, commercial training, training administration process, training hub equipment list and feedback.
- The provider had a performance development and review plan. A blank plan was reviewed. It contained key performance areas to consider.
- The performance development and review plan was supported by a personal development review plan with individual SMART (specific, measurable, achievable, relevant, time-bound) objectives, achieving personal qualities, reflections, future objectives and development and a staff rating was reviewed before signing off by the individual and their manager.
- In performance quality the performance areas included; job knowledge, quality of work, adaptability, team work, dependability and attitude. In safety the areas considered included; attendance/punctuality, customer

focussed, care of equipment, initiative/innovation, continuous improvement and technical skills. Staff identified personal strengths and development opportunities and they devised a plan with their line manager.

- The provider had a personal training and development policy. There were 23 areas covered including training plans, workplace activity observations records and training compliance audits/targets. The document had an owner, who the author was, version control, when the document became active and when it was due for review. During inspection the policy document was reviewed and found to contain extensive information for staff to refer to in relation to their training and development needs.
- We saw evidence the provider recorded the driving licence details of the staff on a software package designed to meet the needs of the organisation. The system recorded staff names, date of birth, driving licence details, date licence expired, date when the licence was checked and the date when the next check needed to be carried out. The system set up an automatic alert to inform managers when the checks were due.
- During inspection we saw evidence of a computer based system linked to front facing cameras in the provider's ambulances. The cameras were activated when the vehicle exceeded a certain speed. The camera footage was stored on a computer hard drive. The system also recorded harsh breaking and over revving of the engine. This information was used by the operations managers to identify any drivers whose driving standards were below what was expected.
- There were no systems to make sure local healthcare providers were informed in cases where a staff member was suspended from duty. Such a system would prevent local health care providers to subsequently employ anyone who had been suspended. The absence of a system could result in a suspended member of staff being employed locally by another ambulance service provider.
- Managers we spoke with told us there was a process set up for appraising staff and we saw evidence of this. The appraisal process had been rolled out to senior managers. They had all completed the accompanying training. The senior managers had begun the process of training team leaders. In 2019, the focus was to have all team leaders to appraise front line staff. At the time of inspection in March 2019, 59% of front line staff had been appraised and they were on target to meet this by December 2019. Managers told us this was because the company priority had been to ensure all staff had been on an induction course and had received statutory and mandatory training. Staff appraisals would follow that.
- Two of six staff we spoke with told us that they had appraisals where their performance was reviewed. Staff told us that they could approach managers if there was something they wished to discuss in relation to their role.

Multidisciplinary working

- **Staff in different roles worked together as a team to benefit patients'.**
- Staff supported each other to make sure patients had no gaps in their care. Team leaders across the two stations held a morning call to discuss the needs of the day and coordinate the daily workload across the different locations.
- There was a member of staff located at two NHS trusts. These staff worked with the staff at the trust to coordinate discharges and ensure that patients were waiting in the correct areas to be collected by the ambulance crews.
- There was evidence that coordination with other providers was achieved through the booking in system which ensured pre-alerting and capacity issues were highlighted to PTS crews.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** The service followed the policy and procedures that was in place when a patient could not give consent.
- The provider had a Deprivation of Liberty Safeguards (DoLS) policy which contained related documents and

legal references, an introduction, policy statements, responsibilities, levels of restriction and restraint, ERS medical responsibilities and death of a person subject to a DoLS order.

- During inspection the policy document was reviewed and found to contain extensive information for staff to refer to in relation to dealing with patients who could be subject to a DoLS order.
- The provider training data had evidence that all PTS staff were all up to date in relation to training in the Mental Capacity Act (MCA) including consent.
- Staff we spoke with confirmed they had received training in consent and Mental Capacity Act. Staff files showed that staff had received training on consent, Mental Capacity Act, and Deprivation of Liberty Safeguards.
- Staff reported they would seek consent from patients, if they had capacity, before conveying them and if a patient did not consent they would not convey them. If the patient lacked capacity to consent or staff were unsure of if they had capacity, staff would obtain an assessment from staff in the hospital. Only as a last resort, would they make a best interests decision and record this. Best interest decisions were undertaken with the on call operational manager.
- They told us that on such occasions ERS staff would ask staff working with the patient to speak with them and further explain the rationale for transport in the hope the patient would consent. Staff said that such decisions would be documented on the running sheet. If consent was not obtained the ERS control would be contacted and advice sought. Staff gave us examples of how they executed the advice given to them by the control centre.
- Staff told us they did not complete a specific form detailing whether the patient had consented and whether staff had completed a Mental Capacity Act assessment. They could explain the assessment process from the training they had received.

Are patient transport services caring?

Good

This was the first inspection of the service under our new methodology. We rated caring as **good.**

Compassionate care

- **Staff cared for patients with compassion.** We reviewed three cards sent by family members who confirmed staff treated patients with compassion and kindness. Patients confirmed they were treated with compassion and kindness.
- Staff we spoke with told us about how they maintained patient dignity during long distance transfers. The crews ensured at least one female member of crew was present when transporting a female patient. If the crew were male and female they would switch roles; for example, if a patient needed to use the toilet so that patient's dignity was preserved.
- Staff told us they would ensure a patient was comfortable, warm and would ask what they could do to make the patient more comfortable; for example, adjusting the patient's head position if transported on a stretcher. Staff told us they would offer patients drinks and if the hospital had sent the patient with a packed lunch they assisted to them, if required, eat and drink at a time which suited them.
- We saw a letter of thanks from staff at a local nursing home in relation to a delay in preparing the room for a patient who had been discharged from the hospital. The crew remained with the patient in the day room to ensure their comfort.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.** Staff we spoke with described providing emotional support by listening to patients and responding in a calm and empathic manner. Staff had received customer care training to assist with positive communication with patients.

Patient transport services (PTS)

- Staff told us sometimes older patients would get very nervous so they offered their hand to them. Staff told us this reassured patient. One member of staff explained how they 'sensed' what was needed. Patients told us staff provided them with reassurance.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment**. Staff told us they would explain to the patient they were going home and keep patients informed about the journey. One patient told us how on a previous long journey, they were told how long the journey would take and were asked they should let staff know when they want to have a comfort break.
- Staff explained how they would phone a relative who was waiting for the arrival of the patient to inform them of their progress.

Are patient transport services responsive to people's needs?

Good

This was the first inspection of the service under our new methodology. We rated effective as **good.**

Service planning and delivery to meet the needs of local people

- **Services were planned and delivered to meet local needs.**
- The service was planned and managed in line with the commissioning agreement in place with the clinical commissioning group (CCG). Managers told us the planning of the service was done through the contract agreements between themselves and commissioners. The service had regular meetings with commissioners to review progress against the contract and to raise and address any issues or concerns. Services were delivered to meet local needs. The service had appointed a hospital liaison assistant based at two NHS trusts to support the safe discharge of patients and to avoid delays for patients leaving the hospital. There had been instances where patient pick-ups were booked just before or after lunch. Once staff arrived onto the ward, they found either the food had just arrived or the patient had just finished their dinner and had to be accommodated with time to use the facilities. In both situations, staff had to wait for them. Staff shared this feedback with the operations manager. As a result, no pick-ups were scheduled one hour before or after dinner.
- During inspection we saw examples of how additional resources as contingency were set up to meet unexpected demand.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Crews were made aware of patients with complex needs through the booking in process. We saw examples of information being shared about patients with learning disabilities, dementia, older people with complex needs and those requiring access to translation.
- There was evidence that all PTS staff had received training in dementia, equality diversity, bariatric patients and paediatric care.
- All staff we spoke could described the steps they would take to support patients with visual or hearing difficulties. They said they would use writing, gesture or verbal explanation.
- Staff had undertaken training in equality and diversity as part of the induction. Staff described being able to access interpreters if required. We saw that there was information about how to request an interpreter displayed in staff areas for ease of access. Staff reported that family members might accompany patients and interpret for them additionally some patients used interpreting devices on their own mobile phones.
- All PTS ambulances carried visual communication aids. Staff told us this was important for patients who were unable to verbally communicate. They gave examples on how they had used the aids.

Access and flow

- People could access the service when they needed it. Managers told us the resourcing levels were agreed with the providers requesting PTS through a service level agreement.

- Due to the nature of the contractual arrangements the provider did not have control over the number of bookings.
- There was a service level agreement with each provider.
- The provider had the ability to track where the PTS ambulances were. We saw evidence of crew members that had provided information and updates about their location and availability to control room staff.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- During the inspection we reviewed the provider's complaints policy. The policy contained related documents and legal references, an introduction, policy statements, responsibilities, definitions, complaints management with key steps, complaint referenced to an incident with key steps, comment and / or concern and compliments. The policy document had a flow chart which explained how a complaint would be investigated.
- The document had an owner, a review date and a version control number.
- Managers told us the procedure for making complaints was through a link on the ERS website or through a phone call to the ERS 24-hour HQ control room in Leeds. The information would be recorded on a computer based business support system overseen by the patient experience coordinator. The system generated an email to the operations manager of the site where the complaint originated from. They had five days to investigate it. The complaint was then routed to the technical lead who had 14 days to complete the investigation before it went back to the patient experience coordinator for quality assurance. The patient experience coordinator drafted a response to the complainant.
- If the complainant was unhappy and wished to appeal the outcome of the investigation this was done through the head of care.
- During the inspection the computer system for recording and investigating complaints was reviewed. The complaints were colour coded to identify at what stage the investigation was at linked to the KPIs. Any completed investigations were archived on the computer system. We reviewed three responses and they were all recorded and completed in time.
- We saw minutes from the monthly Governance and Patient Safety Committee meeting which showed that complaints were an agenda item and had been discussed. This was a location based committee. There was evidence each incident had a reference, event type, region, location, event date, owner, work flow status and submission date. The minutes showed there had been three complaints made in November 2018 three made in December 2018 and one made in January 2019.
- Any wider learning in relation to complaints was shared with staff through a computer system which they could all access. Any individual or crew learning was delivered to staff by the Operations Managers or Regional Manager.
- Staff we spoke with told us if a patient asked to make a complaint they would provide them with the service telephone number.
- The provider had a Whistle blowing (Raising concerns at work) Freedom to speak up policy. The document had an owner, a review date and a version control number. There were 11 areas of information that staff could refer to for them to raise issues at work and inform them of the investigation process.
- To support the policy the provider had a raising a concern(s) report form. The report form had various areas for the person raising the concern to fill in. The information could be anonymous. Once completed the form was sent to the regional manager to investigate.

Are patient transport services well-led?

Outstanding ☆

This was the first inspection of the service under our new methodology. We rated well-led as **outstanding.**

Leadership of service

- **Managers at all levels in the organisation had the right skills and abilities to run a service providing high-quality sustainable care.**

- The corporate leadership consisted of the managing director, group finance director, head of care, head of HR and training, an executive director and a medical director and are based at Leeds. The managing director visited this location every 14 days,
- ERS Medical South had clearly defined managerial and supervisory roles. The regional manager had overall responsibility for Eastleigh and Mitcham. They had operational responsibility for the operations managers. The operations managers were responsible for supervising and managing the team leaders. The team leaders were responsible for the supervision of the lead drivers and road crews. We saw that there was information about the organisational structure and senior management team displayed in staff areas.
- The regional manager had regional responsibility for HR administration and financial administration.
- During inspection we saw evidence that the corporate leadership team and regional leaders had enhanced their visibility by attending regular staff meetings and visiting the two stations. They shared their vision and their values. They also shared their new performance management framework highlighting to staff "what they were doing, we were also doing."
- During the inspection we reviewed the provider's Company Directors Fit and Proper Persons policy which contained references to related documents and legal references, an introduction, policy statements, responsibilities, definitions, requirements of the Health Social Care Act Regulations 2008 Fit and Proper Person, unfit person test, and management and monitoring. We saw three examples of how this was applied and reviewed.
- Managers told us the purpose of the policy was to define a single process in which the provider would manage and meet the requirements of CQC regulated activity, specifically under the Health and Social Care Act 2008 (regulated activities) Regulations 2014 Regulation 5 Fit and Proper Persons: Directors. The document had an owner, who the author was, version control, when the document became active and when it was due for review.
- The directors were closely involved with the local management structure at ERS South. Staff told us that the directors were visible and had attended staff meetings informing them about various aspects of the business including finance. Staff felt the directors were open, transparent and accessible. Staff reported that local managers were approachable and would listen and respond to feedback about the organisation.
- There was a commitment to support and develop staff. In 2017, all directors attended a leadership development programme. In 2018, the programme was rolled out to managers and team leaders. There were plans in place to have all front-line staff attend the programme over 2019-2020.

Vision and strategy for this service

- **The strategy and supporting objectives and plans were stretching, challenging and innovative, whilst remaining achievable**. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to a system wide collaboration and leadership.
- The provider`s vision is to "be recognised as the leading provider of health care transport services in the UK by 2022."The local leadership team identified six objectives to achieve this vision. These were as follows:

1. Improve on performance standards and reduce variation.
2. Deliver excellence in leadership and development.
3. Continually review and improve our quality and clinical effectiveness.
4. Improve satisfaction and experience for all stakeholders.
5. Develop and promote a world-class training model for pre-hospital care.
6. Increase recruitment and retention.

- The providers vision was underpinned by seven values which were; integrity, compassion, respect, professionalism, patient focus, innovation and working in partnership. The senior leadership team (SLT) trained and equipped front line staff and kept them engaged and highly motivated. The SLT spent time communicating the message of values and purpose throughout the organisation.
- During inspection we saw that the provider's vision, values and business vision were displayed on posters in

various prominent places around each of the stations. At Eastleigh there was a screen in the foyer which played a presentation of the provider's vision, values and business vision on a continuous loop. This could be watched by staff and visitors.

- Staff we spoke with told us that the service vision, objective and values and five-year plan had been communicated at a recent staff meeting. They said minutes from the meeting were available to all staff, so those not in attendance were kept informed. We saw evidence of this during the inspection.
- We saw evidence the provider's vision and values were included in the appraisal system and in the monthly National Governance and Performance Review.
- The location had identified key pressures, risks, goals and plans for PTS including how they increased their market share and achieved economy of scale. For example, they recognised the NHS cost pressure would also impact them. They ensured they invested in business management systems to help run an efficient and cost-effective healthcare transport operations.
- Staff that work away from main bases or who were lone workers engaged with strategy, vision and values using social media, conference calls, and access to HR systems remotely.

Governance, risk management and quality measurement

- The organisation had the processes to manage current and future performance. Performance and risk issues were escalated to the appropriate committee and the board through clear structures and processes.
- All clinical incidents were reviewed by the medical director and the local quality assurance manager. For example, the SMT received an action plan for all incidents. The progress on the action plan developed depended on the recording of the incident: Progress on all incidents colour coded as red was weekly. Incidents recorded as amber were reported every two weeks and lower amber was monthly. The medical director ensured greater scrutiny of the implementation process.
- Every day, there was daily control call amongst operations managers. There were weekly operational meetings where the team leaders reported to the operations manager. Once a month, the operation managers reported to the directors at the monthly regional governance and performance reviews. There were also monthly business governance and performance reviews where regional directors reported to the executive directors. There was also a monthly executive committee meeting that reviewed the current business situation. We saw examples of how issues were escalated upwards and how decisions were cascaded downwards.
- We saw evidence the Governance and Performance Review Committee (GaPR) met monthly on a regional basis. The scope of the meeting was all patient care, quality and clinical issues arising from and related to CQC regulated activities within the registered locations and pertaining to ERS Medical, its subsidiary companies and business activities in the UK.
- The core GaPR committee members for each GaPR location were the registered manager; health and safety advisor / manager; care quality manager; site operations managers within the location region; regional clinical trainer and other senior managers, heads of department and business unit managers who could be invited attend on an as required basis. The minutes of these meetings were always reviewed by the medical director. They would attend these meetings at least three times a year as it gave them assurance on how governance was being managed at a local level.
- We saw evidence the provider held monthly board meetings. The minutes for the meetings held in December 2018, January 2019 and February 2019 were reviewed. The meetings had a set agenda with recorded minutes and actions with owners and completion dates. This fed into the national Governance and Performance Review (GaPR) meeting.
- In March 2019, the corporate leadership undertook a review of the key areas of performance where improvements could be made. The information was shared with staff via a power point presentation.
- The provider held local monthly governance meetings. The minutes for the meetings held in December 2018, January 2019 and February 2019 were reviewed. The meetings had a set agenda with recorded minutes and actions with owners and completion dates. The minutes

of these meetings were reviewed by the medical director. During the local unannounced visits, they undertook, the medical director sought assurances from front line staff on the actions undertaken.

- During inspection there was evidence of weekly team leader meetings and monthly staff meetings. If anyone could not attend the minutes were copied and held in folders in each station for staff to read.
- Managers told us that the governance meetings were audio recorded and the recordings were stored on a hard drive along with the minutes of the meeting. The recordings were made and kept ensuring transparency and so there could be no dispute over what had been discussed.
- We reviewed staff files for all employees who had been recruited since registration. We saw evidence of identification, references, and job applications. Managers told us that interview documentation was recorded and held at ERS headquarters. Managers told us that staff were asked about health conditions that could affect their performance or restrict which duties they could perform as part of the interview process. They told us that staff did not undertake a separate occupational health questionnaire or interview.
- We reviewed information for five staff and this showed that all staff had Disclosure and Barring Services checks within the past three years. We inspected the records of five members of staff and they all had appropriate checks done.
- We reviewed a sample of records for five operational employees and found all had been offered the option to receive hepatitis B immunisations free of charge and their decision recorded whether they took up the offer.
- We reviewed information for five PTS staff employees and saw that driving licence checks had been completed within 12 months of the inspection. Managers told us checks were carried out yearly and that when an update was due a reminder was sent to staff and results were checked by managers.
- Driving licence checks provided information about driving penalties and points and identified whether drivers were low, medium or high risk. Decisions about whether staff could drive or not were based on what the contract with other providers specified, the driver risk assessment, and the nature of any driving offence.
- During inspection we saw evidence of a risk register with five risks identified. Each had a date when it was added to the register, with a risk rating, a review date and who the owner was. There was evidence the risk register had been discussed at the Governance and Performance Review (GaPR) meetings. Individual risk owners were responsible for devising actions to mitigate the risk. The managing director reviewed the risk register and undertook assurances for the follow-up.
- Managers told us they received alerts from external organisations relating to medical devices and health and safety. We saw an example of a safety alert relating to wheelchairs. This was displayed in the Mitcham base. The medical director reviewed these alerts and through their local visits sought assurances that action had been taken.
- There was good oversight of staff training and competencies. The service had an online HR system that tracked staff training compliance. At the time of inspection 98% of staff had completed mandatory training and 100% of staff were up to date with their annual update training. There was a monthly audit programme in place. We saw audit compliance were always above the set standard.

Culture within the service

- Leaders had an inspiring shared purpose, and they strove to deliver and motivate staff to succeed. Leaders believed that success was driven by leaders at the front line. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The service had a transparent culture that was customer focussed. Senior leadership team (SLT) were honest and open with facts and focussed on strategies that had been agreed. As a result, the middle management team became more positive and confident and developed a sense of ownership. This resulted in front line staff wanting to be part of the brand.
- All managerial and operational staff we spoke with described the culture at both sites as positive. All the

staff we spoke with said since the buyout of the business, the culture had changed for the better. They were kept informed regularly of significant issues in the company and the leaders were open and visible.

- We saw evidence that change in the organisation was managed through staff consultation, keeping the staff informed through forums and by leaders delivering key messages face-to-face with staff.
- Delivery of organisational change was done by appointing action owners with timescales for completion and holding them to account by the managing director through the governance meetings.

Information management

- **There was a holistic understanding of performance. Performance information was used to hold management and staff to account.**
- The service focussed on technology for a dual purpose: improvement and assurance. The medical director told us the service saw it as two sides of the same coin. As a result, the central call centre in Leeds was made the central hub for all locations. They introduced new technology that worked for people who worked on the front line. For example, hand held devices for recording of incidents, safeguarding concerns and others. By this subtle shift, the SLT found front line staff embracing IT and the change it brought.
- There were clear and robust service performance measures. These were reported and monitored. The service ensured accuracy of the KPI data through regular monitoring and testing of the system. The tracking system resulted in an information system which enabled effective performance management.
- The senior leadership team (SLT) had access to reliable, timely and relevant information. Timely access to such information provided the SLT with the necessary assurance. For example, we saw how by clicking a few icons, the SLT could query a wide range of information such as percentage of staff who had an appraisal done to the last time a vehicle was deep cleaned and the gaps identified in that process.

Public and staff engagement

- **The service proactively engaged and involved all staff and ensured that the voices of all staff were heard and acted on to shape services and culture.**
- The regional manager told us ERS staff attended contract review meetings to discuss with commissioners what was going well and not so well. ERS conducted on board patient surveys, however, the response rate was approximately 2%. As a result, they consulted patients and their relatives to identify ways to increase the response rate. The service recently (February 2019) launched a new on-line survey.
- The service initiated a top down leadership development programme and this was started with the senior leaders in 2017 followed by middle managers and was now being given for all front-line staff to access across other locations.
- Managers we spoke with told us staff engagement was more open and transparent since the ERS 'takeover'. The provider mission performance had been shared with operational teams on site. The head of performance and the ERS managing director had done roadshows in each region in 2018 for team leaders to deliver the provider's vision and mission statement.
- The service undertook staff survey across the ERS Transition. There was evidence of other engagement with staff through team briefings for team leaders and quarterly staff meetings, the minutes of which were reviewed during inspection. For example, front-line staff were encouraged to share ideas that would improve service. Two such ideas from staff included the change to the service by avoiding any pick-ups around lunch time and the appointment of local liaison. Staff told us they felt empowered to make suggestions and positively impact the service.
- Managers told us the managing director had given directions to managers to be very visible to staff. Managers told us the provider's values were the result of engagement with staff and linked to their PDR. For example, a target was set that by the end of 2018, all senior staff and by the end of 2019, all front-line staff had to be appraised. The service met the target for all senior staff. At the end of March 2019, we found 59% of front line staff had been appraised.

Patient transport services (PTS)

- The managing director told us the provider had started publishing a quarterly newsletter for staff called "In Touch." The most recent issue (Spring 2019) was reviewed during inspection and it contained information about performance and plans.
- There was evidence that patient feedback was discussed at the monthly regional governance meetings.
- Staff told us that they received prizes as recognition for times when they went 'above and beyond' their role.
- We saw information displayed on a staff notice board about an employee assistance programme which staff could access for emotional support.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- **The service fully embedded a systematic approach to improvement and made patient experience pivotal for staff to learn and enhance the performance of the organisation.**
- The provider had invested in business management systems to support various parts of their business. Managers told us they had been involved in the design to ensure the systems were appropriate for the services provided.
- We saw evidence the systems produced accurate real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making.
- Managers we spoke with told us that the business was sustainable because the provider had several contracts with NHS trusts.

Outstanding practice and areas for improvement

Outstanding practice

- The senior leadership team had created a culture where information was used to drive improvement and gain assurance resulting in front line staff engaging in the change process. For example, staff told us how their ideas had been implemented to improve the quality of service.
- The service was rolling out a leadership development programme to all its front-line staff. It had started this programme for all senior and operational managers.
- The service had linked the hospital bed flow software with ERS dispatch. Good hospital bed flow allows for an efficient system to arrange the transportation of the patient to their residence. This software had created a seamless link between the hospital and the service. It also allowed patients to track their transport through a special "Patient View" on an accessible portal.
- All vehicles had a forward-facing vehicle camera that recorded continuously. The system captured 40 seconds of footage when triggered by an incident and this was sent by email automatically to the driver's line manager within minutes. It allowed for immediate investigations of any serious incident.

Areas for improvement

Action the hospital SHOULD take to improve

- The service should have a system in place to ensure local healthcare providers were informed in cases where a staff member was suspended from duty.

Question 1.19.16

Response to CQC inspections

Please confirm that your organisation is aware of CQC reports for ambulance service providers over the last 24 months and summarise how you have responded to the key findings and recommendations. (irrespective of whether your organisation has had a CQC inspection report over this period).

Word count 1000

Total Word Count: 863

Over the last 24 months all 4 of our regional sites have been audited by the CQC receiving a "Good" accreditation across all of them. We have attached all 4 full reports.

East CQC Report

Our East region CQC report received "Good" accreditation in all of the criteria except Well-led, which received a "Requires Improvement". This was due to a number of factors including:

- We were still in the process of selling the business from SRCL Ltd to ERS Transition Ltd
- Recent changes to Key Management were still bedding in at the time of inspection – "The CQC report stated "At the time of our inspection there had been a change of` local leadership in the service. The regional manager had been in post for two months, one operations manager had been in post for one month and the team leaders had been in post two weeks and one day respectively."

Since the inspection our new management team have settled into their positions and engaged with the staff leading to stronger leadership.

South CQC Report

Our South region report received "Good" accreditation in all of the criteria except Well-Led which received an "Outstanding" rating. The key findings and recommendations from our Southern Region CQC report included:

- Road staff not aware on how to exchange their oxygen cylinders if it was out of date or empty. The CQC raised it at inspection and followed it up formally with the service following our inspection.

We provided the CQC with evidence that we inform all of our staff of the process for exchanging cylinders during their induction and through annual refresher training. To improve our service delivery, we have also added cylinder exchanging into our toolbox talks.

- The service did not have a system to make sure that local healthcare providers were informed in cases where a staff member was suspended from duty. Following this

inspection, the CQC advised we should make improvements, even though a regulation had not been breached, to help the service improve.

Following the inspection, we put in place a system to inform local healthcare providers of cases where our employees are suspended from duty.

North East CQC Report

The key findings and recommendation from our North East Region CQC report included:

- There were no visual communication aids in any of the PTS ambulances.

We put a system in place that included visual aids as part of the vehicle inspection to ensure they are onboard at the start and end of the shift. We also advised crews of the process when there are no visual aids on the vehicle.

- The provider did not have an effective system in place to identify out of date consumable items. Two automated external defibrillator (AED) pads and the electrocardiogram (ECG) dots on one ambulance were found to be out of date.

We had a process in place through using the loading list and VDI books. We have made this process more visible now.

- There were no complaints forms carried on PTS ambulances.

We added the patient feedback form to the ambulance stock list to ensure the stock is checked prior to leaving for the shift. We also streamlined the ordering process for new patient feedback surveys by giving the operational manager the authority to order new stock to ensure the vehicles remain stocked.

North CQC Report

The key findings and recommendation from our North Region CQC report included:

- Patient review forms were inconsistently completed.

Every transfer now has a PRF completed to ensure consistency

- Not all the running sheets we reviewed contained clinical handover information.

This was a misunderstanding with the CQC auditor as we are not required to have clinical handover information on all run sheets

- The service did not always record that staff returned uniforms or badges when they left the service.

Company memo was sent out to all operations managers to reiterate the importance of collecting badges and uniforms from departing employees.

- The Leeds site did not hold regular staff meetings (albeit the new manager had plans to reintroduce meetings and to increase attendance).

The new manager implemented weekly staff meetings to engage with staff on a regular basis.

Reviewing other ambulance providers CQC reports

To ensure we remain at the forefront of NEPT service delivery we not only reflect and improve our service following our CQC inspections but also analyse other NEPTS providers CQC inspections to see if there are any findings on their services that we could implement into our own.

Through examining the identified good practice in other ambulance services, we are able to ensure that our service encompasses industry wide best practice ensuring that our patients are transported in the most effective, efficient, safe and compliant manner. It also ensures that we are a key part of the development of the NEPTS sector as a whole.

Further to reviewing other businesses CQC reports we also ensure we remain at the forefront of high-quality patient transport by being an active member of the Independent Ambulance Association (iaa). Our director Andrew Pooley is currently one of the directors of the association.

We were also involved in the Nationwide review of PTS the results of which are due to be released in November.

Question 1.19.17

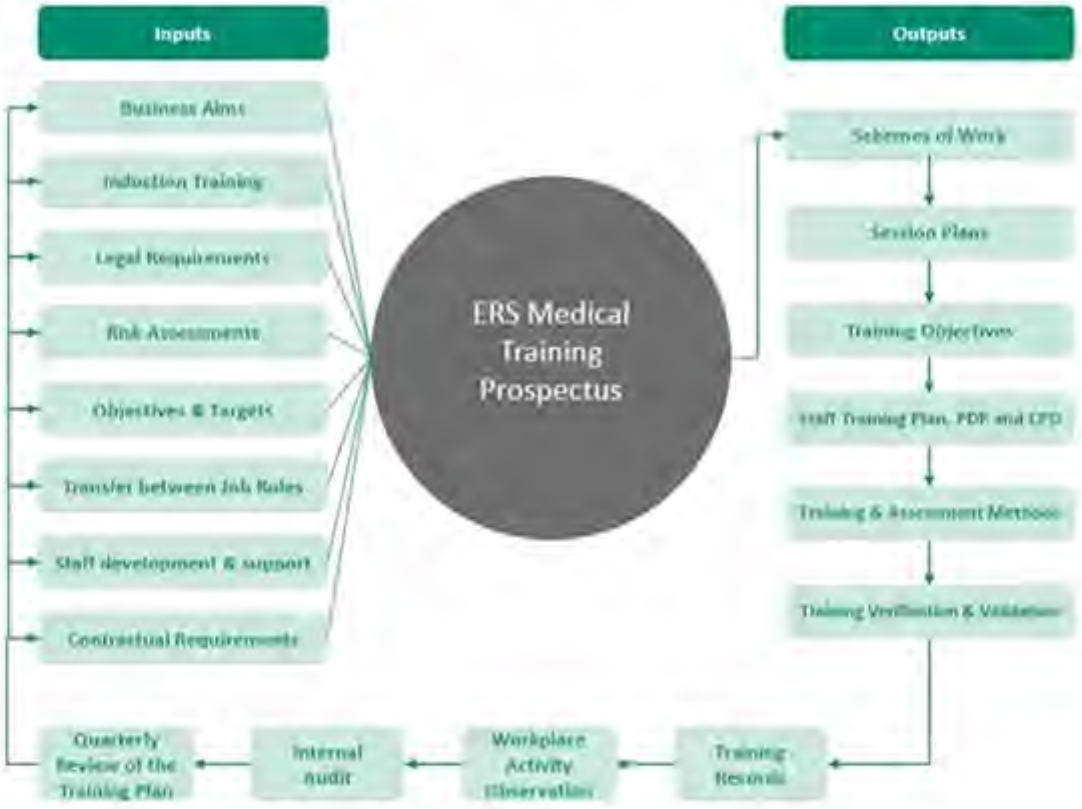
Clinical staff competency

Please provide details of your policies to ensure that clinical staff will always have necessary registration, training, qualifications, experience and current competence to undertake their clinical roles.

Word count 500

Total Word Count: 500

ERS Medical recognises that our staff are the frontline of our service delivery and therefore ambassadors of not only our services, but also the client we are delivering the services on the behalf of. It is paramount that our staff promote the dignity and respect of, and the quality of care to, the service users, carers and their relatives. We therefore provide all employees with customer services training ensuring they understand the importance of their role and conduct themselves accordingly. We provide qualification through ***REDACTED*** that are specific to and approved by the NHS.



We require the following training for each of the specific clinical roles:

Ambulance Care Assistant

Once the candidate has been selected, and subject to their pre-employment checks, they will complete the following program:

- 1-week classroom foundation course
- days professional driver improvement program
- days observing on an operational vehicle
- 1-day classroom for practical and theory assessments.

This will be supported by a comprehensive workbook and E-Learning for the student to complete. Both the e-learning and workbook must be completed within 4 weeks of the start date. Staff will not pass their probation if these are not completed.

Successful completion will lead to a Level 3 Award – Non-Urgent Care Services.

Urgent Care Assistant

UCA Crews deal with patients who are unwell, but not currently in a life-threatening condition. They may deal with interfacility transfers where patients require formal monitoring, HCP admission etc. They will be able to perform a greater range of monitoring, including Pulse Oximetry, Non-invasive Blood Pressures, ECG Rhythms. They will have additional training to manage deteriorating patients.

- Qualified ACA (6 Months)
- Level 3 Certificate – Urgent Care Services

If required by the contract, UCA's may be trained in emergency driving. They will be expected to maintain their CPD to a level commensurate with their grade.

Emergency Care Assistant / Technician

Similar to the role of a UCA, the ECA will provide transport to patients who are more acutely unwell and typically work alongside a qualified clinician (EMT/Paramedic). This may include providing emergency transfers, responding to 999 calls to back up a solo clinician, or dealing with HCP admissions.

- Qualified UCA (6 Months)
- Level 3 Certificate – Emergency Care Services
- IM administration
- Emergency Driving Qualification
- CPD Portfolio

Paramedic

- UK qualified and holding current Health Care Professionals Council registration
- CPD Portfolio
- Annual programme of competency training provided by a recognised training organisation

To further ensure the quality of our service every single member of our operational/clinical staff receive full induction training on a variety of topics including safeguarding. This training is topped up, as a minimum, annually through mandatory update training via our online portal, toolbox talks and classroom-based training.

All training is followed by an assessment to ensure that all our staff have understood and taken onboard the training they have received. All training is logged on our HR system BambooHR. The training is logged with a refresher date that alerts management staff as to when update training is required ensures all staff remain fully trained and compliant.

Period Covered 01/06/2019 to 30/06/2019

Introduction

The Monthly Governance and Performance Review Committee (GaPR) meeting for all sites aligned to the CQC location: ERS Medical East: ERS Medical Site Names, ETC

Areas Covered

- Audits
- Incidents
- Serious [Untoward] Incidents
- Safeguarding Referrals Raised by ERS Medical
- Safeguarding Referrals Raised Against ERS Medical
- Running Calls
- Complaints [Including Escalations – Stage 2]
- Compliments
- Surveys (Query)
- Vehicle Deep Clean Compliance
- Trend Analysis

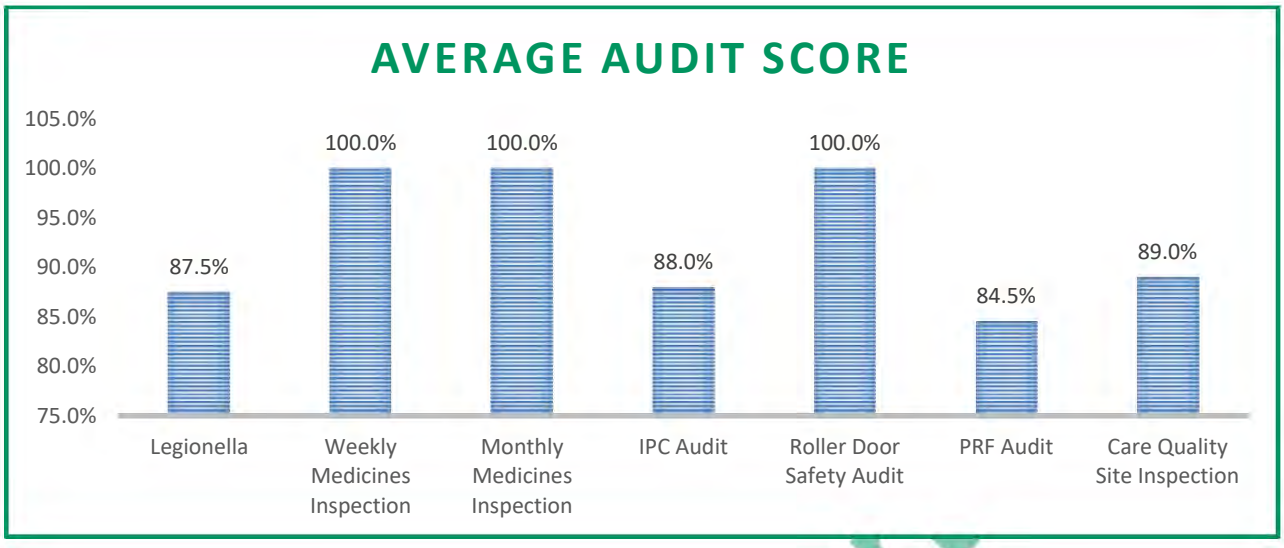
INC	Incident
CPL	Complaint
CONC	Concern
CLM	Compliment
ESC	Complaint Escalated
GPE	Good Practice Examples and Staff Satisfaction
PVT	Prevent
TRN	Transport
SAF	Safeguarding
ENV	Environmental
HS	Health and Safety
IG	Information Governance
MH	Mental Health (use of physical restraints)
OHR	Operational / HR
RC	Running Call
CQ	Care Quality
BC	Business Continuity
EPRR	Emergency Preparedness Resilience and Response

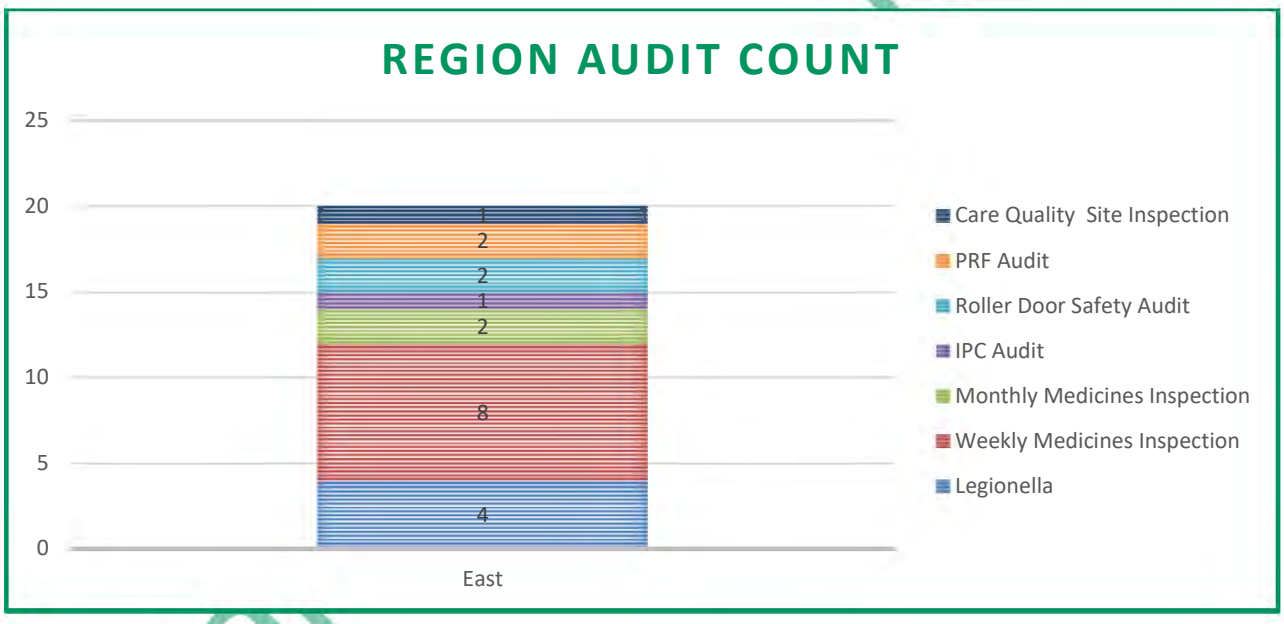
Example Report Only

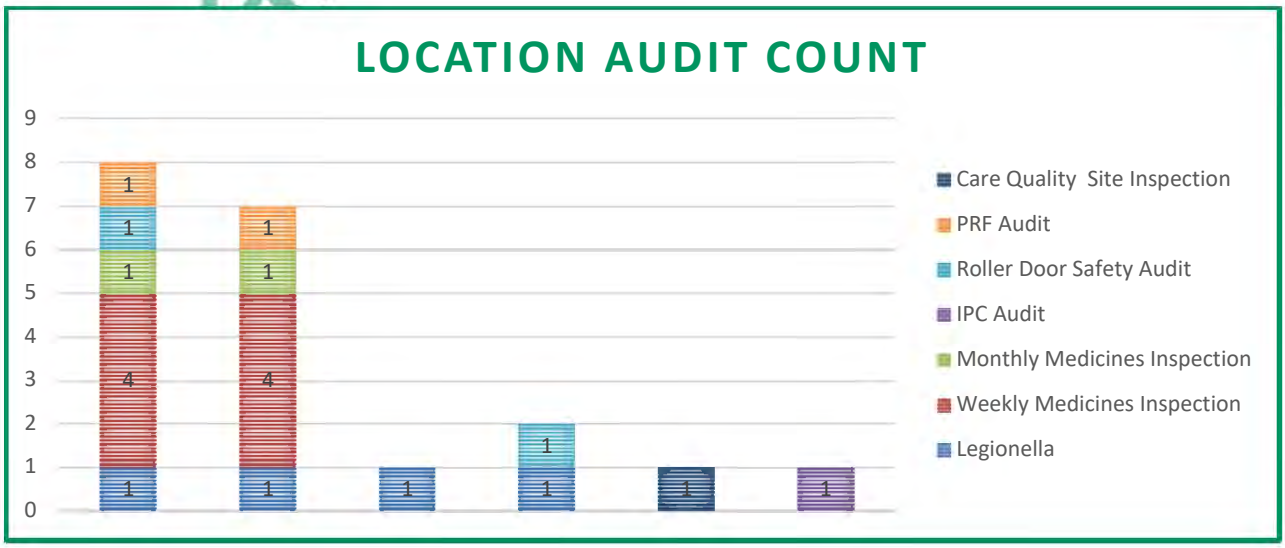
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Site Audits

There was a total of 20 individual audits and inspections scheduled in the East in June 2019.

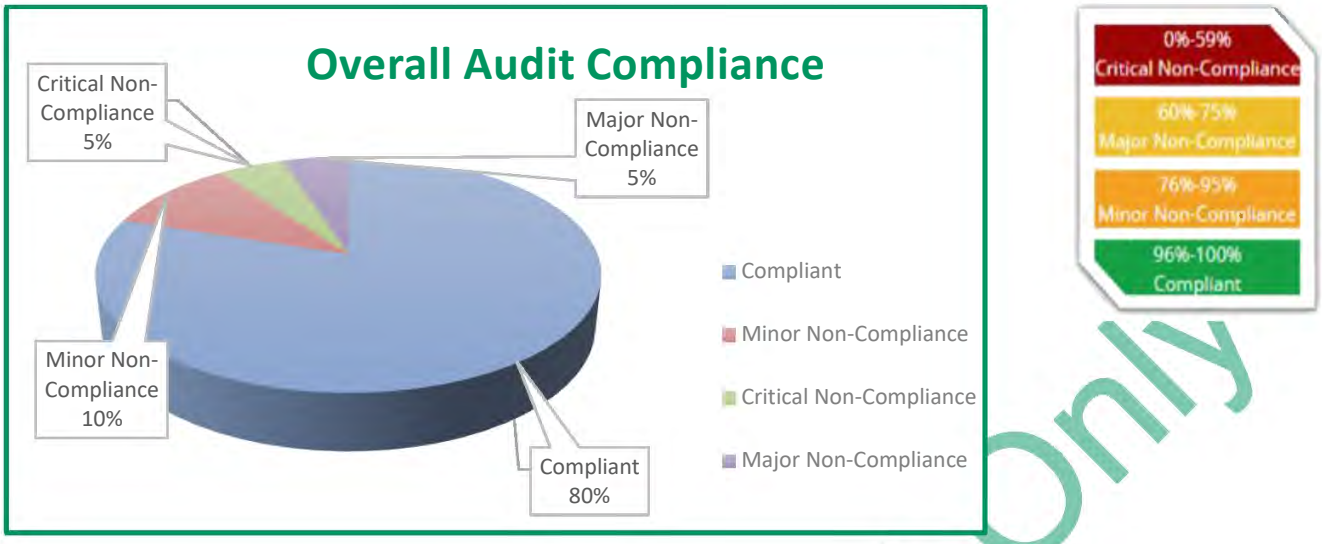






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Audits: Non-Compliance Details

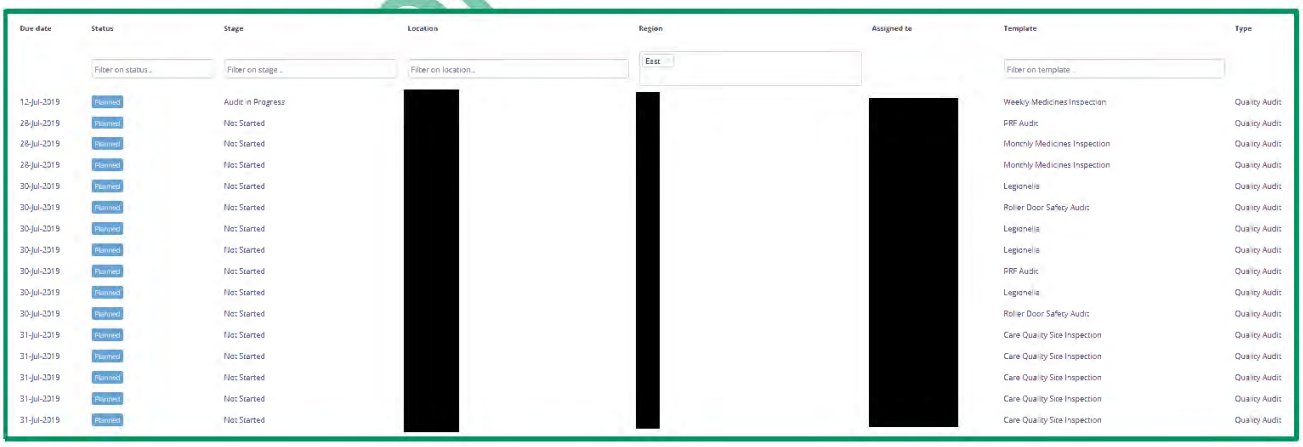


Audits: Non-Compliance (Critical & Major Non-Compliance)

Due Date	Location	Region	Template	Score	Rank
30-Jun-19	Norwich	East	PRF Audit	69%	Major Non-Compliance
30-Jun-19	Norwich	East	Legionella	50%	Critical Non-Compliance

- Major Non-Compliance Fictious Site PRF Audit: Not all PRF's have recorded times / Observations missing / Patient consent not recorded. These are all at ACA level as all HDU PRF's are scored at 100%. Action Plan – 000007 raised.
- Critical Non-Compliance – Fictious Legionella Audit: Cold water is not below the required temperature at site. This is a historical issue and has been raised with the landlord. Action Plan – 000008 has been raised.

Scheduled Audits for July 2019

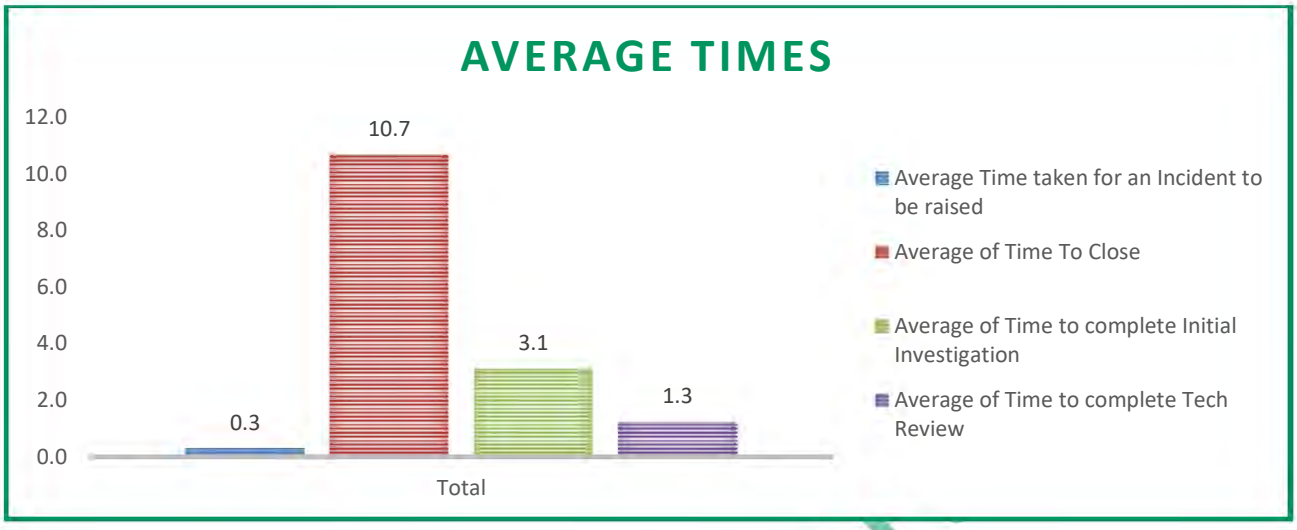


Example Report Only

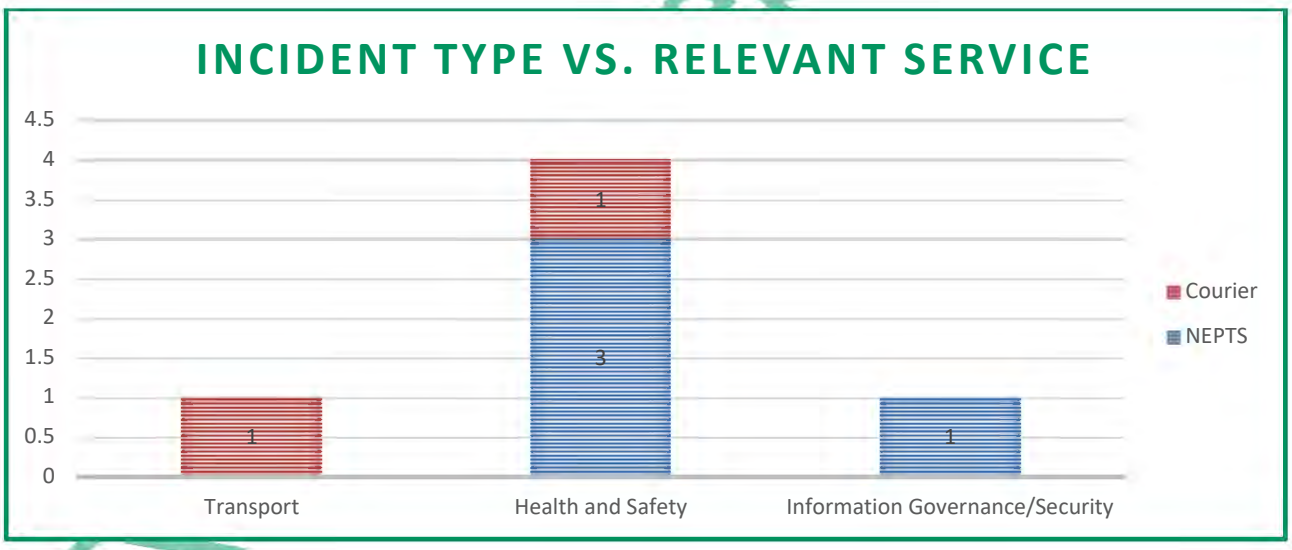
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Incident(s) Overview

There was a total of 6 incidents (combined) recorded on the Radar system in the East in June 2019. There were 13 incidents in May 19.



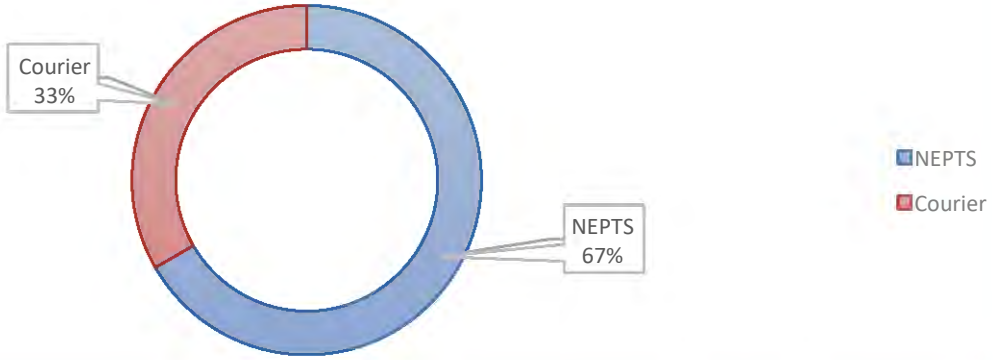
Reporting Time Target = 1 Day:	**Compliant**
Initial Investigation (II) Target Days = 14 Days:	**Compliant**
Technical Review Target = 14 Days from completion of II:	**Compliant**
Target to close = 21 Days:	**Compliant**





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Relevant Service Type



LOCATION INCIDENT TYPE BREAKDOWN



Overdue Workflows (Incidents)

NONE

Example

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Incidents Requiring Notification to Insurance Company/Broker

NONE

Transport incidents are automatically reported to the ERS Medical insurers through the Radar compliance system. These are a Fleet Insurance notification.

Incidents Requiring Regulatory Notification

Reference	Region	Location	Event Date
HS-185	East	Ipswich Mail and Courier	18/06/2019

HSE RIDDOR Notification – Ref: 99173CD141 – Injury Type – Fracture to wrist. Also reported to our insurance provider.

Serious [Untoward] Incidents

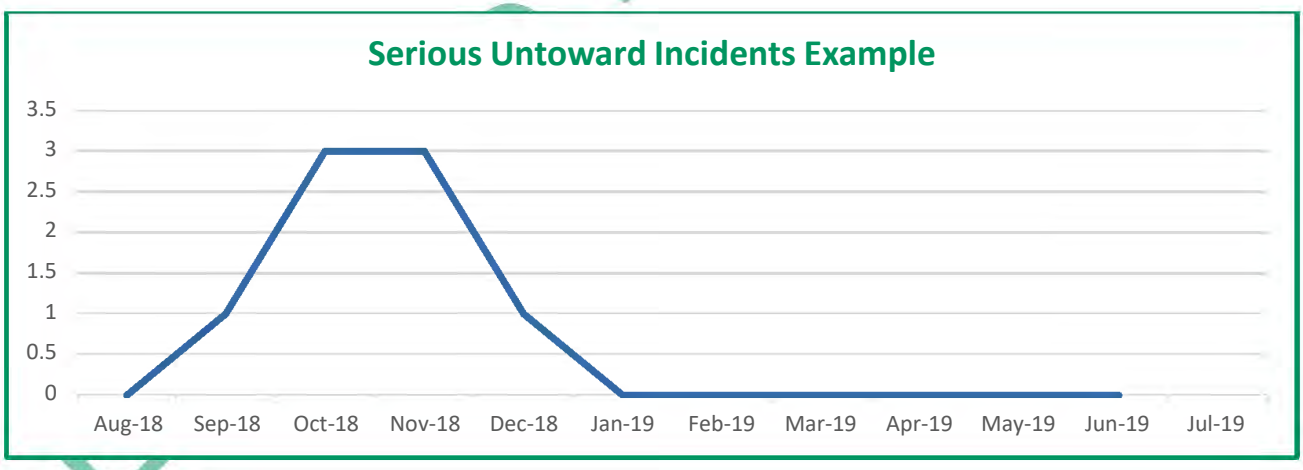
NONE

Incident Detail

Reference	Description	Region	Location	Event Date
Unique Ref from Radar	A full description of the event will be added here direct from our Radar compliance system	East	Site Name	13/06/2019

Incident Trend Analysis

SUI Event Trends – This is aligned to the NHS SUI Framework



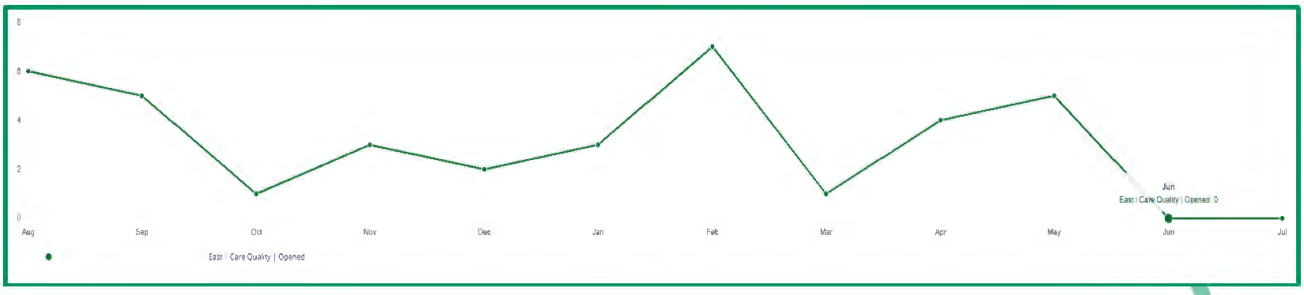
Health and Safety Event Trends



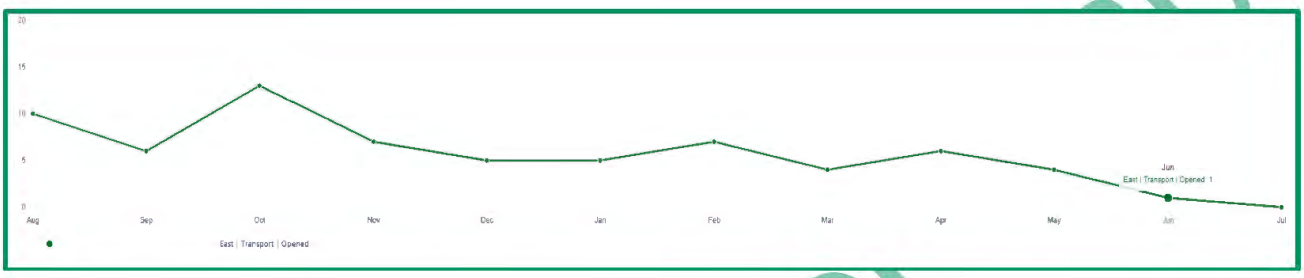
Report Only

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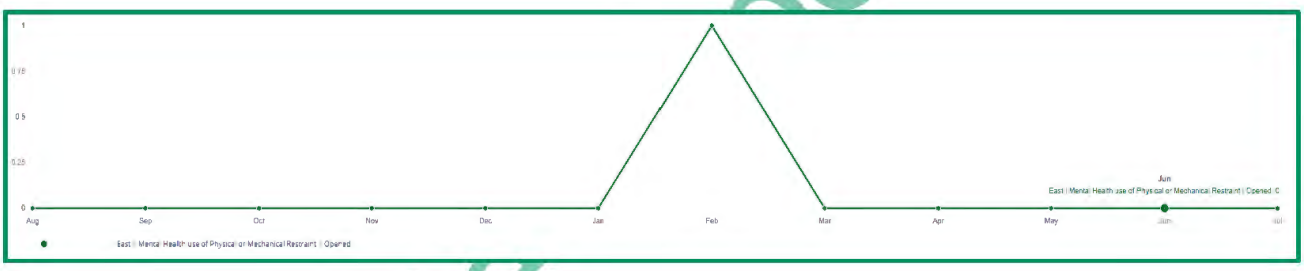
Care Quality Event Trends



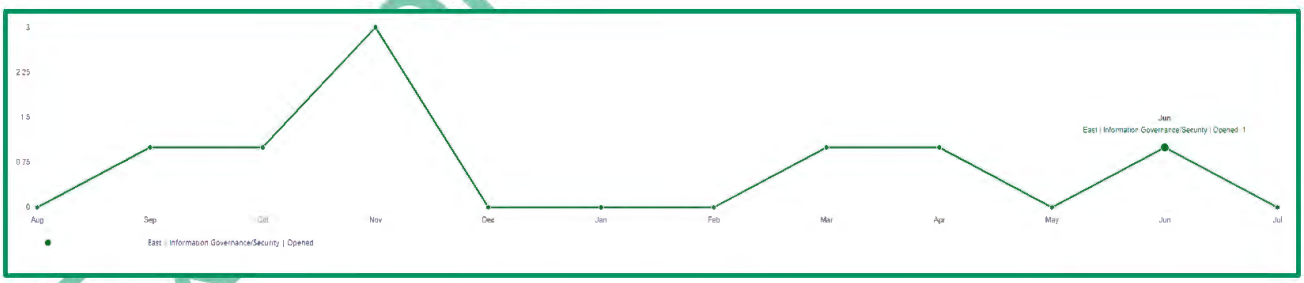
Transport Event Trends



Mental Health Physical Interventions Event Trends



Information Governance Event Trends



Incident Recommendations and Feedback

Reference	Event Type	Region	Location	Technical Review (Recommendations)	Technical Review (Event feedback)
Unique Ref from Radar	Safeguarding	East	Site Name	Feedback provided here direct from the SME Technical Review.	Feedback provided here direct from the SME Technical Review.

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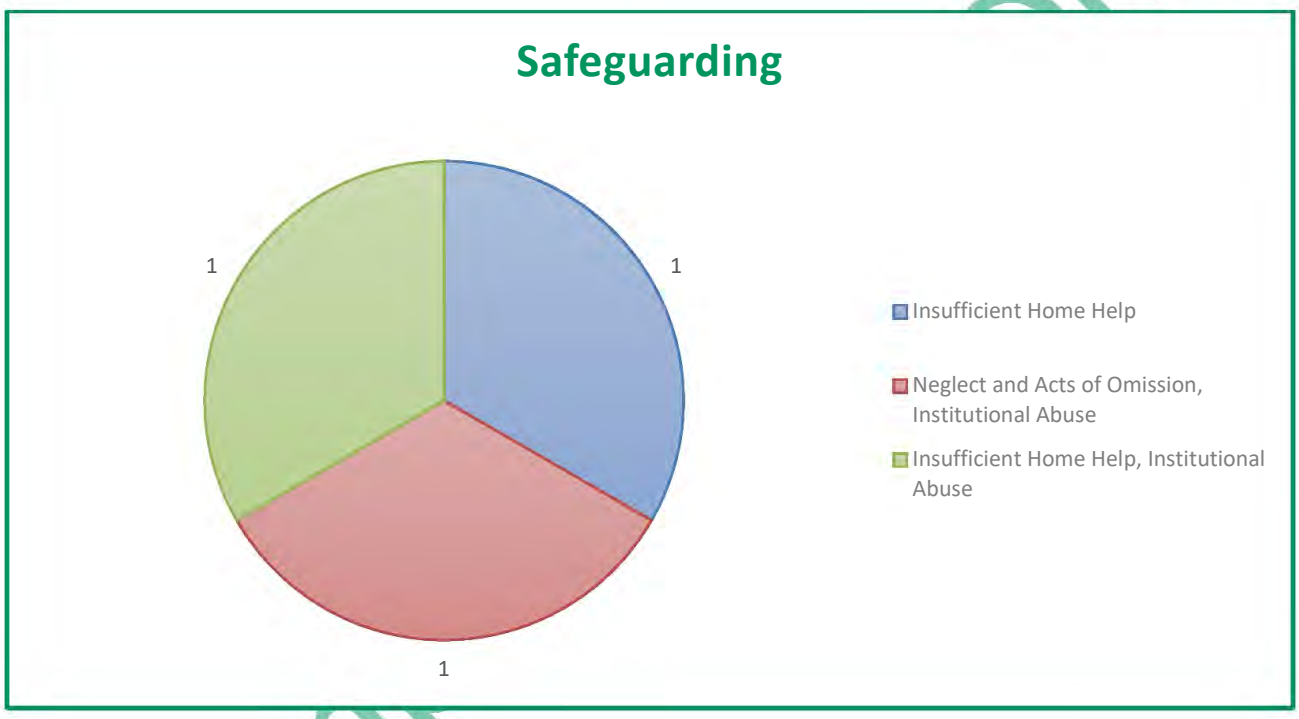
Safeguarding Referrals Raised by ERS Medical

There was a total of 1 Safeguarding referrals made by ERS Medical staff in the month of June 19.

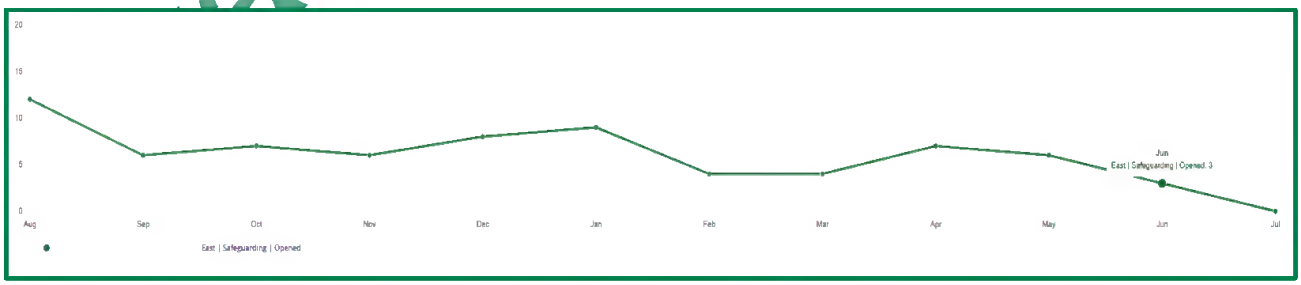
Reference	Description	Location	Event Date	Event Form (Reason for the safeguarding referral)
Unique Radar Ref	Description of the Safeguarding Concern	Site Name	05/06/2019	Type of Concern: Insufficient Home Help

Safeguarding Referrals Raised Against ERS Medical

NONE



Safeguarding Trends



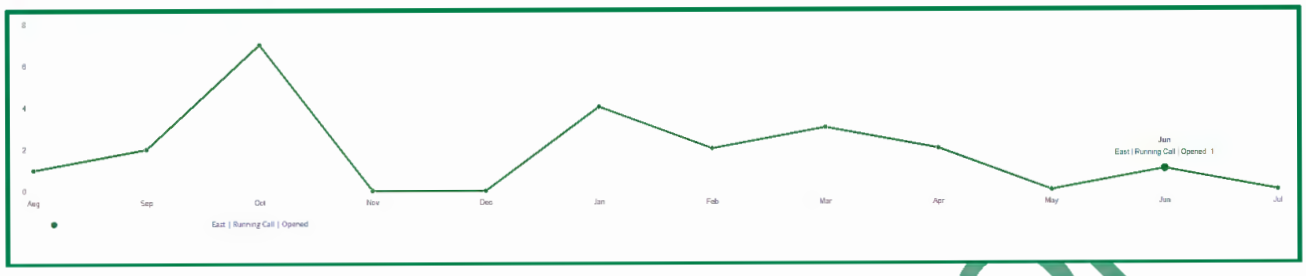
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Running Calls

There was a total of 1 running calls made by ERS Medical in the East for the month of June 19.

Please see the incident details for more information on RC-001 – Site Name 06/06/19.

Running Call Trends



Total Incident Rate Trend Rate

Previous Month

Total Combined Incident Count East:	18
Total Journey Count East:	11,701
Incident Ratio:	**0.15**

Current Month

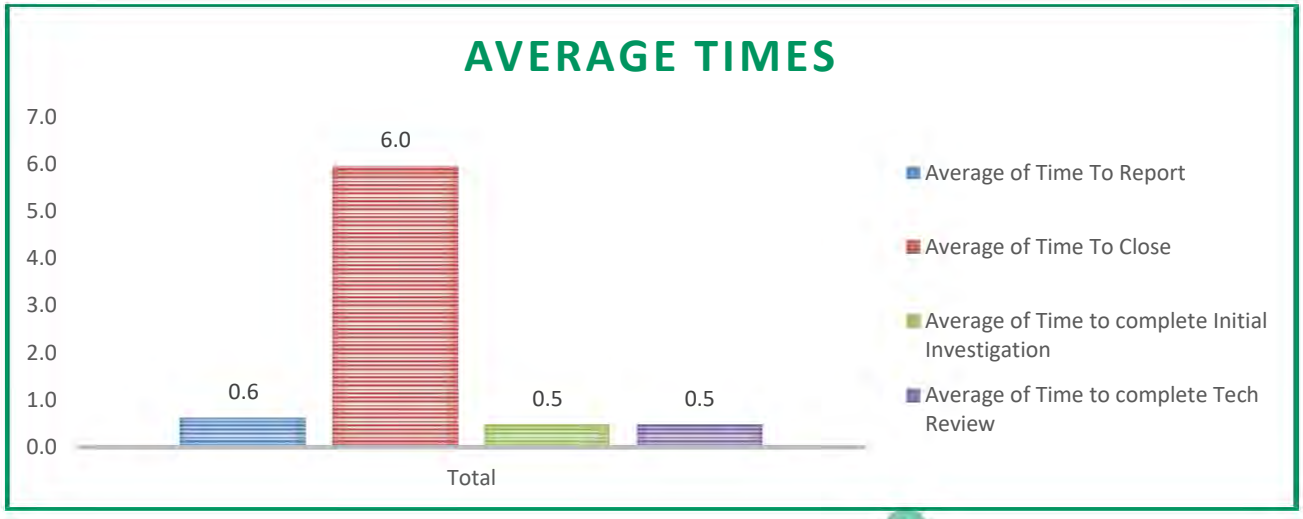
Total Combined Incident Count East (incidents + safeguarding's):	10
Total Journey Count East:	11,007
Incident Ratio:	**0.09**

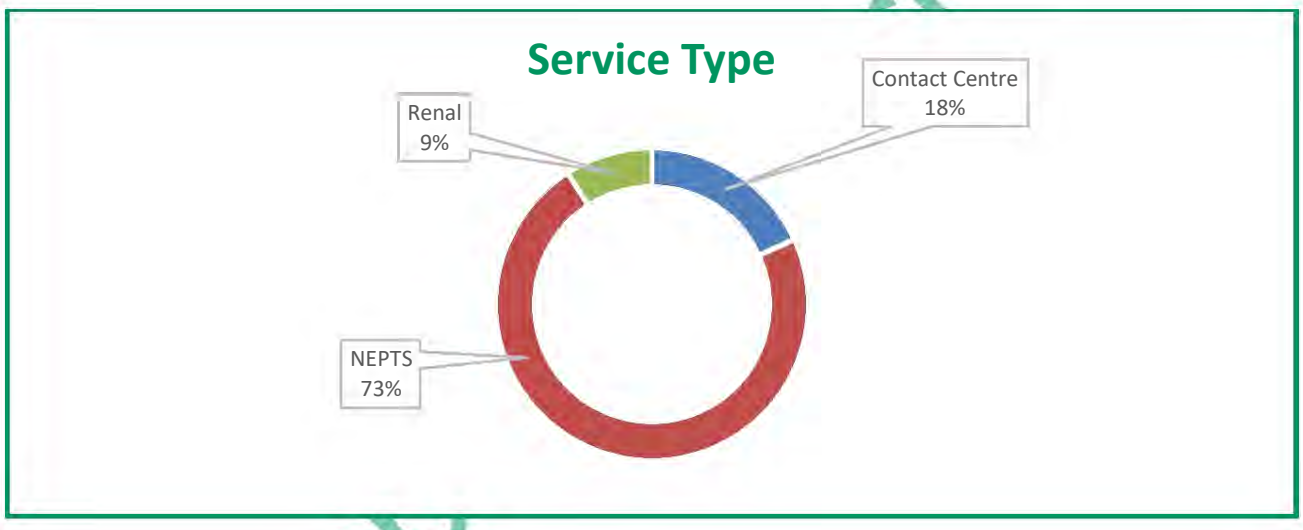
Example Report O

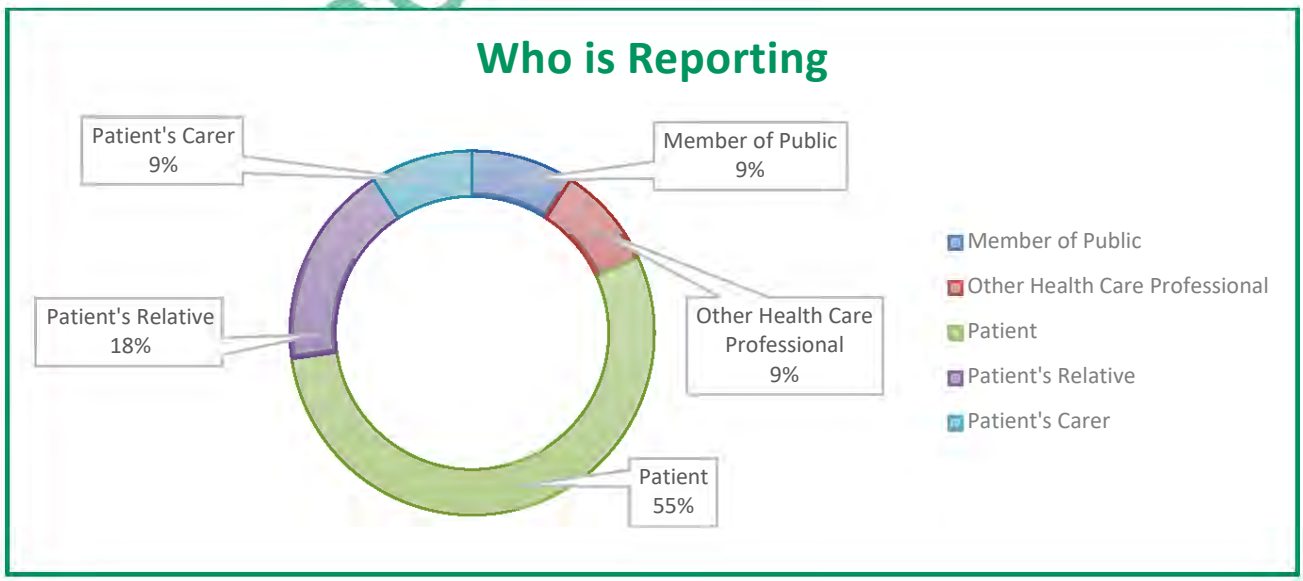
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Complaints

There was a total of 8 complaints recorded for East in June 2019.







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Complaints That Required Notification to Insurance Company/Broker

NONE

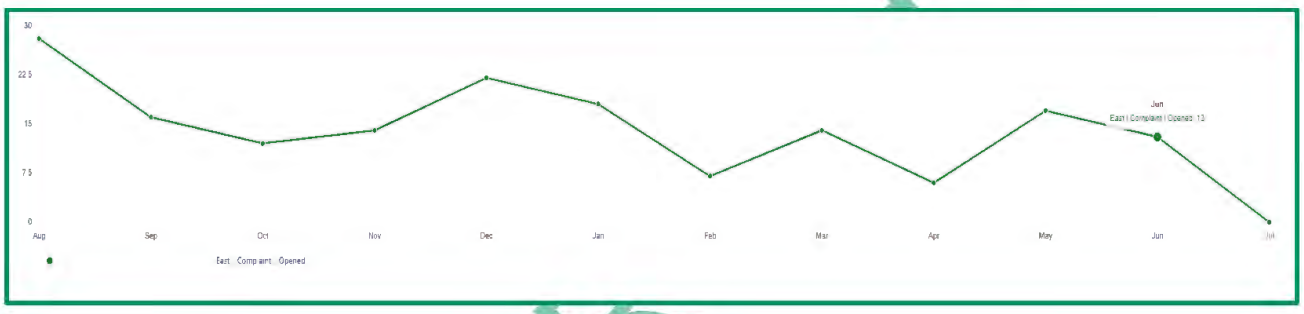
Complaints That Resulted in Regulatory Notification

NONE

Complaints Detail

Reference	Description	Region	Location	Event Date
Unique Radar Ref	Short description of complaint is provided here, direct from our Radar Compliance system.	East	Site Name	26/06/2019

Complaints Trends



Previous Month

Total Combined Complaint Count East : 17
Total Journey Count East: 11,701
Incident Ratio: **0.14**

Current Month

Total Combined Complaint Count East : 11
Total Journey Count East: 11,007
Incident Ratio: **0.09**

Compliments

There was a total of 1compliments recorded for East in June 2019.

Reference	Description	Location	Event Date
Unique Radar Ref	Description of the compliment received direct from our Radar compliance system.	Site Name	05/06/2019

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Compliments Trends



Concerns & QIR's

There was a total of 1 concern raised for the East in the month of June 2019.

There was a total of 1 QIR raised for the East in the month of June 2019.

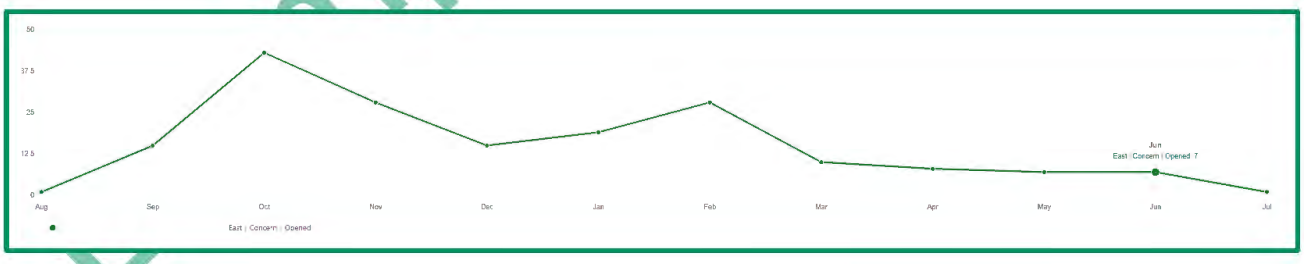
Concerns

Reference	Description	Location	Event Date
Unique Radar Ref	Description of the Concern direct from our Radar compliance system	Site Name	06-Jun-19

QIR's

Reference	Description	Location	Event Date	Concern (QIR Reference)	Who Raised the QIR
Unique Radar Ref	Description of the QIR direct from our Radar compliance system	Site Name	07/02/2019	Trust Datix Ref	Trust / Dept Name

Concerns Trends



Current Month

Concerns Ratio for June 2019 (inclusive of concerns and QIR's) = **0.004** ↓

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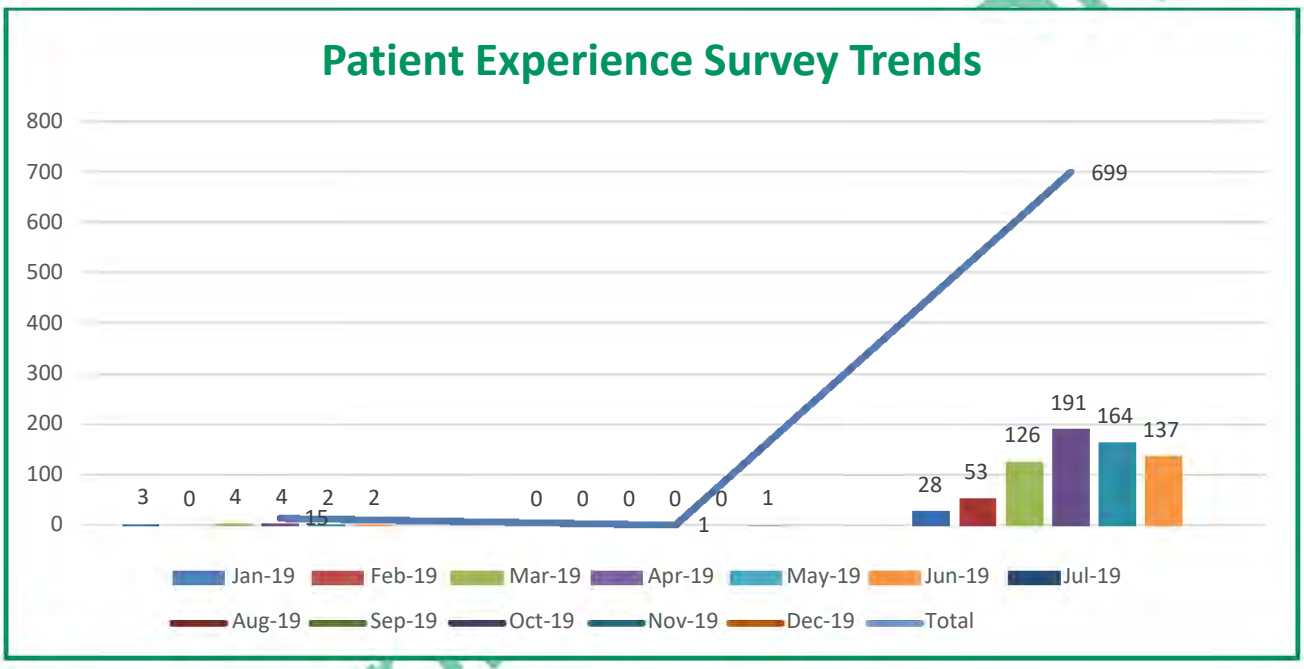
Surveys

Location	Survey Count
Site Name	137

Q: How likely are you to recommend our service to your friends and family?

Site	Extremely Unlikely	Unlikely	Neither Likely or Unlikely	Likely	Extremely Likely	Survey Count
Site Name	1.49%	0.00%	2.99%	18.66%	76.87%	137

Sites	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Site Name	28	53	126	191	164	137



Vehicle Deep Clean Compliance

Site	Not Compliant	Compliant	% Compliant
Site Name	0	17	100%

Deep Clean Mitigation: This is where we would detail any mitigating factors for ambulances not having their scheduled Deep Clean on time. Example: *Ambulance Reg AO 11 ABC currently off the road and in the workshops with an engine fault. It will receive its Deep Clean prior to commencing operational duties again.*

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Due date	Location	Region
30-Sep-20	Kings Lynn	East
31-Oct-20	Kelling	East
31-Oct-20	Kings Lynn	East
31-Oct-20	Quorn Road	Midlands
30-Oct-20	Norwich (M&C)	East
31-Oct-20	Norfolk Control	East
31-Jul-21	Quorn Road	Midlands
31-Jul-21	Mansfield - Notts	Midlands
31-Oct-20	Quorn Road	Midlands
30-Sep-20	Kings Lynn	East
30-Sep-20	Kings Lynn	East
30-Sep-20	Norwich	East
30-Sep-20	Norwich	East
30-Sep-20	Hetton - Head Office	Head Office
28-Feb-21	Norwich	East
28-Feb-21	Kelling	East
30-Sep-21	Hetton - Head Office	Head Office
30-Oct-20	Kings Lynn	East
31-Oct-20	Kings Lynn	East
11-Sep-20	Durham	North East
31-Oct-20	Hull	North East
11-Mar-21	Leeds - Teaching	North
30-Sep-21	Leeds - Teaching	North
30-Oct-20	Mansfield - Notts	Midlands
30-Oct-20	Mansfield - Notts	Midlands
30-Sep-20	Quorn Road	Midlands
30-Sep-20	Quorn Road	Midlands
30-Oct-20	Speke	North
30-Mar-21	Crewe	North
30-Oct-20	Crewe	North
30-Sep-20	Crewe	North
31-Aug-21	Speke	North
04-Oct-20	Durham	North East
30-Oct-20	Durham	North East
11-Sep-21	Durham	North East
30-Mar-21	Durham	North East
30-Oct-20	Blyth	North East
30-Mar-21	Blyth	North East
30-Oct-20	Blyth	North East
30-Oct-20	Leeds - Teaching	North
30-Nov-20	Leeds - Teaching	North
30-Mar-21	Carlton Forest	Midlands
30-Oct-20	Carlton Forest	Midlands
30-Oct-20	Ashville	Midlands
30-Oct-20	Quorn Road	Midlands
30-Oct-20	Quorn Road	Midlands
30-Nov-20	Hull	North East
30-Mar-21	Hull	North East
30-Oct-20	Hull	North East

30-Nov-20	Speke	North
30-Oct-20	Speke	North
30-Oct-20	Leeds - CCO (Not Operations)	North
30-Mar-21	Ashville	Midlands
30-Oct-20	Leeds - Teaching	North
30-Sep-20	Hull	North East
30-Oct-20	Hull	North East
30-Mar-21	Carlton Forest	Midlands
30-Sep-20	Leeds - Teaching	North
30-Oct-20	Manchester	North
30-Sep-20	Manchester	North
28-Feb-21	Manchester	North
30-Sep-20	Mansfield - Notts	Midlands
30-Sep-20	Mansfield - Notts	Midlands
30-Sep-20	Speke	North
30-Sep-20	Ashville	Midlands
30-Sep-20	Blyth	North East
30-Sep-20	Durham	North East
30-Sep-20	Hull	North East
30-Sep-20	Speke	North
30-Sep-20	Leeds - Teaching	North
30-Sep-20	Crewe	North
30-Sep-20	Manchester	North
30-Sep-20	Ashville	Midlands
30-Oct-20	Ashville	Midlands
30-Sep-20	Ashville	Midlands
30-Sep-20	Carlton Forest	Midlands
31-Oct-20	Blyth	North East
31-Oct-20	Durham	North East
31-Oct-20	Hull	North East
30-Sep-20	Blyth	North East
04-Sep-20	Durham	North East
30-Sep-20	Blyth	North East
30-Sep-20	Durham	North East
30-Sep-20	Hull	North East
31-Oct-20	Speke	North
02-Oct-20	Leeds - Teaching	North
31-Oct-20	Crewe	North
31-Oct-20	Manchester	North
30-Sep-20	Leeds - Teaching	North
30-Oct-20	Speke	North
11-Sep-20	Leeds - Teaching	North
30-Sep-20	Crewe	North
30-Sep-20	Carlton Forest	Midlands
02-Oct-20	Ashville	Midlands
30-Sep-20	Carlton Forest	Midlands
30-Mar-21	Quorn Road	Midlands
30-Mar-21	Mansfield - Notts	Midlands
31-Oct-20	Manchester	North
31-Aug-21	Blyth	North East

30-Nov-20	Crewe	North
30-Sep-20	Crewe	North
30-Sep-20	Leeds - Teaching	North
31-Oct-20	Carlton Forest	Midlands
31-Oct-20	Ashville	Midlands
31-Jul-21	Ashville	Midlands
31-Jul-21	Ashville Control Room	Midlands
31-Jul-21	Carlton Forest	Midlands
31-Jan-21	Carlton Forest	Midlands
31-Jan-21	Ashville	Midlands
28-Feb-21	Blyth	North East
28-Feb-21	Durham	North East
30-Mar-21	Crewe	North
30-Mar-21	Leeds - Teaching	North
28-Aug-21	Durham	North East
30-Sep-21	Crewe	North
30-Sep-21	Manchester	North
28-Feb-21	Blyth	North East
30-Mar-21	Manchester	North
30-Sep-20	Manchester	North
30-Sep-20	Crewe	North
30-Sep-20	Manchester	North
30-Nov-20	Leeds - Teaching	North
30-Sep-20	Crewe	North
28-Feb-21	Snetterton	East
28-Feb-21	Kings Lynn	East
28-Feb-21	Norwich	East
31-Jan-21	Ipswich PTS	South
31-Jan-21	Ipswich Mail and Courier	South
31-Jan-21	Mitcham	South
31-Jan-21	Homerton	South
02-Oct-20	Kings Lynn	East
25-Sep-20	Kings Lynn	East
18-Sep-20	Kings Lynn	East
04-Sep-20	Kings Lynn	East
11-Sep-20	Kings Lynn	East
31-Oct-20	Norwich	East
30-Sep-20	Norwich	East
30-Sep-20	Snetterton	East
30-Sep-20	Kelling	East
30-Sep-20	Mitcham	South
30-Sep-20	Ipswich Mail and Courier	South
31-Oct-20	Homerton	South
30-Sep-20	Norwich	East
30-Sep-20	Mitcham	South
31-Oct-20	Mitcham	South
30-Sep-20	Snetterton	East
30-Sep-20	Kings Lynn	East
30-Nov-20	Homerton	South
30-Sep-20	Kelling	East

30-Sep-20	Homerton	South
31-Oct-20	Snetterton	East
31-Oct-20	Ipswich PTS	South
30-Sep-20	Mansfield - Notts	Midlands
30-Sep-20	Quorn Road	Midlands
30-Mar-21	Kings Lynn	East
30-Oct-20	Kings Lynn	East
30-Sep-21	Kelling	East
30-Oct-20	Kelling	East
30-Mar-21	Kelling	East
30-Oct-20	Kings Lynn	East
30-Sep-21	Norwich	East
30-Oct-20	Norwich	East
30-Mar-21	Norwich	East
30-Oct-20	Norwich	East
30-Sep-21	Snetterton	East
30-Oct-20	Snetterton	East
30-Oct-20	Snetterton	East
30-Mar-21	Snetterton	East
31-Oct-20	Snetterton	East
30-Sep-21	Ipswich Mail and Courier	South
30-Oct-20	Ipswich Mail and Courier	South
30-Oct-20	Ipswich Mail and Courier	South
30-Mar-21	Ipswich PTS	South
30-Oct-20	Homerton	South
30-Mar-21	Homerton	South
30-Oct-20	Homerton	South
30-Mar-21	Mitcham	South
30-Oct-20	Mitcham	South
30-Oct-20	Mitcham	South
30-Sep-21	Mitcham	South
28-Feb-21	Snetterton	East
30-Sep-20	Ipswich Mail and Courier	South
30-Sep-20	Ipswich Mail and Courier	South
30-Sep-20	Kings Lynn	East
30-Sep-20	Kings Lynn	East
30-Sep-20	Snetterton	East
30-Sep-20	Snetterton	East
28-Feb-21	Kings Lynn	East
30-Sep-20	Norwich	East
30-Sep-20	Norwich	East
28-Feb-21	Norwich (M&C)	East
28-Feb-21	Kelling	East
30-Sep-20	Kelling	East
30-Sep-20	Mitcham	South
30-Sep-20	Mitcham	South
30-Sep-20	Homerton	South
30-Sep-20	Homerton	South
31-Jan-21	Mansfield - Notts	Midlands
31-Jan-21	Mansfield - Notts	Midlands

31-Jan-21	Quorn Road	Midlands
31-Jan-21	Mitcham	South
31-Jan-21	Ipswich (M&C)	South
31-Jan-21	Homerton	South
31-Jan-21	Ipswich PTS	South
31-Oct-20	Mansfield - Notts	Midlands
30-Sep-20	Ipswich PTS	South
04-Sep-20	Norwich	East
11-Sep-20	Norwich	East
18-Sep-20	Norwich	East
25-Sep-20	Norwich	East
02-Oct-20	Norwich	East

Template	Type
Clinical Setting IPC Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Monthly Medicines Inspection	Quality Audit
PRF Audit	Quality Audit
PRF Audit	Quality Audit
Monthly Medicines Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Monthly Medicines Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Information Governance & Security Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Legionella	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Legionella	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Legionella	Quality Audit

Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Fleet Compliance Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
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Roller Door Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Legionella	Quality Audit
Legionella	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Legionella	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit

Clinical Setting IPC Audit	Quality Audit
PRF Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit
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Care Quality Site Inspection	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
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Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Health and Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
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Information Governance & Security Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Information Governance & Security Audit	Quality Audit
Health and Safety Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Health and Safety Audit	Quality Audit

Health and Safety Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Care Quality Site Inspection	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Legionella	Quality Audit
Health and Safety Audit	Quality Audit
Legionella	Quality Audit
Information Governance & Security Audit	Quality Audit
Legionella	Quality Audit
Health and Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Health and Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Information Governance & Security Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Health and Safety Audit	Quality Audit
Legionella	Quality Audit
Health and Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Health and Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Information Governance & Security Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Medicines Management Internal Audit Site	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Fleet Compliance Audit	Quality Audit
Fleet Compliance Audit	Quality Audit
Legionella	Quality Audit
Legionella	Quality Audit
Roller Door Safety Audit	Quality Audit
Roller Door Safety Audit	Quality Audit
Legionella	Quality Audit
Fleet Compliance Audit	Quality Audit
Clinical Setting IPC Audit	Quality Audit

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Clinical Setting IPC Audit	Quality Audit
Care Quality Site Inspection	Quality Audit
Health and Safety Audit	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit
Weekly Medicines Inspection	Quality Audit

Question 1.19.18

Annual Audit

Please include your annual audit programme showing how all key parts of the proposed service (including clinical quality and safety) will be effectively audited. Please include dates for audit report submission to commissioners. Please also submit an exemplar audit report showing significant findings, lessons learned and recommendations for improvement (the identity of the service may be redacted).

Word count 1000

Total Word Count: 998

Clinical audits are a way for us to ensure that the quality of service we are delivering meets the standards and requirements of the commissioner as well as being complaint with all legislation. It is also an opportunity for us to identify any areas of improvement that can be implemented to increase patient comfort and satisfaction with the service.

A comprehensive timetable of audit activities is maintained for the National Care Standards team. The team consists of four experienced members including a registered nurse and a qualified Health & Safety Inspector. We have attached a spreadsheet containing an overview of the planned Audits for 2020.

Within our Business Management System (BMS) we have a fully defined audit process, which conducts full and frequent audits on the following aspects of our service delivery:

- Business Continuity
- CQC Standard Internal Audit
- Health and Safety
- HR and GDPR
- Information Governance
- Infection Prevention and Control
- Legionella
- Medicines Management Bi-Annual
- Annual Medicines
- Monthly Medicines
- Weekly Medicines
- Patient Report Forms (PRF)
- Racking Safety Audit

- Roller Door Safety Audit

Our audits are not limited to the above list and new audits will be implemented as and when required to ensure the service we deliver is safe, compliant and as efficient and effective as possible.

For internal audits our compliance team will, at least one week before the scheduled date of the audit, inform the relevant manager of the area to be audited outlining:

- The subject and scope of the audit
- The date and likely duration
- The auditor(s)
- Any personnel who are required

A full review of the previous audit will be conducted to identify any outstanding actions prior to the upcoming audit. Any outstanding actions will be discussed as part of the opening meeting of the audit.

For each aspect, the auditor will review the evidence presented against the relevant criteria, record the findings (both positive and negative), and if required, identify any corrective/preventive action necessary.

On completion of the audit, the auditor will discuss performance with the auditee and agree that any non-conformances found, or observations made are factual, graded correctly and are fully understood. They will then agree timeframes for rectification, which will be detailed as Action Plans within ***REDACTED***, with specified target dates for completion.

Recording and monitoring audits

REDACTED is a software system, which has been specifically developed to assist healthcare providers report, track, manage and feedback on governance matters, such as incidents, complaints, audits, action plans and risks. ERS Medical has worked with the developers, on their beta development team, to drive the product forward and have innovative practices within the system such as auto notifications of transport incidents to our fleet insurers. The CQC have inspected ERS and recognised this as truly unique to ERS Medical.

REDACTED

A typical ***REDACTED*** employee dashboard: This details any company and compliance 'Notices' which need to be read and acknowledged, Audits that are due, Assigned 'Actions' to complete, Incidents (events) which need to be investigated and managed, Documents which require reviewing and any employees who have overdue items in their ***REDACTED*** dashboard.

REDACTED

This is a site-specific dashboard, which provides a quick reference oversight of compliance within the ***REDACTED*** system, for audits that have been undertaken.

Lessons Learnt

Compliance and quality are at the very core of our value proposition. Pivotal to this regime is our Business Management System (BMS) which has been written as an integrated set of policies and procedures to cover all aspects of our activities and is aligned to various ISO standards such as ISO 9001, 45001,22301, 14001 & 27001.

All changes to policies or procedures must be approved and mandated by ***REDACTED*** before being implemented into our service delivery. Checking these standards have been implemented to our internal audit arrangements is facilitated by the Care Standards Team whilst performance data is captured to produce monthly performance reports for submission to the GaPR Committees and Senior Leadership Mission Performance Review.

Action Plans

All non-compliances that are identified by our auditing process are raised at our monthly Governance and Performance Review (GaPR) meetings and assigned an action plan to ensure that ratifications are put in place. Non-compliances are logged on our Radar system and assigned to the relevant manager for completion as an Action Plan. By having a manager accountable for the Action Plan, we are able to ensure that it is continually tracked and updates to policies and processes are out in place within the outlined timeframes.

The requirements for Action Plans are detailed within our management system within BMS/1.04 – Action Plans. Non-conformities are assigned a priority within the system based on risk and compliance requirements. This priority then determines the target date for the Action Plan to be completed i.e.

- Critical – Normally within 5 working days (1 week) from date of issue
- Major - Normally within 20 working days (4 weeks) from date of issue
- Minor - Normally within 60 working days (12 weeks) from date of issue
- Observation - Normally within 120 working days (26 weeks) from date of issue

Reporting to Commissioners

We have invested heavily in our Information Management & Technology infrastructure that supports the delivery of our services. We have developed a fully integrated cloud-based system that includes:

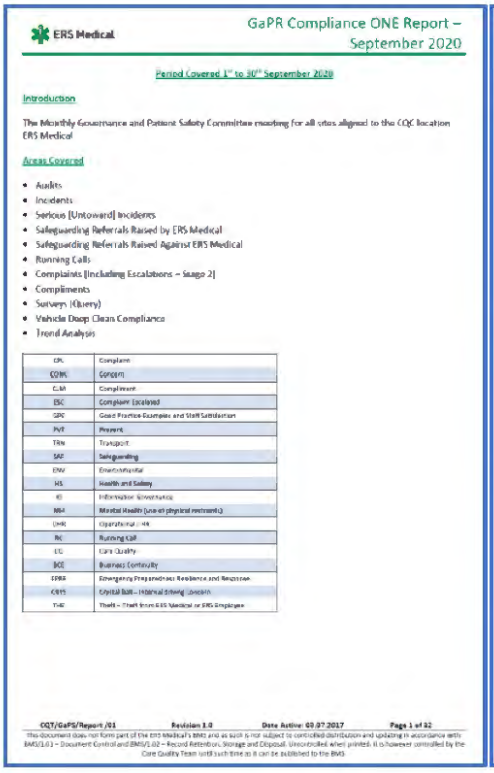
- Scheduling
- Communication and tracking for vehicles
- Data reporting and real-time information
- Call recording
- Compliance and incident management
- Audits
- Employee training and compliance

ERS Medical

> **"The provider had invested in six computer based business management systems to support various parts of their business which provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making."**
>
> **Quality Report, Care Quality Commission**

We will provide the Commissioners with a full overview of all aspects of our service on a monthly basis via our monthly reporting pack supported by our backing data. This ensure we develop our partnership approach by delivering an open and honest service that is fully transparent.

Further to providing our standard monthly report, which we call our 'ONE Report' we are also happy to discuss any bespoke reports that the Commissioners would like to receive on a monthly basis and add them into our reporting pack. Through monitoring and reporting on every aspect of our service we can use the information gathered to continually improve our service delivery and target any areas that require improvement.



ERS Medical GaPR Compliance ONE Report – September 2020

Period Covered 1st to 30th September 2020

Introduction

The Monthly Governance and Patient Safety Committee meeting for all sites aligned to the CQC location ERS Medical

Areas Covered

- Audits
- Incidents
- Serious [Untoward] Incidents
- Safeguarding Referrals Raised by ERS Medical
- Safeguarding Referrals Raised Against ERS Medical
- Running Calls
- Complaints [Including Escalations – Stage 2]
- Compliments
- Surveys (Query)
- Vehicle Deep Clean Compliance
- Trend Analysis

CPL	Complaint
CON	Concern
CLM	Compliment
ESC	Complaint Escalated
GPC	Good Practice Examples and Staff Satisfaction
PVT	Private
TRN	Transport
SAF	Safeguarding
ENV	Environmental
HS	Health and Safety
IG	Information Governance
MH	Mental Health (non-physical restraint)
OHR	Operational / HR
RC	Running Call
CQ	Care Quality
BCE	Business Continuity
EPRR	Emergency Preparedness Resilience and Response
CRYS	Crystal Ball – Internal Sharing Concern
THE	Theft – Theft from ERS Medical or ERS Employee

CQT/GaPS/Report /01 Revision 1.0 Date Active: 03.07.2017 Page 1 of 32

This document does not form part of the ERS Medical's BMS and as such is not subject to controlled distribution and updating in accordance with BMS/L01 – Document Control and BMS/L02 – Record Retention, Storage and Disposal. Uncontrolled when printed. It is however controlled by the Care Quality Team until such time as it can be published to the BMS.



ERS Medical GaPR Compliance ONE Report – September 2020

Radar Analytics Dashboard

Events (events on Radar over the last calendar month)

41 14 5.64 12.11

The average time to report in hours is up from

Event Risk Profile

4.60 1.98 2.36

The risk analytics is up from the

CQT/GaPS/Report /01 Revision 1.0 Date Active: 03.07.2017 Page 3 of 32

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Marketing and Communications Activity Matrix
Stakeholder engagement
Internal communication kick-off meeting with awarding trust
Identification of Key stakeholders, messages, timescales, communication, geography, (Print, website, displays, hospital TV Screen, SMS etc.
Information gathering - Phone number for bookings, hours of operation, geography. Can be gained through focus group meetings
Contract award announcement - if approved
Develop press release for Trust intranet (internal comms) re introductions - if appropriate
Board meeting up-dates
External regular press releases, social media activity and updates for Trust personnel - if required
Website updates
Arrange a walk-around introduction session
Design and preparation of patient survey
Joint awareness session for key stakeholders and community groups
External regular press releases, social media activity and updates for Trust personnel - if required
Board meeting up-dates
Website updates
Design internal and external signage
Preparation of marketing pack for existing patients. PALS leaflets eligibility criteria leaflet, patient appointment reminders etc.
Communication of complaints procedure
Website updates
External regular press releases, social media activity and updates for Trust personnel - if required
Distribution of collateral via appropriate channels
Deliver " walkaround" sessions
Awareness events in hospitals
Install correct signage
Board Meeting Updates
Set up marketing collateral portal
GO LIVE
On going support from ERS Medical comms team as required / additional updated marketing material
Access to Marketing collateral portal


Phase
On award of contract
5 Weeks from award date
7 Weeks required
3 Weeks required
4 weeks onwards
Indefinitely

PROGRAMME / PROJECT NO & NAME: **REPORTING DATE:**
WORKSTREAM: Mobilisation/Project Board **WORKSTREAM LEAD:**

TASK NO.	TASK	DUE DATE	OWNER	% COMPLETE	STATUS (RAG)	COMMENTS
1	**Start Up and Initiation**					
2	Project Board Set Up					
3	Scope of project agreed/Terms of reference					
4	Project plan agreed					
5	Communication Strategy/plan agreed					
6	Work streams & work packages agreed					
7	Project Kick off meeting held					
8	Project Board review meetings scheduled & agreed					
	Structure					
9	Risk & Issues Logs established					
10	Interim Reviews and Sign Off timetable agreed					
11	Interim review of progess by review of sites, IT, vehicles, process and procedures					
12	Final review of progress by review of sites, IT vehicles, process and procedures					
13	Final Sign Off					
14	Operation set up stage complete					
15	Transition Stage complete					
16	Project close					
17	Produce project closure report					
18	Agreed by project board					
19	Handover of risks and issues to settle team/business as usual					

WORK PACKAGE ACCEPTANCE

…… **WORKSTREAM LEAD** …… **PROJECT MANAGER**

Task Number	Department	Action Required	Start Date	Target Completion date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	GO LIVE
	HR	**TUPE process**																													
1	HR	TUPE process	01/02/2021	16/07/2021																											
2	HR	Due dilligence - type of employee and employees details	01/02/2021	05/02/2021																											
3	HR	Complete communications plan for TUPE staff	08/02/2021	05/03/2021																											
4	HR	Hold initial group meetings with all affected personnel	31/05/2021	25/06/2021																											
5	HR	Write to each employee with full details of the proposed transfer	08/03/2021	23/04/2021																											
6	HR	Hold an individual meeting with each employee	31/05/2021	16/07/2021																											
7	HR	Confirm trasfer arrangements with incumbent	01/02/2021	05/03/2021																											
8	HR	New contracts/ Job descriptions required	01/02/2021	16/07/2021																											
9	HR	Formulate and issue Measures Letter	01/02/2021	12/02/2021																											
10	HR	Send second measures letter and ensure that it has been distributed	24/05/2021	04/06/2021																											
11	HR	Confirm start dates	07/06/2021	18/06/2021																											
12	HR/Governance	Work with Governance work stream on training induction for all staff	15/03/2021	16/07/2021																											
13	HR	Identify Training requirements and compare to specification	01/03/2021	30/04/2021																											
14	HR	Induction	12/07/2021	16/07/2021																											
15	HR	Welcome packs	28/06/2021	16/07/2021																											
16	HR	Pension information for TUPE staff	12/07/2021	16/07/2021																											
17	HR	Project Team update	01/02/2021	16/07/2021																											
18	HR	Confirm DBS Checks	21/06/2021	16/07/2021																											
	Operations	**Staff**																													
19	Operations	drivers handbook	14/06/2021	16/07/2021																											
20	Operations	licence check	14/06/2021	16/07/2021																											
21	Operations	accident forms and procedures	14/06/2021	16/07/2021																											
22	Operations	insurance documents	14/06/2021	16/07/2021																											
23	Operations	review driver training given by incumbent	14/06/2021	16/07/2021																											
24	Operations	road risk assessment	14/06/2021	16/07/2021																											
	Operations	**Recruitment**																													
26	Operations	Analyse staffing gaps	25/05/2021	04/06/2021																											
27	Operations	Develop job descriptions (if required)	24/05/2021	04/06/2021																											
28	Operations	Place role adverts	07/06/2021	11/06/2021																											
29	Operations	Screen applications	14/06/2021	18/06/2021																											
30	Operations	Arrange interviews	21/06/2021	25/06/2021																											
31	Operations	Interviews	28/06/2021	09/07/2021																											
32	Operations	Process DBS applications	12/07/2021	16/07/2021																											
33	Operations	Appoint successful candidates	12/07/2021	16/07/2021																											
34	Operations	Develop and sign contracts	12/07/2021	16/07/2021																											
	Compliance	**Ambulance Crew - Core Training**																													
35	Compliance	Arrange meeting to discuss any specific training requirements (DNAR, Scoop Str etc)	24/05/2021	28/05/2021																											
36	Compliance	Hold training requirements meeting	30/05/2021	04/06/2021																											
37	Compliance	Develop training material to include area specific training	31/05/2021	11/06/2021																											
38	Compliance	Produce staff training packs	31/05/2021	11/06/2021																											
39	Compliance	Develop training packs	31/05/2021	11/06/2021																											
40	Compliance	Develop training schedule for each employee	14/06/2021	16/07/2021																											
41	Compliance	Arrange training resource	14/06/2021	16/07/2021																											
42	Compliance	Confirm training locations	14/06/2021	16/07/2021																											
43	Compliance	Notify trainees of training dates	14/06/2021	16/07/2021																											
44	Compliance	Deliver training courses	14/06/2021	16/07/2021																											
45	Compliance	Develop hard copy training records for all employees	14/06/2021	16/07/2021																											
46	Compliance	Upload qualifications to system for each employee	14/06/2021	16/07/2021																											
47	Compliance	Arrange re-test for any course module failures	14/06/2021	16/07/2021																											
48	Compliance	Consult with HR re consistent failures and determine course of action	14/06/2021	16/07/2021																											
	HR	**Workforce relations**																													
49	HR	Meet key leadership positions within workforce	01/02/2021	05/02/2021																											
50	HR	Agree Terms of reference for workforce meeting	01/02/2021	05/02/2021																											
51	HR	Agree first dates for workforce meeting	01/02/2021	05/02/2021																											
	Marketing	**External communications**																													

52	Marketing	Develop press releases for intranet (plus other media) re introductions	01/02/2021	12/03/2021
53	Marketing	Develop schedule for weekly progress meetings with each Trusts management	01/02/2021	05/02/2021
54	Marketing	Regular press releases and intranet updates for Trust personnel	01/02/2021	16/07/2021
55	Marketing	Arrange familiarisation Introduction sessions	01/02/2021	16/07/2021
56	Marketing	Develop supporting material for familiarisation sessions	01/02/2021	19/02/2021
57	Marketing	Deliver "walk-around" sessions	22/02/2021	12/03/2021
58	Marketing	Phone numbers for bookings	22/02/2021	26/02/2021
59	Marketing	Website updates	01/02/2021	16/07/2021
	Operations/HR	**Information Handover**		
60	Operations	Identify existing bookings from incumbent provider	07/06/2021	16/07/2021
61	HR	Request and receive data personnel files from incumbent provider	17/05/2021	16/07/2021
62	HR	Request details of pre-booked annual leave and scheduled absences post transfer	17/05/2021	16/07/2021
63	HR	Receive details of annual leave	17/05/2021	16/07/2021
	HR	**Feedback/Complaints Comms**		
64	Operations	Liaise with Commissioners to develop commincation plan	01/02/2021	12/02/2021
65	Operations	Deliver communications plan	15/02/2021	16/07/2021
66	Operations	Develop patient/user surveys	15/02/2021	16/07/2021
67	Marketing	Welcome pack for existing patients	15/02/2021	16/07/2021
68	Marketing	Appointment reminder service	15/02/2021	16/07/2021
69	Marketing	PALS leaflet detailing service to be reviewed	15/02/2021	16/07/2021
70	Marketing	Compaints procedure	15/02/2021	16/07/2021
71	Marketing	Contract award announcenement	01/02/2021	05/02/2021
72	Marketing	Provide marketing material to advetise new service and contact centre number	28/06/2021	16/07/2021
73	Marketing	stakeholder enagement events in hospitals	28/06/2021	16/07/2021
	Finance	**Contract**		
74	Finance	Confirm KPIs with Commissioners	01/02/2021	16/07/2021
75	Finance	Confirm invoice dates	01/02/2021	16/07/2021
76	Finance	Agree invoice terms	01/02/2021	16/07/2021
77	Operations/ Finance	Agree management information requirements	01/02/2021	16/07/2021
78	Operations	Confirm eligibility criteria	01/02/2021	16/07/2021
	IT	**Systems, comms and hardware**		
79	IT	Agree IT requirements and SLA with Solve - IT	01/02/2021	16/07/2021
80	IT	Ensure integration with Staffordshire service users	01/02/2021	16/07/2021
	Operations	**Call Centre**		
81	IT	Configure call centre	31/05/2021	25/06/2021
82	IT	Agree scrips and eligiblity with CCGs	28/06/2021	16/07/2021
83	IT	Training call centre operatives	28/06/2021	16/07/2021
84	IT	Test system	14/06/2021	16/07/2021
	Operations	**System requirements**		
85	Operations	With Commissioners determine any specific data capture requirements	15/03/2021	14/05/2021
86	Operations	Feed requirements back to IT for system development/ report creation	15/03/2021	14/05/2021
87	IT	Create required reports as per information specified	15/03/2021	14/05/2021
88	Operations	Test reports for completeness and sign off	15/03/2021	14/05/2021
89	Operations	Agree process for confirming journey to patients prior to appointment	15/03/2021	14/05/2021
90	Operations	Agree appointment reminder solution	15/03/2021	14/05/2021
91	Operations	Agree requirements for reminder solution	15/03/2021	14/05/2021
	IT	**Order Hardware and Comms**		
92	IT	Final assessment of hardware requirements	15/03/2021	14/05/2021
93	IT	Order: desktop PCs, Laptops, routers, network components, PDAs, mobile dongles	15/03/2021	14/05/2021
94	IT	Meet with server providers to discuss new capacity and speed requirements	15/03/2021	14/05/2021
95	IT	Final assessment of comms system requirements	15/03/2021	14/05/2021
96	IT	Order: Telephone system for call centre, ADSL lines, mobile phones	15/03/2021	14/05/2021
	IT	**Configuration**		
97	IT	Configure PCs	24/05/2021	16/07/2021
98	IT	Configure Laptops	24/05/2021	16/07/2021
99	IT	Configure Tablet devices	24/05/2021	16/07/2021
100	IT	Identify format of bookings from current provider	24/05/2021	16/07/2021
101	IT	Test hospital firewall allows access to booking system	24/05/2021	16/07/2021
102	IT	Configure PTS Online booking system	24/05/2021	16/07/2021

GO LIVE 1st August 2021

Contingency Period

| | | |

155	Operations	Take measurements for all staff uniforms	17/05/2021	28/05/2021
156	Operations	Order uniforms	31/05/2021	04/06/2021
157	Operations	Take delivery and distribute	28/06/2021	16/07/2021
158	Operations	Take photo and produce ID Cards	28/06/2021	16/07/2021
	Operations	**Policies procedures**		
159	Operations	Check with Trusts for local amendments to current company policies i.e. DNAR Policy	07/06/2021	25/06/2021
160	Operations	Check any site-specific procedures required	07/06/2021	25/06/2021
161	Operations	Draft site-specific procedures	07/06/2021	25/06/2021
162	Operations	Provide Trusts and Commissioners with full policy suite for review	07/06/2021	25/06/2021
163	Operations	create (in hard copy) full suite of policies to be held at contract locations	21/06/2021	16/07/2021
164	Operations	Deliver hard copies to contract sites	12/07/2021	16/07/2021
	Compliance	**Governance, Risk Management and Compliance**		
165	Compliance	Training/Induction	17/05/2021	16/07/2021
166	Compliance	Arrange induction for ambulance crews	17/05/2021	16/07/2021
167	Compliance	Arrange induction for outside organistions	17/05/2021	16/07/2021
168	Compliance	Develop site specific H&S training and reference material	17/05/2021	16/07/2021
169	Compliance	Agree IOSH "Supervising H&S" course dates course dates for manager	17/05/2021	16/07/2021
170	Compliance	Deliver induction days	17/05/2021	16/07/2021
171	Compliance	Sign-off induction competencies	17/05/2021	16/07/2021
172	Compliance	Compile list of outstanding training needs for staff (Drivers)	17/05/2021	16/07/2021
173	Compliance	Upload competencies and expiries into system	17/05/2021	16/07/2021
	Operations	**Sub-contractors**		
174	Operations	Identify potential sub-contractors	17/05/2021	18/06/2021
175	Care Standards	Complete MOU	21/06/2021	16/07/2021
176	Care Standards	Complete due dilligence	21/06/2021	16/07/2021
177	Care Standards	Enter into contract and agree rotas	12/07/2021	16/07/2021
178	Care Standards	Identify Volunteer Drivers	17/05/2021	18/06/2021
179	Care Standards	Train Volunteer Drivers	21/06/2021	16/07/2021
180	Care Standards	Agree contract with volunteer drivers organisation	21/06/2021	16/07/2021
181	Care Standards	Identify suitable taxis	17/05/2021	18/06/2021
182	Care Standards	Conduct due dilligence on Taxis	21/06/2021	16/07/2021
183	Care Standards	Agree Contract with taxi organisation	21/06/2021	16/07/2021
	Operations	**Premises**		
184	Operations	Site specific risk assessments	28/06/2021	16/07/2021
185	Operations	Pat testing	28/06/2021	16/07/2021
186	Operations	Develop Equipment register	28/06/2021	16/07/2021
187	Operations	Install correct Signage	28/06/2021	16/07/2021
188	Operations	DSE assessments	28/06/2021	16/07/2021
189	Operations	Complete COSHH assessments	28/06/2021	16/07/2021
	Compliance	**Compliance**		
190	Compliance	Register local service manager and contract site with CQC	28/06/2021	16/07/2021
191	Compliance	Agree training dates for local managers and supervisors on compliance arrangements	28/06/2021	16/07/2021
192	Compliance	Deliver training session on compliance structure (ISO, CQC, H&S)	28/06/2021	16/07/2021
	Finance	**Finance**		
193	Finance	Sub Account set up	01/02/2021	26/02/2021
194	Finance	Service Area Created	01/02/2021	26/02/2021
195	Finance	Customer Account set up	01/02/2021	26/02/2021
196	Finance	Finance contact details	01/02/2021	26/02/2021
197	Finance	Review Pricing schedule - Fixed Fees and additional work	01/02/2021	26/02/2021
198	Finance	Billing frequencies	01/02/2021	26/02/2021
199	Finance	Invoice style	01/02/2021	26/02/2021
200	Finance	Backing docs	01/02/2021	26/02/2021
201	Finance	Special requirements - SBS	01/02/2021	26/02/2021
202	Finance	Payment terms	01/02/2021	26/02/2021
203	Finance	Purchase order system set up	01/02/2021	26/02/2021
204	Finance	Initial Meeting with Finance contact and project manager	01/02/2021	26/02/2021
205	Finance	Purchase order system training to be arranged	14/06/2021	25/06/2021
206	Finance	Purchase order training to be delivered	28/06/2021	16/07/2021
207	Finance	Authorisation Limits	15/03/2021	30/04/2021

208	Finance	Petty Cash	15/03/2021	30/04/2021
209	Finance	Expenses	15/03/2021	30/04/2021
210	Finance	Order credit cards	15/03/2021	30/04/2021
211	Finance	Implementation Costs recorded	01/02/2021	16/07/2021
	IT	**Cleric**		
212	IT	Desktop set up for Cleric in the Transport office	21/06/2021	16/07/2021
213	IT	Training for staff/ call handlers/ drivers	21/06/2021	16/07/2021
214	IT	Order big TV for GANTT screen in office	17/05/2021	21/05/2021
215	IT	Order Handheld devices	17/05/2021	21/05/2021
216	IT	Test run with Driver	21/06/2021	16/07/2021
217	IT	Test of data extraction	21/06/2021	16/07/2021
218	IT	Test of KPI reports	21/06/2021	16/07/2021
219	IT	Adhoc Pricing schedule for additional work outside of contract	21/06/2021	16/07/2021
220	Operations	Negotiate cross border arrangements with neighbouring providers	07/06/2021	16/07/2021
221	Operations	Pass cross border agreement information to IT lead to input into Cleric	07/06/2021	16/07/2021
222	Operations	Request incumbent to distribute patient information leaflets during last 2 weeks of contract to patients.	07/06/2021	16/07/2021
223	Operations	Discuss transition of go live day with incumbent and agree plan of action	07/06/2021	16/07/2021
224	Operations	Deliver transition plan	01/02/2021	16/07/2021
	Operations	**Operational Readiness**		
225	Operations	Ensure all members of management team are split between locations on go live day	12/07/2021	16/07/2021
226	Operations	Ensure additional resources are in place for go live	12/07/2021	16/07/2021
227	Operations	Ensure all rota's are printed	12/07/2021	16/07/2021
228	HR	Request further due diligence data	28/06/2021	16/07/2021
229	HR	HR meet with each Trusts HR team	28/06/2021	16/07/2021
230	HR	Consider PHI Coverage for staff	28/06/2021	16/07/2021
231	HR	Arrange Pension cover for staff	28/06/2021	16/07/2021
232	HR	Appoint personnel and issue contracts	28/06/2021	16/07/2021
233	Marketing	Patient Survey	17/05/2021	11/06/2021
234	Marketing	Sorry We Missed You postcard	17/05/2021	11/06/2021
235	Marketing	Posters	17/05/2021	11/06/2021
236	Marketing	Frequent User Comms	17/05/2021	11/06/2021
237	Marketing	Nursing Home comms	17/05/2021	11/06/2021

Risk Register

Project name: Provision of Non-Emergency Patient Transport Services
Project Manager:

ID	Date raised	Risk description	Likelihood	Severity	Owner
1		There is a risk that staff may choose not to TUPE on contract start day.	Med	High	Project Manager
2		There is a risk that compliance checks are not up to date (DBS, Drivers Licence, Job reference etc). Leading to risk of patient safety and CQC audit failure.	Med	High	Project Manager
3		There is a risk that gaps in staff training cause issues in quality of delivery and patient safety.	Low	High	Project Manager
4		There is a risk that gaps in recruitment left from the incumbent provider have a negative impact on service delivery. Especially in the early stages of the contract go live.	High	High	Project Manager
5		There are risks that patient journey information passed over from the incumbent provider is incomplete leading to a negative impact on service delivery.	Med	High	Project Manager

6		Premises not transferring	Med	Med	Project Manager
7		IT not being in place for start of contract at new facility	Low	Med	Project Manager
8		Hospital Firewall not allowing access to portal	Low	High	Project Manager
9		There is a risk of IT failure leading to a negative impact on service delivery.	Low	High	Project Manager
10		There is a risk that delays in vehicle build will lead to insufficient vehicles at the start of the contract.	Low	High	Project Manager
11		There is a risk that stakeholders do not engage in communication with ERS. This could lead to frustrations within the healthcare community and important details relevent to each stakeholder being missed.	Low	Med	Project Manager

12		Patients continuing to use old contact details	Med	Med	Project Manager

Mitigating action	Contingent action
Work with CCGs and incumbent providers to ensure effective and supportive continual engagement throughout the mobilisation period. A prior understanding of the staff their roles and responsibilities puts ERS at and advantage an reduces risk on the project.	Work with CCGs quality team and CQC to ensure accurate and realistic timelines for completion are in place. Monitor and report continuous improvement plan to gauge progress of actions.
HR Team manager to check all staff files for gaps in compliance checks. Audit against CQC standards.	Work with CCGs quality team and CQC to ensure accurate and realistic timelines for completion are in place. Monitor and report continuous improvement plan to gauge progress of actions.
Full audit of training records to provide training gap analysis (reliant on incumbents sharing training records risk line 1). ERS training manager to put together package to address gaps within realistic timescale.	Individuals identified and removed form the service until fully trained. Staff gaps filled by ERS adhoc staff as risk line 4.
Analysis of staff numbers against future shift pattern. Gaps identified and recruited for using ERS recruitment process. Additional bank staff recruited to allow for unexpected drop outs from the TUPE process.	Staff from ERS adhoc will be on standby to cover shifts from go live day onwards.
Work with incumbent providers and CCGs to ensure a timely handover of data. Work with acute transport teams to check data accuracy and test system resilience prior to go live.	Liaison with acute transport teams, community healthcare providers and PTAC to ensure all patients are accounted for. Use contingency vehicles to pick up patients that have been missed off the system and require transport at the last minute.

Early engagement with incumbent and premises landlords	Identify alternative premises as contingency and prepare our Leeds and Mansfield premises to deliver contract if required.
Work with incumbent provider to allow access to facilities prior to go live to test and implement IT infrastructure	Redirect all calls and bookings to our Head Office in Leeds
Identify Firewall issues early in mobilisation to allow for IT to provide resolution	Have in place alternative communication methods
A carefully managed IT project implementation using local contractors and liaising with key stakeholders (PTAC, Trusts) throughout. A comprehensive testing phase prior to go live.	Comprehensive, well briefed contingency plans in the event of any IT failure.
Realistic timescales for the vehicle build set with the vehicle converter. Weekly progress meetings with converter to update Project Board.	We have already identified hire companies to provide contingency vehicles if required until our full fleet is available.
ERS will establish good relationships with the key stakeholders. Stakeholders will be invited onto the project board and be updated regularly on the projects progress. This will also enable their input into the planning and execution of the project.	Points relevant to individual stakeholders will be picked up through NEPTS forum and added to the continuous improvement plan. The continuous improvement plan will be reported on monthly to the CCGs.

Marketing will fully advertise the new service throughout the region.	We will also work with incumbent to provide phone message on old number sign posting to new contact details

Progress on actions	Status
	Open
	Open
	Open
	Open
	Open

	Open
	Open
	Open
	Open
	Open
	Open


Open

Question 1.20.1

Mobilisation Plan 2%

Please provide details of your plan to mobilise for August 2021 and mobilisation for the additional activity in April 2022. The plan must detail the key tasks and milestones on a week-by-week basis the bidder will complete during and post the mobilisation period to deliver the services in accordance with the contract.

Word Count 500 plus Project Plan

Total Word Count: 466

Our mobilisation plan is based upon our 'standard' processes, and outlines key activities and milestones based on the specific needs of the Authority.

We have provided a Mobilisation plan based upon a 26-week timescale (01/02/21 – 01/08/21).

Mobilisation Experience

The ERS Management Team have experience in implementing complex operational projects, under strict financial and time constraints, recent examples are:

- In November 2019 we retained our Norfolk contract
- In November 2019 we completed the successful mobilisation of Homerton University Hospital NHS Foundation Trust NEPTS contract.
- In December 2019 we completed the successful mobilisation of Nottinghamshire & Bassetlaw CCG's NEPTS contract

All timelines and targets were met by using our robust and structured mobilisation methodology outlined below.

Mobilisation Phase	Key Tasks
1	This is a kick-off phase, where we focus on relationship-building, tying up contractual matters including KPIs, and agreeing SLAs/SOPs. This phase also includes liaising with the current incumbent providers and beginning the TUPE process, recruitment, ordering vehicles, securing business premises, ordering the relevant technology etc
2	Phase 2 is an operationally-led phase, which includes gathering and sense-checking data, setting up Authority IT systems, stress-testing our SOP and service model, performing any necessary Duty of Care audits, auditing and ordering consumables
3	This is the final phase, during which equipment is delivered and ERS Medical performs a sign off of the Mobilisation activities (for example, performing 'dry runs' and stress-testing customer service and IT systems).

The mobilisation plan is reviewed weekly during every stage to ensure all aspects are completed in the timeline dictated.

The Mobilisation Project Team will meet weekly throughout the Mobilisation period, in order to:

a) Report on tasks completed

b) Share any challenges and seek input from their colleagues

c) Receive feedback from the Authority via the Contract Manager.

Mobilisation team

All of the departments shown below are involved in the tender response and mobilisation process:



Mobilisation activities (Summary)

Phase 1: Key activities

- Immediately after the standstill period, key personnel including the Business Relationship Manager, the Regional Manager and representatives from the Authority will meet to work through the mobilisation plan and agree the Mobilisation timeline.
- Our HR Director will engage with all employees eligible for TUPE and start the consultation period.
- Any additional recruitment requirements will be started at this stage, including interviews, DBS checks, requesting references and driving licence checks.
- All vehicles will be ordered
- Premises will be secured in the key areas identified.

Phase 2: Key activities

- All employee training will commence and be completed

- All pricing schedules and contract requirements will be set up
- Audits and health & safety checks will be carried out and completed
- The Authority will be invited to visit our facilities for audit purposes
- Data is acquired, incorporated into our system and sense checked
- Analyse the data provided by the incumbent and rationalise our service accordingly
- Set up a Cleric account for the Authority, so that all communications are recorded and auditable
- Set up a customer portal

Phase 3: Key activities

- Uniforms, equipment and consumables will be delivered to our facility
- Familiarisation programme at each of the hospitals prior to go live
- Go-Live
- A final mobilisation report will be submitted showing all tasks have been achieved to the agreed timelines.
- Although the mobilisation of the contract has concluded there will be continuous reviews of the service at the monthly contract review meetings to ensure the service provided meets the requirements of the specification. The mobilisation team will continue to be present for a minimum of 6 months or until an agreed date with the Trust.

Question 1.20.2

Mobilisation risk register 1%

Please provide your mobilisation risk register including monitoring arrangements control measures and mitigating actions (in the form of a SMART action plan).

Monitoring arrangements

Mobilising an NEPTS service involves ERS Medical's Commercial, Operational, Compliance/Environment and Sustainability, IT, Customer Support and Human Resources teams, as well as Legal and Procurement colleagues.

In order to streamline the process, we therefore set up a core Mobilisation Project Team, made up of representatives from the Commercial, Operations and Compliance teams, who liaise with – and cascade information to – relevant colleagues in the wider business. The Mobilisation Project Team will meet at least weekly throughout the Mobilisation period, in order to:

a) Report on tasks completed

b) Share any challenges and seek input from their colleagues

c) Receive feedback from the CCGs via the Contract Manager.

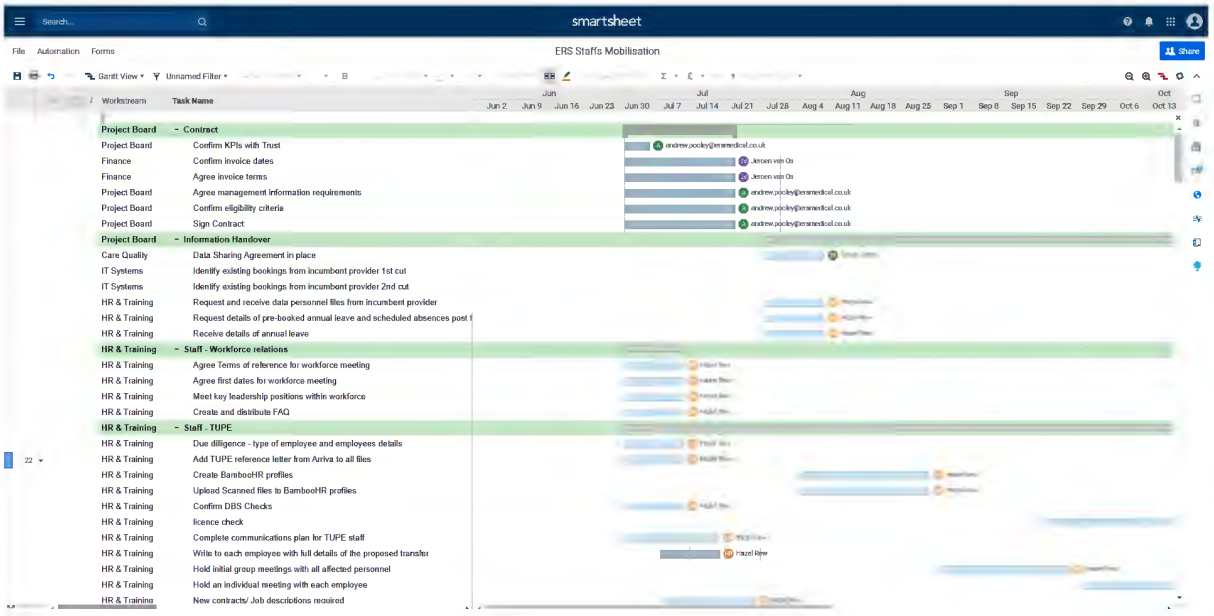
The CCGs Mobilisation Project Team will be headed up by your dedicated Project Manager ***REDACTED***, who will coordinate activities, announce the beginning of the next Phase, etc. Tom will remain in regular and meaningful communication with the CCGs, including scheduling meetings to ensure representatives are fully informed as to the progress of Mobilisation activities.

At the end of each Phase, and before the next can begin, the Mobilisation Project Team reports on their activities and confirms that all tasks have been carried out satisfactorily.



SMART Action Plan

To ensure we deliver a mobilisation plan that is Specific, Measurable, Achievable, Realistic and Time restricted we utilise a dedicated mobilisation team and Smartsheets. Immediately following the contract award, we will arrange a meeting with the Commissioners to go through our mobilisation plan to ensure not only that the timeframes are achievable, but to get the full buy in of the CCGs enabling partnership working throughout. Smartsheets allows us to ensure all involved in the contract mobilisation are aligned to the same goals and are working in unison to deliver the end goal, which in this case is a successful mobilisation.



By assigning the relevant specialists to specific tasks the project manager is able to monitor and manage the progress of each task in real time. They are also able to provide reminders and prompts when a task is nearing its deadline to ensure that it is completed on time. Throughout the mobilisation a weekly meeting will be held to go through the mobilisation tasks and understand any potential roadblocks early so they can be mitigated. By having these control measures in place, we are able to deliver a smooth mobilisation that ensures continuity of service to both the patients and Commissioners.

This methodology has a proven track record of delivering successful service mobilisation of a similar scale to this one.

ERS Medical

Question 1.21.1

Resource plan

Please provide details of your proposed resource plan to meet the requirements of the Contract including current resources available, future resources proposed, staffing structure (operational/management/clinic-al/non-clinical) and justification for the number of staff in each role.

ERS is managed through a decentralised leadership model which empowers local staff to make quick decisions in a controlled environment. The central management consists of the Board and Leadership team which encompasses subject matter experts in all relevant areas such as Human Resources, Care Standards, Health and Safety, Information Systems and Business Intelligence, Fleet, Sales & Marketing and Finance. Support for local contract management is provided through comprehensive integrated software solutions, the aforementioned subject matter experts and third-party expertise.

Within the management structure, we identify several roles which will be dedicated to the operational support of the contract:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

The operational roles have been determined through our comprehensive solution design model identifying resource requirements and shift patterns. The above staffing structure takes into account the entire TUPE obligation with a view to convert zero hours staff to full time roles for resilience. We believe we can keep resource levels stable throughout the contract by increasing efficiency mitigating journey volume increases.

% split of employee type (i.e. permanent, fixed term, interim, secondees, agency workers)

ERS Medical has 4 separate types of on the road staff who work and provide services on behalf of the Company:

- Full Time Employees [redacted]
- Part Time Employees [redacted]
- Zero Hour Employees [redacted]
- Volunteers [redacted]

All staff members are employed on a permanent basis as per the TUPE schedule and supported by 3rd party taxi providers and subcontracted ambulance providers.

Contingency arrangements

We have a Business Continuity Plan that is aligned with ISO-22301 and 22313 and mirrors the requirements of NHS England's Core Assessment Standards for Emergency Planning Resilience and Response (EPRR). To ensure we continually have the required number of crews to deliver an effective, safe and efficient NEPTS service we maintain:

- [redacted] hours of staff resilience per week (shown in Staff rota spreadsheet).
- A national team of [redacted] bank staff
- Cross-trained staff that can be deployed to cover all service aspects
- A national ad hoc crew network that has the capability to surge where required representing [redacted] of the total company capacity.

Question 1.21.2

Resource plan – Responsibility / accountability

Please provide details of your proposed lines of responsibility and accountability for staff.

ERS will have a strong management structure with clear lines of responsibility. All ACA's will report to their Team Leaders or Operations Manager. They will in turn report to the Senior Operations Manager who has overall responsibility for the delivery of the service. The Senior Operations Manager will report directly to our Head of Operations.

Our recent CQC inspection rated as 'Good' made the following reference:

"The provider had invested in six computer-based business management systems to support various parts of their business which provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making"



Leadership Team – Overall responsibility for the Business

Have overall responsibility for setting and directing quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Also responsible for setting ERS objectives and allocating adequate resources to meet those objectives.

Regional & Operations Managers – Contract Management and Financial accountability of contracts

Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations. They ensure the contract is delivered in line with the specification and meets all KPI requirements and are held accountable at monthly performance review meetings.

Team Leaders – Staffing rotas and vehicle maintenance

Are responsible for ensuring all rotas are filled and vehicles are maintained to the standards required to deliver a safe and effective service. They provide the day to day management of our crews ensuring they have the support they need to deliver an efficient and effective service day in day out. They are held accountable through weekly compliance and KPI report meetings with the Operations Manager.

Crews – Representation of the business, patient care, service quality

The crews are responsible for delivering a high-quality, compassionate and caring service to patients. They are required to uphold the standards of both ERS Medical and the CCGs in the way they behave and deliver the service. As the face of this contract it is crucial that they behave appropriately at all times. They are directly managed by their Team Leaders when ensure they are adhering to policies and processes at all times.

Question 1.21.3

Safe staffing levels

Please detail your proposed staffing levels including your justification for these levels.

Word count 750

Total Word Count: 748

ERS is managed through a decentralised leadership model which empowers local staff to make quick decisions in a controlled environment. The central management consists of the Board and Leadership team which encompasses subject matter experts in all relevant areas such as Human Resources, Care Standards, Health and Safety, Information Systems and Business Intelligence, Fleet, Sales & Marketing and Finance. Support for local contract management is provided through comprehensive integrated software solutions, subject matter experts and third-party expertise.

Our operational structure for this contract is:



The staffing levels we have outlined includes 20% additional resource to cover holiday, sickness and unplanned absences. This ensures we can continually deliver a high-quality service.

Our staffing levels are achieved through detailed analysis of the data provided and using our experience in delivering services of a similar size in Nottinghamshire and Norfolk.

They key considerations we apply to understand the requirements and feasibility of the service delivery are:

- Patient journey concentration by area
- Patient mobility demands
- Patient journey and return mileage
- Booked Journey times

The key metrics that drive our service solution are:

- Average patients per journey
- Average mileage per journey
- Mobility determining vehicle and crew requirements
- Anticipated calls from patients and trust staff

Our analysis produced the following shift patterns:

Monday to Friday vehicle shifts



Monday to Friday crew shifts

[redacted]

Saturday vehicle shifts

[redacted]

Saturday crew shifts





Sunday vehicle shifts

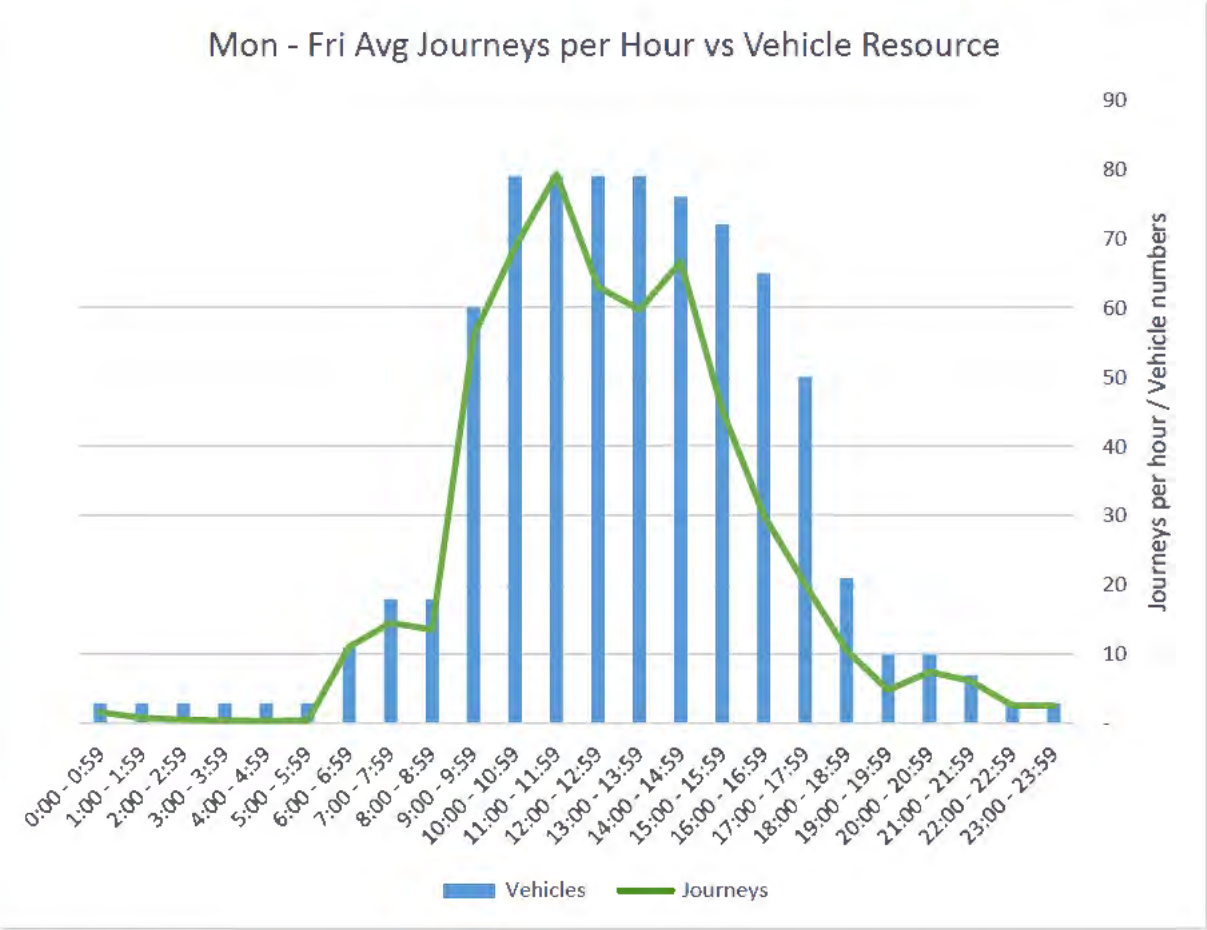


Sunday crew shifts





The below graph shows the number of vehicles we have on shift against the number of required journeys per hour. As you can see, we have ensured that we have capacity to deliver the service and effectively manage any peaks in demand.



Meeting Demand

Our service modelling approach has successfully been implemented throughout the UK delivering high quality services to the NHS. To ensure continued service quality during the life of the contract we will continually monitor our delivery and work with the CCGs to identify any changing needs. By identifying these early, we can put resource in place to ensure continuity of service.

Through analysing the data set provided we have been able to tailor our service model to ensure that our staffing and resource rota mirrors the peaks in daily demand without compromising on quality. Our 20% inbuilt resilience provides us with the ability to absorb spikes in demand within our service to ensure service quality. Additionally, we also have a pool of bank staff that can surge into a specific area should they be required.

To further ensure we deliver a robust service to the CCGs we will have an agreed number of compliant subcontractors that can be called upon to assist in delivering the service if required.

Efficient and effective staff management

To ensure we continually have the required number of crews to deliver an effective, safe and efficient NEPTS service we maintain:

- [redacted] hours of staff resilience per week
- A national team of [redacted] bank staff
- Cross-trained staff that can be deployed to cover all service aspects

Contract Staffing

Workforce is one of the key aspects of maintaining service continuity and is at the core of everything we do. We understand that a key risk to service delivery is not having the required number and quality of operational staff. This can be down to several factors including staff deciding not to TUPE transfer over from the incumbent, staffing gaps not being filled by previous supplier, large skills gaps identified during skills audit and absenteeism.

To mitigate the potential for staff not TUPEing across during the mobilisation period we will work closely with the CCGs and incumbent service provider to ensure effective and supportive continual engagement with staff throughout the mobilisation period. This allows us to identify early any individuals who do not wish to transfer and therefore we can begin our recruitment campaign to ensure the positions are filled prior to the contract go live day.

To mitigate against staff turnover and absenteeism we place our staff at the centre of everything we do to ensure they are motivated and dedicated to delivering a high-quality service. We believe that open and honest communication to current and transferring staff provides confidence in what can be an unsettling time.

ERS have a structured training and development programme that is vital for our staff's competence, confidence and retention. Our training and development programme empowers staff members to continually develop throughout their careers resulting in a high level of staff retention. All new and transferring staff will receive full training to ensure we mitigate any training gaps we identify.

Question 1.21.4

Resource changes

Please detail how you will ensure your resource plan will be capable of meeting increases or spikes in demand and increases in staff absences without compromising quality.

Word count 750

Total Word Count: 680

Our solution design is modelled on existing county wide services in Norfolk and Nottinghamshire. The following key elements allow us to deliver a flexible and equitable service to patients:

Comprehensive data management – Inherent to our value proposition is [redacted] which plans, operates, manages and reports on our ambulance operations. All journeys are timestamped at every relevant action from the crew leaving base to pick up and drop off of patient. This allows our planner and dispatcher to actively manage our whole resource in real time to maximise its efficiency and ability to successfully manage peaks and troughs in demand.

Sustainable resource provision – Our service model is based on delivering a sustainable service that will deliver effective and efficient patient transport every day/every year. Our core resource of [redacted] vehicles and crew are designed to meet the forecast transport needs. Supported by [redacted] resilience vehicles, bank staff, material sub-contractors, volunteer groups and taxis, a flexible and responsive service will ensure we deliver on-time/every-time.

Flexing our scope of operations – Our detailed service model has accounted for the daily, weekly and monthly changes in service demand and has resourced the service accordingly. Further to this we also have [redacted] sites within the Midlands and additional sites further north that we are able to mobilise additional vehicles from. We also have agreements in place with [redacted] subcontractors that can be called upon during peak times.

Managing demand

To ensure we deliver a service that is efficient, effective and sustainable we have conducted a detailed analysis of the data provided. Through analysing the time, day and seasonality of the journeys we have developed a service model that will meet the requirements of the service considering peaks in demand. The below table and graphs provide a summary of the resource we will utilise to deliver this service and how it meets demand.

Managing absences

Our HR management system records all absences and vacancies to allow our operations team to effectively manage our work force.

All holidays are planned and authorised by the operational team through our HR system BambooHR. To ensure we maintain service quality we only allow a certain amount of staff to take holiday at a time. At peak times such as the Christmas period we minimise the number of holidays allowed.

Our HR system has robust sickness and absence monitoring processes and identifies any individuals with high levels, which is then investigated by the operations team to understand why and put any required mitigation in place. Our HR team are also understanding and compassionate to those who require long periods of absence and have a fully supported Return to Work process in place. Further support is provided to our staff and their families through our partnership with [redacted] our Employee Assistance Programme which provides help with work-life stresses, family issues, financial concerns, legal concerns etc.

> "The provider had invested in six computer based business management systems to support various parts of their business which provided real time reporting of information which allowed senior managers to track business performance, staff accountability and supported decision making."
> Quality Report, Care Quality Commission

Unplanned absences or spikes in demand

We have a Business Continuity Plan that is aligned with ISO-22301 and 22313 and mirrors the requirements of NHS England's Core Assessment Standards for Emergency Planning Resilience and Response (EPRR). To ensure we continually have the required number of crews to deliver an effective, safe and efficient NEPTS service we maintain:

- [redacted] hours of staff resilience per week
- [redacted] hours of overtime per week resilience
- A national team of [redacted] bank staff
- Cross-trained staff that can be deployed to cover all service aspects
- A national ad hoc crew network that has the capability to surge where required representing [redacted] of the total company capacity.

Subcontractors

We currently have Memorandums of Understanding (MOU) with [redacted] NEPTS transport providers within the midlands who can be called upon to deliver safe, efficient and compliant transport if required. During the mobilisation period we will identify additional local NEPTS subcontractors that can be called upon should they be required.

All subcontractors will have due diligence carried out on them before any agreement is put in place. Following a successful due diligence process, we will agree an SLA with our subcontracting partners that targets them to the same KPIs that we are targeted to by the Commissioners.

ERS Medical

Question 1.21.5

Staff working patterns

Field Please describe for all Clinical Staff you propose to employ details of:

Planned working patterns and Contractual hours

The percentage of non-clinical (administration) time included in the total working time, intended pay policy and proposed levels of pay for each grade of staff.

Word count 750

Tatal Word Caunt: 522

Through our analysis of the data we have identified that these working patterns ensure we deliver a sustainable and high-quality service that meets all of the CCGs requirements. To deliver the service to a high standard we envisage all TUPE identified staff are required. Within the identified TUPE list there is a group of zero-hour contract staff which we would look to offer full time permanent positions ensuring reliability of services.

Through a range of structured and planned working patterns our dedicated pool of [redacted] PTS ACA's, [redacted] UCA's and [redacted] Paramedic trained staff will cover the contracted working hours outlined in the specification.

Operational Clinical Staff

Contractual hours	Ambulance Care Assistants (ACA)	Urgent Care Assistants (UCA)	Paramedics
37.5 hours per week	[redacted]	[redacted]	[redacted]
40-42 hours per week	[redacted]	[redacted]	[redacted]
Part time	[redacted]	[redacted]	1
Bank staff	[redacted]	[redacted]	[redacted]

Non-clinical Staff

Contractual hours	Management/Team Leaders	Control/Liaison/Call Centre/Admin
37.5 hours per week:	[redacted]	[redacted]
40-42 hours per week:	[redacted]	[redacted]
Part time	[redacted]	[redacted]
Bank staff	[redacted]	[redacted]

In our rota design we plan for staff having a 30-minute break in an 8-hour shift leaving 7.5 operational hours for full time staff. Also, we allow for 30 minutes each shift to perform vehicle and clinical check duties.

Total available staff hours per week: [redacted] hours

Operational clinical time [redacted] hours per week: [redacted]

Non-clinical time [redacted] hours per week: [redacted]

The total identified clinical staff hours have a [redacted] resilience built in for absence and holidays and the above available hours are excluding the resilience hours.

In our financial model we have allowed for a further [redacted] hours of overtime for clinical staff per week which can be taken up by staff when required.

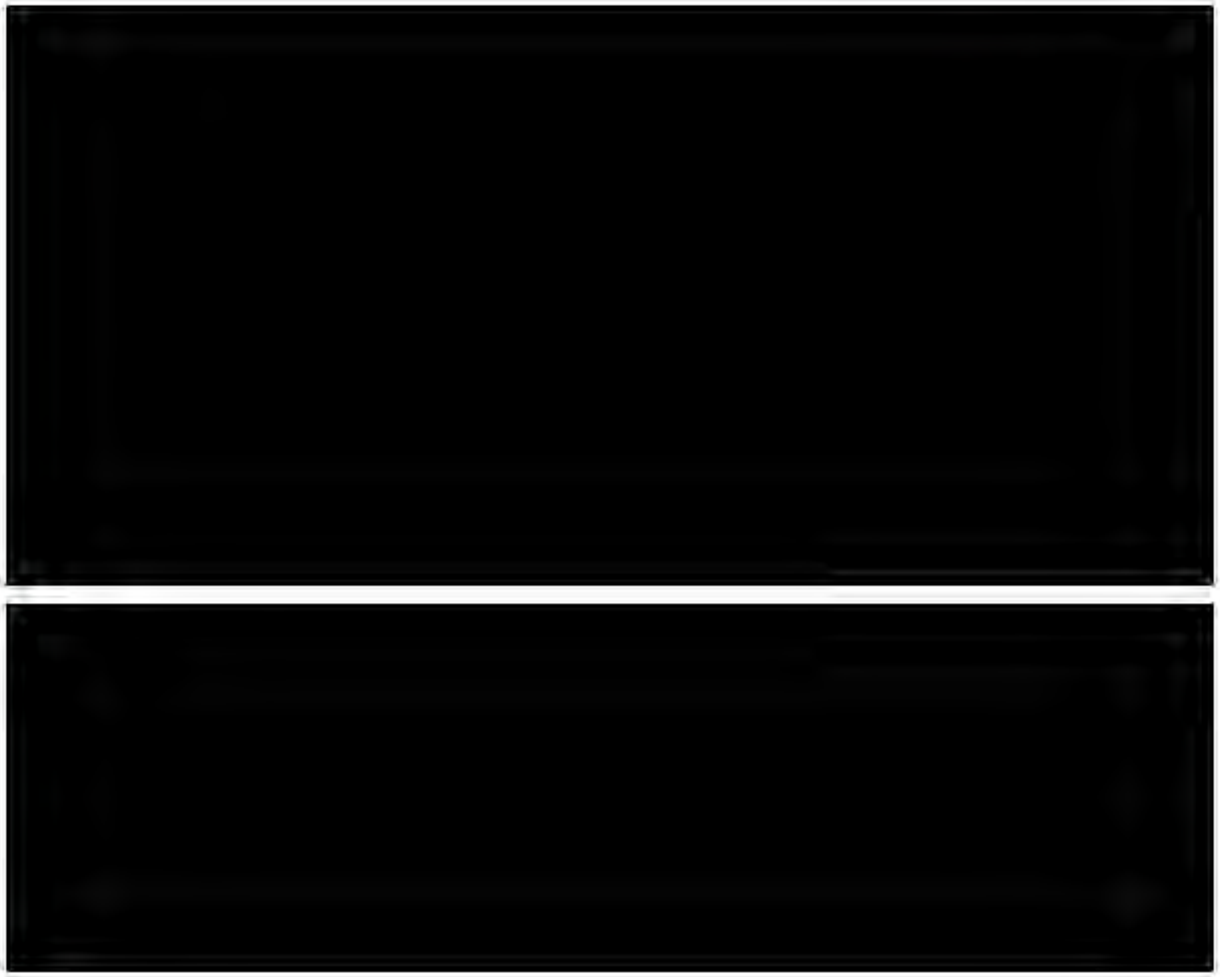
Staff shift patterns

The tables below provide a full overview of our proposed shift patterns for our crews.

Monday to Friday crew shifts

[redacted]

Saturday crew shifts



Sunday crew shifts

[redacted]

[redacted]

Pay Policy

Recognising the TUPE responsibility we will have a variety of different bandings and pay structures within the contract. All staff will be protected upon transfer in respect of their current terms and conditions.

The ERS Medical Terms and Conditions of employment and pay scales for any new and existing staff on these conditions are as follows for 2020/2021:

- Call Centre Operative £[redacted]
- ACA trained staff £[redacted]
- Mental Health trained staff £[redacted]
- UCA trained staff £[redacted]
- ECA trained staff £[redacted]
- Paramedic £[redacted]
- Lead Drivers £[redacted]
- Team Leader £[redacted]

All our pay rates are reviewed annually on the 1st of April to keep up with inflation and adherence to the government guidelines on National Minimum Wage.

All of our staff members will be enrolled into the NEST Auto Enrolment Pension scheme benefiting from employer pension contributions of 3%.

Standard holidays for staff are [redacted] days plus 8 bank holidays.

Standard sick leave policy is [redacted] days unpaid followed by SSP.

Wages are paid monthly on the [redacted] of the month.

As a nationwide service provider, we ensure that all of our workers adhere to the working time directive and that all shifts are designed with this in mind. We also have a Fair and Equal Pay policy.

ERS - TUPE TRANSFER CHECKLIST

TRANSFEREE (NEW EMPLOYER)

Guidance Notes

CONSULT THE ADVICE SERVICE AT ALL STAGES

1) Clarify / establish essential information

- Who is **the transferor (old employer)?**
- What is being transferred or contracted-out? (it could be a business or part of a business or an economic activity i.e. service provision). Does TUPE definitely apply? **It is vitally important that you establish with the advice service whether TUPE does apply.** If there is an element of doubt in terms of whether a transfer will occur under the relevant definitions, then you can consider using letter template **T05** with the approval of the advice line.
- Which employees will be employed by the old employer immediately before it is transferred to you?
- Identify **all affected employees** - any employees of the old employer or you (whether or not employed in the undertaking or the part of the undertaking to be transferred) who may be affected by the transfer or may be affected by measures taken in connection with it.
- Are there any independent trade unions recognised by the old employer or you in respect of the affected employees?
- If there are no independent trade unions, identify any existing employee representatives elected by the affected employees whose remit gives them sufficient authority to act as 'appropriate representatives' or any employee representatives elected specifically for the purposes of consultation and receiving information.
- Are there any measures you envisage taking in connection with the transfer of the business in relation to the affected employees and the likely effect of such measures? Measures include plans or proposals that you foresee and have in mind to implement including any material change in existing work practice or working conditions and will certainly include redundancies (whether voluntary or compulsory). **NB** An economical, technical or organisational (ETO) reason will only be a valid basis for a transfer-connected change where that reason 'entails changes in the workforce'. This phrase is not defined in **TUPE** 2006 but has been held to apply only where there are changes in:
  - the actual numbers employed in the workforce; or
  - the functions performed by employees.

2) Inform old employer of transfer and request 'employee liability' information

- The old employer must provide you with specified employee liability information at least 28 days prior to completion - you can use **T01 and T10** to inform the old employer of their obligations in this respect, in addition to informing them of the details of transfer i.e. the fact that the transfer is to take place; when, approximately, the transfer is to take place and the reasons for the transfer. If special circumstances make this not reasonably practicable, the information must be supplied as soon as is reasonably practicable.

- If the information changes after being provided but before completion of the transfer, the old employer must notify you of those changes in writing.

- The information must be provided in writing or in other forms which are 'readily accessible'.

- The information must be given for every transferring employee (including employees who would have transferred if they had not been automatically unfairly dismissed in connection with the transfer) see **T10 - these highlights what information you should be receiving from the old employer.**

- If the old employer has not provided the relevant information voluntarily or upon request, then you can chase this information using **T06.**

3) Ensure employees are informed of the proposed Transfer and their right to elect employee representatives for consultation purposes

- Send **T02** to the transferring employees to inform them of the transfer and that you accept TUPE applies to the transfer i.e. the fact that the transfer is to take place; when, approximately, the transfer is to take place and the reasons for the transfer

- If the workforce is non-unionised and there is no other suitable representative body, you should ensure that the old employer invites the affected employees to elect their own representatives. **If you are concerned that the affected employees are not being afforded this right, then you can remind the employees within the contents of T02.** The legal obligation to advise the employees of their right to elect representatives' rests initially with the transferor (old employer), however if you are the transferee (new employer) you are also advised to notify/remind the affected employees of this right. **A failure to afford the affected employees this right could have serious financial consequences if a claim is later made by an affected employee or their representatives i.e. Bear in mind that both you and the transferor (old employer) could be jointly liable in these circumstances.** This should be done early enough to allow your affected employees sufficient time to elect their representatives before the information and consultation process is begun.

4) Provide 'measures' information

- You must write to the old employer and inform them of the measures, if any, that you envisage taking in connection with the transfer of the business in relation to the transferring employees. Use template **T03** for this purpose. This consists of:
- the legal implications of the transfer of the business for the affected employees (i.e. the impact of the transfer on the employees' contractual or statutory rights against their employer);
- the economic implications of the transfer of the business for the affected employees (i.e. any effect on pay and prospects);
- the social implications of the transfer of the business for the affected employees (i.e. social security implications such as pensions and National Insurance, amenities such as sporting facilities and socials clubs, employee concessions and staff discounts); and
- the measures you envisage you will take in connection with the transfer in relation to the affected employees, or, if you envisage that no measures will be taken inform them of that fact. Measures is a wide word and includes any action step or arrangement. 'Envisages' is vaguer than 'intends' and means visualises or foresees. The duty to consult arises where the employer has formulated a definite plan or proposal which it has it in mind to implement, if necessary, after appropriate negotiation with the unions.
- The information must be provided long enough before the transfer to enable the information and consultation process to be completed by the time the transfer takes place. If you envisage taking any measures, try to assess whether they are likely to be a contentious issue and/or will need to be discussed at length with the unions or employee representatives. Estimate the time this is likely to

take. Consider whether this will coincide with a traditional holiday period when it may be difficult to arrange meetings and any other factors which may delay consultation.

- The information should also be put in writing and delivered by hand to the unions, employee representatives, or directly to the employees (if no union is recognised and the employees have not opted to nominate reps) or in the post to the appropriate addresses – use letter template **T04**

5) Carry out discussions with unions or employee representatives

- If measures are envisaged in connection with the transfer of the business in relation to any of the affected employees, you must inform, and enter into discussions with the unions, employee representatives or directly to the employees (if no union is recognised and the employees have not opted to nominate reps) with a view to reaching agreement about those measures - use letter template **T04** to provide information in regards to the measures.

- Employers must not merely present their proposals as a 'final' but should strive to enter into full and proper discussions with employee representatives, unions or employees with a view to achieving consensus as to the way the transfer will be carried out and the way in which its effects on employees will be managed.

- During discussions you are under a duty to consider any representations made by the unions, employee representatives or employees and to reply. If you reject any of the representations, you must state your reasons for the rejection.

- Keep detailed notes of the discussions with the unions or employee representatives.

- Information (and consultation where applicable) should be completed before the business is transferred so you need to start as soon as possible.

6) Inform about redundancies

If one of the measures you envisage is that some or all of the affected employees will be made redundant, you may need to begin informing the old employer about potential redundancies in parallel with TUPE consultation. This may involve giving further information to the unions
or employee representatives; and may also require further discussions with unions or employee representatives and with individual employees. It may also be necessary to notify the Department of Trade and Industry.

- You must notify each of the transferring employees in writing, no later than one month after the date of the transfer of the business, of:
  - the identity of their new employer;
  - the date of commencement of their employment with the new employer;
  - the date on which their continuous employment began; and
  - any other changes (improvements), if any.
  - Employers must give employees a written statement containing the key terms of their employment contract and, within a month after any of those terms change, a revised statement i.e. if changes to terms and conditions have been made following formal consultation.

Workstream	Task Name	Duration	Start	Finish	Comments
HR & Training	Request and receive data personnel files from incumbent provider	10d			
HR & Training	Request details of pre-booked annual leave and scheduled absences post transfer	10d			
HR & Training	Receive details of annual leave	10d			
HR & Training	**Staff - Workforce relations**				
HR & Training	Agree Terms of reference for workforce meeting	10d			
HR & Training	Agree first dates for workforce meeting	10d			
HR & Training	Meet key leadership positions within workforce	10d			
HR & Training	Create and distribute FAQ	10d			
HR & Training	**Staff - TUPE**				
HR & Training	Due dilligence - type of employee and employees details	10d			
HR & Training	Add TUPE reference letter from Arriva to all files	10d			
HR & Training	Create BambooHR profiles	20d			
HR & Training	Upload Scanned files to BambooHR profiles	20d			
HR & Training	Confirm DBS Checks	10d			
HR & Training	licence check	45d			
HR & Training	Complete communications plan for TUPE staff	15d			
HR & Training	Write to each employee with full details of the proposed transfer	10d			
HR & Training	Hold initial group meetings with all affected personnel	20d			
HR & Training	Hold an individual meeting with each employee	20d			
HR & Training	Formulate and issue Measures Letter	20d			
HR & Training	Send second measures letter and ensure that it has been distributed	20d			
HR & Training	Work with Governance work stream on training induction for all staff	85d			
HR & Training	Identify Training requirements and compare to specification	85d			
HR & Training	Induction	20d			
HR & Training	Welcome packs	20d			
HR & Training	Pension information for TUPE staff	20d			
HR & Training	**Staff - ACA training**				
HR & Training	Arrange meeting to discuss any specific training requirements (DNAR, Scoop Str etc)	5d			
HR & Training	Hold training requirements meeting	5d			
HR & Training	Develop training material to include area specific training	10d			
HR & Training	Produce staff training packs	10d			
HR & Training	Develop training packs	10d			
HR & Training	Develop training schedule for each employee	50d			
HR & Training	Arrange training resource	50d			
HR & Training	Confirm training locations	50d			
HR & Training	Notify trainees of training dates	50d			
HR & Training	Deliver training courses	50d			
HR & Training	Develop hard copy training records for all employees	50d			
HR & Training	Upload qualifications to system for each employee	50d			
HR & Training	Arrange re-test for any course module failures	50d			
HR & Training	Consult with HR re consistent failures and determine course of action	50d			
HR & Training	Take photo and measurements for all staff uniforms	10d			
HR & Training	Agree rota with union rep	20d			
HR & Training	Develop Go-live day help sheets for all crews	65d			
HR & Training	Arrange demonstration day for vehicles,on board equipment, go-live day arrangements and paper wo	65d			
HR & Training	Deliver Demonstration days	65d			

ERS Medical

HR TUPE Project Plan

TUPE details:	
Owner of project:	
Start date:	**Target Transfer Date:**

TUPE Information:

Highlight in this section, all of the key areas within the new contract that will need to be addressed and will support any measures.

TUPE Transfer Checklist:

1) Clarify/establish essential information

- Who is **the transferor (old employer)?**
- Which employees will be employed by the old employer immediately before it is transferred?
- Identify **all affected employees** - any employees of the old employer (whether or not employed in the undertaking or the part of the undertaking to be transferred) who may be affected by the transfer or may be affected by measures taken in connection with it.
- Are there any independent trade unions recognised by the old employer or you in respect of the affected employees?
- If there are no independent trade unions, identify any existing employee representatives elected by the affected employees whose remit gives them sufficient authority to act as 'appropriate representatives' or any employee representatives elected specifically for the purposes of consultation and receiving information.
- Are there any measures you envisage taking in connection with the transfer of the business in relation to the affected employees and the likely effect of such measures?

2) Inform old employer of transfer and request 'employee liability information'.

- The old employer must provide you with specified employee liability information at least 28 days prior to completion – use template letters **T01 and T10** to inform the old employer of their obligations in this respect, in addition to informing them of the details of transfer i.e. the fact that the transfer is to take place; when, approximately, the transfer is to take place and the reasons for the transfer. If special circumstances make this not reasonably practicable, the information must be supplied as soon as is reasonably practicable.
- If the information changes after being provided but before completion of the transfer, the old employer must notify you of those changes in writing.
- The information must be provided in writing or in other forms which are 'readily accessible'.
- The information must be given for every transferring employee (including employees who would have transferred if they had not been automatically unfairly dismissed in

connection with the transfer) see **T10 - this highlights what information you should be receiving from the old employer**

- If the old employer has not provided the relevant information voluntarily or upon request, then you can chase this information using template **T06.**

3) Ensure employees are informed of the proposed TUPE transfer and their right to elect employee representatives for consultation purposes.

- Send template letter **T02** to the transferring employees to inform them of the transfer and that you accept TUPE applies to the transfer i.e. the fact that the transfer is to take place; when, approximately, the transfer is to take place and the reasons for the transfer.
- If the workforce is non-unionised and there is no other suitable representative body, you should ensure that the old employer invites the affected employees to elect their own representatives. This should be done early enough to allow your affected employees sufficient time to elect their representatives before the information and consultation process is begun.

4) Provide Measures Information

- You must write to the old employer and inform them of the measures, if any, that you envisage taking in connection with the transfer of the business in relation to the transferring employees. Use template **T03** for this purpose.

5) Carry out discussions with unions or employee representatives

- If measures are envisaged in connection with the transfer of the business in relation to any of the affected employees, you must inform, and enter into discussions with the unions, employee representatives or directly to the employees (if no union is recognised and the employees have not opted to nominate reps) with a view to reaching agreement about those measures - use letter template **T04** to provide information in regards to the measures.
- Employer must strive to enter into full and proper discussions with employee representatives, unions or employees with a view to achieving consensus as to the way the transfer will be carried or and in which its effects on employees will be managed.

6) Notify transferring employees of employment changes.

- You must notify each of the transferring employees in writing, no later than one month after the date of the transfer of the business, of:
    - the identity of their new employer;
    - the date of commencement of their employment with the new employer;
    - the date on which their continuous employment began; and
    - any other changes (improvements), if any.
    - Employers must give employees a written statement containing the key terms of their employment contract and, within a month after any of those terms change, a revised statement i.e. if changes to terms and conditions have been made following formal consultation.
- (use Letter template T07).

All individual HR actions are listed within the main TUPE project plan and must align to the HR TUPE Project plan.

ERS Medical

Timescales:

The timescales will depend on the agreed transfer date, once the date has been agreed / decided a timeline can be formed and included in the project plan.

Human impact:

This section will identify the potential impact of the TUPE on the workforce, for example aby potential changes to salary pay dates, holiday year and identified training gap analysis.

People involved:

This section must identify the key project team and their role in delivering the TUPE.

Key deliverables and milestones:

This section should outline the key milestones and key deliverables (items that will be delivered as part of the project) that are critical to the success of the project.

Risks and dependencies:

This section should outline the key risks and dependencies (other processes, systems and departments that may be impacted / require support as part of the TUPE transfer.

Governance:

ERS Medical

This section must cover the governance of the TUPE - i.e. how it will be overseen to track and review progress against the project plan.

ERS to establish the incoming transferor project team to ensure that regular project calls are in place for a smooth transition for the incoming staff.

Question 1.21.6

TUPE

Please provide a project plan that shows how you would manage any potential TUPE transfer of staff into your organisation. Please support this with your approach to staff resource management and retention for the delivery of these services whilst also taking into account the staff planning associated with the required service delivery.

Engagement with staff is not only crucial during the TUPE process but also continually throughout the contract. We have TUPE transferred over [redacted] staff over the past [redacted] years and have a robust and effective communication and engagement plan.

We understand that the TUPE process can be a daunting and unnerving experience for staff and therefore will engage early with all staff and provide continual communication throughout the process. We will also provide staff with a dedicated 24/7 call line to use should they have any questions or concerns regarding their transfer to ERS. We have provided an draft TUPE project plan as an attachment.

Our approach is based on the following essential factors for successful staff transfer:

Initial Engagement - Communication is critical to the transition process, before, during and after the formal consultation process. We engage with current providers and recognised trade unions as early as possible and maintain an effective communications strategy. We facilitate group and individual staff communication before the date of transfer if the current employer agrees.

We will have a dedicated HR team with TUPE expertise to liaise with the incumbent HR lead and to be available to answer any questions regarding the transfer.

Information & Consultation - Once TUPE eligible staff have been identified, we communicate with them regularly through the elected employee representatives and individually in a programme of group briefings and informal sessions.

Data Transfer - We honour all existing terms and conditions as protected under COSOP/TUPE. Details of employment contracts, personnel files, handbooks, collective agreements and payroll related data need to be provided in a timely manner in order to ensure a seamless transition.

Transition - All transferees undertake a structured induction on a number of activities, including group inductions on HR/operational processes and other relevant areas. Training needs analysis and skills audit will be part of this process and relevant training will be delivered.

A comprehensive, structured induction not only makes staff feel motivated and welcomed into the company, but also ensures that they become integrated quickly into the company culture.

Our experience has also told that arranging at an early stage for transferees to meet with staff who have previously transferred to us can benefit them at what can be an unsettling time.

In the event that not all staff transfer to us, we recruit any remaining staffing requirements locally using a recruitment campaign to commence on contract award.

Post go live review with staff – Following the transfer of employees we will continue to have an open door policy to ensure that all enquiries regarding the TUPE process and any general HR queries can be address.

Working with E-Zec

Due to the nature of NEPTS we work closely with other national service providers and have a good existing relationship with E-Zec. We are both part of the Independent Ambulance Association (iaa) which ensures we both follow an outlined code of conduct. This will ensure the smooth transfer of staff and services into the new contract.

Specific arrangement for this tender

Below we have outlined the how specific elements to the TUPE process will be achieved during the mobilisation of this service:

Access to staff

We have provided an a draft TUPE project plan providing an outline of the timeframes of each element of the TUPE process. We will work in an open partnership with both the Commissioners and E-Zec to finalise the specific dates for when each element will be completed. We will also agree a staff access protocol to ensure we have the required access to the staff prior to the new contract start date without having an impact on service delivery. This will be done by providing multiple consultation days including weekends to maximise the potential for individual staff member to attend.

Initial contact

Following the contract award we will contact all staff members who are eligible for TUPE transfer providing details of the new contract (e.g. start date) and an overview of how the transfer process will be conducted and key dates they should be aware of. We will work in partnership with E-Zec's HR team to put together a contact list to ensure all staff are contacted. We will also ensure that E-Zec's HR department and operational managers are kept full informed on how we are delivering the staff transfer to ensure it is harmonious, efficient and effective.

One to ones

We will provide each and every staff member with the option to have a one to one session with our HR team to provide them with any support they require during the transfer process and answer any questions they may have about ERS and the new service.

Uniforms and photos

In the final weeks of the transfer process we will work with the E-Zec operational team to gather the required information to ensure that all of the transferring staff have the correct fitting uniform and a photo-badge.

WI/2.01.18 TUPE Transfer

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Document Owner:	[redacted]		Managing Director		
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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
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Information Governance	BMS/1.09
GDPR	BMS/1.10
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Sickness Absence	WI/2.01.03
Discipline	WI/2.01.04
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Expectant Mothers and Maternity Leave	WI/2.01.06
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Managing Capability	WI/2.01.11
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Recruitment Authorisation Form	F2.01.01
Non-Managerial Post Interview	F2.01.02
Managerial Post Interview	F2.01.03
Leadership Post Interview	F2.01.04
Graduate Development Programme Interview	F2.01.05
Candidate Short-Listing Form	F2.01.06

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3. Purpose

3.1 The purpose of this work instruction is to define and set out a single process for the management of TUPE staff from their current employment to ERS Medical.

3.2 This process has been written in conjunction with our HR provider, ' Peninsula HR'.

4. Scope and Application

4.1 This work instruction applies to all ERS Medical sites and locations, where staff will be transfer to the employment of ERS Medical, under TUPE regulations.

4.2 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the Company's Capability and Disciplinary procedures.

5. Policy Statements

5.1 Please refer to the Company's Quality, Environmental, Safety and Health Policy.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting ERS Medical objectives and allocating adequate resources to meet those objectives.
6.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to ERS Medical's operations.
6.3	**HR Provider**	Is responsible for ensuring that the ERS Medical's recruitment and selection procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to recruit and select prospective employees. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs. Are responsible for coordinating job vacancies, short-listing of candidates, and arrangement of interviews and evaluation of screening assessments.
6.4	**Regional & Operations Managers (Hiring Managers)**	Are responsible for the implementation and management of this process and for ensuring that training is provided. Are responsible for gaining the authorisation to recruit, advertising vacancies, forming the Short-listing and Interview Panels and communication with successful and unsuccessful candidates. A team (that includes the Hiring Manager), of suitably experienced or qualified ERS Medical personnel that are responsible for short-listing and interviewing applications and applicants.
6.5	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Transferee** – New employer and all cases detailed within this work instruction this will be ERS Medical (ERS Transition Limited).

7.2 **Transfer of Undertakings (Protection of Employment) Regulations (TUPE)** – This refers to the TUPE Regulations of 2006, as amended by the 'Collective Redundancies and Transfer if Undertakings (Protection of Employment) (Amendment) Regulations 2014.

8. Clarify / Establish Essential Information

Who is the Transferee (new employer)

8.1 What is being transferred or contracted-out? (it could be a business or part of a business or an economic activity i.e. service provision). Does TUPE definitely apply? **It is vitally important that you establish with the advice service whether TUPE does apply.** If there is an element of doubt in terms of whether a transfer will occur under the relevant definitions, then you can consider using letter template **T05(A)** with the approval of the advice line.

8.2 Which employees will be employed by you immediately before it is transferred to the new employer.

8.3 Identify **all affected employees** - any employees (whether or not employed in the undertaking or the part of the undertaking to be transferred) who may be affected by the transfer or may be affected by measures taken in connection with it.

8.4 Are there any independent trade unions recognised by you or the new employer in respect of the affected employees?

8.5 If there are no independent trade unions, identify any existing employee representatives elected by the affected employees whose remit gives them sufficient authority to act as 'appropriate representatives' or any employee representatives elected specifically for the purposes of consultation and receiving information

8.6 Are there any measures that the new employer envisages taking in connection with the transfer of the business in relation to the affected employees and the likely effect of such measures?

8.7 Measures include plans or proposals that you foresee and have in mind to implement including any material change in existing work practice or working conditions and will certainly include redundancies (whether voluntary or compulsory). **NB** an economical, technical or organisational (ETO) reason will only be a valid basis for a transfer-connected change where that reason 'entails changes in the workforce'.

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8.8 This phrase is not defined in **TUPE** 2006 but has been held to apply only where there are changes in:

- The actual numbers employed in the workforce; or
- The functions performed by employees.

IT IS ESSENTIAL TO CLARIFY WITH THE ADVICE SERVICE IF THE MEASURES WOULD FALL WITHIN CONFINES

9. Inform New Employer of Transfer and Provide Liability Information

9.1 You must provide the new employer with specified employee liability information at least 28 days prior to completion - you can use **T01(A) and T11**. In addition, informing them of the details of transfer i.e. the fact that the transfer is to take place; when, approximately, the transfer is to take place and the reasons for the transfer. If special circumstances make this not reasonably practicable, the information must be supplied as soon as is reasonably practicable.

9.2 If the information changes after being provided but before completion of the transfer, you must notify the new employer of these changes in writing.

9.3 The information must be provided in writing or in other forms which are 'readily accessible' to the new employer.

9.4 The information must be given for every transferring employee (including employees who would have transferred if they had not been automatically unfairly dismissed in connection with the transfer) - see **T11 - this highlights what information you should be providing the new employer with.**

10. Informing Employees

Ensure all employees are informed of the proposed transfer and their right to elect employee representatives for consultation purposes.

10.1 Send **T02(A)** to the transferring employees to inform them of the transfer and that you accept TUPE applies to the transfer i.e. the fact that the transfer is to take place; when, approximately, the transfer is to take place and the reasons for the transfer.

10.2 If the workforce is non-unionised and there is no other suitable representative body, invite your affected employees to elect their own representatives (see letter template **T02(A)).** Employers with fewer than 10 employees do not need to elect representatives and may consult individually. This should be done early enough to allow your affected employees sufficient time to elect their representatives before you begin the information and consultation process.

A failure to afford the affected employees this right could have serious financial consequences if a claim is later made by an affected employee or their representatives i.e. Bear in mind that both the transferee (new employer) and you could be jointly liable in these circumstances.

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10.3 If the employee representatives are to be specially elected ones, certain election conditions must be met. When arranging to elect employee representatives, you must apply the following principles:

1) Make arrangements as are reasonably practical to ensure that the election is fair;
2) Work out the number of representatives to be elected so that there are enough representatives to represent the interests of all affected employees (taking into account the number and classes of employees) **– please seek advice for specific requirements;**
3) Determine whether the affected employees should be represented either by representatives of all the affected employees or by representatives of particular classes of those employees;
4) Before the election, determine the employee representatives' term of office so that it is long enough to enable relevant information to be given and consultations to be completed;
5) Ensure that the candidates for election as employee representatives are affected employees on the date of the election;
6) Ensure no affected employee is unreasonably excluded from standing for election;
7) Ensure all affected employees on the date of the election are entitled to vote for employee representatives;
8) Ensure that the employees entitled to vote may vote for as many candidates as there are representatives to be elected to represent them, or if there are to be representatives for particular classes of employees, may vote for as many candidates as there are representatives to be elected represent their particular class of employee;
9) Hold the election in a way to ensure that (so far as reasonably practicable, those voting do so in secret and ii) the votes given at the election are accurately counted.

Where you give affected employees a genuine opportunity to elect representatives, but the employees' fail to do so, you must provide relevant information to all affected employees individually.

10.4 Employee representatives in transfer situations have certain rights, which - if you breach them - could lead to an employment tribunal claim against you. **Speak to the advice line for further information.**

10.5 Once the employees have been accorded the right to elect representatives, the results of this should be disclosed - see letter **T02(B).**

11. Provide 'Measure' Information

11.1 You must establish if you, or the new employer is (**or is not** as the case by be) intending on taking in measures in connection with the transfer of the business in relation to the transferring employees.

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11.2 Use template **T01(A) and/or T03(A)**. This consists of:

- The legal implications of the transfer of the business for the affected employees (i.e. the impact of the transfer on the employees' contractual or statutory rights against their employer);
- The economic implications of the transfer of the business for the affected employees (i.e. any effect on pay and prospects);
- The social implications of the transfer of the business for the affected employees (i.e. social security implications such as pensions and National Insurance, amenities such as sporting facilities and socials clubs, employee concessions and staff discounts); and
- The measures you envisage you will take in connection with the transfer in relation to the affected employees, or, if you envisage that no measures will be taken inform them of that fact. Measures is a wide word and includes any action step or arrangement. 'Envisages' is vaguer than 'intends' and means visualises or foresees. The duty to consult arises where the employer has formulated a definite plan or proposal which it has it in mind to implement, if necessary after appropriate negotiation with the unions.

11.3 The information must be provided long enough before the transfer to enable the information and consultation process to be completed by the time the transfer takes place. If the information is not forthcoming from the new employer, then you can chase this information by using letter template **T03(B).**

11.4 If measures are envisaged, try to assess whether they are likely to be a contentious issue and/or will need to be discussed at length with the unions or employee representatives. Estimate the time this is likely to take. Consider whether the consultation period will coincide with a traditional holiday period when it may be difficult to arrange meetings and any other factors which may delay consultation.

11.5 The information should be put in writing and delivered by hand to the unions or employee representatives, or directly to the employees (if no union is recognised and the employees have not opted to nominate reps) or in the post to the appropriate addresses - use letter template **T04(A) and T08.**

12. Consultations

Carry out consultations with unions or employee representatives

12.1 If measures are envisaged in connection with the transfer of the business in relation to any of the affected employees, you must consult with unions, employee representatives or directly to the employees (if no union is recognised and the employees have not opted to nominate reps) with a view to reaching agreement about those measures - use letter template **T04(A)** or **T08** to provide information in regards to the measures and if applicable propose a date for a meeting.

12.2 Employers must not merely present their proposals as a ‘final’ but should strive to enter into full and proper discussions with employee representatives, unions or employees with a view to achieving consensus as to the way the transfer will be carried out and the way in which its effects on employees will be managed.

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12.3 During consultation you are under a duty to consider any representations made by the unions, employee representatives or employees and to reply. If you reject any of the representations, you must state your reasons for the rejection.

12.4 Keep detailed notes of the discussions at the consultation meetings with the unions or employee representatives.

12.5 Consultation should be completed before the business is transferred so you need to start as soon as possible.

13. Inform and Consult About Redundancies

13.1 If one of the measures envisaged is that some or all of your affected employees will be made redundant, you may need to begin informing and consulting about collective redundancies in parallel with your TUPE consultation.

13.2 This may involve giving further information to the unions or employee representatives; and may also require further consultation with unions or employee representatives and with individual employees. Its representatives and with individual employees. It may also be necessary to notify Business Innovation and Skills.

14. Notify Transferring Employees of Employment Change

14.1 You must notify each of the transferring employees in writing, no later than one month after the date of the transfer of the business, of:

- The identity of their new employer;
- The date of commencement of their employment with the new employer;
- The date on which their continuous employment began; and
- Use letter template **T09(A)**

14.2 [redacted] offer a HRface2face service consisting of a team of advocates equipped to conduct, or support and assist you to conduct, any face to face meeting you are undertaking with ERS Medical staff. For further information please speak to the ERS Medical Head of HR & Training and or visit:

[redacted]

14.3 Occupational Health intervention and Employee Assistance Programmes are essential tools to effectively manage absence in the workplace, to support staff and to add value to your business. We can provide you with the details of [redacted] a company who can provide such services. For further information please speak to your HR Expert and visit:

[redacted]

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Question 1.21.7

Supervision and training

Please outline your proposed approach to clinical and non-clinical supervision and training for delivery of this service.

Word count 750

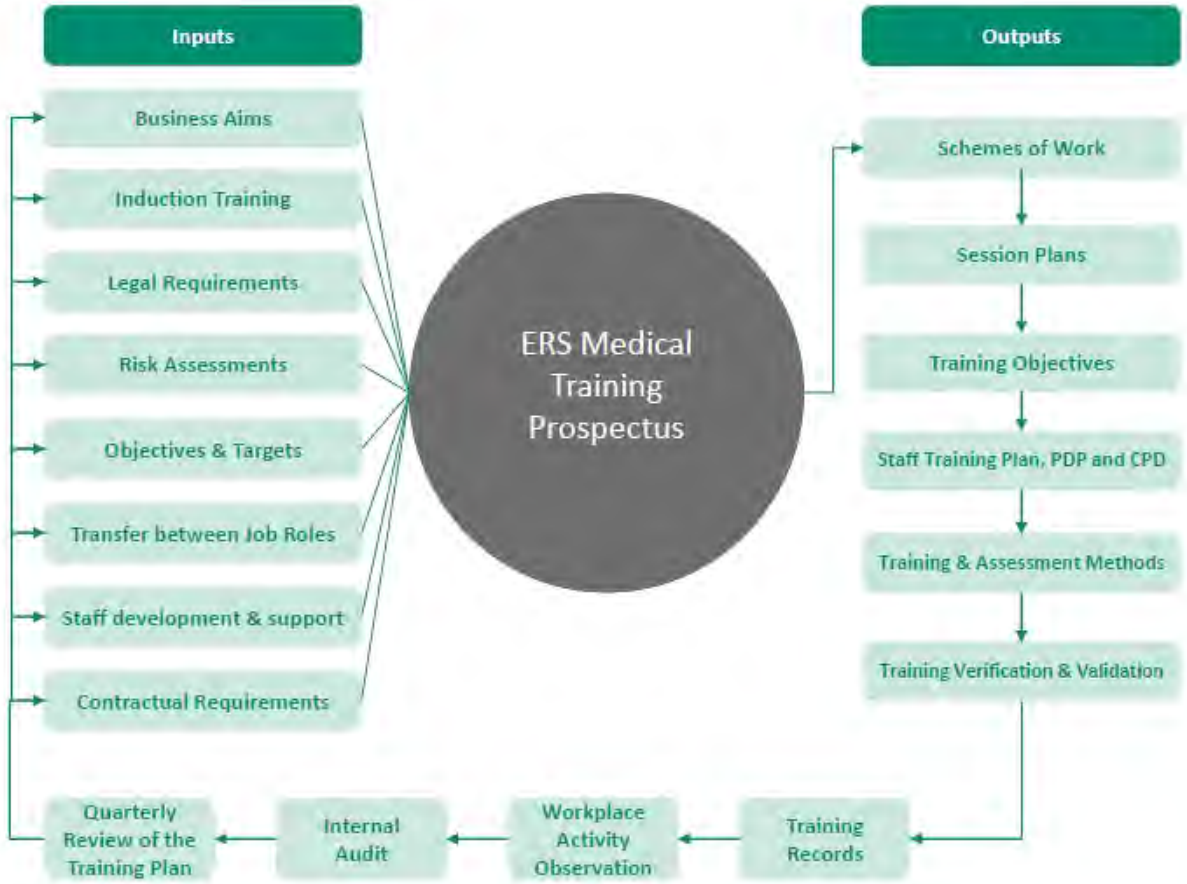
Total word Count: 548

To ensure we meet the needs and requirements of the NHS we deliver training that is specific to the NHS through FutureQuals. These clinical qualifications have been developed and regulated to meet the core requirements of NHS Ambulance Trusts, Independent Ambulance Services and the Voluntary Aid Societies.

All of our patient facing staff are required to complete the following mandatory training modules:

- Student and Assessor Toolkits
- Understanding your Role
- Your Personal Development
- Duty of Care
- Quality and Diversity
- Work in a Person-centred Way
- Communication
- Privacy and Dignity
- Fluids and Nutrition
- Awareness of Mental Health, Dementia and Learning Disability
- Safeguarding Adults
- Safeguarding Children
- Basic Life Support
- Health and Safety
- Handling Information
- Infection Prevention and Control
- Scenarios

Our Training Plan consolidates several inputs and outputs:



We maintain a training database and will retain documentary evidence of training for each staff member assigned to work on this contract, available for audit by the Contracting Authorities during the contract term.

Ambulance Care Assistant

Once the candidate has been selected, and subject to their pre-employment checks, they will complete the following program:

- 1-week classroom foundation course
- 2 days professional driver improvement program
- 2 days observing on an operational vehicle
- 1-day classroom for practical and theory assessments.

This will be supported by a comprehensive workbook and E-Learning for the student to complete. Both the e-learning and workbook must be completed within 4 weeks of the start date. Staff will not pass their probation if these are not completed.

Successful completion will lead to a Level 3 Award – Non-Urgent Care Services.

High Dependency staff

For the delivery of this contract we will have higher acuity trained staff such as technicians and paramedics to deliver the HDU and HDU+ services. This ensure we are able to transport all patients under this contract safely and compliantly.

Call Centre staff

The ERS Call Centre initial training course is delivered over 2 days with a suite of e-learning to be completed prior to finishing the course.

- Approximately 6 hours of e-learning
- 1-day induction
- 1-day role specific training
- 2-days practice placement
- Annual e-learning

ERS understands that it is crucial that our staff are fully trained and that they utilise their training effectively and correctly on a day to day basis. We review all training on a monthly basis through our Senior Management Meeting to ensure that training is being completed in line with our Training and Development plan. As part of their role our IQA qualified Trainers conduct regular spot-checks and ride-a-longs, to ensure that what is being taught in training sessions is put into practice and is effective.

Further to this all employees receive ongoing support, training and assessment:

- Every employee has a 1:1 annual review
- Every employee has a Personal Development Plan
- Road crews have a 'Ride a Long' assessment by their Team Leader annually

A CPD activity is any activity from which our staff learn and develop. This includes the following:

- Work-Based Learning
- Professional Activity
- Webinars - "Walk through" new processes and procedures and Q&A
- Formal Education – e.g. going on formal courses or carrying out research
- Self-Directed Learning – e.g. reading articles or books

Paramedics and Nurses maintain individual CPD as it is a requirement of their professional registration.

Please find attached our Training Prospectus which provides full details of the training each level of our staff receives.

Question 1.21.8

NEET

In relation to the Service Specification please advise how you will help local disadvantaged groups including but not limited to Ex-Offenders, young people who are classed as NEET (Not in Education, Employment or Training), to receive the benefit of training, work experience or apprenticeship opportunities.

Word count 750

Total Word Count: 566

ERS Medical believes in providing equality in its recruitment and services, in treating people fairly with respect and dignity and in valuing diversity both as a health services provider and as an employer.

ERS Medical is committed to a comprehensive policy of equal opportunities that will assist local disadvantaged groups to find work. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment on grounds not relevant to good employment practice.

We strive to recruit staff locally for the services we deliver and will work in partnership with local recruiters as well as the Job Centre. This ensures we deliver training and upskilling to local people and give local disadvantaged groups the opportunity of gaining employment, training and work experience with ERS.

Apprenticeships

ERS Medical are proud to have an apprenticeship scheme within our Contact Centre and Finance and HR Teams. These schemes provide bespoke training in a plethora of transferable skills such as time management, customer service, IT skills, Healthcare Industry training, etc. to enable our apprentices to develop into fully qualified call handlers and administrators that deliver a high-quality service to our customers. Upon completion our apprentices are awarded a Level 2 NVQ in leadership and business administration/management. We offer the option to move to Level 3 NVQ.

Work experience

We work with local schools to engage with young people who may not have decided about further education or apprenticeships. We provide two weeks work experience covering a variety of departments including Contact Centre, Finance, Planning and Commercial.

ERS Academy

In 2020 we will be launching the ERS Academy. The aim of the academy is to provide career and personal development through apprenticeships for all ERS employees. As well as building a career development pathway for the ambulance sector, we will also be offering management and leadership courses.

Armed Forces Covenant

The Armed Forces Covenant is a promise from the nation to those who serve. It says we will do all we can to ensure they are treated fairly and not disadvantaged in their day-to-day lives. This includes offering injured servicemen and women and bereaved families extra support where appropriate.

ERS Medical is proud to have been awarded the Armed Forces Covenant Employer Recognition Scheme Silver Award. This award demonstrates our support for service personnel through employment and actively communicating and upholding a positive stance to our employees through HR policies and processes.

We uphold the principles of the covenant, which are:

- No member of the Armed Forces Community should face a disadvantage in the provision of public and commercial services compared to any other citizen
- In some circumstances, special treatment may be appropriate especially for the injured or bereaved

We welcome job applications from the Armed Forces community, including military spouses and dependants, and we are committed to providing a supportive environment throughout your career with us.

Our core values are closely aligned to those of HM Forces, which puts us in a unique position for you to look for possible employment with us.

Mental Health Awareness

As part of our Mental Health and Wellbeing plan all of our management staff have been through Mental Health Awareness training and we have recruited 15 Mental Health First Aiders across the business to assist employees in whatever way they can. This supports mental health within the workplace, which in turn supports mental health across our local communities.

Question 1.21.9

Disciplinary procedures

Please provide a copy of your policies to ensure that any disciplinary action; referrals to professional bodies or regulatory organisations; any criminal convictions either current or pending and any previous history of poor performance can be identified and managed for all staff.

Staff are the company's greatest asset and we invest heavily in training them to ensure that we not only deliver a high-quality service, but ensure we retain staff and continue to develop them.

Minor faults will be dealt with informally through counselling and training. However, in cases where informal discussion with the employee does not lead to an improvement or where the matter is considered to be too serious to be classed as minor, a formal disciplinarily process will commence.

All incidents of poor performance are reported Radar. Where a performance issue is highlighted following a complaint or investigation, Line Managers will conduct an informal review of staff performance. If a training need is identified a Performance Improvement Plan (PIP) is established to rectify performance. If the PIP does not lead to improved performance, disciplinary measures will commence.

ERS Medical will notify the employee in writing of the allegations against him or her and will invite the employee to a disciplinary hearing to discuss the matter and provide them with relevant information.

Having given the employee reasonable time to prepare their case, a formal disciplinary hearing will then take place. Conducted by a manager, the employee will be given the chance to state his or her case, accompanied if requested.

Stage 1: Written Warning

The written warning will be recorded but nullified after six months, subject to satisfactory conduct and performance.

Stage 2: Final Written Warning

Failure to improve performance, a repeat of misconduct for which a warning has previously been issued, or a first instance of serious misconduct or serious poor performance, will result in a 'Final Written Warning' being issued. This final written warning will be recorded but nullified after twelve months.

Stage 3: Gross Misconduct

For the most serious breaches an employee will be suspended and an investigation completed. Dependant on the outcome of the investigation dismissal without notice may apply.

We support all of our staff through the process using our own internal and external (ACAS) mediation to ensure it is fair and compliant.

We also work with external parties such as the police when disciplinary incidents are brough into ERS from an external source and follow the same process.

We have attached our Disciplinary Process and DBS Guidance.

WI/2.01.04 Disciplinary Procedure

Document Author:	[redacted]		Head of HR & Training	
Document Owner:	[redacted]		Managing Director	
	Version No.:	1.0	Date Active:	12/10/2017

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	10/04/2017
Approved by the Managing Director	[redacted]	12/10/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
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Employee Health and Wellbeing	BMS/2.03
Company Car Driving	BMS/2.04
Whistle-blowing (Raising Concerns at Work)	BMS/2.05
Disclosure and Barring Service Check Policy (DBS)	BMS/2.06
Alcohol and Drugs Policy	BMS/2.07
Recruitment and Selection	WI/2.01.01
Managing Probation Periods	WI/2.01.02
Sickness Absence Policy	WI/2.01.03
Disciplinary Procedure	WI/2.01.04
Grievance Procedure	WI/2.01.05
Family Friendly	WI/2.01.06
Managing Change	WI/2.01.07
Flexible Working	WI/2.01.08
Capability Policy – Managing Underperformance	WI/2.01.09
Home Working	WI/2.01.10
Equality and Diversity	WI/2.01.11

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3. Introduction

3.1 The purpose of the disciplinary process is to ensure that unacceptable conduct is addressed promptly and appropriately.

3.2 The process takes account of the ACAS code of practice on disciplinary processes and will be reviewed periodically in line with developments in good practice and legislation.

3.3 The overall aim of this guide is to support and enable you to performance manage your staff effectively using the informal and formal Disciplinary processes and to provide you with a framework to do this and support you in understanding the steps to follow in using the Disciplinary Process. There is further, detailed guidance on the process in the Employee Handbook.

3.4 We know that most people want to, and do, perform to the best of their ability.

3.5 As managers, we are responsible for managing staff to maximise their potential in line with business priorities.

3.6 Should performance issues arise, the Disciplinary Process is there to help you manage and to enable the employee to improve their performance or exit the organisation.

3.7 To help you do this the performance management cycle provides the framework to effectively manage performance day-to-day, and the Disciplinary Process provides you with the framework to take action.

3.8 If a member of staff is struggling to reach the standard expected of them, their line manager has a responsibility to clearly communicate what the expected standard is, and to support the member of staff as far as possible.

3.9 They should be given every opportunity to perform effectively and to address issues raised with them, both through your support and development and their own actions.

3.10 This guide will introduce you to the subject of disciplinary and should be used in conjunction with the Employee Handbook.

3.11 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.12 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

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4. Policy Statements

4.1 Except for gross misconduct, no employee will be dismissed for a first breach of discipline.

4.2 The level of any formal action will be dependent on the seriousness of the offence, the consequence to ERS Medical, and any mitigating circumstances presented by the employee, having regard to the need for fairness and natural justice.

4.3 The employee has a right to be accompanied by their trade union representative or a work colleague at every stage of the formal process. The process is internal to ERS Medical and apart from external trade union representatives, does not allow for any external representation.

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Are responsible for setting Company objectives and allocating adequate resources to meet those objectives.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Head of HR and Training**	Are responsible for providing advisory services to managers to enable effective management of personnel in relation to this work instruction and for monitoring, reviewing, approving and auditing the process outputs.
5.4	**General and Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
5.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Disciplinary Process

6.1 Whilst the ERS Medical does not wish to impose unreasonable rules of conduct on its employees, certain standards of behaviour are necessary to maintain good employment relations and discipline in the interest of all employees.

6.2 ERS Medical prefers that discipline be voluntary and self-imposed and in the vast majority of cases this is how it works. However, from time to time, it may be necessary for the Company to take action towards individuals whose level of behaviour or performance is unacceptable.

6.3 With the exception of the section entitled 'alternative disciplinary sanction', this disciplinary procedure is entirely non-contractual and does not form part of an employee's contract of employment.

6.4 Minor faults will be dealt with informally through counselling and training. However, in cases where informal discussion with the employee does not lead to an improvement in conduct or performance or where the matter is considered to be too serious to be classed as minor, for example, unauthorised absences, persistent poor timekeeping, sub-standard work performance, etc the following disciplinary procedure will be used. At all stages of the procedure, an investigation will be carried out.

6.5 ERS Medical will notify the employee in writing of the allegations against him or her and will invite the employee to a disciplinary hearing to discuss the matter. The Company will provide sufficient information about the alleged misconduct or poor performance and its possible consequences to enable the employee to prepare to answer the case. This will include the provision of copies of written evidence, including witness statements, where appropriate.

6.6 Having given the employee reasonable time to prepare their case, a formal disciplinary hearing will then take place, conducted by a manager, at which the employee will be given the chance to state his or her case, accompanied if requested by a trade union official, a trade union representative or a fellow employee of his or her choice otherwise known as 'the companion'.

6.7 The employee must make every effort to attend the hearing. At the hearing, the employee will be allowed to set out their case and answer any allegations and will also be given a reasonable opportunity to ask questions, present evidence, call relevant witnesses and raise points about any information provided by witnesses.

6.8 Where the employee is unable to attend a disciplinary hearing and provides a good reason for failing to attend, the hearing will be adjourned to another day. Unless there are special circumstances mitigating against it, if the employee is unable to attend the rearranged hearing, the rearranged hearing will take place in the employee's absence.

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6.9 The employee's fellow worker or trade union official may attend in such circumstances and will be allowed the opportunity to present the employee's case. The employee will also be allowed to make written submissions in such a situation.

6.10 If the companion cannot be available on the date set for the hearing the employee can seek a postponement for up to five working days.

6.11 Please note that it is prohibited for employees to record (whether covertly or otherwise) the proceedings at the disciplinary hearing, and at any appeal hearing, without the express permission of ERS Medical.

6.12 If ERS Medical discovers that an employee has done this covertly, he or she could be subject to further disciplinary action.

6.13 Following the hearing, ERS Medical will decide whether or not disciplinary action is justified and, if so, the employee will be informed in writing of the Company's decision in accordance with the stages set out below and notified of his or her right to appeal against that decision.

6.14 It should be noted that an employee's behaviour is not looked at in isolation but each incident of misconduct is regarded cumulatively with any previous occurrences.

7. Stage 1: Written Warning

7.1 The employee will be given a formal **WRITTEN WARNING**. He or she will be advised of the reason for the warning, how they need to improve their conduct or performance, the timescale over which the improvement is to be achieved, that the warning is the first stage of the formal disciplinary procedure and the likely consequences if the terms of the warning are not complied with.

7.2 The written warning will be recorded but nullified after six months, subject to satisfactory conduct and performance.

8. Stage 2: Final Written Warning

8.1 Failure to improve performance in response to the procedure so far, a repeat of misconduct for which a warning has previously been issued, or a first instance of serious misconduct or serious poor performance, will result in a FINAL WRITTEN WARNING being issued.

8.2 This will set out the nature of the misconduct or poor performance, how he or she needs to improve their conduct or performance, the timescale over which the improvement is to be achieved and warn that dismissal will probably result if the terms of the warning are not complied with.

8.3 This final written warning will be recorded but nullified after twelve months, subject to satisfactory conduct and performance. However, the Company reserves the right to extend the validity of the final written warning to a maximum of three years in cases of very serious misconduct or where the employee has a history of misconduct issues.

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9. Stage 3: Dismissal

9.1 Failure to meet the requirements set out in the final written warning will normally lead to DISMISSAL with appropriate notice. A decision of this kind will only be made after the fullest possible investigation. Dismissal can be authorised only by a senior manager. The employee will be informed of the reasons for dismissal, the appropriate period of notice, the date on which his or her employment will terminate and how the employee can appeal against the dismissal decision.

10. Gross Misconduct

10.1 Offences under this heading are so serious that an employee who commits them will normally be summarily dismissed. In such cases, the Company reserves the right to dismiss without notice of termination or payment in lieu of notice. Examples of gross misconduct include:

- Any breach of the criminal law, such as theft;
- Any unauthorised possession or removal of Company products or property, or property belonging to another employee, client, customer or visitor, fraud (including making fraudulent or false expense claims), deliberate falsification of records, false declarations in connection with employment or applications for employment or any other form of dishonesty;
- Using the Company's property, materials or equipment to carry out work for third parties on a personal basis without permission;
- Misuse of Company benefits, such as improper use of a staff discount card;
- Offering, promising or giving a bribe or requesting, agreeing to receive or accepting a bribe or bribing a foreign public official in connection with employment;
- Wilfully or negligently causing harm or injury to another employee, client, customer or visitor, physical violence, assault, fighting, bullying or grossly offensive, abusive or aggressive behaviour or language;
- Deliberately or negligently causing damage to the Company's property, or to property belonging to another employee, client, customer or visitor;
- Vandalism of, or otherwise intentionally interfering with, the Company's computers or computer or telephone network;
- Causing loss, damage or injury through serious carelessness or gross negligence;
- Dereliction of duty, including sleeping whilst at work and undertaking unauthorised activities during normal working hours;
- Wilful refusal to obey a reasonable management instruction or serious insubordination;
- Serious incapacity at work through an excess of alcohol or illegal drugs, whether consumed on or off Company premises but which affects the employee's ability to carry out their job duties whilst at work;
- Bringing illegal drugs or other illegal substances or items or weapons on to Company premises;
- Smoking on Company premises, other than in designated outside smoking areas;
- Logging on to sexually explicit websites, downloading or circulating pornographic or other offensive, illegal or obscene material or using the internet or e-mail for gambling, illegal activities or the sending of offensive e-mails to work colleagues (in the latter case, including from the employee's home computer in their own time);

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- Engaging in sexual activity on Company premises at any time;
- Posting derogatory, offensive, discriminatory or defamatory comments online (for example, on social media websites) about the Company, its employees, clients or customers or otherwise conducting themselves online in a way that is detrimental to the Company or brings the Company into serious disrepute;
- A serious breach of health and safety rules, including acts or omissions which endanger the safety of another employee, client, customer or visitor;
- A serious breach of security rules;
- Discriminating against, harassing, bullying or victimising another employee, client, customer or visitor because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race (including colour, nationality and ethnic or national origins), religion or belief, sex and/or sexual orientation;
- A serious breach of confidentiality, including unauthorised access of computer and personnel records and communicating or leaking trade secrets or confidential information about the Company or its employees, clients or customers to third parties;
- Working for a competitor without permission;
- Engaging in an unauthorised activity which conflicts with the interests of the Company or its clients or customers;
- Breaching copyright or any other proprietary interest belonging to the Company;
- Knowingly breaking a legal requirement in connection with employment;
- Bringing the Company into serious disrepute, even if done in the employee's own time;
- Unauthorised absence, including failure to return from a period of annual leave or other approved leave of absence.

10.2 The above is intended as a guide and is not an exhaustive list.

11. Alternative disciplinary Sanction

11.1 As an alternative to issuing a final written warning or as an alternative to dismissal, ERS Medical reserves the right to demote an employee for a fixed period, but for no longer than [three] months. This will be done by notice in writing to the employee.

11.2 ERS Medical also reserves the right to impose a reduction in the employee's salary for the period of demotion and the written notice will detail any changes to the employee's terms and conditions of employment arising from such demotion. In particular, the notice will give details of any reduction to salary and/or loss of benefits arising from the demotion.

11.3 Where demotion is used as an alternative to summary dismissal for gross misconduct, the Company may also issue the employee with a final written warning.

11.4 This section of the disciplinary procedure is contractual.

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12. Suspension

12.1 In the event of serious or gross misconduct, an employee may be suspended while a full investigation is carried out. Such suspension will be on full basic pay.

12.2 Suspension is a neutral act, which does not imply guilt or blame, and will be for as short a period as possible. Suspension is not considered a disciplinary action. During the period of suspension the employee will not be entitled access to any of the company's premises except at the prior request or with the prior consent of the company at such times and subject to such conditions as the company may impose.

13. Appeals

13.1 An employee may appeal against any disciplinary decision, including dismissal, to a senior manager of the Company within five working days of the decision.

13.2 Appeals should be made in writing and state the grounds for appeal. The employee will be invited to attend an appeal hearing chaired by a senior manager.

13.3 At the appeal hearing, the employee will again be given the chance to state his or her case and will have the right to be accompanied by a trade union official, a trade union representative or a fellow employee of his or her choice.

13.4 Following the appeal hearing, the employee will be informed in writing of the results of the hearing. The Company's decision on an appeal will be final.

14. Employees with Short Service

14.1 This disciplinary procedure does not apply to any employee who has been employed by the Company for less than two years.

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WI .06.01 Disclosure and Barring Services (DBS) Guidance

Scope of Guidelines

The purpose of this document it to provide guidance to managers on the purpose and process used when assessing Disclosure and Barring Service (DBS) checks in ERS Medical.

This document is meant to act as a guidance for Site Administrators/Recruiting Managers/ Team Leaders/Operations Managers and Regional Managers, you may also need to consult with the Head of HR & Training if unclear as to whether a post meets the criteria for requesting a DBS check.

Before an organisation considers asking a person to apply for a criminal record check through DBS, they are legally responsible for ensuring that they are entitled to submit an application for the job role. Part V of the Police Act 1997 makes criminal record checks available for positions that are identified as exempt under the Rehabilitation of Offenders Act (ROA) 1974 (Exceptions) Order 1975 (as amended).

All staff will require a DBS check (The Head of HR will be able to assist with who does not need a DBS check i.e. non-regulated staff) but such checks are mandatory for all staff who have direct contact with persons in their normal duties. The trigger for a check and the level of check is based on a risk assessment against the roles and duties of the position being offered and the type of contact the individual will have with vulnerable groups.

These guidelines should be used in conjunction with the **DBS Policy BMS 2.06**. This guidance applies to all staff working within ERS Medical.

Criminal record and barring checks have the purpose of helping to prevent unsuitable people from entering the workforce and gaining access to vulnerable groups. The criminal record relates to data held about the individual's criminal history. Not all individuals being appointed into positions within ERS Medical require criminal record or barring checks. The need and level of the check is determined by the activities and the type of access to patients they will have as part of their role.

The DBS check is only one part of the recruitment and selection process; therefore, this guidance should be used in conjunction with the ERS Recruitment Policy.

Types of DBS checks and eligibility

The recruiting manager is responsible for identifying if the position requires a DBS check and, should a check be required to determine which level of check is necessary for the position. There are a number of levels of Disclosure:

- **Basic Check (BC)** – Shows unspent convictions only.
- **Standard checks (SC)** – To be eligible for a standard level DBS certificate, the position must be included in the Rehabilitation of Offenders Act (ROA) 1974 (Exceptions) Order 1975.
- **Enhanced checks (EC) –** To be eligible for an enhanced level DBS certificate, the position must be included in both the ROA Exceptions Order and in the Police Act 1997 (Criminal Records) regulations.

- **Enhanced checks with children's and/or adults' barred list check(s) (EC with CBL & ABL)** – To be eligible to request a check of the children's or adults' barred lists, the position must be eligible for an enhanced level DBS certificate as above and be specifically listed in the Police Act 1997 (Criminal Records) regulations as able to check the appropriate barred list(s).

Procedure

All staff who recruit into posts which are defined as requiring DBS checks will be issued with online access to the Capita recruitment vetting site.

There is no statutory requirement for staff to be checked on a continuous basis however, ERS Medical is a best practice employer and committed to the principals of the safety of vulnerable groups and children all staff in a 3-year cycle will reapply for DBS checks. Site Administrators are responsible for reminders to be sent to Operations Managers, who are responsible for engagement from staff.

Current DBS certificates will be used for applicants registered for the DBS update service in conjunction with an instant online check to see if any new information has come to light since its issue.

All applicants who are not registered for the DBS update service are responsible for and will complete the online application form. Site Administrators/Team leaders will issue applicants with letter **F2.06.05**.

All applicants will present required documents for verification to their Line Manager, via any company site or location, documents listed at **F2.06.01**. Applicants registered for the DBS update service will also present original DBS Certificates to their line manager.

Verification documents will be copied by the Line Manager or designated deputy, and confirmation written on the copy stating that 'originals seen and verified' with date name and signature of the checker.

Documents will then be forwarded to site administrators who will ensure that the ID verification, section Y and application approval is completed, through approved staff within ERS Medical. Approved staff include Team Leaders, Operations Managers and Regional Managers and can be checked with the Head of HR & Training.

For applicants registered for the DBS update service Site Administrators/Team Leaders will undertake instant check online using the certificate registration number.

Any issues with either the application process or the ID verification will be followed up by site administrators. Escalation of any issues will be passed to the Operations Manager who will then be able to escalate any concerns to the Regional Manager/Head of HR & Training for advice.

Site Administrators/Team Leaders will be notified that the check is complete by Capita DBS service. Site administrators will notify the applicant's manager that the disclosure is available and request that the Line Manager views the certificate, a letter which will be sent by the site administrators to request the applicant to present their DBS disclosure (**F2.06.02**).

On receipt of the certificate or the Line Manager's letter the applicant will present the disclosure certificate for verification of contents. For applicants registered for the DBS update service results will be instantly viewable for site administrators.

Certificates with no reprimands, cautions or convictions will be logged straight onto the individuals HR records on Bamboo. Site Administrators/Team Leaders are responsible for completing the Capita site 'certificate seen' verification. The staff member will then be approved for work with regulated activity.

Site Administrators are responsible for maintaining a database of permissible information, including logging the serial number and date of the certificate.

DBS details are stored electronically on our Bamboo HR system on the staff members 'Personal' and 'Training' tabs. The dates entered are used to generate reports to ensure compliance with DBS's completed 3 yearly.

Certificates containing any reprimand, caution or conviction will be passed to the Operations Manager to review.

On receipt of any 'positive' DBS checks, Operations Managers will forward the certificate along with the relevant supporting information and statement from the candidate onto the Regional Manager to complete a DBS basic Risk Assessment **F2.06.03.**

For serious cases, Regional Managers will need to send all information from 2.15 to the Head of HR to take forward to the DBS Panel.

The Panel is made up from Operations (Managing Director), HR (Head of HR & Training) and Care Standards (Head of Care Standards), to discuss the case. A full review will take place in line with **F2.06.04**. The DBS Panel will determine whether the staff member will be removed from duty until such time as the case has been approved.

The following points will be considered for all such cases:

- The seriousness of the offence and its relevance to the safety of vulnerable groups including adults, children, patients and other employees and property.
- Whether the applicant disclosed the offence on application.
- The length of time since the offence occurred.
- Any relevant information offered by the applicant about the circumstances which led to the offence being committed, e.g. the influence of domestic or financial difficulties.
- Where the offence was a one-off, or part of a history of offending was committed, making re-offending less likely.

ERS Medical is a best practice employer and under the Safeguarding Vulnerable Groups Act, has a legal duty to refer information to the Disclosure and Barring Service if an employee or volunteer has harmed, or poses a risk of harm to vulnerable groups and where they have dismissed them, or removed them from working in a regulated activity with children or adults.

This duty equally applies where an individual has resigned before a formal decision to dismiss or remove their duties has taken place. The Head of HR & Training will be responsible in terms of

ensuring ERS Medical is compliant in regard to referring any such cases to the DBS. Legal counsel may be required prior to submitting such referrals.

However, it must be remembered that there are some offences which effectively ban individuals from ever working with children, and it is a criminal offence to knowingly employ such individuals in such a role.

It is a criminal offence for an organisation to offer employment involving regular contact with young people under the age of 18 to anyone who has been convicted of certain specified offences, or is included on list of people considered unsuitable for such work held by the Department of Education (DoE) and the Department of Health (DoH).

It is also an offence for people convicted of such offences to apply for work with young people.

The **specified** (Schedule Four) offences are:

- Murder or manslaughter.
- Rape or burglary with intent to commit rape.
- Grievous bodily harm.
- Cruelty to children.
- Kidnapping, false imprisonment and abduction.
- Indecent assault on a man or a woman.
- Sexual intercourse with a child under 13.
- Intercourse with a girl aged between 13 and 16.
- Buggery with a child under 16.
- Abuse of trust.
- Incest and related offences.
- Assault with intent to commit buggery.
- Indecency with children under the age of 14.
- Offences relating to or encouraging child prostitution.
- Offences relating to child pornography.

Under 18 years old will only be banned if a Court believes that there is a likelihood of the offender in question committing a further offence against a young person.

The applicant / employee must be given the opportunity to discuss the Disclosure Information before a final employment decision is made. It may be that the Disclosure contains information the applicant was not asked about during interview, or the applicant / employee was unaware they had a criminal record.

Applicants / employees are entitled to appeal to the DBS through their Disputes procedure, if they think a mistake has been made and may be required to give fingerprints for secure identification.

ERS Medical reserves the right to oppose conditions on acceptance of positive DBS such as the applicant registering for the DBS update service.

DBS Check Portal

DBS checks must be completed on the Following portal.

When contacting new starters to attend interview please provide them with the following link below and ask them to login and complete all details requested on the application portal.

[redacted]

To submit their DBS application forms, employees will need to use the following login details, selecting Option 1 (the DBS application portal – the orange box on the left) on the main site:

[redacted]

Once this has been done please request them to bring with them 3 forms of ID documents from the attached list to the interview.

You are able to log into the section 3 the green section and you will be logged in as ID checkers, this means you will be able to add the details requested from their documents and save, it will then come to us in the office in Exeter to complete the process, that is the section Y.

Question 1.19.15

Health and Social Care Act 2008

Please provide details of your compliance with the Health and Social Care Act 2008 and code of practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

Word count 1000

Total Word Count: 542

We are committed to minimising all risks associated with infection control and reducing the impact of healthcare associated infection on patients, staff and the organisation overall. As such we have a clear Infection Control policy and stringent procedures in place for cleaning and decontamination of medical devices and work equipment in accordance with MHRA guidelines, such as:

- Infection Prevention and Control Policy
- Infection Control Operational Procedures
- Decontamination Policy
- Decontamination Procedures
- Deep Cleaning Procedures
- Infection Control Training Record

All clinical policies are reviewed and authorised by our Governance and Patient Safety committee, chaired by ***REDACTED***, our Medical Director. The committee ensure that policies follow best practice, are comprehensive and include the latest NICE and Public Health England guidance.

ERS Medical have a detailed IPC policy that provides full details on all of our processes, training and auditing that we undertake to deliver a high quality and safe service including:

- Staff training requirements
- Personal hygiene
- Hand hygiene and care
- IPC PPE
- Frequency of decontamination of vehicles and equipment
- Cleaning and decontamination levels
- ChemEx products and training
- IPC Environmental Management
- Site housekeeping and inspection form

- Uniform inspection
- Daily inspection record
- IPC Risk Assessments

We have an ongoing audit plan for IPC and Health and Safety at all sites. This ensures that all of our sites are continually monitored (minimum of twice per year) to ensure they comply with all relevant legislation at all times enabling them to deliver a safe service to our customers.

Standard Operating Procedures

Our staff conduct a visual check of vehicle cleanliness before their shift to ensure vehicles are maintained in a clean and hygienic condition. These checks are retained for reporting and auditing purposes. Regular daily checks are made of the vehicles by the Management team to ensure compliance.

Cleaning and decontamination has been broken down into 5 distinct levels which are:

- Level 1: Pre-Shift
- Level 2: Patient Handover – After every patient
- Level 3: Risk of contamination i.e. exposure to bodily fluids
- level 4: Post shift
- level 5: Scheduled deep cleans – every 90 days for NEPTS vehicle and 45 days for HDU vehicles

At the end of each shift it is the crew's responsibility to ensure that the vehicle is left in a clean and hygienic condition ready for the following shift.

Each vehicle is scheduled for deep cleaning in line with our IPC policy or when an incident dictates the need. These schedules are on our ***REDACTED*** systems which alerts managers as to when a deep clean is required. Once the clean has been completed the system must be updated to confirm completion.

All vehicles are equipped with cleaning kits and decontamination equipment to ensure that spillages during a transfer can be dealt with immediately. Vehicles are equipped with protective clothing for our staff for this purpose.

We believe that having our crews undertake checks for their own vehicles ensures they take ownership and responsibility for the quality service delivery of their work. Ad Hoc spot checks are completed weekly by our Infection Control Teams.

We have attached our Infection Prevention and Control policy for full details on how we comply with the Health and Social Care Act 2008 and code of practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

Question 1.21.10

Skills mix

Please include an outline or summary of each role with essential skills, experience and training needs analysis.

Word count 750

Total Word Count: 678

Please find attached our training prospectus that provides a full outline of the skills and training required for each role within our business.

Below we have outlined the experience and training requirements for each role:

Ambulance Care Assistant

Once the candidate has been selected, and subject to their pre-employment checks, they will complete the following program:

- 1-week classroom foundation course
- 2 days professional driver improvement program
- 2 days observing on an operational vehicle
- 1-day classroom for practical and theory assessments.

This will be supported by a comprehensive workbook and E-Learning for the student to complete. Both e-learning and the workbook must be completed within 4 weeks of their start date. Staff will not pass their probation if these are not complete.

Successful completion will lead to a Level 3 Award – Non-Urgent Care Services. The qualification has no expiry date, however, to be considered valid, the individual must maintain their continuing professional development. ERS Medical will support this requirement via mandatory training and classroom-based learning.

Mental Health Escort

ERS Medical recognise that patients with mental health problems may require additional care and support during transport yet are still patients. To best meet the needs of this group of patients, we have set the standard for training as follows:

- Qualified ACA
- 1-Day Legal Considerations – MHA / MCA / PACE / Common Law
- 4 days External Accreditation – Prevention and Management of Violence and Aggression (PMVA)

This accreditation requires updating in line with the regulatory body's requirements. In addition, you will be required to maintain regular updates via mandatory training and classroom-based learning.

Urgent Care Assistant

UCA crews deal with patients who are unwell, but not currently in a life-threatening condition. They may deal with interfacility transfers where patients require formal monitoring, HCP admissions etc. They will be able to perform a greater range of monitoring, including Pulse Oximetry, Non-Invasive Blood Pressures, ECG Rhythms. They will have additional training to manage deteriorating patients.

- Qualified ACA (6 months min.)
- Level 3 Certificate – Urgent Care Services

If required by the contract, UCA's may be trained in emergency driving. They will be expected to maintain their CPD to a level commensurate with their grade.

Emergency Care Assistant

Similar to the role of a UCA, the ECA will provide transport to patients who are more acutely unwell and typically work alongside a qualified clinician (EMT / Paramedic). This may include providing emergency transfers, responding to 999 calls to back up a solo clinician, or dealing with HCP admissions.

- Qualified UCA (6 months min.)
- Level 3 Certificate – Emergency Care Services
- Emergency Driving Qualification
- CPD Portfolio

Further Steps

The Futurequals suite allows progression directly on to the next stage, which would be Associate Ambulance Practitioner (previously Technician), and then in turn to undergraduate Paramedic Programs.

Paramedic training

Our paramedics are required to be registered with the HCPC. We have provided an overview of the general training our Paramedic must complete below, however many of our contracts have contract specific elements that require bespoke training. We will work with the CCGs during the mobilisation to identify and bespoke additional training and ensure it is in place.

Module Title		*1 Module Attendance Study Time	Pre-Requisites for Commencing Module	*2 Modular Examination/s	*3 Placements	Modular Assignment
HEFA	Hazardous Environment First Aid	5 days	Nil	MCQ, OSCE	• Nil	Nil
HEFR	Hazardous Environment First Responder	15 days	HEFA	MCQ, OSCE, Viva	• 20hrs Emergency Department	Nil
P1	Portfolio 1	1 year	Starts on commencement of HEFA	Practice Competencies	• 960hrs Practice Setting • 20hrs Emergency Department • 20hrs Operating Department	1 x 2500 Words
HEMT	Hazardous Environment Medical Technician	1 year	Certificated on completion of HEFA, HEFR, P1			
AP	Anatomy and Physiology	3 days	HEMT	MCQ (at beginning of CS)	• Nil	1 x 2500 Words
CS	Paramedic Core Skills	4 days	HEMT, AP	MCQ, OSCE	• 40hrs Operating Department	Nil
T	Trauma	3 days	HEMT, AP, CS	MCQ, OSCE	• 40hrs Emergency Department	
ALS	Advanced Life Support	3 days	HEMT, AP, CS	2x OSCE	• 40hrs Coronary Care Unit	1 x 2500 Words
MS	Medical & Surgical Emergencies	3 days	HEMT, AP, CS	2x OSCE, Viva	• Nil	1 x 2500 Words
S	Social	3 days	HEMT, AP, CS	Nil	• Nil	1 x 2500 Words
OGP	Obstetrics, Gynaecology & Paediatrics	4 days	HEMT, AP, CS, T, ALS, S, MS	MCQ, OSCE	• 20hrs Obstetric Department • 20hrs Paediatric Department	
A	Assessment	3 days	HEMT, AP, CS, T, ALS, S, MS, OGP	MCQ, OSCE	• Nil	Nil
P2	Portfolio 2	2 years	Starts on commencement of A&P	Practice Competencies	• 1500hrs Practice Setting	1 x 2500 Words CPD
HEMP	Hazardous Environment Medicine Paramedic	3 years	Certificated on completion of HEMT, AP, CS, T, ALS, S, MS, OGP, A, P2			

*1 Indicated time does not include Modular pre-attendance activities, post-attendance activities or placements. The time indicated illustrates the number of days the student will need to attend formally taught sessions with ORMS.
*2 MCQ = Multi Choice Questionnaire, OSCE = Observed Structured Clinical Assessment
*3Durations stated are a minimum number of hours to be spent in each of the practice environments, where a student is unable to achieve the objectives through lack of exposure to opportunities to practice then it is a requirement that the student is provided with additional opportunities to achieve the learning objectives. This may be achieved by extending the placement duration or by seeking an alternative placement venue, agreed by ORMS

The above training is the current requirement. We are aware that as of January 2021 all paramedic education will have to be at level 6 on the approved paramedic programme laid down by the HCPC. We will update our training accordingly.

Non-Clinical Staff Training

Control and Communications Operator Initial Training Course

The ERS Control and Communications Operator initial training course is delivered over 2 days with a suite of e-learning to be completed prior to finishing the course.

Approximately 6 hours of e-learning.

1-day induction – 8 hours.

1-day role specific training – 8 hours.

2-days practice placement – 16 hours.

Annual e-learning (core update – 'Health Education Learning Path').

Non-Patient Contact Staff Initial Training Course

ERS has various non-patient contact roles which are too numerous and varied to state specific training packages, however the core minimum induction package includes a mix of e-learning and face to face induction training.

Approximately 6 hours of e-learning.

1-day induction – 8 hours.

Annual e-learning (core update – 'Health Education Learning Path').

Role	Required Training	When	Renewal	Method	Delivered By
ACA	Level 3 Award in Non-Urgent Care Services	Recruitment	None (subject to CPD)	Blended Learning	Clinical Trainers
	Care Certificate (CCT)	Within 4 Weeks of start	None (subject to CPD)	E-Learning	Self-Study
	Professional Driver	Recruitment	3 years	Face to Face	Driver Trainer
	Annual Core Update Day (PTS) Training	Annual	1 year	Face to Face	Regional Trainer
	Quality Audit	Annual	1 year	Face to Face	Team Leader
	Toolbox Talks / Clinical Updates	As Required (Min 3 monthly)	As Required	Face to Face	Team Leader
Mental Health Escort	All ACA package				
(Secure Patients)	Physical Intervention	At Start of Role	1 year	Face to Face	Dynamis
	Mental Health Act	At Start of Role	1 year	Blended Learning	Clinical Trainers
UCA	All ACA package				
	Level 3 Certificate in Urgent Care Services	At start of role	None (subject to CPD)	Blended Learning	Clinical Trainers
	Emergency Driving (Subject to contract)	At start of role	3 Years	Face to Face	Driver Trainer
ECA	As per UCA				
	Level 3 Certificate in Emergency Care	At start of role	None (subject to CPD)	Blended Learning	Clinical Trainers
	Emergency Driving	At start of role	3 Years	Face to Face	Driver Trainer
Courier	Role Specific Induction	Recruitment	Once Only	Face to Face	Clinical Trainers
	Annual Core Update Day Training	Annual	1 year	Face to Face	Regional Trainer
GP OOH Driver	Role Specific Induction	Recruitment	Once Only	Face to Face	Clinical Trainers
	Annual Core Update Day Training	Annual	1 year	Face to Face	Regional Trainer
Call Handler / Admin	Role Specific Induction	Recruitment	Once Only	Face to Face	Line Manager
	Statutory and Mandatory Training (SMT) - Health Education Learning Path	Annual	1 year	E-Learning	Self-Study

We have attached our Training Prospectus for full details of the skill and training requirements for each role.

Question 1.21.11

Recruitment and retention

Please supply arrangements for recruitment and retention including arrangements to ensure optimum turnover levels.

Word count 750

Total Word Count: 749

ERS has developed a comprehensive solution design with human resource planning a key feature. During mobilisation the following recruitment/TUPE tasks will be completed:

- Reconciliation between solution design and available TUPE employees
- Identification of recruitment needs
- Skills/compliance audit of all transferring employees
- GAP analysis and training solution planned

Below we have provided an overview of how we attract, recruit and retain our staff.

Attracting

Having a positive external (and internal) image is crucial to become an employer of choice and needs the collective effort of a wide range of engaged staff in all areas to deliver a brand development strategy.

ERS is committed *to* building a reputation as a positive place to work within the Healthcare Industry. We attract new employees by advertising through the following mediums:

- Agencies
- Job Centre
- Online advertising
- Social Media
- LinkedIn
- Recruitment Events
- Defence Employer Recognition Scheme

Recruitment

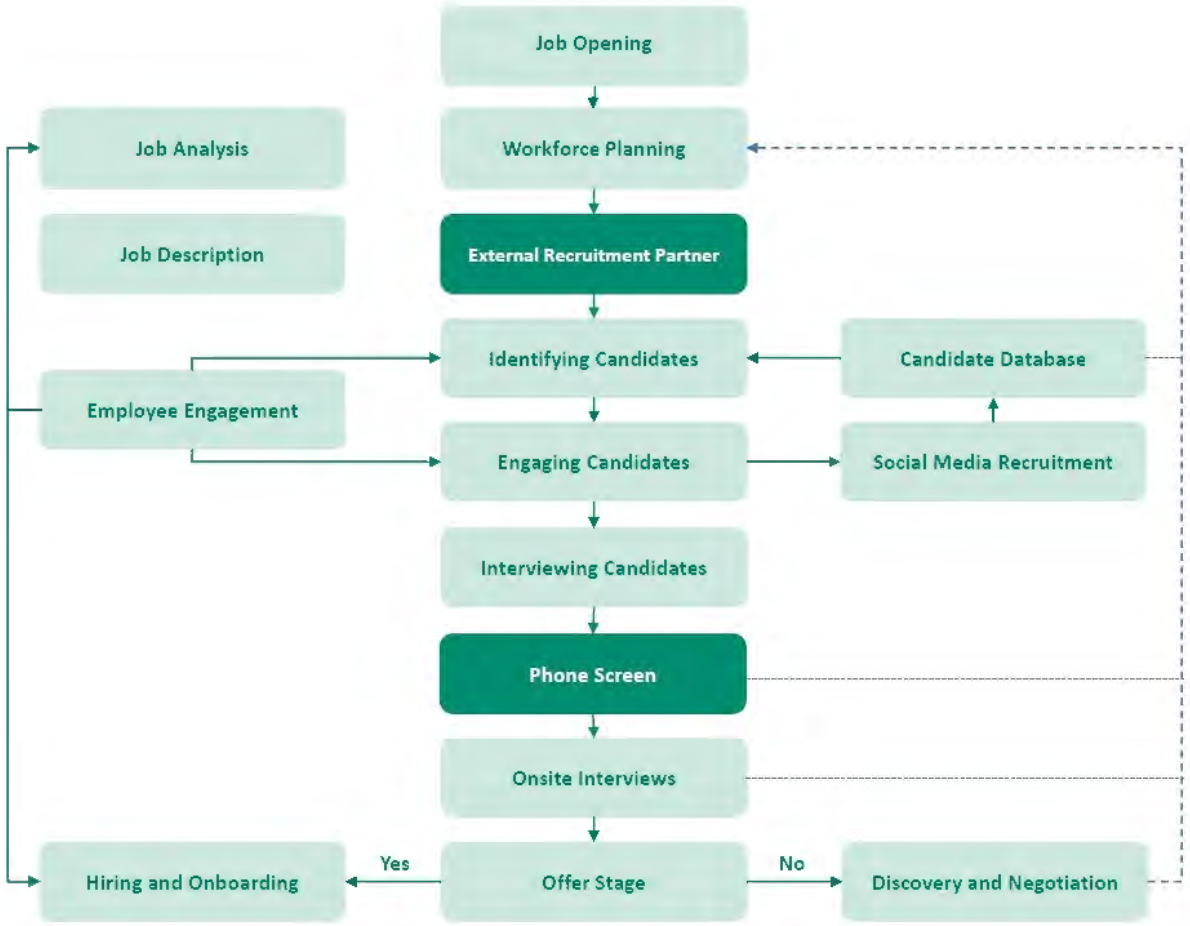
ERS Medical believes in providing equality in its recruitment and services, in treating people fairly with respect and dignity and in valuing diversity both as a health services provider and as an employer.

ERS Medical is committed to a comprehensive policy of equal opportunities in employment in which individuals are selected and treated on the basis of their relevant merits and abilities without regard

to race, religion or belief, colour, sex, age, national origin, disability or sexual orientation and are given equal opportunities within the company. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment on grounds not relevant to good employment practice.

We also hold recruitment days to ensure candidate meet the required criteria, understand the role, what is expected of them and that ERS is a values driven business.

Recruitment process flowchart:



Our Recruitment Policy complies with the NHS Employment Check Standard incorporating the following checks into our selection process:

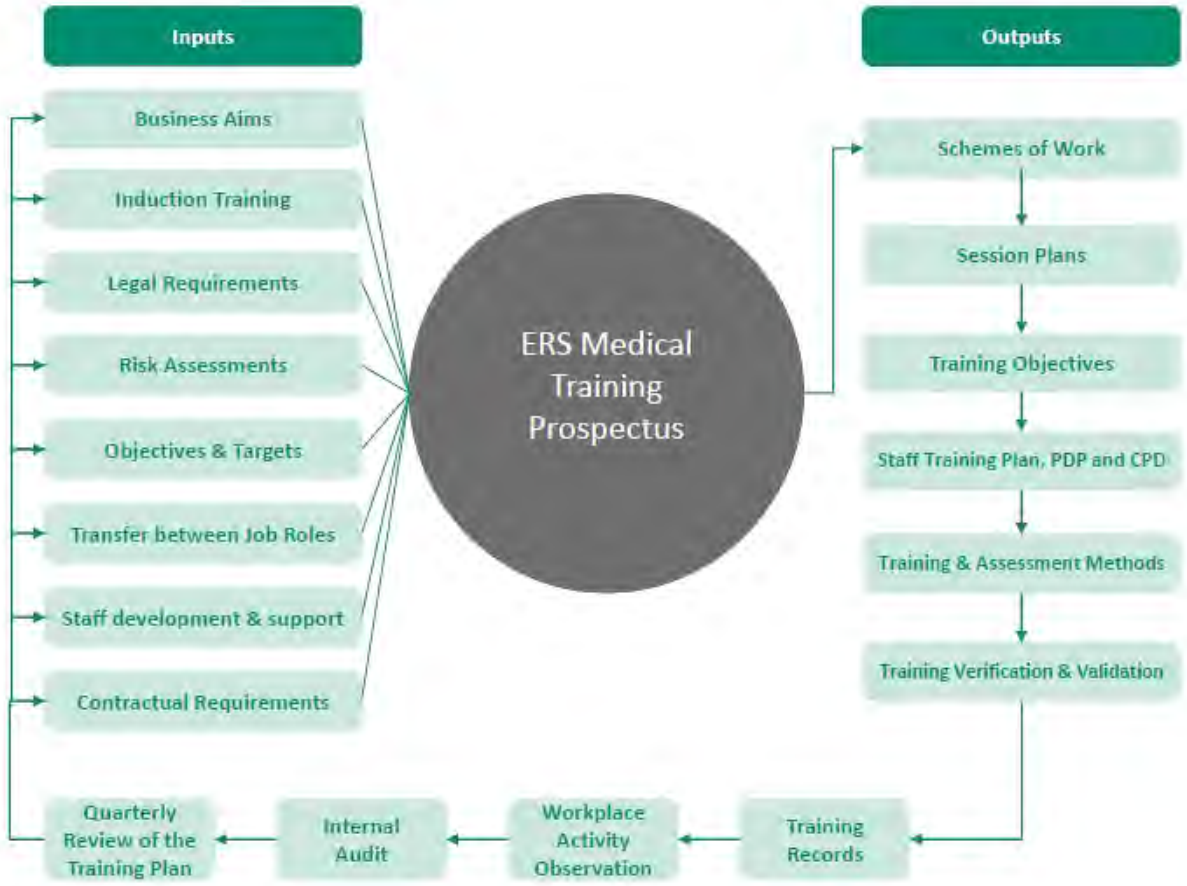
- Verification of identity checks
- Right to work checks
- Employment history and reference checks
- Registration and qualification checks
- Work health assessments
- Full enhanced DBS disclosure
- Driving licence checks

Our policy also covers the HORUS categorisation, the four strands of the NHS information governance agenda and the Caldicott principles.

Effective Induction

All new staff, whether recruited directly or transferred via TUPE, are subject to a robust induction to ensure they have the required skills to deliver the service. We have attached our training prospectus outlining the induction training and continual development training that all of our staff receive.

Our Training Plan consolidates several inputs and outputs:



We maintain a training database and will retain documentary evidence of training for each staff member assigned to work on this contract, available for audit by the Contracting Authorities during the contract term.

Retention strategy

Our training and development programmes empower staff members to continually develop throughout their careers resulting in our increased level of staff retention.

All employees receive ongoing support, training and assessment:

- Every employee has a 1:1 annual review
- Every employee has a Personal Development Plan

As part of the new company we have introduced a staff engagement schedule including:

- Site TV
- Senior Management 'Walk Talks'
- In Touch Magazine
- Employee Recognition Scheme

We also offer all of our employees the following benefits:

Wagestream	Allows staff to draw on their wages as they earn them
Employee Assistance Programme	The EAP was introduced in 2019 and provides a wide range of support for ERS employees and their families. From mental health advice to support with bereavement and legal information, the Health Assured EAP team are at the end of the phone 24/7 and are completely free to use.
ERS Academy	In 2020 we will be launching the ERS Academy. The aim of the academy is to provide career and personal development through apprenticeships for all ERS employees. As well as building a career development pathway for the ambulance sector, we will also be offering management and leadership courses from NVQ to master's level.

Minimising turnover

To mitigate against staff turnover and absenteeism we place our staff at the centre of everything we do to ensure they are motivated and dedicated to delivering a high-quality service. We believe that open and honest communication with our staff at all times via memos, site TV, Toolbox talks, Senior Management site walks, etc ensures that all employees within the business feel like part of the team aiming in the same direction with the same goal of deliver exemplary healthcare transport services.

ERS have a structured training and development programme that is vital for our staff's competence, confidence and retention. Our training and development programme empower staff members to continually develop throughout their careers resulting in a high level of staff retention. We actively encourage our employees to continue to develop themselves throughout their careers and give them the opportunity to grow within the business. The ensures that employees don't feel like they need to leave the business to progress their careers and move up the employment ladder. By having clear progression paths and regular one to one review meetings we are able to guide employees to achieve their career goals.

We have also implemented Perkbox to ensure that not only to we provide our employees with career progression support but also ensure they feel valued for the outstanding job they do day in day out.

Question 1.21.12

Workforce training

Please supply workforce training and development plans with timescales. Please show year one separately and then annual for the remainder of the contract. The plan must show how delivering training and development programmes will not impact upon operation delivery of the service.

Word count 750

Total Word Count: 724

ERS understands that it is crucial that our staff are fully trained and that they utilise their training effectively and correctly on a day to day basis. We review all training on a monthly basis through our Senior Management Meeting to ensure that training is being completed in line with our Training and Development plan. As part of their role our IQA qualified Trainers conduct regular spot-checks and ride-a-longs, to ensure that what is being taught in training sessions is put into practice and is effective.

We also deliver regular refresher training through toolbox talks and classroom-based teaching. To ensure that all of our employees training, and certifications are up to date we utilise a HR management system called ***REDACTED***. This system provides alerts to Team Leaders and Operational Managers to inform them when an individuals' training and certifications are due to expire. This allows us to provide the required refresher training to ensure that all crews are compliant at all times.

Alerts also notify managers when an employee's professional registration is due to expire. This ensures that our managers are aware of the employees who must update their registrations and can assist them in doing so. It also enables them to manage employees and not allow any shifts to be covered by employees whose professional memberships have expired.

REDACTED allows us to fully manage, monitor, maintain and audit the training of every staff member ERS utilise. This system holds all employee data in one secure location which collates healthcare data, contact information for the employee directory and also customised data to record any relevant information on our employees including training files, professional registrations and driving license checks.

ERS have a structured training and development programme that is vital for our staff's competence, confidence and retention. Our training and development programmes empower staff members to continually develop throughout their careers resulting in a high level of staff retention.

All employees receive ongoing support, training and assessment:

- Every employee has a 1:1 annual review
- Every employee has a Personal Development Plan
- Road crews have a 'Ride a Long' assessment by their Team Leader annually

A CPD activity is any activity from which our staff learn and develop. This includes the following:

- Work-Based Learning – e.g. reflecting on experiences at work, considering feedback from service users or being a member of a committee
- Professional Activity
- Webinars - “Walk through” new processes and procedures and Q&A
- Formal Education – e.g. going on formal courses or carrying out research
- Self-Directed Learning – e.g. reading articles or books

Paramedics and Nurses maintain individual CPD as it is a requirement of their professional registration.

All management level employees are continually supported with their CPD and receive two HR management training courses each year as well as monthly webinars that not only provide updated information from across the business but also support new skills and strengthen existing skills through providing greater depth and knowledge from subject experts.

During the first year all staff will be transferred to Level 3 – Non-Emergency Care Certification. This will be done through scheduled training in the first year of the contract. Below we have provided an anonymised training schedule providing an overview of how we arrange training and how it is recorded within our system.



We have also provided our training prospectus to give a full overview of the training that our workforce receives as an induction and annually thereafter.

To ensure that all staff are fully trained to our standard prior to the commencement of the contract we will conduct update training on the weekends preceding the 'golive' date. Once we receive to the full TUPE information we will conduct a skills analysis to understand any training gaps there might be and formulate a training session to cover them.

To ensure we do not disrupt the current service we will deliver this training on Saturdays and Sundays when a reduced service is being delivered. We will also carry out the training over 4 weekends to allow us to capture all employees with minimal disruption to the service. We will work with the incumbent supplier to arrange for the staff to be fully paid for their training and to cover any cost associated with back filling staff. This method has been successfully delivered to over 200 staff in our recent mobilisation of NEPT services in Homerton and Nottinghamshire.

Question 1.21.13

Staff recognition

Please supply arrangements for staff recognition and access to non-mandatory career development.

Word count 500

Total Word Count: 499

We believe that by having strong relationships with our employees it creates a strong organisational culture. We listen to our staff and they feel listened to, we communicate with our staff regularly to ensure they are aware of what is happening at, not only their site and region but across the organisation. We offer two staff surveys a year and continue to implement the changes based on the feedback that we are given. We have strong communication channels across the organisation by way of quarterly newsletters ensuring that staff are aware of what else is happening across the business. Our Managing Director visits each site at the start of the year to communicate and update any changes to our company mission and vision, as well as our senior team visiting sites throughout the year. We send out regular staff updates that are emailed to all staff in relation to any changes or news updates from across the organisation and staff have regular meetings with their line managers

ERS have 7 core values that are embedded within the organisation, they are also linked to our monthly employee recognition scheme, staff nominate other staff members within the organisation based on reflecting one or more of our values. We also have quarterly and annual regional nominations that are put forward and awards are given to staff, we enjoy recognising a job well done across the organisation and we publish all nominees and winners. Our values are also linked through our appraisal process and are discussed and linked to the staff members performance, discussing successes and growth areas. Our appraisal system also supports career progression, as we strive to promote from within and provide our current staff with career progression and opportunities.

As an Investors in People certified organisation our staff have Continuing Professional Development plans ensuring their development throughout their career. This plan includes multiple activities from which they can learn and develop:

- Work-Based Learning
- Professional Activity
- Webinars - “Walk through” new processes and procedures and Q&A
- Formal Education – e.g. going on formal courses or carrying out research
- Self-Directed Learning – e.g. reading articles or books

In 2020 we launched the ERS Academy. The aim of the academy is to provide career and personal development through apprenticeships for all ERS employees. As well as building a career development pathway for the ambulance sector, we will also be offering management and leadership courses from NVQ to master’s level.

Perkbox

We have recently implemented ***REDACTED*** to further build on our culture of employee recognition. ***REDACTED*** is a platform which includes employee benefits, feedback, recognition and wellness, such a free monthly coffee, wellness videos and gym membership discounts. Through ***REDACTED*** we provide:

- Peer to peer recognition
- Manager rewards
- Individual thanks/recognition
- Company wide recognition feed
- Tangible rewards for outstanding work

We believe it's important for us to recognise our staff in line with our values. We use the platform to say thank you to individuals with a perk, such as a voucher or an extra day's leave.

Question 1.21.14

Please supply arrangements for staff support and wellbeing.

Word count 500

Total Word Count: 492

The health and wellbeing of our staff is one of our core values as we understand that a happy and healthy workforce is an efficient and effective workforce.

ERS is managed through a decentralised leadership model which empowers local staff to make quick decisions in a controlled environment. This is achieved through our strong support network where clear responsibility's and escalation processes are in place ensuring that all our employees have the support they need to deliver high quality care. The emphasis we put on staff support and wellbeing is reflected in our recent Investors in People accreditation.

As well as a strong support network we have a number of initiatives in place to support our staff and improve their wellbeing. These include:

Employee Assistance Programme - The EAP was introduced in 2019 and provides a wide range of support for ERS employees and their families. As part of our drive to develop and improve the health and wellbeing of the communities we work in we believe it is vital to support our staff as much as we can. This is why we have an Employee Assistance Plan in place provided by our delivery partners Health Assured. This provides a free 24-hour helpline for all our staff to access care and support for both themselves and their immediate families. Health Assured provide the following:

- Life support: Unlimited access to counselling for emotional problems and a pathway to structured telephone counselling or face-to-face counselling sessions
- Legal information: For any issues that cause anxiety or distress including debt management, accountancy, lawsuits, consumer disputes, property or neighbour legalities
- Bereavement support: Health Assured offers qualified and experienced counsellors who can help with grief and related stress.
- Medical information: Qualified nurses are on hand to offer advice on a range of medical or health related issues.
- CBT online: Access to a range of CBT self-help modules, informative factsheets and invaluable advice videos.

Access to money - We are partnered with ***REDACTED*** a charity backed organisation that allows staff to draw on their wages as they earn them. It moves us away from a rigid monthly pay cycle and enables people to manage their money as they see fit. It also reduces the likelihood of

using expensive emergency short term loans and provides access to independent financial advice and savings accounts.

The service allows our staff to;

- Stream their wages and understand earnings on an hourly basis
- Track wages in real time including key information such as days to payday, days since payday
- Set up savings within the app
- Develop their financial education

Cycle to work scheme – This allows our staff with an easy and affordable way to purchase a bike for commuting to work. Decreases our environmental impact and provides health and mental health benefits that come from commuting to work.

REDACTED - Offers staff discounts, access to free wellbeing videos/free film rental every month, free monthly coffee from Café Nero and over 200 perks.

Question 1.21.15

Workforce engagement

Please supply details of how you will ensure workforce engagement and involvement in service development.

Word count 500

Total Word Count: 490

Our staff are the company's greatest asset and as such we invest heavily in training them to ensure that we not only deliver a high-quality service, but ensure we retain staff and continue to develop them throughout their career. We understand that this is a two-way process and continually engage with our staff via working groups, Staff surveys, annual one to ones, monthly breakfast mornings, Senior Management "Talk Walks, an internal quarterly magazine and through our HR management system.

Working Groups – Each site has a working group that meets monthly to discuss any on the ground topics such as rotas, new consumables, changes to equipment, etc. This is then fed back to the management team for further discussions on how any issues can be resolved

Staff survey – We provide two staff surveys each year and provide a full internal report of the findings and any changes we are making due to the feedback we have received

One to one – As part of our staff continual professional development they have quarterly one to one meetings with their manager to discuss their performance, training requirements, career aspirations and any other topics they wish to discuss.

Our constant interaction and communication allows staff to voice ideas and promote changes that they would like to see which has recently led to the following;

Rationalisation of the vehicle layout – We worked with our crews to redesign our vehicle layouts to make them more flexible and user friendly.

Changes to the rotas to fit the on the ground demand – At each of our contract sites we conduct quarterly meetings to engage with our crews regarding the shift rotas and any changes/improvements they would like to see. This not only ensures our crews remain engaged in delivering the service, but this also allows us to maximise the efficiency of our service and streamline our rotas.

Changes to the PDA screen set up to make it more user friendly – During a working group meeting our crews flagged up that the colour schemes on the PDA made it occasionally hard to read and confusing. Following this we consulted with our crews to identify a preferred colour scheme which was then implemented.

Enhancement to uniforms – During the previous winter our crews notified us that their hi-vis jackets weren't warm enough. This was raised with our clothing supplier and higher insulated jackets were provided.

Improving the staff room facilities – We provided our crews their own kitchen facilities that includes a kettle, fridge, microwave and small oven.

Employee recognition

ERS have 7 core values that are embedded within the organisation, they are also linked to our monthly employee recognition scheme, staff nominate another staff member within the organisation based on reflecting one or more of our values. We also have quarterly and annual regional nominations that are put forward and awards are given to staff, we enjoy recognising a job well done across the organisation and we publish all nominees and winners.

Question 1.21.16

Employment opportunities

The Authority is keen to understand how the successful Bidder will have regard to the Public Services (Social Value) Act 2012 in the delivery of the service, and what benefits their solution will offer in respect to improving employment opportunities such as apprenticeships, jobs for long term unemployed and targeted training.

Word count 500

Total Word Count: 301

Social value is the term used to describe the additional value created in the delivery of a service contract which has a wider community or public benefit. This extends beyond the social value delivered as part of the primary contract activity.

ERS recognises its' responsibilities to the wider community and our purpose is aligned to providing services that represent value for money, respect and contribute to the environment in which we work.

Social Benefits

To deliver social benefits in the areas that we provide services we;

- Are committed to the Armed Forces Covenant through the Defence Employer Recognition Scheme (ERS). Reservists and veterans bring a variety of transferable skills and qualities to the civilian workplace, developed throughout their military careers that can add value to our organisation. It is important that whilst we continue to improve support for the minority of service leavers and their families who face challenges after leaving, as a business we also recognise and celebrate that most veterans leave enriched by their service.
- Will arrange a recruitment day annually at local Job Centres to ensure we are offering job opportunities to local people
- Engage with local agencies who work with long term unemployed
- Provide work experience
- Have an apprenticeships scheme
- Deliver a targeted personal development and training programme for all of our staff

Economic Benefits

- Locally employed staff
- Our engaged sub-contractors are all based locally
- Vehicle servicing and maintenance will be provided by local businesses
- ERS will source consumables at a local level wherever possible

Environmental Benefits

Our sustainability and environmental impact target and standards include:

- 40% of our fleet to be ultra-low emission by 2025
- Actively monitor and reduce CO2 from staff travel
    - Cycle to work scheme
    - Advocate train travel to training courses and meeting
    - Car share scheme
    - Training by Teams webinars

Question 1.21.17

R High quality care

Please provide details of how the service will be led and how staff training will be managed to make sure it is delivering high quality care, encourages learning and innovation and promotes an open and fair culture.

Word count 1000

Total Word Count: 694

ERS Medical prides itself on delivering a high-quality, efficient, effective and safe transport service to all of our customers. To ensure quality is embedded throughout our business we have integrated our Vision, Mission and Values into everything we do.

We recognise employees as the key resource and have developed a management style and structure that empowers all colleagues to fulfil their duties in a well led environment that encourages dynamic decision making through;

- Decentralising authority to the Regions
- Rigorous performance management, reinforcing accountability for mission delivery
- Regular strategic alignment with Senior Managers and Regional Managers to establish prioritised action plans and allocate resource needed for success
- Decision making devolved to the most appropriate level, allowing responsive management
- Establishing an agile mindset to deal with the unexpected and speed up decision making
- Encouraging challenge within the team

Staff training

We will train all our staff to the appropriate levels; each staff member has a training plan tailored to their individual job role to ensure they continually deliver high quality care. Training needs and future aspirations are appraised quarterly, we consider this vital to the competence, confidence and retention of our staff.

ERS staff operate a clear training programme aligned to our Personal Development and Training policy, designed to ensure:

- Systematic timely training/development of all employees
- Company aims/objectives/competencies identified and communicated, and necessary training given to achieve the required levels and fulfil individual duties
- Training reviewed/assessed/validated against appropriate standards and records maintained

- Training coordinated fairly and consistently in line with regulatory and individual development requirements

We maintain a training database and will retain documentary evidence of training for each staff member assigned to work on this contract, available for audit by the Contracting Authority during the contract.

Learning

To encourage learning we provide each employee with a Continual Professional Development (CPD) plan. Each plan is tailored to the specific job requirements and personal aspirations of the employee and includes the following:

- Work-Based Learning
- Professional Activity
- Webinars - "Walk through" new processes and procedures and Q&A
- Formal Education – e.g. going on formal courses or carrying out research
- Self-Directed Learning – e.g. reading articles or books

Innovation

Through encouraging our employees to speak up we are able to harness and investigate any ideas or processes that they raise as potential benefits to the company, our staff or the patients themselves. Recently we have made the following changes to our services following employee suggestions:

- Changes to the PDA screen set up to make it more user friendly
- Enhancement to uniforms
- Improving the staff room facilities
- Rationalisation of the vehicle layout
- Changes to the rotas to fit the on the ground demand

Open and fair culture

We have developed an open and fair culture of reporting and communication throughout our business. This encourages staff to report incidents, openly discuss areas of the service that require improvement and areas where they feel changes may deliver an improved service to the patients. Through reporting incidents, we are able to conduct full investigations that will result in a number of actions to ensure the incident doesn't occur again. This allows our organisation to continually improve the quality and safety of the service that we deliver to both the patient and the CCGs. We also have staff working groups where we discuss any changes that they would like to see to our service to deliver a higher quality service to our patients. These groups also provide feedback on any new implementations and how they are working.

Our operational managers act as cultural ambassadors providing a link between our operational bases and head office in terms of flow of communications. Through the monthly management meetings, information, best practice and upcoming events are shared in an open dialogue. This information is then disseminated to our operational staff at each site by the operation manager.

We ensure all staff hear about patient feedback through regular team meetings, Site TV, our internal InTouch magazine and through the personal 121s, should the feedback be specifically about that employee. We also have an Employee Recognition scheme where anybody in the company can nominate any of their colleagues to recognise that they are delivering our services by living by our Company values.

Question 1.22.1

Capacity aligned with fluctuations in demand

How will you ensure sufficient capacity to deliver the service given inevitable fluctuations in demand? Your response should demonstrate flexibility to cope with significant increases or decreases in activity over the immediate, short, medium and long term.

Word count 1500

Total Word Count: 1029

Over the last 2 years our Senior Management has focused on delivering the highest quality health transport solutions with patient care at the heart of every decision.

This has delivered a CQC rating of Good/Outstanding across our four registered regions.

The NHS is recognising the quality solutions that ERS can offer with long term partnerships established in Norfolk, Nottingham, The North East, North London and Devon.

Our solution design is modelled on data mining from existing county wide services in Devon, Norfolk and Nottinghamshire which leads to detailed operational metrics allowing us to predict demand and plan resources accordingly.



Service Solution Design Methodology

REDACTED

Shift patterns

REDACTED

Shift patterns at each facility

REDACTED

Seasonality and Peak Flex Analysis

REDACTED

Meeting demand

REDACTED

Accurately predicting demand

REDACTED

Immediate short-term fluctuations

REDACTED

Local

REDACTED

Regional

REDACTED

National

REDACTED

Extreme short-term fluctuations

REDACTED

Long term fluctuations

REDACTED

Question 1.23.1

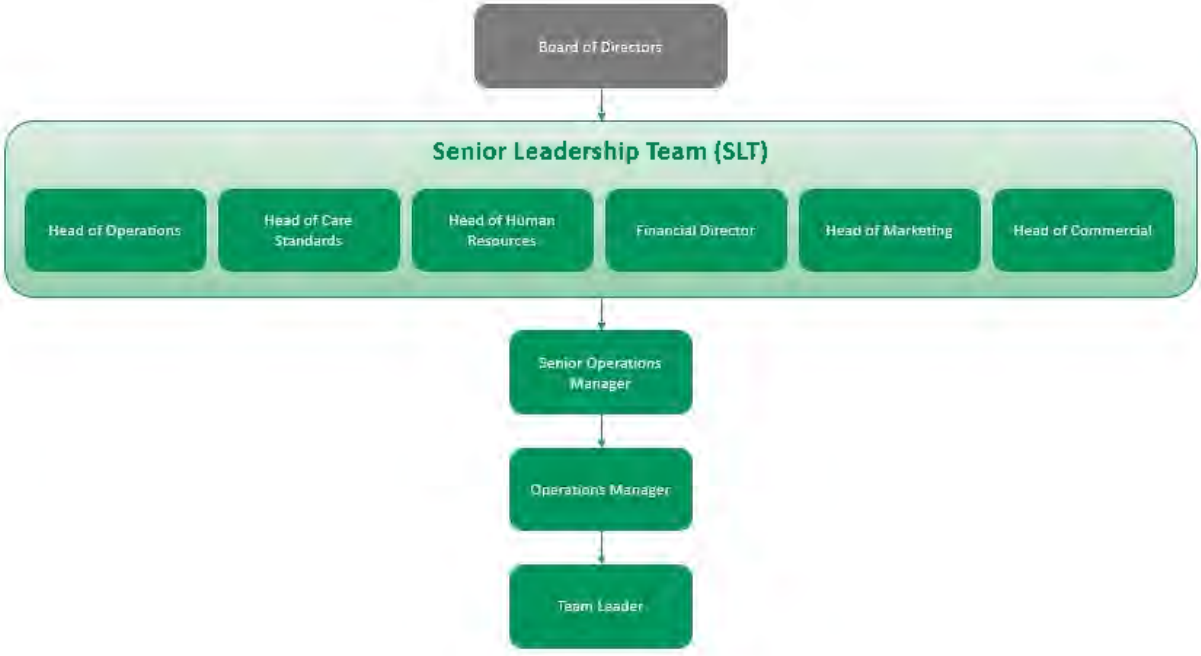
Corporate Governance Structure

Please provide your corporate Governance Organisational structure, including Executive Leadership and accountability, SIRO, Caldicott Guardian and individual roles).

Word count 500

Total Word Count: 500

Corporate Governance refers to the way in which companies are governed and to what purpose. It identifies who has power and accountability, and who makes decisions. Corporate governance ensures that our business has the appropriate decision-making processes and controls in place so that the interests of all stakeholders are balanced. Below we have provided an overview of our Corporate Governance organisational structure:



Governance at a corporate level includes the processes through which a company's objectives are set and pursued in the context of the social, regulatory and market environment. It is concerned with practices and procedures for trying to make sure that a company is run in such a way that it achieves its objectives, while ensuring that stakeholders can have confidence that there is accountability protecting their interests.

The below table provides a full overview of our roles and responsibilities for this contract:

Managing Director	Has overall responsibility for setting and directing - quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting ERS Medical objectives and allocating adequate resources to meet those objectives.
Senior Leadership Team	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the ERS Medical subscribes and the legislation relative to the ERS Medical's operations.
Senior Operations Manager and Operational Managers	Are responsible for ensuring that sufficient time and resource is afforded to the Internal Audit Teams to allow ERS Medical's audit schedules to be achieved. Are additionally responsible for ensuring that sufficient time and resource is afforded to any external audit the Internal Audit Teams to allow the ERS Medical audit schedules to be achieved.
All Team Members	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times. Are additionally responsible for completing all actions that they are allocated for in a timely manner and for notifying the issuer upon completion.

Below we have provided an overview of the executive leadership responsibilities thorghout the business:

REDACTED

Continual improvement

As an organisation continually striving to improve and develop our governance we regularly audit and analyse our internal business structures, processes and projects. The following ten principles allow us to maintain our focus on good governance and ensure we continually deliver services to the best of our ability:

Roles & Responsibilities – We have a clear and open outline of individual responsibilities, organisational expectations of executives and the role of executive and steering committees

Structure & Composition – Our board of directors comprises of individuals with diverse backgrounds ensuring we have a plethora of skills, experience and capability to deliver a robust governance strategy throughout the business

Purpose & Strategy – The board of directors has set out a clear vision, purpose and strategies of the business and disseminates this to all employees ensuring they understand these and apply them in their day to day activity

Risk Management – Our Risk Register provides a robust system of risk oversight and internal controls ensuring all risks are identified and managed

Organisational Performance – The board of directors determines and assesses appropriate performance categories and indicators for the organisation and conducts monthly review meetings to understand how the business is performing against them

Committee Effectiveness – Our board of directors carefully plans board-related activities; ensures committee meetings are run in an efficient manner; conduct regular assessments of business performance; have an executive succession plan; and effectively utilise sub-committees, where appropriate

Accountability – We provide transparent accountability to all stakeholders and employees throughout the business. We also provide integrity of financial statement.

Culture & Ethics - The board of directors sets the tone for ethical and responsible decision-making throughout the business

Engagement – Our board of directors utilise multiple methods to engage with both employees and stakeholders. These include internal and external newsletters, webinars, siteTV, posters and talk walks.

By conducting systematic Lessons Learnt and feedback reviews, we learn from identifying areas of improvement quickly and effectively. Following the identification of an area of improvement the board of directors discuss required changes to the business and how these will be implemented.

	WK 1							WK 2							WK 3							WK 4			
MTG CHAIR	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	
TL	DCC	DCC	DCC	DCC	DCC			DCC	DCC	DCC	DCC	DCC			DCC	DCC	DCC	DCC	DCC			DCC	DCC	DCC	
OM	OPS MTG							OPS MTG							OPS MTG							OPS MTG			
RM									REGIONAL (GaPR) MTG																
MD																	BUSINESS GaPR MTG								
MD																		EXEC COMMITTEE MTG							

DCC	Daily Control Call
OPS MTG	Weekly Operational Meeting (Team Leaders report to Ops Manager)
REGIONAL (GaPR) MTG	Monthly Regional Governance and Performance Review (Ops Managers report to Regional Manager)
BUSINESS GaPR MTG	Monthly Business Governance and Performance Review (Regional Manager report to Directors)
EXEC COMMITTEE MTG	Monthly Executive Committee Meeting (Review business situation, focus resources, key decisions)

STRATEGY & COMPLIANCE (STANDARD YEAR)

	2018												2019										
MONTH	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**
	Q1			**Q2**			**Q3**			**Q4**			**Q1**			**Q2**			**Q3**			**Q4**	
	EC	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**	**EC**
	MB			**MB**			**MB**			**MB**			**MB**			**MB**			**MB**			**MB**	
			PSC			**PSC**			**PSC**			**PSC**			**PSC**			**PSC**			**PSC**		

Notes:

1. The Executive Committee **(EC)** is the link between operations and strategy.
2. Quarterly Management Board **(MB)** NonExec governance.
3. Patient Safety Committee **(PSC)** maintain compliance, H&S, clinical standards. Medical Director oversight.
4. Reporting structure and timeline can be sequenced with key reports (issue of accounts) and any major decisions.

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Question 1.23.2

Corporate Governance Arrangements

Please provide a description of how the planned Corporate Governance and risk management arrangements will work in practice.

Word count 1000

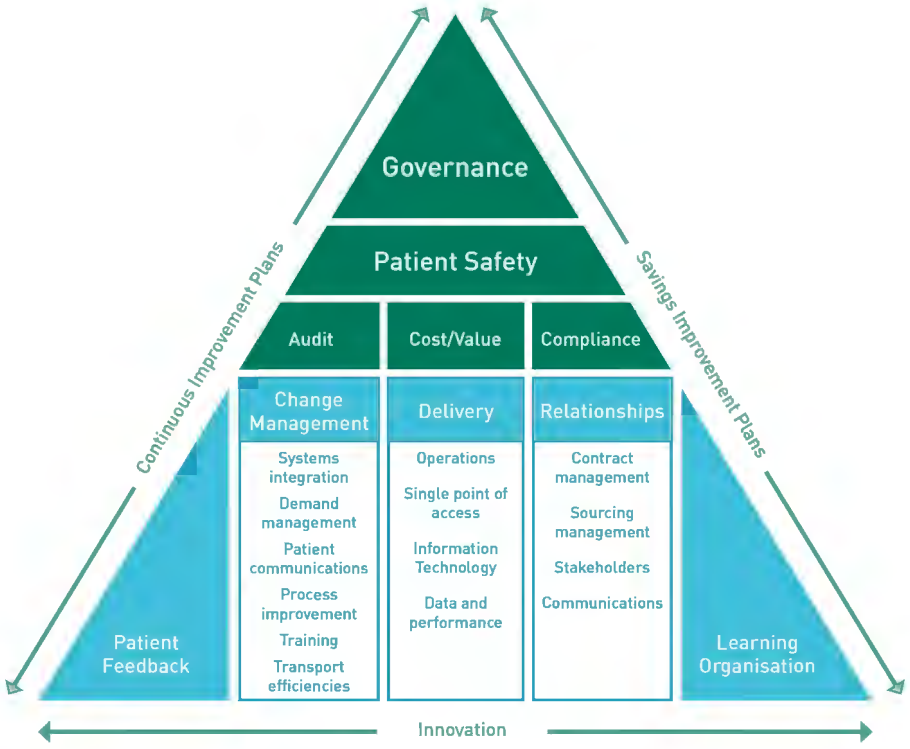
Total Word Count: 992

Corporate governance is the system of rules, practices, and processes by which our business is directed and controlled. Our corporate governance practices have been developed with risk management as a priority.

Our board of directors' responsibilities are:

- Ensuring the design and implementation of appropriate risk management and internal control systems that identify the risks facing the Business and enable them to make a robust assessment of the principal risks
- Determining the nature and extent of the principal risks faced and those risks which the business is willing to take in achieving its strategic objectives
- Ensuring that appropriate culture and reward systems have been embedded throughout the organisation
- Agreeing how the principal risks should be managed or mitigated to reduce the likelihood of their incidence or their impact
- Monitoring and reviewing the risk management and internal control systems, and the management's process of monitoring and reviewing, and satisfying itself that they are functioning effectively and that corrective action is being taken where necessary
- Ensuring sound internal and external information and communication processes and taking responsibility for external communication on risk management and internal control

To ensure we governance is applied to everything we do we utilise a consistent approach with an outlined set of internal governance controls. The below diagram outlines how this are applied:



We continually manage and monitor the effectiveness of our Corporate Governance processes, practices and policies through regular meetings. We have developed a governance plan that outlines how corporate governance and risk management are interrogated into our daily operation. This plan has an annual schedule for the following meetings:

Daily Control Calls

These are calls between the on the ground crews and Team Leaders. They are used to discuss the service delivery and any issues that might impact on the service quality.

Weekly Operational Meetings

This meeting is for Team Leaders report to Operations Managers providing an overview of the previous 7 days service delivery. The topics discussed include:

- Staff availability and any issues (e.g. high sickness levels)
- Vehicle availability and any issues
- Subcontractor usage

Monthly Regional Governance and Performance Review

This meeting is for Operations Managers to report Regional managers delivering an overview of the previous months service and look ahead to the coming month. This is used to discuss any service issues that have arisen, incidents that occurred, complaints received and best practice to be disseminated throughout the business.

Monthly Business Governance and Performance Review

This meeting is for the Regional Managers to report to the Head of Operations and the Senior Leadership Team. This meeting looks at how each of our contracts are performing against their targets. Where a contract is not meeting its required targets a mitigation and rectification plan is discussed and agreed to be implemented in the coming month.

Monthly Executive Committee Meeting

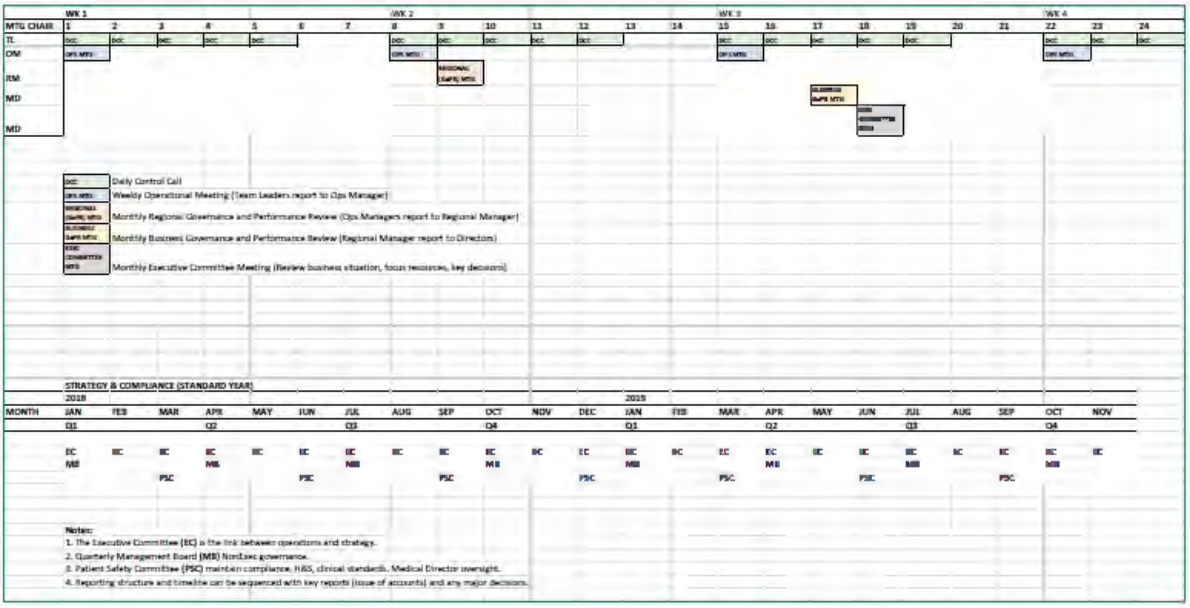
This meeting is for the board of directors to review the current situation of business, focus on high level resource allocation and discuss and make any key business decisions.

Quarterly Board Meeting

This meeting is for a full business review by the Board of Directors

Below we have provided a sample of the meeting schedule:

ERS Medical Annex A



Risk identification and management

The identification of risk is a corner stone to any risk management process and is essential in ensuring that all risks are adequately controlled, managed to acceptable levels and / or receive suitable and sufficient further risk treatment.

Risk can be identified using various techniques and tools such as:

- Audit and Inspection Reports via RADAR
- Trend identification through regular Audits
- Experience
- Discussions with Stakeholders
- Interviews
- Post Incident Reports and Investigations

- Risk Identification Checklists
- Employee and or External Feedback
- Strategic and Business Plans
- Surveys and Questionnaires

Once identified risks are managed using our incident reporting system and our online Risk Register, Radar, which is accessible to all employees to record any serious issues that may impact on patient care, service delivery or the business as a whole.

These measures ensure that:

- Required standards and performance are being achieved
- All potential business risks are identified, and mitigations are put in place
- Areas of good practice in the service are highlighted and shared across the business
- We can identify and manage risks to clients and service delivery. Once a risk is identified clear processes are then put in place to reduce or eliminate the risk

Business Impact Assessment (BIA) is a process used by ERS Medical to analyse its activities at each location and to establish and understand the effect that a business disruption might have upon them. A work instruction has been devised and implemented, which defines the process to be followed.

Business Management Systems (BMS)

To enable staff in all roles to make efficient and effective decisions ERS has established an internal controls framework which focuses on processes, authority and responsibility. Our BMS covers all aspects of the organisational control including:

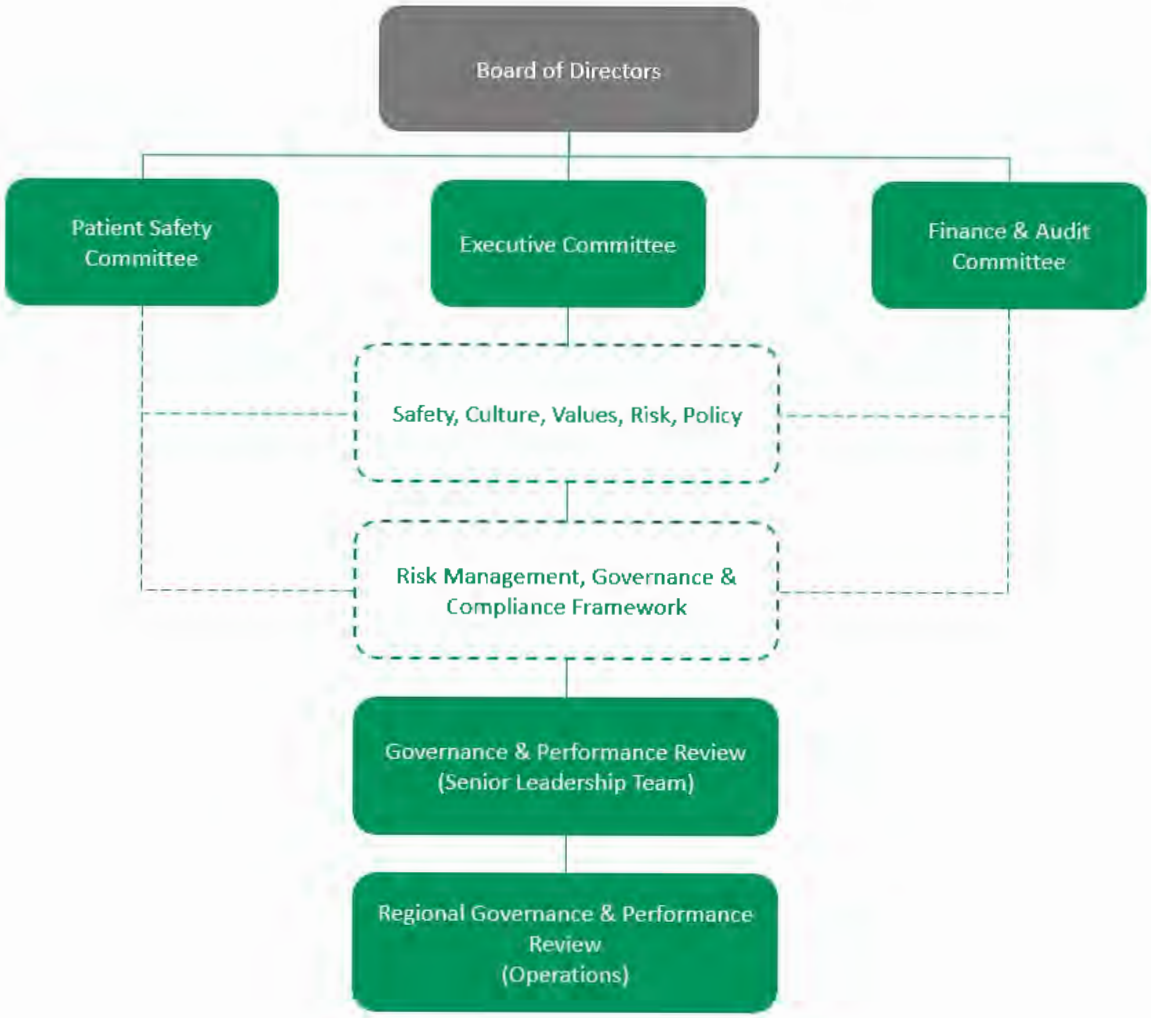
- Standard Operating Procedures (e.g. Care to Care, manual handling)
- Compliance requirements (e.g. staff, fleet, equipment)
- Authorisation levels by roles (e.g. financial purchasing limits, recruitment & payroll changes, asset management, treasury sign off)

The framework is controlled through approval requests which are checked by independent members of the team such as HR, Finance and IT to ensure the appropriate level of authorisation has been obtained prior to decision making. Our software systems around HR, Compliance, Fleet and Finance ensure electronic approvals are in place within a rigid authorisations control matrix.

Furthermore, a number of review and audits take place ensuring the organisation remains compliant and BMS is followed:

- Monthly balanced scorecard review to hold Operations Managers and Senior Leadership team accountable to their business area directives
- Regular site audits focusing on compliance around Care, Information Governance, Safety, Staff and Fleet compliance
- Monthly Income Statement reviews including variance analysis with Operations Managers ensuring financial compliance is upheld
- Weekly and monthly compliance reports for HR and recruitment ensuring relevant documentation is in place

- Weekly and monthly care and safety reports ensuring processes are followed
- Independent audits by external auditors for financial and regulatory compliance



Question 1.23.3

Please provide your service delivery risk register including monitoring arrangements, control measures and mitigating actions (in the form of a SMART action plan).

Word count 500

Total Word Count: 499

ERS uses the ***REDACTED*** compliance software for its monitoring and management of risk as well as clinical and regulatory governance. This system has been designed specifically with the healthcare market in mind by ***REDACTED*** and it allows ERS to quickly and efficiently capture and record the main aspects required for evidencing compliance with the requirements of regulated activity.

All incidents, comments, complaints and compliments are recorded on ***REDACTED*** allowing us to fully monitor the quality and clinical governance of our service. The key indicators that we use to monitor the quality of our services are incidents, complaints, near misses, patient feedback, staff feedback and commissioner feedback. Through ***REDACTED*** we are able to monitor, manage and report on all of these key indicators providing both ourselves and the Commissioners with comprehensive information to ensure the service is meeting the delivery requirements.

We chose the ***REDACTED*** solution because it provides a platform to allow ERS to continually improve its service offering through the following 5-stage process:

- Capture – ***REDACTED*** allows us to capture large amounts of data and translate it into comprehensive reporting formats
- Report – Accurate reporting is crucial to understanding trends, best practice and early indicators. Through ***REDACTED*** we can do this quickly and efficiently
- Action – ***REDACTED*** allows us to identify existing and potential non-conformances, and supports us to create, execute and monitor corrective and preventative action plans
- Improve – Sustainable quality improvement is delivered through well-led engagement. ***REDACTED*** allows us to centrally collate evidence-based data and easily identify and share best practice
- Standardise – A systematic approach to identifying good practice through ***REDACTED*** allows us to turn good practice into standard behaviour

REDACTED details any company and compliance 'Notices' which need to be read and acknowledged, Audits that are due, Assigned 'Actions' to complete, Incidents which need to be investigated and managed, Documents which require reviewing and any employees who have overdue items in their ***REDACTED*** dashboard. This ensures that all actions related to our services delivery and risk register are continually monitored, managed and delivered within specific

timeframes. Below we have provided screenshots of our system and how it is used as a SMART action plan tracker.

REDACTED

Within ***REDACTED*** we maintain our Risk Register that is a working document and updated at regular monthly intervals as new risks and mitigation are identified and managed by technical leads. Below we have provided a screenshot of our Risk Register.

REDACTED

REDACTED allows us to identify appropriate and effective controls and mitigating actions to address the identified risks. It also allows us to easily monitor and report on the effectiveness of these actions.

Actions taken

Following the identification, investigation, and outcomes of an incident we provide a full report to the Commissioners and disseminate any relevant updates to our Work Instructions throughout the business. Learning from investigations are shared by:

- Site and Regional staff meetings
- Direct from our ***REDACTED*** incident management system
- Specific and directed 'Notices'
- The monthly GaPR 'One Compliance Report'
- The monthly Mission Performance Review
- Make required changes to policy

BMS/1.09 Information Governance

Document Author:	[redacted]			Care Standards Manager & SIRO	
Document Owner:	[redacted]			Managing Director	
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2.1	All	All	All	13/04/18	[redacted]	Addition of set revision date
3.0	All	All	All	01/05/18	[redacted]	Revised for GDPR
4.0	All	All	All	03.05.19	[redacted]	Annual Review
5.0	All	All	All	12.05.20	[redacted]	Annual Review

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Subject Access Requests	WI/1.09.01
Subject Access Request Form	F1.09.01

3. Introduction

3.1 Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in Clinical Governance, service planning and performance management.

3.2 It is therefore of paramount importance to ensure that information is effectively managed and that appropriate policies, procedures and management accountability and structures are in place to provide a robust governance framework for information management. Within the NHS and private healthcare setting this aspect of information management is termed either Information Governance (IG) or Information Security (IS).

3.3 This procedure details the arrangements in place to provide a robust IG framework in ERS Medical and to provide assurance that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

3.4 IG is formed by those elements of law and policy from which applicable IG standards are derived. It encompasses legal requirements, central guidance and best practice in information handling including:

- The common law duty of confidentiality;
- Data Protection Act 1998;
- Human Rights Act;
- Information Security;
- Information Quality;
- Records Management;
- Freedom of Information Act 2000 (this only applies to public bodies).

3.5 This procedure provides a high level description of the arrangements in ERS Medical for developing, implementing and monitoring IG policy and procedure. Detailed procedural guidance for staff is contained in separate specific policies and therefore the contents of this document are most relevant to staff who exercise a supervisory or managerial role or have a role with an information management component.

3.6 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.7 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Information Security Policy.

5. Responsibilities

5.1	**Managing Director**	The Managing Director has overall responsibility for the standards of Information Governance in ERS Medical. As the accountable officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the ERS Medical subscribes and the legislation relative to the ERS Medical's operations.
5.3	**Data Protection Officer (DPO)**	Is responsible for monitoring internal compliance, inform and advise on data protection obligations and act as a point of contact for data subjects and the supervisory authority (ICO). The DPO is also responsible for monitoring and coordinating at Subject Access Requests received by ERS Medical and ensuring response are sent out in compliance with GDPR.
5.4	**Head of Care Standards / Caldicott Guardian**	ERS Medical's Caldicott Guardian is the Head of Care Standards who has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information. ERS Medical's Caldicott Guardian is responsible for ensuring patient identifiable information is shared in an appropriate and secure manner. In addition to this is responsible for setting the routine management and co-ordination of IG within the ERS Medical.
5.5	**Senior Information Risk Owner (SIRO)**	Is responsible for taking ownership of ERS Medical's information risk policy, act as an advocate for information risk to the SLT and report within the Patient Safety Committee (PSC).
5.6	**Senior Operations Manager/ Operations Managers**	Are responsible for ensuring that the procedures and resources provided for IG is communicated, available and utilised within their areas of control at all times.
5.7	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **IG** – Information Governance.

6.2 **IS** – Information Security.

6.3 **IGT** – Information Governance Toolkit.

6.4 **PDA** – Portable Data Appliance.

6.5 **CAD** – Computer Aided Dispatch.

7. General ERS Medical Principles

7.1 There should be proactive use of information within the organisation, both for patient care and service management as determined by law, statute and best practice.

7.2 There should be proactive use of information between ERS Medical, its NHS and other partner organisations to support patient care as determined by law, statute and best practice.

7.3 ERS Medical will establish and maintain policies and procedures to ensure compliance with requirements contained in the NHS Information Governance Toolkit (IGT).

7.4 ERS Medial will annually assess its performance against the requirements set out for AQP in the IGT. ERS Medical will report the results of its self-assessment to the Department of Health in accordance with current guidance in the IGT.

7.5 ERS Medical will follow a program of continual improvement to increase IG compliance throughout the company.

7.6 Individual members of staff will be provided with the opportunity to attend training and awareness sessions to equip them to meet their individual responsibilities in relation to IG.

7.7 All new developments and changes to policies and procedures will be assessed to identify any impact of information handling and information quality.

8. The IG Framework

8.1 The Information Governance framework for Health and Social Care is formed by those elements of law and policy from which applicable information governance standards are derived, and the activities and roles which individually and collectively ensure that these standards are clearly defined and met.

8.2 The Information Governance Framework is the combination of policies, responsibilities and arrangements for the management of IG described in this document. The IG framework will be reviewed annually by the IGSG as part of the IGT assessment process.

8.3 There are a number of separate work steams with individual functions that combined underpin IG in ERS Medical. These are:

- Data Protection;
- Freedom of Information (only in support of our NHS partners and public bodies);
- Information Security;
- Information Quality;
- Clinical Records Management;
- Company Records Management;
- The legitimate sharing of information, when and where required.

8.4 ERS Medical recognises the need for an appropriate balance between openness and confidentiality in the management and use of information.

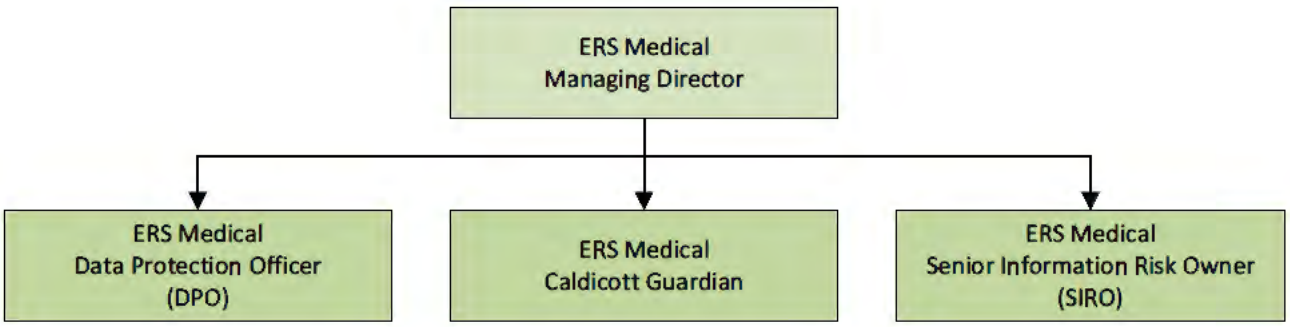
8.5 Information will be defined and where appropriate kept confidential, underpinning the principles of Caldicott and the regulations outlined in the Data Protection and Freedom of Information Acts.

8.6 Non-confidential information on ERS Medicals services will be available to the public through a variety of means such as websites and marketing materials.

8.7 ERS Medical will follow established procedures to deal with queries from patients and the public and will have clear procedures via the communications department for liaison with the press and broadcasting media.

9. Information Governance Structure

9.1 The ERS Medical Information Governance structure is:



10. Caldicott Principles

10.1 The primary responsibilities of the ERS Medical's Senior Management Team, through the Head of Care Standards (Caldicott Guardian):

- To monitor the ERS Medical IG policy and procedure and ensure any changes to legislation are reflected in IG policy and procedure;
- To complete and submit the assessment of compliance with IG requirements published in the IGT and provide assurance to SMT that the minimum mandated level of compliance is met;
- To develop and implement a programme of improvement designed to show year on year improvement in IG compliance across ERS Medical as measured by the IGT assessment.
- To review and set IG for all staff groups and work with the Training Team to ensure the required training is delivered.

10.2 In addition to this ERS Medical will remain compliant, enforce and advocate the 7 Caldicott Principles, which are:

1. Justify the purpose(s);
2. Don't use personal confidential data unless absolutely necessary;
3. Use the minimum necessary personal confidential data;
4. Access to personal confidential data should be on a strict need-to-know basis;
5. Everyone with access to personal confidential data should be aware of their responsibilities;
6. Comply with legislation;
7. The duty to share information can be as important as the duty to protect patient confidentiality. Health and Social Care professionals should have confidence to share information in the best interests of their patients within the framework set by these principles. This should be supported by the policies of their employers, regulators and professional bodies.

11. Principle 7 - Caldicott

11.1 When required to share data that is categorised as personal confidential, such as PID and PSI ERS Medical will start from the position of 'Yes' we can share under Principle 7. However, before any transmission or sharing takes place principles 1 to 6 must be explored.

11.2 We should only share such information that is required for the requested purpose and any request must also detail from the requesting organisation the following:

- The purpose of the request;
- How long they will keep the data;
- How the plan to dispose of the data.

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11.3 If you have any doubts about sharing any data, staff must contact the Caldicott Guardian for further guidance.

12. Reporting and Accountability

12.1 The primary responsibilities of the ERS Medical's Senior Management Team, through the Head of Care Standards (Caldicott Guardian):

- To monitor the ERS Medical IG policy and procedure and ensure any changes to legislation are reflected in IG policy and procedure;
- To complete and submit the assessment of compliance with IG requirements published in the IGT and provide assurance to SMT that the minimum mandated level of compliance is met;
- To develop and implement a programme of improvement designed to show year on year improvement in IG compliance across ERS Medical as measured by the IGT assessment.
- To have IG as a fixed agenda item on the monthly regional Governance and Patient Safety (GaPR) committee reports;
- To review and set IG for all staff groups and work with the Training Team to ensure the required training is delivered.

13. Data Security and Protection Toolkit Annual Assessment

13.1 Annually ERS Medical will complete a self-assessment of compliance with the requirements applicable to AQP in the current version of the Data Security and Protection Toolkit. The summarised results of this assessment will be made available to the SLT and wider organisation and its contractual partners.

13.2 All assessments are completed by making a formal declaration of the level of compliance assessed for each requirement and identifying and uploading copies of appropriate evidence (documents, policies, meeting minutes etc) to support the level of compliance assessed.

13.3 A minimum assessment of level 2 compliance is expected in order to demonstrate adequate governance practice and procedure. Where this is not being achieved actions to improve should be identified and implemented.

13.4 As part of ERS Medical's internal audit process an IG internal audit will be conducted by either the Head of Care Standards or a member of the Care Quality Team for each registered locations and its sub-sites. These audits will be available via the ERS Medical compliance software system.

13.5 The Data Security and Protection Toolkit must be completed annually by the end of March. During the 2019/2020 assessment period this has been extended to September 2020, due to COVID-19.

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14. WhatsApp – Mobile Communications

14.1 ERS Medical utilises the 'WhatsApp' mobile communications application, as a secondary communications platform to enable road staff to communicate with either the CCO in Leeds or their local control and despatch.

14.2 WhatsApp should be used as a platform for lower priority communication ie 'running late, 10 minutes away' freeing up phone line and CAD for priority communications, such as those that require passing on PID information. Each WhatsApp 'Group' will be kept small and only accessible through an ERS PDA.

14.3 **NO** Patient Identifiable Information (PID) or Patient Sensitive Information (PSI) is permitted to be sent via the 'WhatsApp' system. This type of information can include, but not be limited to:

- Patient name(s);
- Patient addresses;
- Patient NHS numbers;
- Patient medical history;
- Any clinical information that relates to a patient;
- Photographs, where the patient is in the image;
- Video and other recordings where the patient is either seen or heard;
- Images of printouts from monitoring equipment;
- Patient Report Forms (PRF's) and associated documents;
- Any information that can be linked back with additional information or access to systems that might readily identify a patient.

14.4 The 'WhatsApp' system will be monitored by the CCO and local controls to ensure that this type of information is not transmitted. Any breaches to this procedure will require an 'Information Governance (IG)' incident to be raised on the 'Radar Healthcare' compliance system.

14.5 The Care Standards Team will audit for compliance to this procedure as part of their monthly Care Quality Site Inspection. Any non-conformities to this procedure, will be recorded within Radar Healthcare, as an IG incident and investigated as required.

14.6 The setting up of additional 'WhatsApp' groups, other than those authorised by ERS Medical, on devices owned and operated by ERS Medical is prohibited. Compliance with this requirement will form part of the Physical IG audit conducted by the Care Standards Team.

14.7 It is prohibited for ERS Medical staff to engage in Peer to Peer communications with other ERS Medical devices set up on WhatsApp. Compliance with this requirement will form part of the Physical IG audit conducted by the Care Standards Team

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15. Continual Improvement

15.1 The ERS Medical IG strategy is to follow a programme of continual improvement to show a year on year increase in IG compliance as measured by the annual assessment against the IG requirements set out in the IGT.

15.2 Annually the SMT will agree a target for the year identifying the priorities of work and actions required to improve IG compliance in the company. The results of the previous year's IGT assessment will identify key areas for improvement and will be used in conjunction with audit findings and other sources of information to identify priorities for action.

15.3 The progress of the IG target will be reported back to the SMT through regular SMT meetings throughout the year.

15.4 In addition to the SMT monitoring for IG, all CQC Registered locations hold monthly 'Governance and Performance Reviews (GaPR)' committee meetings, chaired by the Registered Manager. Information Governance is a fixed agenda item for all of these meetings.

15.5 The minutes of the all regional GaPR meetings will be reviewed by the IG Lead (Head of Care Standards) and the finding reported back through to the SMT. Similarly, any relevant IG decisions taken by the SMT may also be communicated back through the IG Lead to the regional GaPR.

16. Subject Access Requests

16.1 For specific details relating to all 'Subject Access Requests' please refer to **WI/1.09.01 – Subject Access Requests.**

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BMS/1.10.01 GDPR – Communications Policy

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2.0	All	All	All	06.06.19	[redacted]	Annual Review
3.0	All	All	All	01.07.20	[redacted]	Annual Review

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GDPR Subject Access Request (SAR) Policy	BMS/1.10.05
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02

3. Introduction

3.1 IT and Communication plays an essential role in the conduct of our business. The IT infrastructure including e-mail and internet access have therefore significantly improved business operations and efficiencies.

3.2 How you communicate with people not only reflects on you as an individual but also on us as a business. As a result of this the company values your ability to communicate with colleagues, clients/customers and business contacts but we must also ensure that such systems and access are managed correctly, not abused in how they are used or what they are used for.

3.3 This policy applies to all members of the Company who use our or our clients' communications facilities, whether Directors/Consultants, full or part-time employees, contract staff or temporary staff. The parameters and restrictions are outlined below and you are required to read them carefully.

4. Responsibilities

4.1	**Managing Director**	Has overall responsibility for ensuring that ERS Medical complies with GDPR legislation.
4.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
4.3	**Head of HR and Training**	Is responsible for ensuring that the ERS Medical's HR procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to undertake their duties. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
4.4	**Senior Operations Managers & Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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5. General Principles

5.1. You must use our and our clients' information technology and communications facilities sensibly, professionally, lawfully, consistently with your duties and in accordance with this policy and other Company rules and procedures.

5.2. At all times employees must behave with honesty and integrity and respect the rights and privacy of others in relation to electronic communication and information. The company reserves the right to maintain all electronic communication and files.

5.3. Every employee will be given access to the Intranet and/or Internet as appropriate to their job needs. For those who do not have daily PC access occasional access will be arranged, as necessary, by Management.

5.4. All PC/network access will be through passwords, and no individual is permitted onto the system using another employee's password. Employees are not permitted to share their password with anyone inside or outside the company. Individuals will be allowed to set their own passwords, and must change them as frequently as requested by the system set-up requirements.

5.5. All information relating to our clients/customers and our business operations is confidential. You must treat our paper-based and electronic information with utmost care.

5.6. Many aspects of communication are protected by intellectual property rights which can be infringed in a number of ways. Downloading, copying, possessing and distributing material from the internet may be an infringement of copyright or of other intellectual property rights.

5.7. Particular care must be taken when using e-mail as a means of communication because all expressions of fact, intention and opinion in an e-mail may bind you and/or the Company and can be produced in court in the same way as other kinds of written statements.

5.8. If you are speaking with someone face to face, via the telephone, in writing via whatever medium you are a representative of the Company. Whilst in this role you should not express any personal opinion that you know or suspect might be contrary to the opinions of the Directors or Company policy.

5.9. You must not use any of our or our clients' media to do or say anything which would be subject to disciplinary or legal action in any other context such as sending any sexist, racist, defamatory or other unlawful material. If you are in doubt about a course of action, take advice from a member of management.

6. Use of Email

Business Use

6.1. Always use the "Bcc" box when mailing to groups whenever the members of the group are unaware of the identity of all the others (as in the case of marketing mailing lists), or where you judge that the membership of the group of one or more individuals should perhaps not be disclosed to the others (as in the case of members of a staff benefit scheme), because if you use the "Cc" box each recipient is informed of the identity (and in the case of external recipients, the address) of all the others. Such a disclosure may breach any duty of confidence owed to each recipient, breach the Company's obligations under the General Data Protection Regulation and Data Protection Act or may inadvertently disclose confidential business information such as a marketing list. This applies to both external and internal e-mail.

6.2. Expressly agree with the customer/client that the use of e-mail is an acceptable form of communication bearing in mind that if the material is confidential, privileged or commercially sensitive then un-encrypted e-mail is not secure.

6.3. If you have sent an important document, always telephone to confirm that the e-mail has been received and read.

6.4. Considering the security risks inherent in web-based e-mail accounts, you must not e-mail business documents to your personal web-based accounts. You may send documents to a customer's/client's web-based account if you have the customer's/client's express written permission to do so. However, under no circumstances should you send sensitive or highly confidential documents to a customer's/client's personal web-based e-mail account (e.g. Yahoo, or Hotmail), even if the customer/client asks you to do so.

Personal Use

a) Although our e-mail facilities are provided for the purposes of our business, we accept that you may occasionally want to use them for your own personal purposes. This is permitted on condition that all the procedures and rules set out in this policy are complied with. Be aware, however, that if you choose to make use of our facilities for personal correspondence, the Company may need to monitor communications for the reasons shown below.

b) Under no circumstances may the Company's facilities be used in connection with the operation or management of any business other than that of the Company or a customer/client of the Company unless express permission has been obtained from a member of management.

c) You must ensure that your personal e-mail use:

- Does not interfere with the performance of your duties;
- Does not take priority over your work responsibilities;
- Does not cause unwarranted expense or liability to be incurred by the Company or our clients;
- Does not have a negative impact on our business in any way, and;
- Is lawful and complies with this policy.

d) The Company will not tolerate the use of the E-mail system for unofficial or inappropriate purposes, including:

i. Any messages that could constitute bullying, harassment or other detriment;
ii. On-line gambling;
iii. Accessing or transmitting pornography;
iv. Transmitting copyright information and/or any software available to the user; or
v. Posting confidential information about other employees, the Company or its customers or suppliers.

7. Use of Internet and Intranet

7.1. We trust you to use the internet sensibly. Although internet facilities are provided for the purposes of our business, we accept that you may occasionally want to use them for your own personal purposes. This is permitted on condition that all the procedures and rules set out in this policy are complied with and your use of the internet does not interfere in any way with the performance of your duties.

7.2. Whenever you access a web site, you should always comply with the terms and conditions governing its use. Care must be taken in the use of information accessed through the Internet. Most information is unregulated, and as such there is no guarantee of accuracy.

7.3. The use of the Internet to access and/or distribute any kind of offensive material, or material that is not work-related, leaves an individual liable to disciplinary action which could lead to dismissal.

7.4. You must not:

- use any images, text or material which are copyright-protected, other than in accordance with the terms of the license under which you were permitted to download them;
- Introduce packet-sniffing or password-detecting software;
- Seek to gain access to restricted areas of the Company's network;
- Access or try to access data which you know or ought to know is confidential;
- Introduce any form of computer virus; nor
- Carry out any hacking activities.

8. Virus Protection Procedures

8.1. In order to prevent the introduction of virus contamination into the software system the following must be observed:

- Unauthorised software including public domain software, magazine cover disks/CDs or Internet/World Wide Web downloads must not be used; and
- All software must be virus checked using standard testing procedures before being used.

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9. Use of Computer Equipment

9.1. In order to control the use of the Company's computer equipment and reduce the risk of contamination the following will apply:

- The introduction of new software must first of all be checked and authorised by a member of management or a client's nominated senior member of management before general use will be permitted;
- Only authorised staff should have access to the Company's computer equipment;
- Only authorised software may be used on any of the Company's computer equipment;
- Only software that is used for business applications may be used;
- No software may be brought onto or taken from the Company's premises without prior authorisation;
- Unauthorised access to the computer facility will result in disciplinary action;
- Unauthorised copying and/or removal of computer equipment/software will result in disciplinary action, such actions could lead to dismissal.

10. System Security

10.1. Security of our or our clients' IT systems is of paramount importance. We owe a duty to all of our customers/clients to ensure that all of our business transactions are kept confidential. If at any time we need to rely in court on any information which has been stored or processed using our IT systems it is essential that we are able to demonstrate the integrity of those systems. Every time you use the system you take responsibility for the security implications of what you are doing.

10.2. The Company's system or equipment must not be used in any way which may cause damage, or overloading or which may affect its performance or that of the internal or external network.

10.3. Keep all confidential information secure, use it only for the purposes intended and do not disclose it to any unauthorised third party.

11. Working Remotely

11.1. This part of the policy and the procedures in it apply to your use of our systems, to your use of our laptops, and also to your use of your own computer equipment or other computer equipment (e.g. client's equipment) whenever you are working on Company business away from our premises (working remotely).

11.2. When you are working remotely you must:

- password protect any work which relates to our business so that no other person can access your work;
- position yourself so that your work cannot be overlooked by any other person;
- take reasonable precautions to safeguard the security of our laptop computers and any computer equipment on which you do Company business, and keep your passwords secret;
- inform the police and the Company as soon as possible if either a Company laptop in your possession or any computer equipment on which you do our work has been stolen, and;
- ensure that any work which you do remotely is saved on the Company system or is transferred to our system as soon as reasonably practicable.

11.3. PDAs or similar hand-held devices are easily stolen and not very secure so you must password-protect access to any such devices used by you on which is stored any personal data of which the Company is a data controller or any information relating our business, our clients or their business.

12. Personal Telephone Calls/Mobile Phones

12.1. Telephones are essential for our business. Incoming/outgoing personal telephone calls are allowed at the Company's head office but should be kept to a minimum. We reserve the right to recharge for excessive personal use. When visiting or working on client premises you should always seek permission before using our clients' telephone facilities.

12.2. Personal mobile phones should be switched off or 'on silent' during working hours and only used during authorised breaks.

13. Monitoring of Communications by the Company

13.1. The Company is ultimately responsible for all business communications but subject to that will, so far as possible and appropriate, respect your privacy and autonomy. The Company may monitor your business communications for reasons which include:

- Providing evidence of business transactions;
- Ensuring that our business procedures, policies and contracts with staff are adhered to;
- Complying with any legal obligations;
- Monitoring standards of service, staff performance, and for staff training;
- Preventing or detecting unauthorised use of our communications systems or criminal activities, and;
- Maintaining the effective operation of Company communication systems.

13.2. From time to time the Company may monitor telephone, e-mail and internet traffic data (i.e. sender, receiver, subject; non-business attachments to e-mail, numbers called and duration of calls; domain names of web sites visited, duration of visits, and non-business files downloaded from the internet) at a network level (but covering both personal and business communications). This includes monitoring of any additional accounts you may be requested to set up for the purposes of performing your work tasks, which are subject to the same rules as your work email account. Information acquired through such monitoring may be used as evidence in disciplinary proceedings.

13.3. Sometimes it is necessary for us to access your business communications during your absence, such as when you are away because you are ill or while you are on holiday.

14. Data Protection

14.1. As an employee using our communications facilities, you will inevitably be involved in processing personal data for the Company as part of your job. Data protection is about the privacy of individuals, and is governed by the General Data Protection Regulation and current Data Protection Act.

14.2. Whenever and wherever you are processing personal data for the Company you must keep this secret, confidential and secure, and you must take particular care not to disclose such data to any other person (whether inside or outside the Company) unless authorised to do so. Do not use any such personal data except as authorised by us for the purposes of your job. If in doubt ask a member of management.

14.3. The Act gives every individual the right to see all the information which any data controller holds about them. Bear this in mind when recording personal opinions about someone, whether in an e-mail or otherwise. It is another reason why personal remarks and opinions made should be given responsibly, must be relevant and appropriate as well as accurate and justifiable.

14.4. For your information, the Act provides that it is a criminal offence to obtain or disclose personal data without the consent of the data controller. "Obtaining" here includes the gathering of personal data by employees at work without the authorisation of the employer. You may be committing this offence if without authority of the Company: you exceed your authority in collecting personal data; you access personal data held by us; or you pass them on to someone else (whether inside or outside the Company).

15. Use of Social Networking Sites

15.1. Any work-related issue or material that could identify an individual who is a customer/client or work colleague, which could adversely affect the company a customer/client or our relationship with any customer/client must not be placed on a social networking site. This means that work related matters must not be placed on any such site at any time either during or outside of working hours and includes access via any computer equipment, mobile phone or PDA.

16. Confidentiality

16.1. Employees are not permitted to register with sites or electronic services in the company's name without the prior permission of their manager. They are not permitted to reveal internal company information to any sites, be it confidential or otherwise, or comment on company matters, even if this is during after-hours or personal use. The company confidentiality policy applies to all electronic communication and data.

17. Compliance with this Policy

17.1. Failure to comply with this policy may result in disciplinary action being taken against you. If there is anything in this policy that you do not understand, please discuss it with a member of management.

17.2. Please note that the procedures and policies outlined in this policy, and in any related policy, may be reviewed or changed at any time.

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BMS/1.10.02 GDPR – Data Breach Notification Policy

Document Author:	[redacted]			Head of HR & Training	
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IT and Data Security	BMS/10.04

3. Introduction

3.1 We are aware of the obligations placed on us by the General Data Protection Regulation (GDPR) in relation to processing data lawfully and to ensure it is kept securely.

3.2 One such obligation is to report a breach of personal data in certain circumstances and this policy sets out our position on reporting data breaches.

4. Responsibilities

4.1	**Managing Director**	Has overall responsibility for ensuring that ERS Medical complies with GDPR legislation.
4.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
4.3	**Head of HR and Training**	Is responsible for ensuring that the ERS Medical's HR procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to undertake their duties. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
4.4	**Senior Operations & Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

5. Personal Data Breach

5.1 A personal data breach is a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or processed.

5.2 The following are, but not limited to, examples of data breaches:

- Access by an unauthorised third party;
- Deliberate or accidental action (or inaction) by a data controller or data processor;
- Sending personal data to an incorrect recipient;
- Computing devices containing personal data being lost or stolen;
- Alteration of personal data without permission;
- Loss of availability of personal data.

6. Breach Detection Measures

6.1 We have implemented the following measures to assist us in detecting a personal data breach:

- Training of staff in information governance and requirements of GDPR;
- Maintain and periodically, when available, update Anti-Virus and Anti Malware Software;
- Secure internal email systems;
- The provision of NHS.net email account, where needed;
- GDPR intelligence monitoring software;
- Radar Healthcare compliance system for the reporting of incidents;
- Promoting a culture where employees are not fearful of reporting breaches;
- IG internal audits.

7. Investigation into Suspected Breach

7.1 In the event that we become aware of a breach, or a potential breach, an investigation will be carried out. This investigation will be carried out by the Head of Care Standards and or the Data Protection Officer who will make a decision over whether the breach is required to be notified to the Information Commissioner.

7.2 A decision will also be made over whether the breach is such that the individual(s) must also be notified.

8. Notifying Information Commissioner

8.1 In accordance with the GDPR, we will undertake to notify the Information Commissioner of a breach which is likely to pose a risk to people's rights and freedoms. A risk to people's freedoms can include physical, material or non-material damage such as discrimination, identity theft or fraud, financial loss and damage to reputation.

8.2 Notification to the Information Commissioner will be done without undue delay and at the latest within 72 hours of discovery. If we are unable to report in full within this timescale, we will make an initial report to the Information Commissioner, and then provide a full report in more than one instalment if so required.

8.3 The following information will be provided when a breach is notified:

- A description of the nature of the personal data breach including, where possible;
- The categories and approximate number of individuals concerned and;
- The categories and approximate number of personal data records concerned;
- The name and contact details of the person where more information can be obtained;
- A description of the likely consequences of the personal data breach and;
- A description of the measures taken, or proposed to be taken, to deal with the personal data breach, including, where appropriate, the measures taken to mitigate any possible adverse effects.

9. Notifying Individual Subject to Breach

9.1 In accordance with the GDPR, we will undertake to notify the individual whose data is the subject of a breach if there is a *high* risk to people's rights and freedoms. A high risk may be, for example, where there is an immediate threat of identity theft, or if special categories of data are disclosed online.

9.2 This notification will be made without undue delay and may, dependent on the circumstances, be made before the supervisory authority is notified.

9.3 The following information will be provided when a breach is notified to the affected individuals:

- A description of the nature of the breach;
- The name and contact details of the person who can provide more information about the breach;
- A description of the likely consequences of the personal data breach and;
- A description of the measures taken, or proposed to be taken, to deal with the personal data breach, including, where appropriate, the measures taken to mitigate any possible adverse effects.

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10. Record of Breaches

10.1 The Company records all personal data breaches regardless of whether they are notifiable or not as part of its general accountability requirement under GDPR. It records the facts relating to the breach, its effects and the remedial action taken.

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BMS/1.10.03 GDPR – Data Protection Policy

Document Author:	[redacted]			Head of HR & Training	
Document Owner:	[redacted]			Managing Director	
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3. Introduction

3.1 We may have to collect and use information about people with whom we work. This personal information must be handled and dealt with properly, however it is collected, recorded and used, and whether it be on paper, in computer records or recorded by any other means.

3.2 We regard the lawful and correct treatment of personal information as very important to our successful operation and to maintaining confidence between us and those with whom we carry out business. We will ensure that we treat personal information lawfully and correctly.

3.3 To this end we fully endorse and adhere to the principles of the General Data Protection Regulation (GDPR).

3.4 This policy applies to the processing of personal data in manual and electronic records kept by us in connection with our human resources function as described below. It also covers our response to any data breach and other rights under the GDPR.

3.5 This policy applies to the personal data of job applicants, existing and former employees, apprentices, volunteers, placement students, workers and self-employed contractors. These are referred to in this policy as relevant individuals.

4. Responsibilities

4.1	**Managing Director**	Has overall responsibility for ensuring that ERS Medical complies with GDPR legislation.
4.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
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4.4	**Senior Operations Managers & Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

5. Definitions

Personal Data

5.1 "Personal data" is information that relates to an identifiable person who can be directly or indirectly identified from that information, for example, a person's name, identification number, location, online identifier. It can also include pseudonymised data.

Special Categories of Personal Data

5.2 "Special categories of personal data" is data which relates to an individual's health, sex life, sexual orientation, race, ethnic origin, political opinion, religion, and trade union membership. It also includes genetic and biometric data (where used for ID purposes).

Criminal Offence Data

5.3 "Criminal offence data" is data which relates to an individual's criminal convictions and offences.

Data Processing

5.4 "Data processing" is any operation or set of operations which is performed on personal data or on sets of personal data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction.

6. Data Protection Principles

6.1 Under GDPR, all personal data obtained and held by us must be processed according to a set of core principles. In accordance with these principles, we will ensure that:

- Processing will be fair, lawful and transparent;
- Data be collected for specific, explicit, and legitimate purposes;
- Data collected will be adequate, relevant and limited to what is necessary for the purposes of processing;
- Data will be kept accurate and up to date. Data which is found to be inaccurate will be rectified or erased without delay;
- Data is not kept for longer than is necessary for its given purpose;
- Data will be processed in a manner that ensures appropriate security of personal data including protection against unauthorised or unlawful processing, accidental loss, destruction or damage by using appropriate technical or organisation measures;
- We will comply with the relevant GDPR procedures for international transferring of personal data.

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7. Types of Data Held

7.1 We keep several categories of personal data on our employees in order to carry out effective and efficient processes. We keep this data in a personnel file relating to each employee and we also hold the data within our computer systems, for example, our holiday booking system.

7.2 Specifically, we hold the following types of data:

a) Personal details such as name, address, phone numbers;
b) Information gathered via the recruitment process such as that entered into a CV or included in a CV cover letter, references from former employers, details on your education and employment history etc;
c) Details relating to pay administration such as National Insurance numbers, bank account details and tax codes;
d) Medical or health information;
e) Information relating to your employment with us, including:

i) Job title and job descriptions;
ii) Your salary;
iii) Your wider terms and conditions of employment;
iv) Details of formal and informal proceedings involving you such as letters of concern, disciplinary and grievance proceedings, your annual leave records, appraisal and performance information;
v) Internal and external training modules undertaken.

7.3 All of the above information is required for our processing activities. More information on those processing activities are included in our privacy notice for employees, which is available from your manager.

8. Employee Rights

8.1 You have the following rights in relation to the personal data we hold on you:

- The right to be informed about the data we hold on you and what we do with it;
- The right of access to the data we hold on you. More information on this can be found in the section headed “Access to Data” below and in our separate policy on Subject Access Requests”;
- The right for any inaccuracies in the data we hold on you, however they come to light, to be corrected. This is also known as ‘rectification’;
- The right to have data deleted in certain circumstances. This is also known as ‘erasure’;
- The right to restrict the processing of the data;
- The right to transfer the data we hold on you to another party. This is also known as ‘portability’;
- The right to object to the inclusion of any information;
- The right to regulate any automated decision-making and profiling of personal data.

8.2 More information can be found on each of these rights in our separate policy on employee rights under GDPR.

9. Responsibilities

9.1 In order to protect the personal data of relevant individuals, those within our business who must process data as part of their role have been made aware of our policies on data protection.

9.2 We have also appointed employees with responsibility for reviewing and auditing our data protection systems.

10. Lawful Bases of Processing

10.1 We acknowledge that processing may be only be carried out where a lawful basis for that processing exists and we have assigned a lawful basis against each processing activity.

10.2 Where no other lawful basis applies, we may seek to rely on the employee's consent in order to process data.

10.3 However, we recognise the high standard attached to its use. We understand that consent must be freely given, specific, informed and unambiguous. Where consent is to be sought, we will do so on a specific and individual basis where appropriate. Employees will be given clear instructions on the desired processing activity, informed of the consequences of their consent and of their clear right to withdraw consent at any time.

11. Access to Data

11.1 As stated above, employees have a right to access the personal data that we hold on them. To exercise this right, employees should make a Subject Access Request. We will comply with the request without delay, and within one month unless, in accordance with legislation, we decide that an extension is required. Those who make a request will be kept fully informed of any decision to extend the time limit.

11.2 No charge will be made for complying with a request unless the request is manifestly unfounded, excessive or repetitive, or unless a request is made for duplicate copies to be provided to parties other than the employee making the request. In these circumstances, a reasonable charge will be applied.

11.3 Further information on making a subject access request is contained in our Subject Access Request policy.

12. Data Disclosures

12.1 The Company may be required to disclose certain data/information to any person. The circumstances leading to such disclosures include:

a) Any employee benefits operated by third parties;
b) Disabled individuals - whether any reasonable adjustments are required to assist them at work;
c) Individuals' health data - to comply with health and safety or occupational health obligations towards the employee;
d) For Statutory Sick Pay purposes;
e) HR management and administration - to consider how an individual's health affects his or her ability to do their job;
f) The smooth operation of any employee insurance policies or pension plans;
g) To assist law enforcement or a relevant authority to prevent or detect crime or prosecute offenders or to assess or collect any tax or duty.

12.2 These kinds of disclosures will only be made when strictly necessary for the purpose.

13. Data Security

13.1 All our employees are aware that hard copy personal information should be kept in a locked filing cabinet, drawer, or safe.

13.2 Employees are aware of their roles and responsibilities when their role involves the processing of data. All employees are instructed to store files or written information of a confidential nature in a secure manner so that are only accessed by people who have a need and a right to access them and to ensure that screen locks are implemented on all PCs, laptops etc when unattended. No files or written information of a confidential nature are to be left where they can be read by unauthorised people.

13.3 Where data is computerised, it should be coded, encrypted or password protected both on a local hard drive and on a network drive that is regularly backed up. If a copy is kept on removable storage media, that media must itself be kept in a locked filing cabinet, drawer, or safe.

13.4 Employees must always use the passwords provided to access the computer system and not abuse them by passing them on to people who should not have them.

13.5 Personal data relating to employees should not be kept or transported on laptops, USB sticks, or similar devices, unless prior authorisation has been received. Where personal data is recorded on any such device it should be protected by:

a) Ensuring that data is recorded on such devices only where absolutely necessary.
b) Using an encrypted system — a folder should be created to store the files that need extra protection and all files created or moved to this folder should be automatically encrypted.
c) Ensuring that laptops or USB drives are not left where they can be stolen.

13.6 Failure to follow the Company's rules on data security may be dealt with via the Company's disciplinary procedure. Appropriate sanctions include dismissal with or without notice dependent on the severity of the failure.

14. Third Party Processing

14.1 Where we engage third parties to process data on our behalf, we will ensure, via a data processing agreement with the third party, that the third party takes such measures in order to maintain the Company's commitment to protecting data.

15. International Data Transfers

15.1 The Company does not transfer personal data to any recipients outside of the EEA.

16. Requirement to Notify Breaches

16.1 All data breaches will be recorded on our Data Breach Register. Where legally required, we will report a breach to the Information Commissioner within 72 hours of discovery. In addition, where legally required, we will inform the individual whose data was subject to breach.

16.2 More information on breach notification is available in our Breach Notification policy.

17. Training

17.1 New employees must read and understand the policies on data protection as part of their induction.

17.2 All employees receive training covering basic information about confidentiality, data protection and the actions to take upon identifying a potential data breach.

17.3 The nominated data controller/auditors/protection officers for the Company are trained appropriately in their roles under the GDPR.

17.4 All employees who need to use the computer system are trained to protect individuals' private data, to ensure data security, and to understand the consequences to them as individuals and the Company of any potential lapses and breaches of the Company's policies and procedures.

18. Records

18.1 The Company keeps records of its processing activities including the purpose for the processing and retention periods in its HR Data Record. These records will be kept up to date so that they reflect current processing activities.

19. Data Protection Compliance

19.1 Our Data Protection Officer is:

[redacted]

BMS/1.10.04 GDPR – Your Rights in Relation to Data

Document Author:	[redacted]			Head of HR & Training	
Document Owner:	[redacted]			Managing Director	
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3. Introduction

3.1 This policy outlines the rights that data subjects have, under the General Data Protection Regulation (GPDR), in relation to the data about them that we hold. Data subjects, for the purposes of this policy includes employees (current, prospective and former), workers and contractors.

4. Responsibilities

4.1	Managing **Director**	Has overall responsibility for ensuring that ERS Medical complies with GDPR legislation.
4.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
4.3	**Head of HR and Training**	Is responsible for ensuring that the ERS Medical's HR procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to undertake their duties. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
4.4	**Senior Operations Managers & Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

5. The Right to Be Informed

5.1 In order to keep you informed about how we use your data, we have a privacy notice for employees. You can obtain a copy of the privacy notice from your manager.

5.2 The Company also has a separate privacy notice applicable to job applicants, available from your manager.

5.3 You will not be charged for receiving our privacy notices.

5.4 Our privacy notices set out:

- The types of data we hold and the reason for processing the data;
- Our legitimate interest for processing it;
- Details of who your data is disclosed to and why, including transfers to other countries. Where data is transferred to other counties, the safeguards used to keep your data secure are explained;
- How long we keep your data for, or how we determine how long to keep your data for;
- Where your data comes from;
- Your rights as a data subject;
- Your absolute right to withdraw consent for processing data where consent has been provided and no other lawful reason for processing your data applies;
- Your right to make a complaint to the Information Commissioner if you think your rights have been breached;
- Whether we use automated decision making and if so, how the decisions are made, what this means for you and what could happen as a result of the process;
- The name and contact details of our data protection officer.

6. Right of Access

6.1 You have the right to access your personal data which is held by us. You can find out more about how to request access to your data by reading our Subject Access Request policy.

7. The Right of 'Correction'

7.1 If you discover that the data we hold about you is incorrect or incomplete, you have the right to have the data corrected. If you wish to have your data corrected, you should complete the Data Correction Form.

7.2 Usually, we will comply with a request to rectify data within one month unless the request is particularly complex in which case we may write to you to inform you we require an extension to the normal timescale. The maximum extension period is two months.

7.3 You will be informed if we decide not to take any action as a result of the request. In these circumstances, you are able to complain to the Information Commissioner and have access to a judicial remedy.

Third parties to whom the data was disclosed will be informed of the rectification.

8. The Right of 'Erasure'

8.1 In certain circumstances, we are required to delete the data we hold on you. Those circumstances are:

- where it is no longer necessary for us to keep the data;
- where we relied on your consent to process the data and you subsequently withdraw that consent. Where this happens, we will consider whether another legal basis applies to our continued use of your data;
- where you object to the processing (see below) and the Company has no overriding legitimate interest to continue the processing;
- where we have unlawfully processed your data;
- where we are required by law to erase the data.

8.2 If you wish to make a request for data deletion, you should complete the Data Erasure form.

8.3 We will consider each request individually, however, you must be aware that processing may continue under one of the permissible reasons. Where this happens, you will be informed of the continued use of your data and the reason for this.

8.4 Third parties to whom the data was disclosed will be informed of the erasure where possible unless to do so will cause a disproportionate effect on us.

9. The Right of 'Restriction'

9.1 You have the right to restrict the processing of your data in certain circumstances.

9.2 We will be required to restrict the processing of your personal data in the following circumstances:

- where you tell us that the data we hold on you is not accurate. Where this is the case, we will stop processing the data until we have taken steps to ensure that the data is accurate;
- where the data is processed for the performance of a public interest task or because of our legitimate interests and you have objected to the processing of data. In these circumstances, the processing may be restricted whilst we consider whether our legitimate interests mean it is appropriate to continue to process it;
- when the data has been processed unlawfully;
- where we no longer need to process the data but you need the data in relation to a legal claim.

9.3 If you wish to make a request for data restriction, you should complete the Data Restriction form.

9.4 Where data processing is restricted, we will continue to hold the data but will not process it unless you consent to the processing or processing is required in relation to a legal claim.

9.5 Where the data to be restricted has been shared with third parties, we will inform those third parties of the restriction where possible unless to do so will cause a disproportionate effect on us.

9.6 You will be informed before any restriction is lifted.

10. The Right to Data 'Portability'

10.1 You have the right to obtain the data that we process on you and transfer it to another party. Where our technology permits, we will transfer the data directly to the other party.

10.2 Data which may be transferred is data which:

- You have provided to us; and
- Is processed because you have provided your consent or because it is needed to perform the employment contract between us; and
- Is processed by automated means.

10.3 If you wish to exercise this right, please speak to your manager.

10.4 We will respond to a portability request without undue delay, and within one month at the latest unless the request is complex or we receive a number of requests in which case we may write to you to inform you that we require an extension and reasons for this. The maximum extension period is two months.

10.5 We will not charge you for access to your data for this purpose.

10.6 You will be informed if we decide not to take any action as a result of the request, for example, because the data you wish to transfer does not meet the above criteria. In these circumstances, you are able to complain to the Information Commissioner and have access to a judicial remedy.

10.7 The right to data portability relates only to data defined as above. You should be aware that this differs from the data which is accessible via a Subject Access Request.

11. The Right to 'Object'

11.1 You have a right to require us to stop processing your data; this is known as data objection.

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11.2 You may object to processing where it is carried out:

- In relation to the Company's legitimate interests;
- For the performance of a task in the public interest;
- In the exercise of official authority; or
- For profiling purposes.

11.3 If you wish to object, you should do so by completing the Data Objection Form.

11.4 In some circumstances we will continue to process the data you have objected to. This may occur when:

- We can demonstrate compelling legitimate reasons for the processing which are believed to be more important than your rights; or
- The processing is required in relation to legal claims made by, or against, us.

11.5 If the response to your request is that we will take no action, you will be informed of the reasons.

12. The Right Not to Have Automated Decisions Made About You

12.1 You have the right not to have decisions made about you solely on the basis of automated decision-making processes where there is no human intervention, where such decisions will have a significant effect on you.

Delete as appropriate

12.2 However, the Company does not make any decisions based on such processes.

OR

12.3 If you wish to exercise this right, you should speak to your manager.

12.4 However, we may carry out automated decision making with no human intervention in the following circumstances:

- When it is needed for entering into or the carrying out of a contract with you;
- When the process is permitted by law;
- When you have given explicit consent.

12.5 In circumstances where we use special category data, for example, data about your health, sex life, sexual orientation, race, ethnic origin, political opinion, religion, and trade union membership the Company will ensure that one of the following applies to the processing:

- You have given your explicit consent to the processing; or
- The processing is necessary for reasons of substantial public interest.

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BMS/1.10.05 GDPR – Subject Access Request Policy

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3. Introduction

3.1 You have a right, under the General Data Protection Regulation, to access the personal data we hold on you. To do so, you should made a subject access request, and this policy sets out how you should make a request, and our actions upon receiving the request.

4. Responsibilities

4.1	**Managing Director**	Has overall responsibility for ensuring that ERS Medical complies with GDPR legislation.
4.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
4.3	**Head of HR and Training**	Is responsible for ensuring that the ERS Medical's HR procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to undertake their duties. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
4.4	**Senior Operations Managers & Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

5. Definitions

Personal Data

5.1 "Personal data" is any information relating to an identifiable person who can be directly or indirectly identified in particular by reference to an identifier, including your name.

Special Categories of Personal Data

5.2 "Special categories of personal data" includes information relating to:

a) Race;
b) Ethnic origin;
c) Politics;
d) Religion;
e) Trade union membership;
f) Genetics;
g) Biometrics (where used for ID purposes);
h) Health;
i) Sex life or;
j) Sexual orientation.

6. Making A Request

6.1 Although subject access requests may be made verbally, we would advise that a request may be dealt with more efficiently and effectively if it is made in writing. If you wish to make a request, please use the Subject Access Request form.

6.2 Requests that are made directly by you should be accompanied by evidence of your identity. If this is not provided, we may contact you to ask that such evidence be forwarded before we comply with the request.

6.3 Requests made in relation to your data from a third party should be accompanied by evidence that the third party is able to act on your behalf. If this is not provided, we may contact the third party to ask that such evidence be forwarded before we comply with the request.

7. Timescales

7.1 Usually, we will comply with your request without delay and at the latest within one month. Where requests are complex or numerous, we may contact you to inform you that an extension of time is required. The maximum extension period is two months.

8. Fee

8.1 We will normally comply with your request at no cost. However, if the request is manifestly unfounded or excessive, or if it is repetitive, we may contact you requesting a fee. This fee must be paid in order for us to comply with the request. The fee will be determined at the relevant time and will be set at a level which is reasonable in the circumstances.

8.2 In addition, we may also charge a reasonable fee if you request further copies of the same information.

9. Information you will recieve

9.1 When you make a subject access request, you will be informed of:

a) Whether or not your data is processed and the reasons for the processing of your data;
b) The categories of personal data concerning you;
c) Where your data has been collected from if it was not collected from you;
d) Anyone who your personal data has been disclosed to or will be disclosed to, including anyone outside of the EEA and the safeguards utilised to ensure data security;
e) How long your data is kept for (or how that period is decided);
f) Your rights in relation to data rectification, erasure, restriction of and objection to processing;
g) Your right to complain to the Information Commissioner if you are of the opinion that your rights have been infringed;
h) The reasoning behind any automated decisions taken about you.

10. Refusal: Acceptable Circumstances

10.1 We may refuse to deal with your subject access request if it is manifestly unfounded or excessive, or if it is repetitive. Where it is our decision to refuse your request, we will contact you without undue delay, and at the latest within one month of receipt, to inform you of this and to provide an explanation. You will be informed of your right to complain to the Information Commissioner and to a judicial remedy.

10.2 We may also refuse to deal with your request, or part of it, because of the types of information requested. For example, information which is subject to legal privilege or relates to management planning is not required to be disclosed. Where this is the case, we will inform you that your request cannot be complied with and an explanation of the reason will be provided.

BMS/1.10.06 GDPR – CCTV

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3. Introduction & Summary

3.1 Modern surveillance camera technology provides increasing potential for the gathering and use of images and associated information. These advances vastly increase the ability and capacity to capture, store, and share and analyse images and information.

3.2 Technology can be a valuable tool in the management of public safety and security, in the protection of people and property, in the prevention and investigation of crime, and in bringing crimes to justice.

3.3 Technological advances can also provide greater opportunity to safeguard privacy. Used appropriately, current and future technology can and will provide a proportionate and effective solution where surveillance is in pursuit of a legitimate aim and meets a pressing need.

3.4 Any increase in the capability of surveillance camera system technology also has the potential to increase the likelihood of intrusion into an individual's privacy. The Human Rights Act 1998 gives effect in UK law to the rights set out in the European Convention on Human Rights (ECHR).

3.5 Some of these rights are absolute, whilst others are qualified, meaning that it is permissible for the state to interfere with the right provided that the interference is in pursuit of a legitimate aim and the interference is proportionate. Amongst the qualified rights is a person's right to respect for their private and family life, home and correspondence, as provided for by Article 8 of the ECHR3.

3.6 The purpose of this Procedure is to regulate the management, operation and use of the closed-circuit television (CCTV) surveillance systems owned by ERS Medical.

3.7 This Procedure sets out the appropriate actions and procedures to be followed in order to ensure that ERS Medical complies with the relevant legislation and the current Information Commissioner's Office Code of Practice.

3.8 This Procedure has been written in accordance with the legislative and regulatory requirements of:

- The General Data Protection Regulation (GDPR);
- The Data Protection Act 1998;
- The CCTV Code of Practice produced by the Information Commissioner 2013;
- The Human Rights Act 1998;
- The Regulation of Investigatory Powers Act 2000;
- Caldicott Report 1997.

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3.10 The use of CCTV is controlled by a number of statutes, regulations and guidance:

- CCTV Systems and the Data Protection Act 1998 - Guidance issued by the
  - General Medical Council: Making and Using Visual and Audio Recordings of Patients May 2002 www.gmc-uk.org/standards/aud_vid.htm;
- Guidance to be issued by the NHS Security Management Service in their NHS Security Management Manual;
- Information Commissioner 2000;
- Section 16 (4) of the Private and Voluntary Health Care Regulations 2001;
- The Data Protection Act 1998;
- The Human Rights Act 1998;
- The Mental Health Act 1983 and its Code of Practice (last published in 1999);
- The Regulation of Investigatory Powers Act 2000.

4. Responsibilities

4.1	**Managing Director**	Has overall responsibility for ensuring that ERS Medical complies with GDPR legislation.
4.2	**Senior Leadership Team**	Is responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the ERS Medical's operations.
4.3	**Head of HR and Training**	Is responsible for ensuring that the ERS Medical's HR procedures remain within the legislative framework are fit for purpose and provide the necessary information to enable managers to undertake their duties. Are responsible for the training of personnel in relation to this process and for monitoring, reviewing, approving and auditing the process outputs.
4.4	**Senior Operations Managers & Operations Managers**	Are responsible for the implementation and management of this process and for ensuring that training is provided.
4.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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5. General Principles

5.1. Prior to considering compliance with the principles of the Data Protection Act, a user of CCTV or similar surveillance equipment, will need to determine two issues:

5.2. The type of personal data being processed, i.e. is there any personal data which falls within the definition of sensitive personal data as defined by virtue of Section 2 of the Act. 'Sensitive personal data' includes:

- Gender;
- Ethnic origin or race;
- Political opinion;
- Religious beliefs;
- Health – mental or physical;
- Sexual life;
- Commission of any offence (or alleged);
- Any court proceedings or findings.

5.3. The purpose(s) for which both personal and sensitive personal data is being processed must be:

- Fairly and lawfully processed;
- Processed for limited purposes and not in any manner incompatible with those purposes;
- Adequate, relevant and not excessive;
- Accurate;
- Not kept for longer than is necessary
- Processed in accordance with individual's rights;
- Secure;
- Not transferred to countries without adequate protection.

5.4. The Information Commissioner will take into account the extent to which users of CCTV and similar surveillance equipment have complied with this Code of Practice when determining whether they have met their legal obligations when exercising their powers of enforcement.

6. Initial Assessment Procedures

6.1. The Managing Director has the legal responsibility for all ERS Medical CCTV systems. However, the Data Protection Officer will assume day to day responsibility for the operations of all CCTV systems.

6.2. The purpose of ERS Medicals CCTV systems are:

- Prevention or detection of crime or disorder;
- Apprehension and prosecution of offenders (including use of images and audio as evidence in criminal proceedings);
- Interest of public and employee Health and Safety;
- Protection of public health;
- Protection of ERS Medical property and assets;
- To provide a deterrent to verbal and physical abuse against ERS Medical staff.
- To provide video records of incidents which can occur within or around ERS Medical sites and vehicles.

6.3. Data (footage) obtained from the CCTV system will only be used for purposes set out in section 5.6 and will not be used for performance monitoring or performance management.

6.4. Prior to any new camera installation, the site Operations Manager must contact the ERS Medical Data Protection Officer and Care Standards Team, to ensure that its proposed purpose and use complies with the requirements of this procedure.

7. ICO License

7.1. Every organisation that operates a CCTV system does so by license granted by the Information Commissioners Office.

7.2. ERS Medical's license details are stored on our [redacted] system. In addition to this our registration details are available from the ICO's Data Protection Public Register:

ERS Transition Ltd [trading as ERS Medical] Data Protection Public Register

7.3. ERS Transition Ltd has been registered with the ICO since: 17 August 2017.

8. Equipment & Operations of CCTV

8.1. ERS Medical will restrict the placement of CCTV systems to the following:

- ERS Medical sites and offices;
- All vehicles fitted with Crystal Ball Tracking and Dash Camera's;
- Ambulances (contract specific) exterior only;
- Ambulances (contract specific) exterior and interiors.

8.2. All CCTV surveillance is automatically recorded, and any breach of these Codes of Practice will be detected via controlled access to the system and auditing of the system.

8.3. CCTV information and warning signs will be displayed at all ERS Medical sites and on the exterior and interior of vehicles fitted with CCTV systems.

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9. Processing and Use of CCTV Data

9.1. Images, which are not required for the purpose(s) for which the equipment is being used, should not be retained for longer than is necessary. While images are retained, it is essential that their integrity be maintained, whether it is to ensure their evidential value or to protect the rights of people whose images may have been recorded. It is therefore important that access to and security of the images is controlled in accordance with the requirements of the Data Protect Act 1998.

9.2. All images are digitally recorded and stored securely within the systems hard drives. Automatic erasure takes place after 30 days.

Access to and Disclosure of Images to Third-Parties

9.3. It is important that access to, and disclosure of, the images recorded by CCTV surveillance equipment is restricted and carefully controlled. This will ensure that the rights of individuals are preserved, but also to ensure that the continuity of evidence remains intact should the images be required for evidential purposes e.g. a Police enquiry or an investigation being under taken as part of the ERS Medical's disciplinary procedure.

9.4. Access to images is permitted only if it supports the purpose which ERS Medical has declared.

9.5. Under these conditions the CCTV images can be formally requested by completing and submitting a **F1.10.02 – CCTV Data Request Form**. This form must be submitted initially to ERS Medical Caldicott Guardian, who will liaise with the DPO and SIRO on any decision to release the data to a third-party, if required.

GDPR & Subject Access Request

9.6. CCTV footage is data and is therefore subject to the rights of the individual as detailed by GDPR and specifically Subject Access Requests (SAR's).

9.7. If a SAR is received any CCTV data will be checked to comply with the request.

9.8. Specific details on how to manage subject access requests can be found in **BMS/1.10.05 – Subject Access Requests**.

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BMS/10.01 Information Systems (IS)

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
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2. Related Documents & Legal References

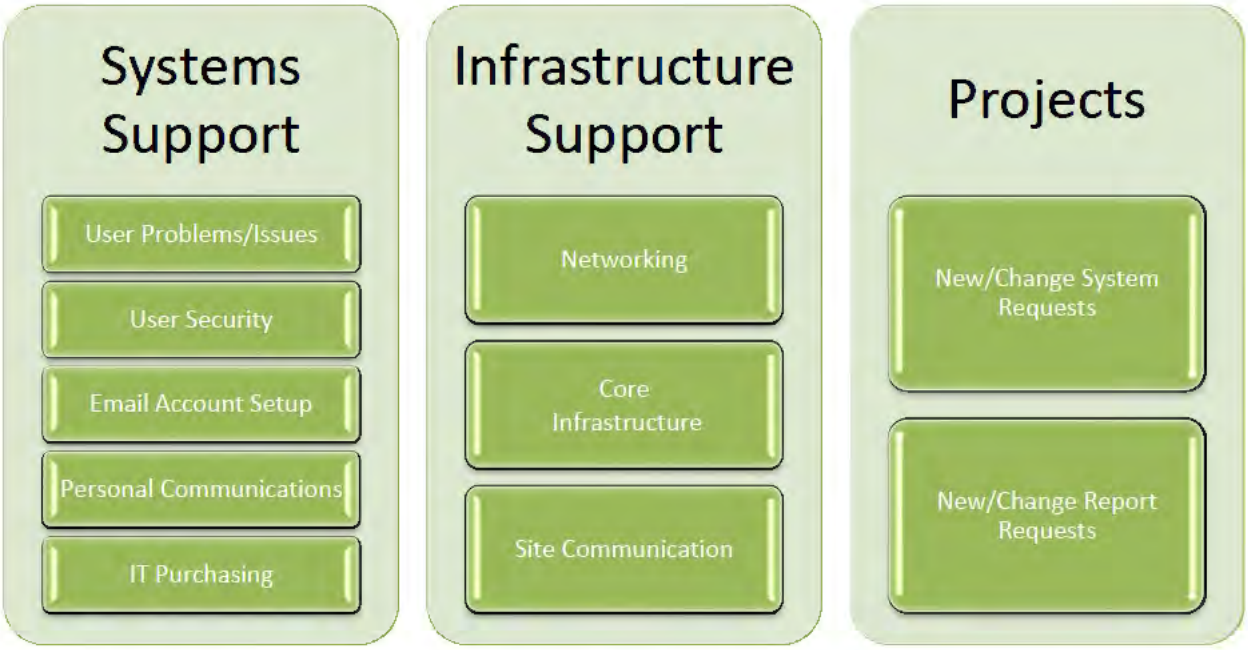
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3. Introduction

3.1 The IT Provider and support team are responsible for providing ERS Medical with a range of services and technologies that includes:

- Client applications and support;
- Telecommunications and data networking;
- Co-ordinating business requirements for applications;
- Collating application changes;
- Project management and subsequent implementation plans across UK and ROI.

3.2 The IT Providers services are split into distinct areas as shown below. Contact details for the IT Provider can be obtained through your line manager.



3.3 **Systems Support** - Provide 1st and 2nd line support to all business users. Provide out of hours cover and prioritise tickets according to business impact.

3.4 **Infrastructure Support** – provide support for implementing planned IT Infrastructure maintenance and development work. To provide 3rd line support to all business users.

3.5 **Project Team** –For managing IS Projects through requirement definition, planning, testing and implementation. For further information please refer to **WI/10.01.01 – IS Projects – Change Requests.**

3.6 To ensure a single procedure is defined and utilised at all locations within ERS Medical that provides instruction and guidance to all personnel on IT activities.

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3.7 To define the responsibilities of the personnel in relation to IT activities, ensuring consistency is achieved throughout ERS Medical.

3.8 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.9 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 The IS Policies can be found in **WI/10.01.02 – Acceptable Use (IS)**. This includes:

- IS Security Policy;
- Internet Code of Conduct;
- Email Policy Guidelines.

4.2 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.3 Please refer to the ERS Medical Business Continuity Policy.

4.4 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**IT Provider**	Is responsible, through the SLT for providing a wide range of technologies such as client applications, telecommunications and data networking across UK. Ensure new technologies and solutions are aligned with the business focus and standard policies. Is responsible for the implementation of a wide range of technologies across the UK. Provides support to new acquisitions and minimises disruption during the integration phase. Manages and develops the IS Project Managers and IS Supervisors, ensuring continuous improvement and reduction of departmental costs. Are responsible for managing IS Projects through requirement definition, planning, testing and implementation. Project Managers must ensure that the businesses requirements have been understood and prioritised correctly, the correct change process is followed and that the project meets it's deadlines and come in on budget Are responsible for ensuring team projects and daily activities are completed with competence and quality; assigning responsibilities to individuals while maintaining the overall team balance. Stay in keeping with the customer needs and proactively search for ways to increase customer satisfaction. Are responsible for providing IT support to all business users and applications. Support the development, implementation and maintenance of applications, telecommunications, databases and networking
5.4	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **IT** – Information Technology – The development, implementation and maintenance of computer hardware and software systems to organise and communicate information electronically.

6.2 **IS** – Information Systems – Hardware and software utilised by the Company to support operations, management and Company decision making.

6.3 **AD** – Active Directory – A directory service implemented by Microsoft for Windows domain networks. It is included in most Windows serving operating systems. An AD domain controller authenticates and authorises all users and computers in a Windows domain type network – assigning and enforcing security policies for all computers and installing or updating software.

6.4 **SAN** – Storage Area Network - Is a dedicated network that provides access to consolidated, block level data storage. SANs are primarily used to make storage devices such as disk arrays and tape libraries accessible to servers so that the devices appear like locally attached devices to the operating system. A SAN typically has its own network of storage devices that are generally not accessible through the local area network by other devices.

6.5 **DR** – Disaster Recovery - Is the process, policies and procedures that are related to preparing for recovery or continuation of technology infrastructure which are vital to an organisation after a natural or human induced disaster. Disaster recovery is a sub-set of business continuity. While business continuity involves planning for keeping all aspects of the Company functioning during a disruptive event, disaster recovery focuses on the IT or technology systems that support Company operations and functions.

6.6 **CCTV** – Closed Circuit Television – Is the use of video cameras to transmit a signal to a specific place on a limited set of monitors.

6.7 **UPS** – Uninterrupted Power Supply – Is the implementation of battery systems to support the main electrical supply which will activate should a loss of power occur.

6.8 **Application** – Business Systems and software programmes that are utilised by the Company to provide a particular task or service function, (e.g. Microsoft Outlook etc).

6.9 **SLA** – Service Level Agreement – Is part of a service contract where a service and agreed performance levels are formally defined.

6.10 **MOU** – Memorandum of Understanding – A document describing a bilateral or multilateral agreement between two or more parties, It expresses a convergence of will between the parties, indicating an intended common line of action.

7. Fault Reporting

7.1 All IS faults are to be reported to the IT Provider. Details of how to make contact can be obtained by contacting your line manager.

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8. New User Requests

New User Introductions

8.1 The IT Provider has been tasked with giving a detailed introduction to all new starters on the services / resources provided by the IT Provider.

Pre-Meeting

8.2 When a new starter begins working for ERS Medical, an e-mail is sent out to the IT Provider providing details (date, time and duration), of the next scheduled “new user meeting” for them to attend.

8.3 An email will be sent to their manager detailing where and when this contact is to be made with the new user.

At the Meeting

8.4 The IT Provider will present the “New User Intro to IT” presentation to the attendees.

8.5 Approximately 30 minutes in duration, the presentation covers:

- IT Provider Structure
- Network Structure
- IT Standards
- IT Resources
- Our commitment

9. Appointments and Terminations

9.1 The IT Provider is tasked with keeping the ERS Medical users up to date (starters and leavers), within all aspects of the electronic systems and equipment used. This ranges from e-mail accounts to company phones.

Starters

9.2 When a new user starts joins the business the Line Manager must complete a IT Security Request form located on the intranet system:

9.3 The Line Manager will then forward the request by email the IT Provider.

9.4 The following steps will be taken:

- The new user account will be created using Active Directory for the details provided on the security request form.
- User logins will be created for each application and access granted to network drives, reporting tools and share mailboxes where specified on the Security Request Form.
- The username and password will be e-mailed to the authoriser of the IT Security Request Form to inform the new user on arrival.

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Leavers

9.5 Once an employee has left ERS Medical their e-mail account will be disabled. This will remain disabled for approximately 2-3 weeks.

9.6 Once 2-3 weeks has passed, the users Active Directory Account will be disabled. All application, reporting and network drive access will be removed.

9.7 The user's PC or Laptop is wiped, and all data is removed including emails.

9.8 Records will be maintained by the IT Provider.

10. Hardware / Software Purchasing

10.1 Prior to the purchase of any hardware or software all personnel must first complete an IT Hardware Request form.

10.2 All requests for smart phones and laptops must be approved and authorised by a member of the Senior Management Team.

10.3 A list of Company personnel who can approve and authorise the purchase of smart phones and laptops is maintained by the IT Provider.

10.4 All requests for PDTs and Tablet Devices must be approved by a General Manager or equivalent.

10.5 All other hardware requests must be approved by either a General Manager (or equivalent) or a Head of Department.

10.6 The completed and authorised form should be sent to the IT Provider.

11. Data / Tape Back-ups

11.1 The IT Provider is tasked with ensuring that all ERS Medical data is backed-up and recoverable. This process covers:

Data Back-up

11.2 The data held on ERS Medical computer systems is essential for the running of the business. Back-ups are made to ensure that in the case of loss or corruption, this data can be recovered.

SAN Replication

11.3 **Storage Area Networks (SAN)** - All ERS Medical critical data is stored on a storage area network, which allows for the failure of multiple physical hard drives without the loss of data.

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11.4 **Replication** - Data is regularly replicated from the primary SAN to a secondary SAN, at a remote location, to ensure that in the case of the loss of the primary SAN, the data can still be recovered.

Tape Back-ups

11.5 **Overnight Back-ups** – ERS Medical makes nightly backups of data to tape storage. Backups are rotated in an industry standard Grandfather, Father, Son fashion, providing staged historical backup locations.

11.6 **Off-site Storage** - A weekly backup tape is sent to a secure offsite storage location, providing a restore point in case of a full loss of the data centre, or corruption of data.

12. Disaster Recovery

12.1 Managed by the IT Provider, IT disaster recovery focuses on allowing ERS Medical to continue running, even when there is a failure of a critical component (such as a server or network). Preventative measures are taken to reduce the chance of a disaster occurring, and recovery measures are put in place to allow fast restoration of service in the event of a disaster.

Preventative Measures

12.2 **Power Supply** - The power supply to the data centre is isolated from the rest of the office, so that if the office loses power from a local cause (e.g. faulty equipment) this will not affect the data centre.

12.3 **Redundant Server Links** - All critical servers and network equipment in the data centre have multiple, redundant links for network and power. Due to this resilient design, any single connection can fail without affecting the capability of the system.

12.4 **Data-centre Network Connections** - The data-centre has multiple redundant connections from different suppliers, allowing a connection failure without affecting the business connectivity.

12.5 **Security** - Access to the main ERS Medical Head Office are restricted by access card, with CCTV and alarm monitored by a national security provider. Security patrols are made out of office hours. Access to the data centre is further restricted, again by access card issued to specific, identified personnel. All access to the data centre is recorded by continuous CCTV.

12.6 **Temperature** - Electronic equipment produces large amounts of heat, which can cause damage if uncontrolled. Multiple and redundant air conditioning systems keep the data centre at a constant operating temperature. These are regularly maintained under contract. Temperature monitors issue alarms if the temperature rises above the controlled level.

12.7 **Fire Protection** - The data centre is protected by an automatic fire gas suppressant system which would suppress a fire if needed. These are controlled by multiple redundant sensors.

12.8 **Testing -** Disaster recovery testing is performed on a different selection of systems every quarter. This is arranged by the Infrastructure Supervisor to cover all critical systems every 12-month period. Please see the Disaster Recovery Testing Plan for more details.

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Recovery Measures

12.9 **UPS Power** - All equipment located in the data centre are provided power through Uninterrupted Power Supplies (UPS). These provide short term power from batteries if the building or room supply is interrupted, and also provide protection from power surges.

12.10 **Generator** - An onsite diesel generator, capable of supplying the whole building, will automatically start if the power supply to the building fails. This will automatically take over supplying the power to the building and the data centre in under a minute. The generator is tested every month by the Infrastructure Team and can run for 3 days before requiring refuelling. Refuelling is under contract and is within 24 hours of a request.

12.11 **Spare Hardware** - 'Hot Spare' equipment is retained at our disaster recovery location for use in an emergency.

12.12 **Server Replication** - Critical servers are regularly replicated to a virtual copy and transferred to our disaster recovery centre. This allows us to power up a replica of our critical servers in a virtual environment if there is a complete failure or loss of the original server.

12.13 **SAN replication** - All data from critical servers is stored on a Storage Area Network (SAN). This stores data on specialist hardware which prevents the failure of a single hard drive from corrupting or causing loss of data. The SAN system also has a replica in our disaster recovery centre and duplicates the data regularly.

Disaster Recovery Testing

12.14 ERS Medical has a rigorous testing plan for the disaster recovery (DR) systems in place. This ensures that systems perform as expected and provide an opportunity for improvement.

12.15 The IT Provider will be responsible for testing the recovery effectiveness of the system and reporting their findings and recommendations for improvement to the SMT.

12.16 The IT Provider will be responsible for establishing a test plan and submitting this plan to SMT on an annual basis for consideration and approval.

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BMS/10.02 Information Security Code of Conduct

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
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2.0	All	All	All	20.04.18	[redacted]	Addition of review date
3.0	All	All	All	12.04.19	[redacted]	Annual Review
4.0	All	All	All	16.04.20	[redacted]	Annual Review

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3. Introduction

3.1 To educate ERS Medical employees on the importance of Information Security / Governance.

3.2 To ensure that all users have a clear understanding of ERS Medical's requirements for information security and how it affects them. In particular they should understand the following:

- ERS Medical's Information Security Policy;
- How to protect the confidentiality of service users, clients and customers;
- ERS Medical's responsibility to protect the information provided to it by its employees, suppliers and contractors;
- Users' responsibility to handle ERS Medical systems, software and hardware responsibly and what constitutes unacceptable behaviour;
- How to abide by password rules and keep system access confidential and secure;
- How to recognise and handle a Freedom of Information Request;
- How to adhere to the clear desk and screen policies at all times, keeping physical equipment and locations safe and secure;
- The need to report to their line manager, any issue that is believed to violate this guidance in anyway.

3.3 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.4 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to ERS Medical's Information Security Policy which is available on Bamboo HR or from your Line Manager.

4.2 The purpose of the policy is to establish ERS Medical's commitment to information security, ensuring the safeguarding of all personal and sensitive information within a secure environment.

4.3 It also aims to ensure the confidentiality, integrity and availability of information assets. The policy also defines how ERS Medical will minimise risk or disruption to business processes through the implementation of controls and procedures which support the policy.

5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Head of Care Standards (IG Lead)**	Making any concessions to this procedure. Producing training literature for Information Security. Ensuring that it forms part of ERS Medical's training plans.
5.4	**Legal Council**	Provide expert and strategic legal advice to ERS Medical. Provides evaluation of the inputs and impacts of decisions relating to information security matters.
5.5	**Caldicott Guardian**	Is responsible for protecting the confidentiality of patient and service-user information and actively supports work to enable information sharing when appropriate
5.6	**Senior Operations Managers and Operations Managers**	Are responsible for ensuring that all personnel in their area or under their control have received this procedure and understand its requirements. Additionally responsible for ensuring that all personnel under their control receive appropriate training.
5.7	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **Confidentiality** – To ensure that access to the information is limited to authorised personnel only.

6.2 **Availability** – To ensure that the correct information is available at point of use and to only authorised personnel.

6.3 **Integrity** – To ensure that the information is trustworthy, accurate and free from unauthorised modification.

6.4 **Employee** – An individual who works part-time or full-time under a contract of employment, whether oral or written, express or implied.

6.5 **Contractor** – An individual or organisation that undertakes a job or contract to provide materials, services or labour.

6.6 **Information Security Advisory Committee (ISAC)** – Committee chaired by the Information Security Manager which considers and implements ERS Medical's information security needs.

6.7 **Relevant Legislation** – Is the UK Data Protection Act 1998 and the Republic of Ireland Data Protection Act 1988 (Data Protection Amendment Act 2003) which are derived from EU Data Protection Directive 95/46/EC.

6.8 **Data** – A set of values of qualitative or quantitative variables. When collected together in a meaningful way, data can provide us with information.

6.9 **Information** – Something which informs us. It could be the answer to a question or the results from a set of data. Information allows us to understand things.

6.10 **Personal Data** – Data which relates to any living individual and when several pieces of personal data are brought together this becomes Personal Identifiable Information.

6.11 **Patient Identifiable Information** – Similar to Personal Identifiable Information but can be identified within a healthcare context.

6.12 **Sensitive / Patient Sensitive information** – Any information that has the ability to cause harm, distress or negative implications through its unauthorised disclosure. This could be clinical information, mental health status or religious or political beliefs.

6.13 **Information Commissioners Office (ICO)** – The UK and ROI independent regulators set up to uphold information rights.

6.14 **ISO 27001** – Information Security standard which provides the requirements for establishing, implementing and continually improving an information security management system.

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7. Confidentiality for Customers, Service Users and the Company

7.1 ERS Medical considers the confidentiality of the information with which it is entrusted, of paramount importance. All employees and contractors must be exceptionally diligent in ensuring they comply with the requirements laid down in this code of conduct.

7.2 All employees and contractors must be aware of their responsibilities for safeguarding confidentiality and information security. The responsibility is to protect any personal information that they may come into contact with during the course of their work.

7.3 This is not only a contractual requirement but also a legal obligation based on the relevant Data Protection legislation. (See 7.7)

7.4 All Company employees and contractors are required to participate in induction, training and awareness-raising sessions carried out to inform and update staff on information security and confidentiality issues.

7.5 Employees and contractors must not disclose any Company, customer or service user related information to anyone other than the intended recipient of that information.

7.6 Employees and contractors must ensure that the following principles are adhered to:

- Person-identifiable or confidential information must be effectively protected against improper disclosure when it is received, stored, transmitted or disposed of;
- Access to person-identifiable or confidential information must be on a need to know basis;
- Disclosure of person identifiable or confidential information must be limited to the purpose for which it is required;
- Recipients of disclosed information must respect that it is given to them in confidence;
- If the decision is taken to disclose information, that decision must be justified and documented.

7.7 Any concerns about disclosure must be raised immediately to a Line Manager or the Information Security Manager.

Confidentiality for Employees, Contractors and Job Applicants

7.8 ERS Medical is committed to respecting the privacy of its employees, contractors and job applicants.

7.9 ERS Medical will only hold information in its records which is required, relevant and timely for specific purposes.

7.10 From time to time, letters or communications from third parties may contain information about employees, contractors or job applicants. This information will be kept for as long as required by the purpose of the communication.

7.11 ERS Medical will allow any individual to see both computerised and written information held about them, except where this has been given in confidence or by a third party. Individuals must be given the chance of correcting any claimed inaccuracies in Company records.

7.12 Hard copies of personnel files will be kept in a locked filing cabinet, cupboard or room. Electronic versions of files will be kept secure and are accessible to the employee's line manager, human resources, payroll and health and safety team members where required.

7.13 Any person seeking personal information on employees, contractors or job applicants must be informed that ERS Medical has an Information Security Policy and that this information is subject to it.

7.14 The following types of information held by ERS Medical regarding its employees or contractors will be treated as confidential:

- Age;
- Gender and Sexual Orientation;
- Current Address and Telephone Number;
- National Insurance Number;
- Income;
- Family and Marital Status;
- Nationality and Country of Origin / Ethnic Origin;
- Medical Conditions, Disabilities and Current Medication;
- Disciplinary / HR Information;
- Bank Details;
- Accidents at Work.

7.15 ERS Medical has a duty to protect this type of information even after the employee or contractor is no longer working for or on behalf of ERS Medical. However, the above types of information may be divulged to third parties with the employees or contractors consent or where there is a legal or statutory requirement to do so.

7.16 When information is requested from a third party about an employee, contractor or job applicant, requests should be made in writing.

7.17 Staff must consult the General Counsel before releasing any information. This must involve confirming the validity of the request and determining whether ERS Medical should release the information.

7.18 Personal approaches by people claiming to be police officers must be verified by checking official Identity Cards.

7.19 If there is any doubt about whether consent has been granted for the information to be released, it must be confirmed in writing by the person concerned.

7.20 A record of all information passed to third parties must be placed on the individual's personnel file.

7.21 A few examples of circumstances where information may be released are listed below:

7.22 An enquiry from the Police, regulators or other agencies in connection with a criminal investigation.

7.23 An attempt to trace someone on an urgent matter.

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7.24 Where it is a statutory duty to give information, e.g. in relation to Inland Revenue or Customs & Excise:

- Where ERS Medical's appointed persons (e.g. external and internal auditors) need to verify financial statements by checking relevant information from an individual's file;
- ERS Medical is required to do so by a court;
- Where consent has been given by the employee or contractor.

8. Acceptable Use Requirements

8.1 It is essential that all Company employees and contractors are aware that inappropriate use of Company equipment, systems, software and hardware may create business risks.

8.2 More information on ERS Medical's expectations on employees regarding acceptable use can be found within **BMS/10.04 - Acceptable Use**.

8.3 Topics covered include:

- Using the internet at work;
- Using your company mobile phone;
- Using your own phone for work;
- Looking after patient information;
- Data protection for ambulance crews;
- Your privacy at work.

9. Password Management

a. Password controls are the principal means of ensuring that only authorised personnel can access Company information and systems. Passwords are only effective if they are of good quality, never shared or written down and changed periodically.

System Policy for Staff Passwords

9.1 The following policies are enforced by ERS Medical systems as a minimum

- Maximum password age 90 days;
- Minimum password age 1 day;
- Cannot use any of last 24 passwords;
- Minimum length 8 characters;
- May not contain the user's account name or parts of the user's full name that exceed two consecutive characters;

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- Must contain characters from three of the following four categories:
- Upper case characters;
- Lower case characters;
- Base 10 digits (0 through 9);
- Non-alphabetic characters (e.g.!, $, &).

9.2 Higher requirements may apply to some business units based on the sensitivity of information they handle or based on legal or regulatory obligations.

Password Selection

9.3 This additional guidance is not enforced by systems, but is the user's responsibility:

- Passwords should not contain more than two consecutive identical characters;
- Passwords that are easy to guess should be avoided e.g. important dates, family names, initials, pet names, car registrations or any work related references such as user ID.

Change of Password

9.4 Passwords must be changed if it is suspected that a system or password has been compromised.

9.5 If you do suspect that a system or password has been compromised, IS must be informed immediately and a security incident will be raised.

9.6 All temporary passwords must be changed at first logon.

Access to Multiple Services

9.7 Users of multiple services may select a single password for all services, provided all of the above requirements are met, however, this is not advised. Having the same password for multiple services, means that if a password is compromised, more information is at risk.

Employee PCs / Laptops

9.8 All employee PCs are subject to the following Windows domain policies:

- Password required before operating system boot;
- Selected laptops have a screen lock applied after 5 minutes inactivity for added security measures;
- CRTL+ALT+DEL required to logon;
- Encryption may be used where necessary for security purposes.

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10. Requests for Information

10.1 Although ERS Medical is not a public body, as an NHS Business Partner, it does occasionally receive Freedom of information Requests. The Freedom of Information Act legislation recognises that any member of the public has a right to know how public services such as the NHS are organised and run, how much they cost and how to make a complaint if they need to.

10.2 For ERS Medical, as the data processor; requests for information about the service that is offered to a particular Trust or indeed, information about a Trust must be sent to ERS Medical's Management Team. This is passed to the appropriate Trust for review. It is then the Trust's responsibility to handle and respond to the request.

10.3 It is the responsibility of all employees and contractors to be able to recognise a request for information. This must be made in a recorded format e.g. disc, email or letter. The request does not need to formally state that it is a Freedom of Information Request; it simply needs to ask for the information to be provided.

10.4 Additionally, the requester does not need to state why the information is being requested.

10.5 If a request is received, it is the employee or contractor's responsibility to do the following:

10.6 Determine if the request is a Freedom of Information Request relating to a Trust or service; e.g. does the request ask for information about a public body or service that we work with?

10.7 If so, the employee / contractor must inform their line manager immediately to confirm the validity of the request.

10.8 It should then be sent, without delay to the General Council who will assess the request and forward it to the appropriate senior manager to be handled.

10.9 Most requests relating to a Trust will be directed to the Caldicott Guardian who will issue the request, without delay, back to the Trust to allow them to respond to it.

10.10 Any request not relating to Trust activity will be issued to the appropriate manager who will, with support from the General Council determine the appropriate course of action.

10.11 It is important to note that a public body has 21 days in which to respond to a Freedom of Information request. It is therefore crucial that any requests are handled immediately and passed to the General Council without delay.

11. Access Control Policy

11.1 Authorisation and Control of Access to IT assets is an important element of Information Security and compliance with ISO 27001 requirements.

11.2 Controls are required to ensure that only authorised personnel have access to information systems and that such access is limited, dependent on the role of the individual concerned.

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11.3 This covers all tasks, ranging from initial access to final removal, with the necessary tracking in-between. It applies to both permanent and temporary employees and contractors within ERS Medical.

Access Levels

11.4 ERS Medical sets access levels to ensure that all user hardware / software assets are controlled and managed in a manner that is both repeatable and verifiable, for both legal and financial purposes and that those user hardware / software assets are appropriate to the user's duties and responsibilities.

11.5 Access levels will generally fall into categories according to role.

Access Management

11.6 The need for user access will be identified by the user's line manager during the recruitment / induction process, and they shall raise a Security Request Form found on the IS work area on the intranet with specific details of the access required.

11.7 Alterations and deletions will be initiated by the relevant line manager by amending the access form and will then be carried out by the IT Provider.

11.8 Access rights for all users will be reviewed bi - annually as part of ERS Medical's internal audit process.

11.9 Access rights for leavers will be removed as part of the leaver's process.

11.10 Access to server racks and associated equipment will be strictly limited to trained, authorised personnel.

12. Clear Desk and Clear Screen Policy?

12.1 Material left exposed (e.g. on a desk, printer or cupboard top) is more susceptible to damage, disclosure or theft, particularly outside of office hours. ERS Medical's clear desk and screen policy is applicable to all staff whether office or home based.

12.2 When leaving your desk, your computer or laptop should be locked using 'Ctrl, Alt, Del'.

12.3 When finishing work at the end of the day, your computer or laptop should be fully shut down. Not only is this for security, but it allows for any updates to be run which are essential for the maintenance and security of your device.

12.4 Any Company laptop user should ensure that the device is taken home with them where possible. If this is not possible, the laptop should be secured or locked away out of sight.

12.5 Printers should be turned off and no jobs run unless the print outs can be collected immediately. Passcodes should be used where possible.

12.6 Fax machines and other forms of mail delivery that are likely to receive sensitive information are to be turned off and adequately protected.

12.7 When leaving your desk or at the end of the day, desks should be completely cleared of all documented and papers. This is particularly important for any documents containing personal information. These documents should be kept in lockable storage and should never be left in boxes, trays or desks.

12.8 All users are responsible for ensuring that these controls are adhered to. Failure to follow this may cause a security breach or result in information being lost, stolen or damaged.

13. Physical Security

13.1 It is important for information security purposes that any of the physical locations from which we operate (e.g. office, vehicles and premises) should never be left unsecured and unattended at any time for any reason.

13.2 During absences, doors should be secured and the windows checked as being locked and closed.

13.3 Any alarms should be enabled and any additional barriers should be used where available (e.g. steering locks, perimeter fencing, and parking barriers).

13.4 Anyone who is allowed entry to a physical location must be known to staff and have legitimate reason to be there and have an appointment.

13.5 Visitors should be directed to waiting areas and must not be left unattended in secure areas where work activities are conducted. Visitors should not be directed to make their own way around in the building; instead they should be escorted to their location.

13.6 When entering an office, premises or restricted area (e.g. server room), employees must ensure that no-one is allowed to follow them. Everyone must be individually and legitimately authorised to enter.

14. Data Security Agreement

14.1 All employees and contractors are required to sign a Data Security Agreement as part of their employment / contract. They must also agree to adhere to ERS Medical's information security policies.

14.2 This agreement covers, but is not limited to, obligations under:

- The Data Protection Act 1998 (UK);
- The Data Protection Act 1988 (IE);
- The Computer Misuse Act 1990 (UK);
- The European Union Data Protective Directive 95/46/EC;
- The ERS Medical Confidentiality Policy Statement.

14.3 This agreement may be revised and reissued from time to time and it is a condition of employment / contract.

15. Security Breaches and Incidents

15.1 If you are ever concerned that information has not been transferred securely, or you become aware that information has been lost, stolen, damaged or used incorrectly, it is your responsibility to report it as soon as possible.

15.2 This can be done by raising a Security Incident as instructed by BMS/5.01 - Incident Reporting and Investigation procedure.

15.3 Where there has been a loss of ERS Medical equipment such as a laptop or mobile phone, IS must be contacted immediately to ensure that the device can be wiped to prevent any access to information.

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BMS/10.03 Secure Transfer of Information

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IT and Data Security	BMS/10.04
Secure File Transfer Protocol (sFTP)	WI/10.03.01
Physical Transfer of Information	WI/10.03.02

3. Introduction

3.1 ERS Medical handles large amounts of information on a daily basis. This information can be held within ERS Medical about staff, contractors, customers and service users. Similarly, it can be transferred out in reports, emails and onto systems and databases used by ERS Medical.

3.2 It is ERS Medical's responsibility to ensure that this information is handled safely, securely and with appropriate protection based on its content.

3.3 This process will instruct users on the best way to transfer different kinds of information securely; reducing the risk of the confidentiality, integrity or availability of the information being affected.

3.4 To provide practical guidance on the secure transfer of information.

3.5 To minimise the risk of ERS Medical breaking the law and being subject to enforcement action by the Information Commissioners Office or other regulators.

3.6 To provide reassurance to our customers that we can be trusted to handle their information.

3.7 To ensure a wider employee understanding of the importance of safe information sharing and greater insight into what should be shared and how best to do so.

3.8 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.9 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**IT Provider**	Responsible for supporting information security practises by administrating email accounts and setting up sFTP sites where required. Reporting any issues or concerns regarding security or raising incident forms for any breaches.
5.4	**Head of Care Standards (IG Lead)**	Is responsible for administration and management of the NHS IG toolkit and setting the internal standards for all IG training and compliance agreed through the SMT. Responsible for managing security incidents, conducting investigations and consulting with the ICO in relation to breaches.
5.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times. All staff are responsible for reporting any data breaches including loss, damage, modification through ERS Medical's incident reporting system.

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6. Definitions

6.1 **Confidentiality** – The insurance that access to the information is limited to authorised personnel only.

6.2 **Availability** – The insurance that the correct information is available at point of use and to only authorised personnel.

6.3 **Integrity** – The insurance that the information is trustworthy, accurate and free from unauthorised modification.

6.4 **Relevant Legislation –** Is the UK Data Protection Act 1998 and the Republic of Ireland Data Protection Act 1988 (Data Protection Amendment Act 2003) which are derived from EU Data Protection Directive 95/46/EC.

6.5 **Data –** A set of values of qualitative or quantitative variables. When collected together in a meaningful way, data can provide us with information.

6.6 **Information –** Something which informs us. It could be the answer to a question or the results from a set of data. Information allows us to understand things.

6.7 **Personal Data –** Data which relates to any living individual and when several pieces of personal data are brought together this becomes Personal Identifiable Information.

6.8 **Patient Identifiable Information –** Similar to Personal Identifiable Information but can be identified within a healthcare context.

6.9 **Sensitive / Patient Sensitive Information –** Any information that has the ability to cause harm, distress or negative implications through its unauthorised disclosure. This could be clinical information, mental health status or religious or political beliefs.

6.10 **Encryption –** The process through which information is encoded so that only authorised recipients can access it.

6.11 **Information Commissioners Office (ICO)** – The UK and ROI independent regulators set up to uphold information rights.

7. What Information do we need to Protect

7.1 Not all information handled by ERS Medical needs to be protected in specific ways. Most information should just be treated sensibly and care taken not to lose it or to send it to recipients who shouldn't have it or don't need it.

7.2 However, if you can answer yes to the following questions then the data you're handling is more sensitive and should be protected sufficiently.

- Does it relate to a living individual and can they be identified by it? If so, it is classed as Personal data and must be protected as mandated by law. Remember personal information also includes information about employees.

- Does it have any health related data such as specialty information or hospital locations? If so, then it is patient identifiable. This is a class up from personal data as it can identify the individual in the context of a healthcare setting and should also be protected.

- Does the information about the individual contain data which could potentially cause harm, upset, or distress by its unauthorised disclosure, then it is likely to be Sensitive / patient sensitive information. Some examples of this may be mental health information, HIV status, attendance or treatment information at a sexual health clinic, religious or political affiliations.

7.3 Any information which falls into the above categories requires protection and should be handled with extra care.

7.4 The work instructions detailed in this document will give further instruction as to how the information should be protected and handled but as brief guidance; the following should always be adhered to.

- Sensitive information should never be left unattended. This refers to paper documents which must be locked away when not in use. It also refers to electronic information which must be controlled by access permissions (passwords). In addition, devices must be screen locked when not in use.
- Sensitive information must be properly destroyed when no longer required. This means shredded or placed into confidential waste bins. It should never be placed into normal bins.
- Before distributing sensitive information, consider if it really needs to be distributed and try to limit the amount of people it is shared with where possible.
- Always check recipients to ensure that information is being sent to the correct people.
- If you're concerned about the sensitivity of the information you're working with, contact the IS team or the Information Security Manager for solutions to further protect the information.

7.5 For the purposes of this guidance, information containing personal information, patient identifiable information, sensitive or patient sensitive information will be called 'Confidential information'. However, it is important to remember the distinction between the different types.

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8. Relevant Legislation

8.1 If your role requires you to transfer any of this information there is legislation which you must be aware of.

8.2 If you are based within the UK, the UK Data Protection Act 1998 gives 8 principles which must be adhered to if you're handling or processing confidential information. They are summarised below:

- Information should be used fairly and lawfully;
- It should be used for limited, specifically stated purposes;
- It should be used in a way that is adequate, relevant and not excessive;
- Information must be accurate;
- It should be kept for no longer than is absolutely necessary;
- It should be handled in accordance with people's data protection rights;
- It should be kept safe and secure, even when being transferred;
- It should not be transferred outside the European Economic Area without adequate protection;

Note: Republic of Ireland Data Protection Act 1988 (Data Protection Amendment Act 2003) has similar principals although they are produced in a different order.

8.3 If you are based within the Republic of Ireland, the Republic of Ireland Data Protection Act 1988 (Data Protection Amendment Act 2003) gives a similar set of 8 principles which must be adhered to if you're handling or processing confidential information. They are summarised below:

- Information must be obtained and processed fairly.
- It should be kept for one or more specified and lawful purpose only.
- It should be processed only in ways compatible with the purposes for which it was initially given.
- It should be kept safe and secure.
- Information must be accurate and up to date.
- It should be adequate, relevant and not excessive
- It should not be retained for any longer than is necessary.
- A copy of the individual's personal data should be given to them, if requested.

8.4 If you are ever concerned about the type of information you need to share and feel that it needs further protection or you're unsure if it should be shared, please contact the Head of Care Standards.

9. Unsecured Email / Outlook

9.1 Not all information is considered to be confidential information; it is quick and easy to send reports to customers over email. For such purposes, Company email is useful and productive.

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9.2 It is important to note that Company email is known as 'unsecured' when you are emailing people outside of ERS Medical. Because the information travels freely across the public internet it is vulnerable to interception.

9.3 If you think that the unauthorised disclosure of this information could pose a risk to ERS Medical, then there are more secure methods of sending the data.

9.4 No information of a sensitive nature or containing personal information about an individual should be transferred using unsecured email.

10. Telephone / Face to Face

10.1 When relaying information over a telephone or in a face to face conversation, always consider the following:

- Is the call being recorded?
- Will you need to rely on this conversation for audit trail purposes in the future? e.g. agreements with customers, if so, it is always better to back this up in writing.
- If the call / conversation is private, have you checked your surroundings to ensure that you cannot be overheard by unauthorised persons.

11. Secure File Transfer Protocol (sFTP)

11.1 **WI/10.03.02** outlines the reasons and benefits for using sFTP and how a user should gain access to a file. It also gives instruction on how a user should issue credentials out to an external party for the secure transfer of information to regulators, customers or other relevant third parties.

11.2 An sFTP site allows staff to share information securely externally. This should be used whenever information cannot be sent via NHSMail due to the file size being too large or the recipient not having access to a secure email account.

11.3 FTP (file transfer protocol) is a widely used method of transferring files between two systems. To add an extra layer of security sFTP (Secure File Transfer Protocol) is used to encrypt the data in transit. The level of encryption we use is SSH2, This means we support up to 256Bit.

12. Physical Transfer of Information

12.1 **WI/10.03.03** outlines the appropriate steps that should be taken when transferring physical information such as paper documents or media. It also gives advice on what type of information should not be transferred using this method.

12.2 Where information cannot be transferred by NHSMail or sFTP and there is no alternative, confidential information should, in the first instance be held on an encrypted storage device.

12.3 In exceptional circumstances, information can be printed out and hand delivered or sent by courier.

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12.4 It is important to note that physical transfer of confidential information carries significant risk and should be avoided where possible.

13. Security Breaches and Incidents

13.1 If you are ever concerned that information has not been transferred securely, or you become aware that information has been lost, stolen, damaged or used incorrectly, it is your responsibility to report it as soon as possible.

13.2 This can be done by raising a Security Incident as instructed by **BMS/5.01 - Incident Reporting and Investigation** procedure.

13.3 Where there has been a loss of ERS Medical equipment such as a laptop or mobile phone, IS must also be contacted immediately to ensure that the device can be wiped to prevent any access to information.

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BMS/10.04 IT and Data Security

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IS Projects – Change Requests	WI/10.01.01
Acceptable Use	WI/10.01.02
Disaster Recovery Test Form	Intranet

3. Introduction

3.1 This policy defines a framework by which ERS Medical computer systems, assets, infrastructure and computing environment will be protected from threats whether internal, external, deliberate or accidental.

- It portrays a professional business image to our clients, customers and suppliers when they visit ERS Medical premises;
- It reduces the threat of a security breach as passwords and other confidential information are locked away or otherwise securely stored;
- It ensures compliance with data protection requirements because personal data must be held securely at all times;
- It protects employees' health and safety by reducing the risk of workplace accidents;
- It reduces the risk of damage or destruction to information in the event of an unforeseen disaster such as a fire, flood or explosion.

3.2 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.3 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Health, Safety, Quality and Environmental Policy.

4.2 Please refer to the ERS Medical Business Continuity Policy.

4.3 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Have overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available.
5.2	**Senior Leadership Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**IT Provider**	Is responsible, through the SMT for providing a wide range of technologies such as client applications, telecommunications and data networking across UK. Ensure new technologies and solutions are aligned with the business focus and standard policies. Is responsible for the implementation of a wide range of technologies across the UK. Provides support to new acquisitions and minimises disruption during the integration phase. Manages and develops the IS Project Managers and IS Supervisors, ensuring continuous improvement and reduction of departmental costs. Are responsible for managing IS Projects through requirement definition, planning, testing and implementation. Project Managers must ensure that the businesses requirements have been understood and prioritised correctly, the correct change process is followed and that the project meets it's deadlines and come in on budget Are responsible for ensuring team projects and daily activities are completed with competence and quality; assigning responsibilities to individuals while maintaining the overall team balance. Stay in keeping with the customer needs and proactively search for ways to increase customer satisfaction. Are responsible for providing IT support to all business users and applications. Support the development, implementation and maintenance of applications, telecommunications, databases and networking
5.4	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times.

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6. Key Principles

6.1 All central computer systems, environments and information contained within them will be protected against unauthorised access.

6.2 All use of the ERS Medical IT facilities will comply with the IT Acceptable Use Policy.

6.3 Information kept within these systems will be managed securely, to comply with relevant data protection laws and to satisfy ERS Medical expectations that such assets will be managed in a professional, safe and dependable manner.

6.4 All members of staff are required to familiarise themselves with this policy, to adhere to it and comply with its requirements.

6.5 The Operations Manager and team leaders have a responsibility for ensuring the implementation of, adherence to and compliance with this policy throughout their areas of functional responsibility.

6.6 The integrity of all central computer systems, the confidentiality of any information contained within or accessible on or via these systems is the responsibility of ERS Medical Management Board.

6.7 All breaches of security will be reported to and initially investigated by The Operations Manager.

6.8 All users have a responsibility to report promptly (through the reporting structure) any incidents which may have an IT security implication for ERS Medical.

7. Security

7.1 As many computer files contain some form of confidential or otherwise sensitive business information, ERS Medical takes the security of these files very seriously. With this in mind, employees must abide by the following security precautions:

- If you need to leave your computer for more than a couple of minutes, lock the computer screen;
- If you need to leave your computer for a long period of time, log off – never leave an unattended computer logged on;
- When creating a computer password, do not use one that is obvious, such as your date of birth or the name of a close family member – passwords should preferably be a mix of letters and numbers and should not be the same as any other personal passwords you may have (such as online banking passwords);
- Always keep your password private, do not write it down and do not divulge it to anyone else (including other members of staff);
- If you suspect that someone knows your password, change it in the normal way;
- Change your password at regular intervals in any event;
- Always shut down your computer when you go home at the end of the day;
- If you notice any suspicious activity, for example an employee trying to gain unauthorised access to another employee's computer, notify your line manager immediately.

8. Data

8.1 The computers and the data they contain are provided to undertake business-related activities and to enable employees to carry out their job duties. As such, data should not be amended, deleted, copied or taken away unless this is both specifically related to the work the employee is undertaking and they have the authority to make such amendment, deletion or copy. In particular, employees should not delete or amend any documentation or programs which are stored on ERS Medical's communal drives unless they have the requisite level of authority to do so.

8.2 Non-work related data should not be copied onto or stored on Company computers.

9. Use of Portable Storage Devices

9.1 Some employees may be provided with portable storage devices (such as memory sticks and portable hard drives) that can be plugged into the USB port of a computer. Whilst they are provided so as to allow for the copying and transferring of files and images between an employee's desktop or laptop computer, their small size and storage capacity makes them vulnerable to misuse.

9.2 For this reason, any employee issued with these devices must not transfer any data to a third party computer (including one at home) without first having obtained approval from their line manager. From time to time, user guidelines will be produced on the usage of such devices and employees will be expected to follow them.

9.3 Any employee who transfers files to a third party without permission is likely to be subject to disciplinary action. In the event that this involves the deliberate transfer of sensitive commercial information to a competitor, it will be treated as gross misconduct.

10. Computer Misuse

10.1 Some employees have access to computers in the workplace for the use by them in connection with ERS Medical's business. Computers are provided to employees to undertake business-related activities only.

10.2 Employees who are discovered unreasonably using ERS Medical's computers for personal and private purposes will be dealt with under ERS Medical's disciplinary procedure.

10.3 Vandalism of, or intentionally interfering with, ERS Medical's computers or network a potential gross misconduct offence and could render the employee liable to summary dismissal under ERS Medical's disciplinary procedure.

11. Computer Software

11.1 ERS Medical licences the use of computer software from a variety of outside companies. ERS Medical does not own this software or its related documentation and, unless authorised by the software developer, neither ERS Medical nor any of its employees have the right to reproduce it. To do so constitutes an infringement of copyright. Any employee found to be contravening this may face disciplinary action under ERS Medical's disciplinary procedure. 5

12. Computer Viruses

12.1 ERS Medical's computer network makes it vulnerable to viruses and virus protection software has been installed. Therefore, only duly authorised personnel have the authority to load program software onto the network system and re-configuring or disabling the virus protection software is prohibited.

12.2 Data compatible with ERS Medical's system may be loaded only after being checked for viruses by the IT department. Any employee found to be contravening this may face disciplinary action under ERS Medical's disciplinary procedure.

13. Computer Games

13.1 There are computer games on the network. Employees may only access these outside their normal working hours, for example during lunch breaks. Employees must not install their own games on to work computers.

14. E-Mail and Internet Usage

14.1 Some employees also have access to internal and external e-mail and the internet for the exclusive use by them in connection with ERS Medical's business and as part of the normal execution of their job duties. Only duly authorised personnel have the authority to use e-mail and the internet at work.

14.2 Any employee found to be contravening this may face serious disciplinary action under ERS Medical's disciplinary procedure.

14.3 The purpose of these rules is to protect ERS Medical's legal interests. Unregulated access increases the risk of employees inadvertently forming contracts through e-mail and increases the opportunity for wrongful disclosure of trade secrets and other confidential information.

14.4 In addition, carelessly worded e-mail can expose ERS Medical to an action for libel. As such, e-mail to clients and customers must follow ERS Medical's designated house style, which will be supplied to authorised users. Failure to follow house style is a disciplinary matter and will be dealt with under ERS Medical's disciplinary procedure.

14.5 E-mail should not be used for unsolicited correspondence or marketing campaigns and employees may not commit ERS Medical financially by e-mail unless they have been granted a specific level of delegated authority to do so.

14.6 Employees who are authorised users are not permitted to surf the internet or to spend excessive time “chatting” by e-mail for personal and private purposes during their normal working hours. Employees are also prohibited from using e-mail to circulate any non-business material.

14.7 Not only does excessive time spent online lead to loss of productivity and constitute an unauthorised use of ERS Medical’s time, sexist, racist or other offensive remarks, pictures or jokes sent by e-mail are capable of amounting to unlawful harassment.

14.8 Employees are also prohibited from using ERS Medical’s electronic communications as a means of intimidating or bullying employees or third parties. Employees who are discovered contravening these rules may face serious disciplinary action under ERS Medical’s disciplinary procedure.

14.9 Depending on the seriousness of the offence, it may amount to gross misconduct and could result in the employee’s summary dismissal.

14.10 Use of instant messaging systems must be expressly approved in advance by the employee’s line manager. Employees who are authorised users are permitted to surf the internet for personal purposes outside their normal working hours.

14.11 ERS Medical considers acceptable personal use of the internet to include activities such as personal online shopping, booking holidays and banking. It does not include visiting online gambling sites or participating in online gaming.

14.12 Employees should note that any purchases or other transactions made online whilst at work are made entirely at their own risk. Employees must not use their work e-mail address to make orders for personal goods and services.

14.13 Employees who are authorised users are not permitted to log on to social networking and video sharing websites such as Facebook, Twitter and YouTube or use ERS Medical IT systems to keep a personal weblog (‘blog’) at any time. ERS Medical has added websites of this type to its list of restricted websites.

14.14 Logging on to sexually explicit websites or the downloading and/or circulation of pornography or other grossly offensive, obscene or illegal material or using the internet for illegal activities constitutes gross misconduct and renders the employee liable to summary dismissal under ERS Medical’s disciplinary procedure.

14.15 Rogue” websites exist that appear harmless but instead direct the user automatically to another website that may contain inappropriate material. If this occurs, please contact the IT department immediately.

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15. Social Networking and Video Sharing Websites

15.11 When logging on to and using social networking and video sharing websites and blogs at any time, employees must not:

- Publicly identify themselves as working for ERS Medical, make reference to ERS Medical or provide information from which others can ascertain the name of ERS Medical;
- Conduct themselves in a way that is detrimental to ERS Medical or brings ERS Medical into disrepute;
- Use their work e-mail address when registering on such sites;
- Allow their interaction on these websites or blogs to damage working relationships between employees and clients of ERS Medical;
- Include personal information about ERS Medical's employees, suppliers, customers or clients without their express consent (an employee may still be liable even if employees, suppliers, customers or clients are not expressly named in the websites or blogs as long as ERS Medical reasonably believes they are identifiable);
- Make any derogatory, offensive or defamatory comments about ERS Medical, its employees, suppliers, customers or clients (an employee may still be liable even if ERS Medical, its employees, suppliers, customers or clients are not expressly named in the websites or blogs as long as ERS Medical reasonably believes they are identifiable);
- Make any comments about ERS Medical's employees that could constitute unlawful discrimination, harassment or bullying;
- Disclose any confidential information or trade secrets belonging to ERS Medical or its suppliers, customers or clients, or any information which could be used by one or more of ERS Medical's competitors.

15.12 Employees who are discovered contravening these rules, whether inside or outside the workplace may face serious disciplinary action under ERS Medical's disciplinary procedure.

15.13 Depending on the seriousness of the offence, it may amount to gross misconduct and could result in the employee's summary dismissal.

15.14 ERS Medical reserves the right to deny, remove or limit e-mail and/or internet access to or from any employee who contravenes these provisions.

16. Downloading Information from the Internet and File Sharing

16.1 Employees may be tempted to make illegal downloads of material that is subject to copyright. This includes, but is not limited to, music, film and business software. As this and any subsequent file sharing of this material constitutes an infringement of copyright, it is prohibited on any Company computer.

16.2 This also applies to any download or dissemination of material made outside of normal working hours. Any breach is likely to lead to disciplinary action being taken.

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16.3 Employees may need to download documents and information from the internet in order to undertake their job duties. Employees should only download documents and information that they are sure about and which is required to fulfil the job duties they are undertaking.

17. E-Mail and Internet Monitoring

17.1 ERS Medical reserves the right to monitor employees' internal and external e-mails and use of the internet, both during routine audits of the computer system and in specific cases where a problem relating to excessive and/or unauthorised use is suspected. The purposes for such monitoring include:

- To promote productivity and efficiency;
- To ensure the security of the system and its effective operation;
- To ensure there is no unauthorised use of ERS Medical's time, for example to check that an employee has not been using e-mail to send or receive an excessive number of personal communications;
- To ensure the smooth running of the business if the employee is absent for any reason and communications need to be checked;
- To ensure that all employees are treated with respect and dignity at work, by discovering and eliminating any material that is capable of amounting to unlawful harassment;
- To ensure that inappropriate websites are not being accessed by employees;
- To ensure there is no breach of commercial confidentiality.

17.2 Communications of a sensitive or confidential nature should not be sent by e-mail because it is not guaranteed to be private.

17.3 When monitoring e-mails, ERS Medical will, save in exceptional circumstances; confine itself to looking at the address and heading of the e-mails. However, where the circumstances warrant it, ERS Medical may open e-mails and access the actual content. Employees should mark any personal e-mails as such and encourage those who send them to do the same. ERS Medical will avoid, where possible, opening e-mails clearly marked as private or personal.

18. Reading and Storing E-Mails

18.1 Employees must check their mailboxes regularly during normal working hours. It is their responsibility to read and action any e-mail received.

18.2 If an employee is going to be out of the office for a day or longer and as such they will be unable to check e-mail, they should switch on their "out of office assistant" message. E-mail received in their absence will not normally be read by other members of staff unless the employee has specifically requested a colleague to undertake this task. However, e-mail may need to be checked by line managers for business-related reasons when the employee is absent for any reason. It may therefore be unavoidable that some personal e-mails might be read in these circumstances.

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19. E-Mail Viruses and Spam

19.1 All incoming and outgoing external e-mails are checked for computer viruses and, if a virus is found, the message will be blocked. E-mails may also be checked for other criteria, for example, having an attached image file or containing offensive or inappropriate material or including a banned word or from a banned user under the criteria in ERS Medical's spam software which indicates the message is spam. Again, the e-mail will be blocked. ERS Medical reserves the right for the IT department to block and then read these messages to ascertain whether they are business-related.

19.2 If employees receive an e-mail or data file that is in a format or comes from a source that they do not recognise, they should not open the item but should contact the IT department immediately. Any executable files received by e-mail must be referred to the IT department for clearance before any other action is taken.

19.3 If employees receive any unsolicited e-mails or spam that manages to bypass ERS Medical's spam software, they must not respond in any way. The e-mail should be forwarded to the IT department and they will add the sender to the list of banned users.

20. Telephone Misuse

20.1 ERS Medical's telephone lines (including Company mobile phones) are for the exclusive use by employees in connection with ERS Medical's business. Whilst ERS Medical will tolerate essential personal telephone calls concerning an employee's domestic arrangements, excessive use of the telephone for personal calls is prohibited. This includes lengthy, casual chats and calls at premium rates. Not only does excessive time engaged on personal telephone calls lead to loss of productivity, it also constitutes an unauthorised use of ERS Medical's time.

20.2 If ERS Medical discovers that the telephone has been used excessively for personal calls, this will be dealt with under ERS Medical's disciplinary procedure and the employee will be required to pay to ERS Medical the cost of personal calls made.

20.3 Acceptable telephone use should be no more than five minutes of personal calls in each working day. Personal telephone calls should be timed so as to cause minimum disruption to the employee's work and should, as a general rule, only be made during breaks except in the case of a genuine emergency.

20.4 Employees should be aware that telephone calls made and received on ERS Medical's telephone network will routinely be monitored and recorded to assess employee performance, to ensure customer satisfaction and to check that the use of the telephone system is not being abused or used in an unauthorised manner.

20.5 In addition, an itemised call log may be maintained and retained of all external calls made and received on ERS Medical's telephone network. This may include details of the external caller's number and the date, time and duration of the call.

20.6 Employees should also be aware that voicemail messages may be checked by line managers for business calls when they are absent for any reason. It may therefore be unavoidable that some personal messages might be heard in these circumstances.

21. Mobile Telephones

21.1 Whilst ERS Medical will tolerate the use of employees' own mobile phones for essential personal calls during normal working hours, excessive use for personal calls is prohibited.

21.2 Also prohibited are lengthy calls, casual chats, text messaging, e-mailing, web browsing and the taking of video and/or still images. Personal mobile phones should be set to a silent ring during normal working hours. If employees wish to use their personal mobile phone, they should do so outside their normal working hours.

22. Appendix 1 – Clear Desk Policy

- **Leaving Desks or End of Day Process**

At the end of your working day or whenever you leave the office for an extended period during the day, you must tidy your desk and clear away all work-related paperwork and files into your desk drawer, filing cabinet or cupboard in an efficient and organised manner. These should then be locked overnight where locking facilities are available. Confidential information or information containing personal data must always be securely stored. If you are unsure of the information's sensitivity, either ask your line manager or lock it away securely.

- **Paperwork Disposal Process**

Put any paperwork that you no longer need in your rubbish/recycling bin on a daily basis. Please use ERS Medical's approved shredding facilities / confidential waste bags (Paper Chain box) where the information in the paperwork is confidential. Any unwanted paperwork that contains personal data or sensitive information should be shredded.

Paperwork that you do need should be acted upon and then appropriately filed.

- **Removable Storage Devices**

This policy also extends to removable storage media which may contain files downloaded from your computer, such as memory sticks, portable hard drives and CDs. Media of this type must also be cleared from your desk at the end of your working day.

- **Environmental Factors**

Additionally, this policy is designed to reduce the amount of paper that ERS Medical uses, which in turn reduces the amount of printing costs and filing space needed. You should not print out hard copies of e-mails or documents just to read them unless this is really necessary. All information stored on ERS Medical's computer and e-mail systems are backed-up so you will not lose the information unless you have specifically deleted it.

- **Printers**

When printing out information, it should be cleared from printers immediately, particularly if the information is confidential or contains personal data. Faxes should also be taken from the fax machine immediately. Documentation should not be left lying around on printers, photocopiers or fax machines at the end of the working day.

- **Floor space**

Finally, the floor space around your desk and work area should remain tidy and free from obstructions at all times.

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ERS Medical

Employee confidentiality agreement

THIS AGREEMENT is dated

And is made between:

ERS Medical and

of

It is hereby agreed as follows:

Definitions

1. In this Agreement, unless the context otherwise requires, 'Confidential Information' includes but is not limited to:

    a. any information relating to the trading position, business, products, services, affairs and finances of ERS Medical including (but not limited to) marketing information and plans, market opportunities, product lists, ERS Medical's financial information, results and forecasts, manpower or expansion plans, the remuneration and benefits paid to ERS Medical's employees and officers, lists of suppliers, agents, consultants, distributors, clients or customers and their needs and requirements, the terms of business with them and the fees and commissions charged to or by them, information relating to prospects and tenders contemplated, offered or undertaken by ERS Medical and any other matters connected with the products or services manufactured, marketed, provided or obtained by ERS Medical;

    b. technical data and know-how relating to the business of ERS Medical or any of its suppliers, agents, consultants, distributors, clients or customers including (but not limited to) product designs and specifications, product lists, ideas, inventions, drawings and plans, research and development, manufacturing processes, techniques, formulae, trade secrets, computer systems and software, costs, margins, prices, production and business methods, business plans and forecasts and any other technical matters connected with the products or services manufactured, marketed, provided or obtained by ERS Medical;

    c. any incident or investigation relating to ERS Medical's operations or business, or confidential reports or research commissioned by or provided to ERS Medical; and

    d. any document or item marked as confidential or which you are told is confidential and any information which is given to ERS Medical in confidence by suppliers, agents, consultants, distributors, clients, customers or other persons.

Obligation of confidentiality

2. The Employee agrees to treat as confidential all information supplied by or on behalf of ERS Medical in connection with ERS Medical's business and all other confidential aspects of the business as defined in 'Confidential Information' above.

3. This restriction will continue to apply after the termination of the Employee's employment.

Exclusions

4. This obligation of confidentiality does not apply to:

    a. any information received from a third party who was legally free at the time of disclosure to disclose it; or

b. any information already in the public domain, otherwise than as a result of direct or indirect disclosure by the Employee in breach of the terms of this Agreement.

Duties of Employee

5. The Employee shall not, without the prior written consent of ERS Medical, permit any of the Confidential Information:

    a. to be disclosed, divulged or communicated, whether directly or indirectly, to any third party (including to any other employee or officer of ERS Medical), except to those authorised by ERS Medical to know or as required by law; or

    b. to be copied or reproduced in any form or to be commercially exploited in any way; or

    c. to be used for your own purposes or for any purposes other than those of ERS Medical or to be used or published by any other person; or

    d. to be transferred to the Employee's own personal e-mail account, regardless of the proposed reasons for doing so; or

    e. to pass outside the Employee's control.

6. The Employee will keep a record of Confidential Information received and of the people holding that information and will make that available to ERS Medical on request.

7. The Employee will return to ERS Medical all documents containing Confidential Information and all copies of those documents which are in their possession or under their control on the termination of their employment or, at the request of ERS Medical, at any time during employment. For this purpose, the term 'documents' includes computer discs, memory sticks, portable hard drives and all other materials capable of storing data and information. If required by ERS Medical under the terms of this clause, the Employee will also give a written undertaking that all confidential information has been duly returned to ERS Medical or permanently deleted or destroyed.

SIGNED:

REDACTED

.....

Managing Director
For and on behalf of ERS Medical Ltd.

SIGNED:

.....

Question 1.23.4

Please provide details of the technical and physical measures in place to ensure the security of any person confidential data (PCD) held by your organisation (to include both physical and electronic information).

Please provide copies of any Information Security Policies you have in place which will apply to the proposed approach to this opportunity.

Word count 500 and Copy of Policies

Total Word Count: 486

Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in Clinical Governance, service planning and performance management.

It is therefore of paramount importance to ensure that information is effectively managed and that appropriate policies, procedures and management accountability and structures are in place to provide a robust governance framework for information management.

ERS's technical and physical measures for the safe storage and transfer of PCD are based upon the following legal requirements, central guidance and best practice:

- The common law duty of confidentiality;
- Data Protection Act 1998;
- GDPR;
- Human Rights Act;
- Information Security;
- Information Quality;
- Records Management;
- Freedom of Information Act 2000.

All access to PCD is restricted to only those who have a legitimate need to access it for the purposes of conducting their normal duties, and we control this access in several ways. Any staff member who requires access to ERS Medical systems needs to be authorised by their line manager. Access is the given through our IS provider to our systems. All individuals are then provided with a unique and secure user name and are required to create a secure password. This will only grant them access to our general IT system and for access to systems that contain PCD they require additional authorisation. All systems can and are monitored for misuse and access can be removed immediately ensuring that there is no unauthorised access to the information in our systems.

The majority of the PCD that we hold is within our PDA's and Ceric. These are encrypted and secured with a PIN to prevent any unauthorised access and can be remotely locked and erased by our IT provider upon request.

Physical PCD in the form of run sheets and Patient Report Forms are securely stored in vehicles cabs and then in the office at the end of each shift.

Technical security

To ensure the security of PCD held on our system and devices each of our crews PDAs are encrypted, password protected and can be locked and erased remotely by our IT partner should it be required. All computers used throughout the business are password protected and encrypted to ensure no unauthorised access with automatic locking when not in use as a further protection. We use ***REDACTED*** as our cybersecurity platform, which is purpose built to deliver IT security for a remote workforce.

ERS Medical has policies that deal with the technical side of data protection and security, which are:

- BMS/10.01 – Information Services -includes IS change requests & acceptable use
- BMS/10.02 – Information Services Code of Conduct
- BMS/10.03 – Secure Transfer of Information
- BMS/10.04 – IT and Data Security

We have provided these policies as an attachment.

Information Governance

On the 30th September 2020 we were assessed against the Data Security and Protection Toolkit and successfully met the requirements. Please see the results below.

ERS Medical

NHS Digital Data Security and Protection Toolkit

ERS MEDICAL (8JR11)

Assessment | Report an Incident | Admin

Assessment progress

Export assessment

You can download your assessment as a spreadsheet (.csv) which can then be opened in Excel. This will not include any files that have been uploaded as evidence.

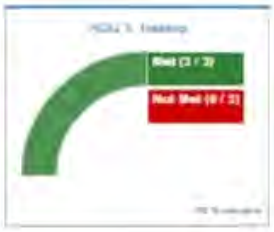
Download Assessment

National Data Guardian Standards

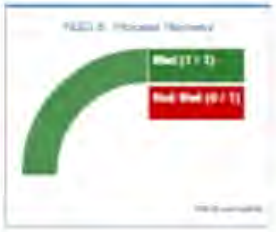
The National Data Guardian (NDG) standards have been calculated for your organisation based on the responses provided to your organisation profile.











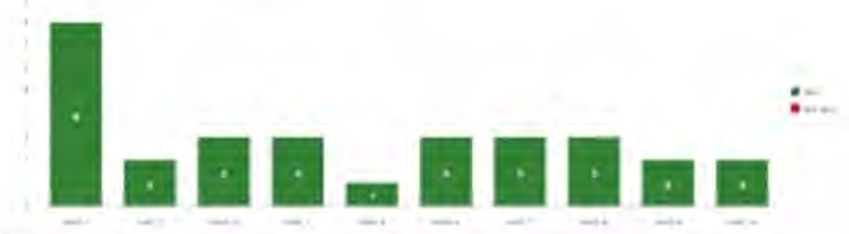












NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

ERS Medical

Question 1.23.5

Control of person confidential data

Please advise how access to person confidential data (PCD) held by your organisation will be controlled and managed in your proposed approach?

Word count 500

Total Word Count: 442

With ERS Medical all access to Person Confidential Information (PCD) is restricted to only those who have a legitimate need to access it for the purposes of conducting their normal duties, and we control this access in several ways. We only hold information that we need to know to deliver our transport service safely and compliantly.

All access to PCD is restricted to only those who have a legitimate need to access it for the purposes of conducting their normal duties, and we control this access in several ways.

All staff who require access to the ERS Medical system need to be authorised by their line manager and granted access, through our IS provider to our systems. All individuals are then provided with a unique and secure username and are then required to create a secure password. This will only grant them access to our general IT system and for access to systems that contain PCD they require additional authorisation, login credentials and passwords.

The line manager of a new starter is required to complete an access request for that is sent to our IT provider, ***REDACTED***. This ensures that new starters only have access to the information they are trained to handle and authorised to see.

Further to this ***REDACTED*** logs any access to the system data and notes the type of activity (update/change details, uploading notes, etc), which is fully auditable. Therefore, if we are notified of any data breach or individuals access information that they don't require access to we are able to track it through our audits and reports. Following identification of where the breach came from the required action can be taken.

All of our systems are monitored remotely and if signs of misuse or unauthorised access are detected mitigation, such as the freezing of an account, can be applied instantly from a remote location by our IT provider.

When a staff member leaves the business all accounts and accesses are deactivated on the day of their departure to ensure access can no longer be gained. Further to this all controlled area access such as keys and pass card as taken as part of the staff member exit interview ensuring both our systems and sites remain secure.

ERS Medical runs a 'Additions & Terminations' report monthly ***REDACTED***to identify and track all new users who require IT access and remove permissions for those who have left the business and had IT access. This is safety net to the onboarding and offboarding process, to ensure that nobody is missed.

REDACTED

Screenshot of ERS Medical ***REDACTED***and the ‘Additions and Terminations’ report.

WI/1.07.03 Information Governance Risk Assessment (IGRA)

Document Author:	[redacted]		Head of Care Standards	
Document Owner:	[redacted]		Managing Director	
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3. Introduction

3.1 This document describes the risk assessment and treatment methodology adopted by ERS Medical to assess the risks associated to its information assets.

3.2 To ensure all relevant, identifiable risks are assessed and treated in accordance with this work instruction, in order to accept, transfer or treat the discovered risk.

3.3 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.4 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Information Security Policy.

4.2 Please refer to the ERS Medical Quality, Environmental, Safety and Health Policy.

4.3 Please refer to the ERS Medical Business Continuity Policy.

4.4 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: HSQE, business continuity and information governance policy and for ensuring the appropriate resources are available. Is responsible for setting ERS Medical objectives and allocating adequate resources to meet those objectives.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**Head of Care Standards**	Is responsible for developing, co-ordinating and implementing quality, health & safety, environmental, business continuity and information governance policy, procedures and work instructions.
5.4	**Information governance Technical Expert**	Facilitates and leads the information governance risk assessment programme and conducts reviews at least annually and prior to any major operational change. Ensures that the methodologies, risk assessments and current risk profile is a permanent agenda item for management review and discussed at operations meetings and the Information governance Advisory Committee when required.
5.5	**General / Operations Managers**	Overall responsibility for the risk assessment process and ensuring that is completed as per this guidance and on a prescribed basis. Ensuring that all items of the risk register are thoroughly reviewed at least once annually. To agree on the criteria for assessing, scoring and treating risk based on recommendations from the Information governance Manager. Ensure that all relevant personnel receive the necessary information governance training in relation to their role and that this training is documented.
5.6	**Asset Owners**	Ensure that any significant changes within their areas are noted to the risk profile for any asset and are transferred to the risk assessment with the help of the Information governance Manager and raised as an agenda item at the next review. Additionally responsible for ensuring that any new assets are subject to risk assessment
5.7	**All Team Members**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **Impact –** The evaluated consequence of a particular outcome or the result of a threat occurring.

6.2 **Information Asset –** A body of information defined and managed as a single unit so it can be understood, shared, protected and exploited effectively.

6.3 **Information Asset Owner** – Identified and documented individual or team with overall responsibility for the Information Asset.

6.4 **ISO 27001: 2013 –** The international standard for Information Security. It contains a set of requirements and an Annex of controls which should be implemented if applicable, by any company wishing to achieve certification to the standard.

6.5 **Likelihood - The** chance of something happening based on the contribution of two factors; vulnerability and probability.

6.6 **Payment Card Industry Data Security Standard (PCI DSS) –** A set of standards designed to ensure that all companies that process, store or transmit credit card information maintain a secure environment.

6.7 **Probability –** A measure of external factors outside of ERS Medical's control e.g. pandemic or flood.

6.8 **Resource –** Information Assets are referred to as resources for the purposes of the risk assessment process.

6.9 **Resource Attributes –** A rating on Confidentiality, integrity and availability from insignificant to major for each information asset. This allows assessors to establish the value of the information asset to the business.

6.10 **Risk Appetite** – The total amount of risk that an organisation is prepared to accept, tolerate or be exposes to at any point in time.

6.11 **Risk Assessment** – The systematic process of evaluating the potential risk involved in a particular activity, process or undertaking.

6.12 **Risk Treatment –** The techniques employed by ERS Medical to manage risk.

6.13 **Vulnerability** – a weakness within an Information Asset or group of Information Assets that can be exploited by threats.

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7. Process Overview

7.1 Suitable and sufficient information governance risk assessments are required for all information assets that pose a foreseeable risk for loss, damage, theft or destruction of ERS Medical's information.

7.2 A suitable and sufficient risk assessment should identify the threats, evaluate the magnitude of the risk involved and select appropriate control measures in order to mitigate the risk.

7.3 It is important to remember that risk assessments are one aspect of the key elements utilised by ERS Medical to keep information secure and that procedures, work instructions and safe working practises must also be established, trained, followed and monitored.

7.4 All risk assessments are subject to periodic monitoring and review to ensure they are and remain valid in light of new technology, knowledge, experience, processes or working methods. Results of information governance risk assessment will be discussed at Management Review, Operations meetings where appropriate.

7.5 Additionally, risk assessments form part of the audit trail in the event of an incident investigation that may involve the scrutiny / action of the enforcing authority and / or legal proceedings.

7.6 Training is provided to all personnel involved in the risk assessment process to ensure that they have suitable knowledge and understanding. Risk assessments will generally be conducted by the Information governance technical expert with support from asset owners.

7.7 For each asset or group of assets an asset owner will be nominated. The asset owners in conjunction with the Information governance technical expert are responsible for identifying the value of important business assets.

7.8 The objective of any risk assessment is to allow the selection, implementation and maintenance of suitable risk control measures for safe systems of work.

7.9 Information governance risk assessments are conducted by ERS Medical in order to address information governance in a way that encompasses people processes and technology.

7.10

7.11 ISO 27001: 2013 is a risk based standard, therefore the risk assessment is a key part of complying with its requirements and any future desire of the business to either obtain certification or align itself to the standard.

7.12 Additionally, conducting a risk assessment helps ERS Medical protect its Information Assets and reduce the chance negative activity relating to the information it holds.

8. Asset Identification and Resource Attributes

8.1 Assets are assigned to the business unit to which they belong. Similarly, group information assets such as shared service staff members or company issued electronic devices are assigned to the overall group structure meaning that they will be relevant to any individual business unit or activity.

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8.2 Assets are grouped by type allowing for consistent and repeatable assessment of similar information assets e.g.; threats that relate to paper can be attributed to all paper based information assets.

8.3 This functionality ensures that all relevant threats are considered for each asset, meaning that the overall risk assessment is as comprehensive as possible.

8.4 This method of grouping information assets also gives guidance to users about where to place new information assets, saving time and ensuring greater consistency of assessments.

8.5 Categories for information assets are as follows:

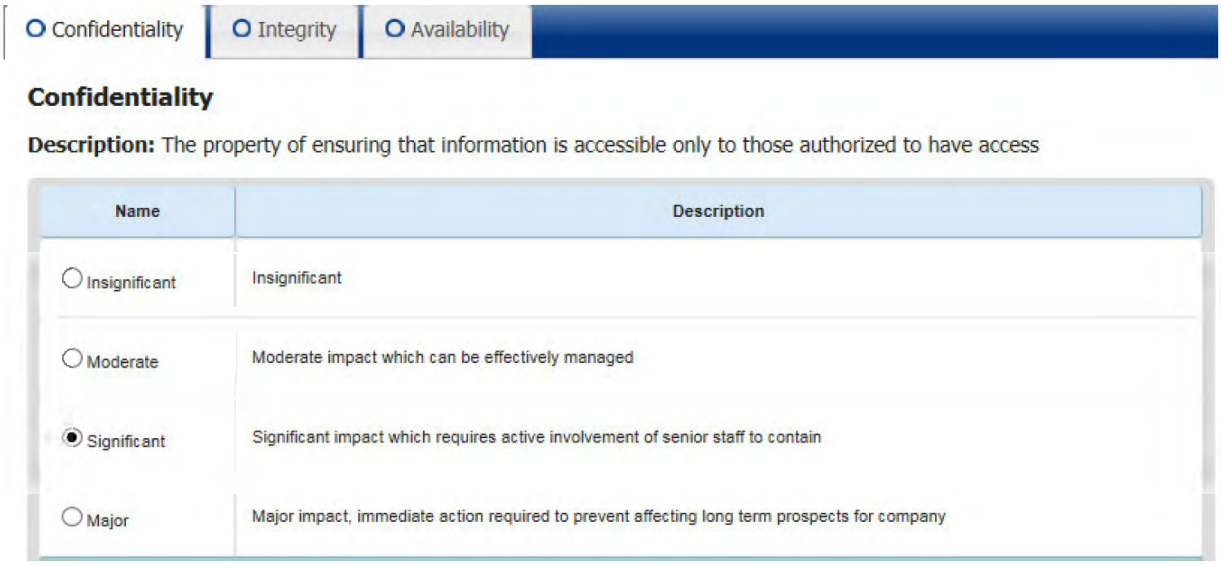
- Equipment;
- Information;
- People;
- Premises;
- Suppliers;
- Technology.

8.6 Once all information assets have been identified, the resource attributes must be assigned.

8.7 The asset owner or individual conducting the risk assessment must complete this step for each individual information asset in scope.

8.8 The resource attributes are used to value an information asset based on Confidentiality, Integrity and Availability.

8.9 A rating between 'Insignificant' to 'Major' must be given to each information asset as shown below.



8.10 Ratings should be selected according to the information asset's importance to ERS Medical and the impact that partial or total loss of the information asset will have upon the operation and management of ERS Medical.

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8.11 The rating should consider the loss with absolutely no controls in place to mitigate it. This enables us to determine an accurate reflection of the risk as a starting point.

8.12 As guidance, asset owners should use the information classification scheme below when determining the impact to Confidentiality, Integrity and Availability over the loss of an asset. For example; if the asset is classified as 2A – Patient Confidential because it holds identifiable information about a patient within it, then the impact would be 3 – Major.

Classification	Impact Rating	Impact
0 Unclassified	**0 Insignificant**	Loss of the asset will have no effect on ERS Medical.
1 Commercial in Confidence	**1 Moderate**	Loss of the asset will have little effect on ERS Medical and not cause disruption.
2 Confidential	**2 Significant**	Loss of the asset will have an impact on ERS Medical, which can be resolved in a number of hours and may affect the customer.
2A Patient Confidential	**3 Major**	Loss of patient data could lead to serious legal and regulatory consequences.
3 Restricted (Business Critical)	**3 Major**	Loss of the asset will disrupt ERS Medical and may significantly impact on the customer.

8.13 Information Assets can have their resource attributes valued directly or the value can be inherited from other assets based on the relationship between them. For example; if a database holding patient confidential information is held on a Company server, the server as an information asset will take on the same attribute value as the database.

8.14 Connected information assets will always be valued by the most sensitive piece of information stored within it.

8.15 These interconnected relationships allow asset owners to understand what other assets are affected by or impact the information.

8.16 Valuations will differ between Confidentiality, Availability and Integrity for each information asset. For example, the loss of an information asset may have a major impact on Confidentiality however; it may not impact the integrity of the asset.

8.17 Similarly, failure of an information asset such as a server may have a great impact to availability but it may not impact confidentiality because the information stored within may not be accessible.

9. Control Maturity Assessment

9.1 The next stage in the process is to assess the control measures currently in place relating to information governance.

9.2 Additional items can also be added such as: the controls required to meet PCI DSS compliance or other contractual or regulatory requirements.

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9.3 These controls cover all technical, managerial and procedural aspects that help protect ERS Medical's information assets.

9.4 The control maturity assessment first requires the assessor to determine which controls are applicable to ERS Medical or particular business activity, e.g. if ERS Medical does not outsource software development, Annex A control A14.2.7 would not be applicable.

9.5 Once this has been completed, the maturity of all applicable controls are rated against a consistent 0-5 scale:

Maturity Rating	Description
0.Non-existent	Complete lack of any recognisable processes. The organisation has not even recognised that there is an issue to be addressed.
1.Initial / Ad hoc	There is evidence that the organisation has recognised that the issues exist and need to be addressed. There are, however, no standardised processes; instead, there are ad hoc approaches that tend to be applied on an individual or case-by-case basis.
2.Repeatable but Intuitive	Processes have developed to the stage where similar procedures are followed by different people undertaking the same task. There is no formal training or communication of standard procedures, and responsibility is left to the individual. There is a high degree of reliance on the knowledge of individuals and, therefore, errors are likely.
3.Defined Process	Procedures have been standardised and documented, and communicated through training. It is mandated that these processes should be followed; however, it is unlikely that deviations will be detected. The procedures themselves are not sophisticated but are the formalisation of existing practices.
4.Managed and Measurable	Management monitors and measures compliance with procedures and takes action where processes appear not to be working effectively. Processes are under constant improvement and provide good practice. Automation and tools are used in a limited or fragmented way.
5.Optimised	Processes supporting this control have been refined to a level of good practice, based on the results of continuous improvement. Security is used in an integrated way to automate the workflow, providing tools to improve quality and effectiveness, making the organisation quick to adapt.

10. Setting up the Risk Assessment

10.1 There are 4 distinct steps to setting up the risk assessment, these are:

- Establishing the risk appetite;
- Agreeing the risk strategies;
- Agreeing risk types;
- Identifying and recording threats.

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10.2 Firstly, the risk appetite for ERS Medical must be agreed. ERS Medical has implemented a 4x4 risk appetite matrix as shown below. This risk appetite matrix will be used for all information governance risk assessments conducted.

		Potential Impact or Severity				
		Minor (1)	Moderate (2)	Serious (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (4)	5	10	15	20	25
	Likely (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Extremely Unlikely (1)	1	2	3	4	5

10.3 This risk appetite shows that the business will not tolerate any risk with a score of 16 which must be treated immediately.

10.4 Risks with a score of 15 – 25 will be considered as high risk and will be a priority to treat.

10.5 Risks with a score of 10 – 12 will be considered as medium risk and will be the next priority to treat.

10.6 Risks with a score of 6 -4 or less likely as a risk and will be the next priority to treat.

10.7 Risk with a score of 3 or below are low risk and generally viewed as being acceptable. Treatment of these risks will be low priority.

10.8 The risk strategies chosen by ERS Medical are as follows:

- Accept;
- Reduce;
- Avoid;
- Transfer.

10.9 ERS Medical has also identified three types of risk that will be considered for any information governance Risk Assessment. These are shown below:

Risk Types

Risk Type Name:	Absolute	The risk if no controls were in place
Risk Type Name:	Controlled	The current risk taking into account existing controls
Risk Type Name:	Treated	The projected risk once proposed controls are implemented

10.10 Lastly, all relevant threats should be identified and recorded.

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10.11 The list of threats are categorised under the following headings:

- Business Related;
- Criminal Activity;
- Human Related;
- Infrastructure Failure;
- Severe Weather;
- Structural Hazards;
- Technological Failure;
- Third Parties;
- Unauthorised Access and Use.

10.12 For each threat identified, a threat distribution must be recorded based on Confidentiality, Integrity and Availability. This will give a percentage split of the impact of the threat based on Confidentiality, Integrity and Availability.

11. Risk Assessment Methodology - Vulnerability

11.1 The first calculation to produce the risk assessment is the vulnerability calculation.

11.2 Each information asset with its relevant threats and gives a score based on the minimum maturity of controls relating to them. For example, a database may be linked to the threat of hacking or virus infection.

11.3 Therefore, all identified controls relating to anti-virus or vulnerability protection will be used within the calculation.

11.4 If the lowest maturity level of control is '2 Repeatable but intuitive', the vulnerability score is returned as 3.1 as shown in the table below.

12. Risk Assessment Methodology - Probability

12.1 The next calculation conducted is the probability of a specific threat occurring to a particular information asset. This is inputted by the assessor for each information asset and threat combination and is assessed on a 1-4 scale.

12.2 The scale used to determine probability is displayed as follows:

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Probability	Description
1.Very Unlikely	The assets have little or no value to a potential attacker. There is nothing that can be gained from exploiting this threat. Exploitation of the threat requires high level of skill. There are no threat sources nearby.
2.Unlikely	There is little that can be gained from exploiting this threat. Exploitation of the threat requires some skill, experience or knowledge. There are no threat sources nearby. This threat has rarely led to an incident in the past.
3.Likely	The associated assets have a high value and are attractive to attackers to the extent that people will be motivated to exploit the threat. It requires a reasonable level of skill, expertise and/or knowledge to exploit. There are threat sources close by that could affect the assets. There is a history of incidents relating to this threat, (more often than once every 3 years).
4.Almost Certain	There is a strong motivation to exploit this threat and it is simple to exploit (i.e. needs no special skill or equipment). There is a recent history of incidents of this threat. The associated assets are very close to a threat source and/or have a high real or perceived value.

12.3 Once the probability score has been determined and recorded for each threat and asset combination, the assessor will move onto the next stage in the assessment.

13. Risk Assessment Methodology - Probability

13.1 The likelihood of a risk happening is now able to be calculated using the scores from the Vulnerability and Probability calculations. This is shown below.

Vulnerability Score	Probability			
	4	3	2	1
4.00	4.00	3.00	2.00	1.00
3.70	3.70	2.80	1.90	1.00
3.10	3.10	2.40	1.70	1.00
2.50	2.50	2.00	1.50	1.00
1.45	1.45	1.30	1.15	1.00
1.00	1.00	1.00	1.00	1.00

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14. Risk Assessment Methodology - Probability

14.1 Finally a score based on the consequence of a threat occurring.

14.2 This calculation is based on the resource attribution values given to each information asset on Confidentiality, Availability and Integrity when compared with the distribution of the associated threat. This is completed for each information asset and threat combination.

Consequence

Minimum: 1
Maximum: 4

This variable is calculated for each resource/threat combination based on the value of the resource attributes (Confidentiality, Integrity, Availability) and the threat distribution percentages.

Attribute Name	Threat Distribtion Value	Resource Value	Score
Confidentiality	25%	2	0.5
Integrity	25%	3	0.75
Availability	50%	2	1
Score			2.25

15. Risk Assessment Methodology 0 Final Risk Score

15.1 Now calculate the final score for each individual risk.

15.2 The likelihood score is established from the probability and vulnerability calculations.

15.3 The impact score is established from the consequence calculations.

		Potential Impact or Severity				
		Minor (1)	Moderate (2)	Serious (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (4)	5	10	15	20	25
	Likely (4)	4	8	12	16	20
	Possible (3)	3	6	9	12	15
	Unlikely (2)	2	4	6	8	10
	Extremely Unlikely (1)	1	2	3	4	5

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15.4 This will give a breakdown of risks against each information asset colour coding to show the highest risk. The colour coding is determined by ERS Medical's risk appetite and can give a clear visual on what risks can be accepted and which risks require further treatment.

16. Options of Treatment

16.1 ERS Medical has reviewed industry standards regarding information governance and adopted best working practice and considers the following risk treatment options:

- Reduce – e.g. through policies and procedures to perform detection, deterrence, prevention, limitation, correction, recovery, monitoring and awareness; by insuring or duplicating / distributing the asset, or deploying counter measures within a Business continuity or Disaster recovery plan;
- Transfer the risk – e.g. outsource the asset or service;
- Avoid the risk– dispose of the asset;
- Accept the risk – where the scenario is unlikely to happen.

16.2 The reduction and / or management control option selected to address a particular risk is noted in the risk register.

17. Risk Treatment Plan

17.1 This report prioritises the risks within the assessment and allows actions to be taken. This may be done by improving the controls relating to the asset.

17.2 This report will show the current risk level and the projected level of risk if the suggested improvements were taken that as outlined within the control maturity assessment.

17.3 The risk treatment plan is a mandatory requirement of ISO 27001: 2013 and must be documented. This report serves to meet this requirement. Additionally, it can be used to evidence progress in risk treatment activities and is discussed at the Governance and Patient Safety (GaPS) committee meetings.

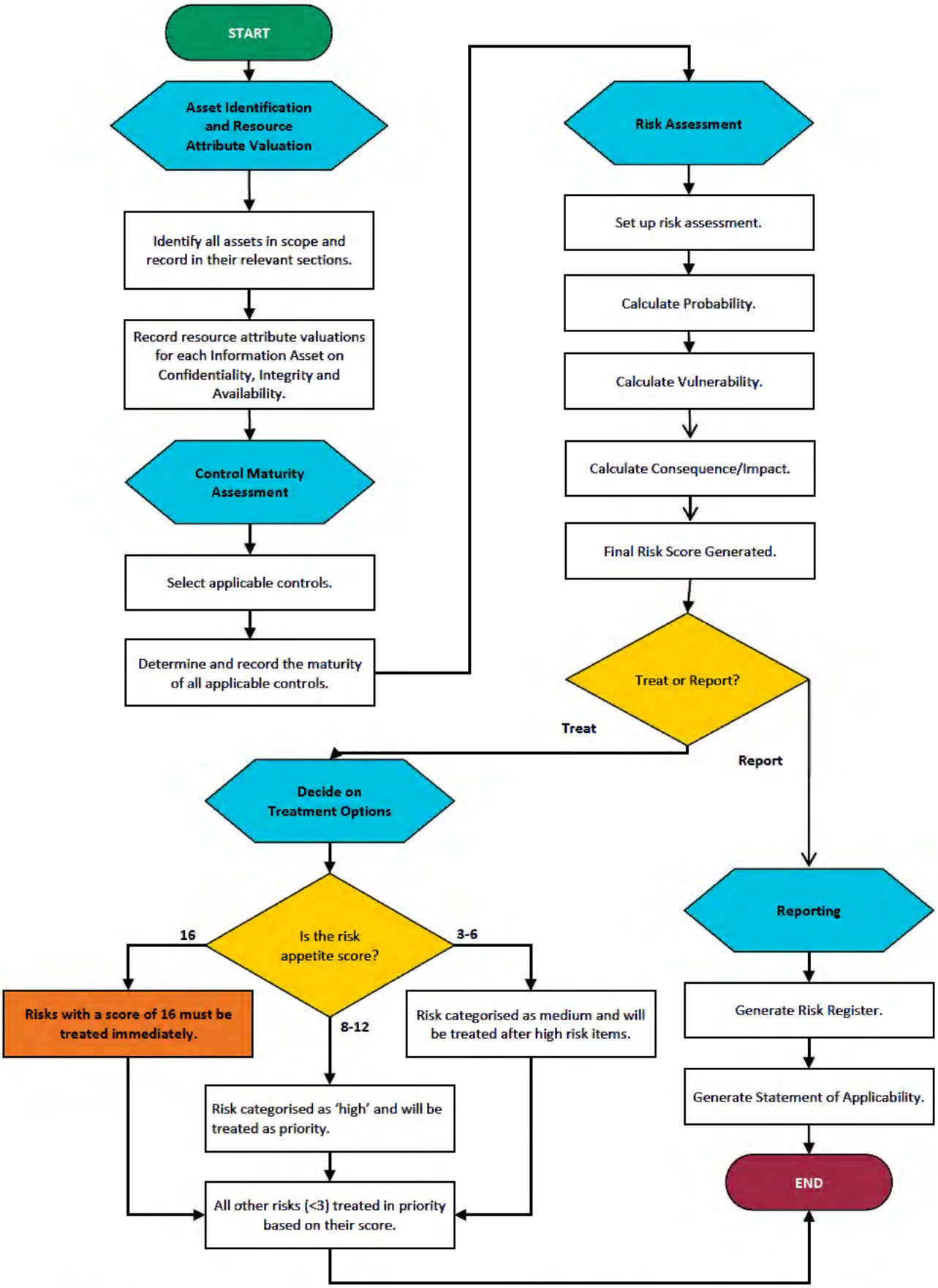
18. Statement of Applicability

18.1 The Statement of Applicability is a mandatory requirement of ISO 27001: 2013 and informs the reader about the controls relevant to ERS Medical in relation to Information governance.

18.2 Statements of Applicability are stored within the Information governance pages of ERS Medical's intranet, Steripoint.

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19. Key Steps



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Question 1.23.6

Transfer of person confidential data

Please advise how your organisation proposes to facilitate the transfer of person confidential data (PCD) into and out of your organisation?

Word Count 500

Total Word Count: 251

Our ***REDACTED*** system stores and reports on Patient Confidential Data for the purpose of producing KPI packs and minimum data sets for billing purposes and data analysis.

Should it be required that PCD needs to be sent outside of the company then all files are password protected and sent via our secure nhs.net email account to a secure recipient nhs.net account, therefore reducing the risk of data being accessed by unauthorised personnel.

No one individual will send the data without it being checked and encrypted first and this includes a check for the correct email recipient.

Authorised personnel at the Trust can access reports directly from ***REDACTED***so that data does not have to be transferred. This also provides an audit trail to ensure data is not manipulated in any way prior to issuing to a customer.

All employees are trained on the Data Protection Act 1998 as part of their induction training to fully understand their responsibility of protecting the confidential data of our patients, customers and employees.

If an employee is concerned that information has not been transferred securely, or they become aware that information has been lost, stolen, damaged or used incorrectly, they are trained to understand that it is their responsibility to report it as soon as possible following the procedure in our Incident Reporting and Investigation policy.

ERS has a dedicated Caldicott Guardian and Serious Incident Reporting Officer (SIRO) in our Care Standards department.

Please find attached our Secure Transfer of Information Policy.

WI/10.03.01 Using Secure File Protocols (SFTP) to Securely Transfer Information

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.0	**Date Active:**	17.04.2020	**Review Date:**	30.04.2021

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Approved by the Managing Director	[redacted]	03/07/2017

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3.0	All	All	All	12.04.19	[redacted]	Annual Review
4.0	All	All	All	17.04.20	[redacted]	Annual Review

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Information Security Code of Conduct	BMS/10.02
Secure Transfer of Information	BMS/10.03
IT and Data Security	BMS/10.04
Physical Transfer of Information	WI/10.03.02

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3. Introduction

3.1 To provide practical guidance on the secure transfer of information by sFTP

3.2 To advise users on the benefits of using sFTP and how to create a sFTP location.

3.3 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.4 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

5.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety and health, business continuity and information security policy and for ensuring the appropriate resources are available. Is responsible for setting Company objectives and allocating adequate resources to meet those objectives.
5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**IT Provider**	Responsible for supporting security practises by administrating and setting up sFTP sites. Reporting any issues or concerns regarding security or raising incident forms for any breaches.
5.4	**Head of Care Standards (IG :Lead)**	Is responsible for providing advice to employees on secure methods of transfer when required. Responsible for managing security incident and consulting with the ICO in relation to breaches.
5.5	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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6. Definitions

6.1 **Confidentiality** – The insurance that access to the information is limited to authorised personnel only.

6.2 **Availability** – The insurance that the correct information is available at point of use and to only authorised personnel.

6.3 **Integrity** – The insurance that the information is trustworthy, accurate and free from unauthorised modification.

6.4 **Relevant Legislation –** Is the UK Data Protection Act 1998.

6.5 **Data –** A set of values of qualitative or quantitative variables. When collected together in a meaningful way, data can provide us with information.

6.6 **Information –** Something which informs us. It could be the answer to a question or the results from a set of data. Information allows us to understand things.

6.7 **Personal Data –** Data which relates to any living individual and when several pieces of personal data are brought together this becomes Personal Identifiable Information.

6.8 **Patient Identifiable Information –** Similar to Personal Identifiable Information but can be identified within a healthcare context.

6.9 **Sensitive / Patient Sensitive Information –** Any information that has the ability to cause harm, distress or negative implications through its unauthorised disclosure. This could be clinical information, mental health status or religious or political beliefs.

6.10 **Encryption –** The process through which information is encoded so that only authorised recipients can access it.

6.11 **Information Commissioners Office (ICO)** – The UK and ROI independent regulators set up to uphold information rights.

7. Secure File Transfer Protocol (sFTP)

7.1 When transferring confidential information, we have a duty to the data subject (individual to whom the data refers), to protect it and ensure that it is not lost, damaged or at risk of unauthorised access or modification.

7.2 To allow staff to share information securely externally, an sFTP site can be created. This should be used whenever information cannot be sent via NHSMail due to the file size being too large or the recipient not having access to a secure email account.

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8. What is sFTP

8.1 FTP (file transfer protocol) is a widely used method of transferring files between two systems. To add an extra layer of security sFTP (Secure File Transfer Protocol) is used to encrypt the data in transit. The level of encryption we use is SSH2. This means we support up to 256Bit.

8.2 Mostly this is controlled by what the client can handle on both ends, so if a user is using software that supports 128Bit encryption then the transfer will be encrypted at 128bit, 256Bit is the current maximum level of encryption, When transferring particularly sensitive data, you may wish to ask the recipient what level of encryption they can accept.

9. Applying for Access

9.1 In order to gain access to an sFTP site you will need to contact the IT Provider by raising a request which is available on the intranet in the IS work area.

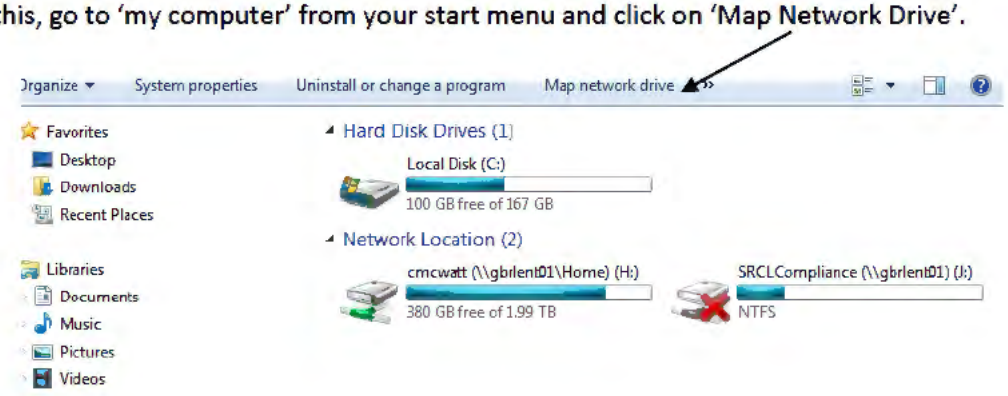
9.2 You will need to inform the IT Provider of what the site is to be used for and who will require access to it.

9.3 Once the site has been created the IT provider will let you know that it is ready for use.

10. Map Network Location

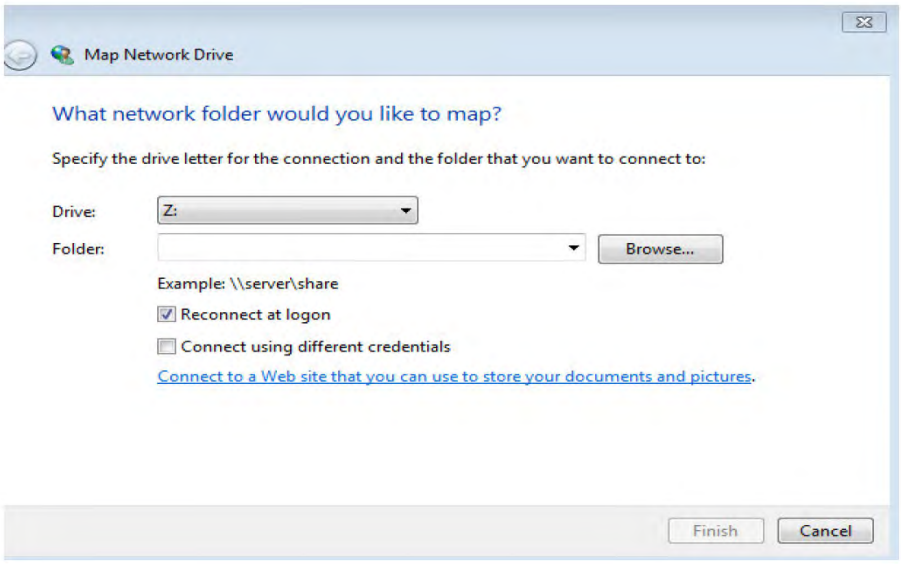
10.1 To start using the sFTP location, you will need to map the network location.

10.2 To do this, go to 'my computer' from your start menu and click on 'Map Network Drive'.



10.3 A new window will appear, select the drive you wish to use for the sFTP site (IS will be able to advise which drives are suitable) and type in the site location given to you by IS within the 'Folder' box and then click on 'Finish'.

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10.4 You should now see the sFTP network location alongside your own 'H' drive.

11. sFTP Site External Use?

11.1 When you wish to share information externally you will need to ask the recipient to download a sFTP client. Many organisations will already have such a client installed, however, if they do not, you can recommend the following one for their use:

- [redacted]

11.2 Once the person you want to exchange information with has a sFTP client installed, you will be able to start sharing information with them.

11.3 Please raise a request with the IT Provider asking for a sub folder to be added to your team folder for the specific recipient.

11.4 Let the IT Provider know who you require to have access to this folder internally and ask for an external username and password for the external recipient.

11.5 The IT Provider will set the permissions on the folder and will provide you with the following information for your 3rd party to access through their sFTP client:

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- File location (Host); Username and Password.



11.6 It is essential that you share this information with them securely.

11.7 The recommended method is to email the file location and username and then share the password over the telephone.

11.8 This is critical to preserve the security of the account information. Sharing it all over email may result in the information being compromised or the email being sent or forwarded to someone else, thus giving unauthorised access to the account.

11.9 Please ensure that you ask the 3rd party not to share the access information and limit the number of recipients that you issue the information to.

11.10 The image above shows how the external party will view the site using Filezilla. The section on the left shows their files where they will pull information from if they are sharing with us. The section on the right is the information that we have chosen to share with them.

11.11 You can then drag and drop the required information into the folder as required. Always remember to delete the files once they have been picked up by the recipient.

11.12 You can choose to keep this sub-folder open with the username and password for the 3rd party active if you have the requirement to send information on a regular basis or you can ask for the folder to be removed if you no longer require it.

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11.13 Please remember that whatever decision you make, consider the impact of the information being read by an unauthorised person, so ensure you are protecting it as much as possible.

11.14 For large files you will be able to put zip folder onto the site and these can also be password protected for an extra layer of security if you feel it is required.

12. Security Breaches and Incidents

12.1 If you are ever concerned that information has not been transferred securely, or you become aware that information has been lost, stolen, damaged or used incorrectly, it is your responsibility to report it as soon as possible.

12.2 This can be done by raising a Security Incident as instructed by **BMS/5.01 - Incident Reporting and Investigation**.

12.3 Where there has been a loss of company equipment such as a laptop or mobile phone, IS must also be contacted immediately to ensure that the device can be wiped to prevent any access to information.

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WI/10.03.02 The Secure Transfer of Physical Information

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version:	4.0	**Date Active:**	17.04.2020	**Review Date:**	30.04.2021

Document Approval Process (workflow)		
Document Action	**Completed By**	**Date**
Version 1 written for new ERS Medical BMS	[redacted]	03/07/2017
Approved by the Managing Director	[redacted]	03/07/2017

Revision / Amendment Information						
Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
2.0	All	All	All	20.04.18	[redacted]	Addition of review date
3.0	All	All	All	12.04.19	[redacted]	Annual Review
4.0	All	All	All	17.04.20	[redacted]	Annual Review

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Media Interactions	BMS/1.08
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3. Introduction

3.1 To provide practical guidance on the secure transfer of Physical information.

3.2 Some examples of physical information are listed below:

- Print outs of patient identifiable information;
- Printed medical records of service users;
- Memory sticks / storage devices;
- Hard drives;
- Any device which holds information e.g. laptop or mobile phone.

3.3 To provide information to users on how to transfer physical information securely and what types of information can be transferred in this way.

3.4 This procedure applies to all ERS Medical Team Members, facilities and to all documents that form the BMS.

3.5 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the ERS Medical's Capability and Disciplinary procedures.

4. Policy Statements

4.1 Please refer to the ERS Medical Information Security Policy.

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5. Responsibilities

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5.2	**Senior Management Team**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which ERS Medical subscribes and the legislation relative to ERS Medical's operations.
5.3	**IT Provider**	Advising on the secure transfer of any devices holding sensitive information such as hard drives, disks, phones, laptops and any other equipment. Approving, issuing and managing encrypted ERS Medical storage devices for use in exceptional circumstances.
5.4	**Head of Care Standards (IG Lead)**	Is responsible for advising staff of secure methods of transferring information and for investigating all information security incidents.
5.5	**All Personnel**	Are responsible for ensuring they understand ERS Medical policy and procedures and follow the processes at all times. All staff are responsible for reporting any data breaches including loss, damage, modification through the Stericycle UK incident reporting system.

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6. Definitions

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6.2 **Availability** – The insurance that the correct information is available at point of use and to only authorised personnel.

6.3 **Integrity** – The insurance that the information is trustworthy, accurate and free from unauthorised modification.

6.4 **Relevant Legislation –** Is the UK Data Protection Act 1998 and the Republic of Ireland Data Protection Act 1988 (Data Protection Amendment Act 2003) which are derived from EU Data Protection Directive 95/46/EC.

6.5 **Data –** A set of values of qualitative or quantitative variables. When collected together in a meaningful way, data can provide us with information.

6.6 **Information –** Something which informs us. It could be the answer to a question or the results from a set of data. Information allows us to understand things.

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7. Holding Confidential Information on Paper

7.1 Where it can be avoided, information regarding a service user, customer, employee or contractor should never be printed out, as confidential information in hard copy format is very susceptible to being lost, stolen or viewed by an unauthorised person.

7.2 However, there will be circumstances where there is no alternative but to print out information.

7.3 In this instances, users must adhere to the following controls in order to protect the information:

- Don't send information to a printer unless you can collect it immediately, preferably, use a printer code where available;
- Check the printer you're sending your document to in order to make sure it's the correct one;
- Don't leave paper documents lying around. Even if you're leaving your desk for a short space of time, sensitive documents should be out of sight and preferably locked away;
- All information must be held within lockable storage at the end of the day;
- Don't print out any more copies than are necessary;
- Make sure that documents are clearly labelled as sensitive or confidential;
- Keep close custody of the documents and ensure that they are not passed around to unauthorised personnel.

8. Royal Mail / Courier Services

8.1 When transferring information on paper, there is a high risk of it being intercepted or not reaching its destination.

8.2 ERS Medical does not allow Patient Identifiable or Patient Sensitive information to be transferred using this method.

8.3 Circumstances may arise where personal information has to be sent in this way and the information must be appropriately protected. The following process must be followed when transferring information in this way.

- Ensure that there is no patient identifiable or sensitive information within the document / package;
- Confirm with your line manager that it is permitted to send the information using Royal Mail / Courier Services;
- Consider the use of tracked / recorded delivery and where possible, the use of a courier service;
- The letter / parcel must be addressed to a specific person and not a department;
- Ensure that the letter is secured appropriately and that nothing can fall out of the envelope and that it is free from the risk of unnoticeable tampering;
- Always follow up with the recipient to ensure that it has arrived successfully.

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8.4 Remember that information holding devices such as laptops and mobile phones are also subject to this process.

8.5 Any equipment that is being returned to IS or being sent to a user containing sensitive information must be secured and a courier must be used.

8.6 If possible, the sensitive information should be removed before the device is transferred. Please contact the IT Provider or the Head of Care Standards for further information on how to secure devices prior to the transfer.

9. Removable Media / Storage Devices

9.1 ERS Medical prohibits the use of removable media devices to store or transfer information except in exceptional circumstances where the IS team may be able to authorise and issue an encrypted device.

9.2 Under no circumstances should home purchased storage devices be used on a Company device.

9.3 Unauthorised devices introduce the risk of viruses to ERS Medical network and also mean that ERS Medical has little control over the information being stored on unknown devices.

9.4 If the use of such a device is authorised, the information should be transferred to the device and delivered either in person or by courier. If a courier is used, all courier instructions must be followed.

9.5 It is essential that once the device has reached the recipient that the information is extracted from the device and then permanently deleted before being returned to IS to be securely wiped and reused.

9.6 Any instances of suspected personal device usage should immediately be reported to your line manager and a security incident raised.

10. Security Breaches and Incidents

10.1 If you are ever concerned that information has not been transferred securely, or you become aware that information has been lost, stolen, damaged or used incorrectly, it is your responsibility to report it as soon as possible.

10.2 This can be done by raising a Security Incident as instructed by **BMS/5.01 - Incident Reporting and Investigation**.

10.3 Where there has been a loss of ERS Medical equipment such as a laptop or mobile phone, the IT Provider must be contacted immediately to ensure that the device can be wiped to prevent any access to information.

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Question 1.23.7

Code of confidentiality

Please provide details of the training you propose to undertake by employees involved in the delivery of your proposed solution to ensure that they are aware of their responsibilities when working with person confidential data (PCD).

ERS understands that IG is the responsibility of each and every employee and therefore the importance that our staff, and individuals delivering services on our behalf, are aware of their responsibilities. Therefore, as part of our induction process all staff, including volunteer drivers and sub-contractors, receive training on Information Governance and Confidentiality. Our mandatory induction training includes:

- Introduction to Information Governance
- NHS eLearning for Health training
- HORUS principle training
- Data Security Awareness – Level 1
- Duty of Care
- Patient Safeguarding
- Privacy and Dignity
- Equality and Diversity

Further to this all staff attend annual GDPR workshops and refresher training.

This training is completed as part of staff members induction and all staff receive update training on a minimum of an annual basis. All training is followed by an assessment to ensure that all of our staff have understood and taken onboard the training they have received. All training is logged on our HR system. The training is logged with a refresher date that alerts management staff as to when update training is required. This ensures that all of our staff remain fully trained and compliant at all times. For sub-contractors their refresher training is delivered as part of their annual audit ensuring their staff remain up to date and compliant.

Our IT and Data Security policy fully outlines the security measure all employees are to adhere to at all times to ensure the security of PCD. This includes the following basic security measures:

- If you need to leave your computer for more than a couple of minutes, lock the computer screen
- If you need to leave your computer for a long period of time, log off – never leave an unattended computer logged on
- When creating a computer password, do not use one that is obvious, such as your date of birth or the name of a close family member – passwords should preferably be a mix of

letters and numbers and should not be the same as any other personal passwords you may have (such as online banking passwords)

- Always keep your password private, do not write it down and do not divulge it to anyone else (including other members of staff)
- If you suspect that someone knows your password, change it in the normal way
- Change your password at regular intervals in any event
- Always shut down your computer when you go home at the end of the day
- If you notice any suspicious activity, for example an employee trying to gain unauthorised access to another employee's computer, notify your line manager immediately

We have attached our full IT and Data Security policy for full details.

We also have an Employee Code of Confidentially Policy, which is signed by all employees prior to the commencement of work. All sub-contractors are required to sign our Supplier Code of Conduct prior to commencing work which includes complying with our Information Governance Policies and processes.

We have attached our employee handbook which outlines our staff code of conduct.

Question 1.23.12

Cyber attack case study

Please set out how you will respond to a cyber-attack occurring at 06:00 which renders the provider main booking centre IT systems inoperable for 24 hours.

Word count 1500

Total Word Count: 633

ERS uses *** REDACTED *** as our integrated system that plans, operates, manages and reports on our operations. Cleric shows full details of our service including planned journeys, on the day journeys and vehicle locations.

The *** REDACTED *** system is cloud-based and therefore not stored on a single server which dramatically reduces the potential for downtime. By having a cloud-based system we are able to overcome issues such as power cuts and internet outages easily and effectively with minimal disruption to the patients. This is because we are able to run our system remotely and therefore if there are any outages in an area, we can operate our service from another one of our facilities.

In the very unlikely event that our IT systems are unavailable for 24 hours we would revert back to use our paper-based systems and telephonic communication. Our paper-based system is a tried and tested method of delivering a successful and efficient patient transport service and was the default method used prior to the implementation of our *** REDACTED *** system. As part of their training all crews, call handlers, planners and dispatchers are all trained on how to efficiently and effectively use the paper-based system in the event of a cleric outage. The required blank run sheets are, as part of our BCP, already printed out and stored at each of our facilities to ensure the paper-based system can be implemented immediately in the event of an outage. The crews mobile phones also have all of the required numbers preinstalled to ensure the freeflow of information.

*** REDACTED *** automatically backs up all bookings and allocated journeys to our Sharepoint system and therefore at the point of *** REDACTED *** going down we would have access to the latest bookings and allocated journey information.

Upon the *** REDACTED *** system going down our Operations Manager will contact the Authorised Officer and make them aware of the situation and inform them that we will be reverting to our paper-based system. A notification will be sent to all *** REDACTED *** users that all bookings for the next 24 hours need to be made via our HLAs based at each of the acute hospitals. If transport is required to be booked from outside the acute hospitals these can be made via phoned into our contact centre.

Our booking centre will revert to hardwire phone lines to allow external communication to still be received. The hardwired lines use the same phone number ensuring there will be no changes to the way Authorised staff contact the booking centre. We will increase the capacity of our call centre to ensure we are able to cope with the increase in call numbers. We will also have our call centre based in Leeds on hand to provide overflow coverage.

The crews will be informed of the situation and that they will receive jobs telephonically and not via the *** REDACTED *** app. All crews have a mobile phone and will be asked to continually update the dispatchers. Crews will call when they collect a patient and call again when they have completed that journey to receive details of their next journey. The *** REDACTED *** mobile app will also store information of journeys that were allocated prior to *** REDACTED *** going down allowing the impact to be mitigated somewhat.

During the outage all new bookings will be taken by our HLA desk in each of the Acute hospitals and taken down into our paper-based system before being passed on to our dispatchers and the crews. This ensures all of the relevant data is taken down to ensure the patient transportation continues with minimal impact on the patients. It also ensures that all of the bookings made, and journey allocated during the outage can be entered into the system as soon as it is back online. This minimises any ongoing disruption to the service.

Location:	Durham / Blyth	**Time Started:**	11.00
Date:	27/09/2019	**Time Completed:**	16.00
Conducted by:	*** REDACTED***		

BC Exercise Type:	Communication (other:
Resources Compromised:	Durham/ Blyth sites

Narrative Summary of Exercise:

11.00 The Durham team leader has been informed by a member of staff that they have tried to phone the office but it appears that the landline is not working

11.10 the team leader attempted to ring the office landline from his mobile phone but was unable to get through

11.20 The team leader also tried to ring the Blyth office landline to check but again was unable to get through

11.30 The team leader has contacted both Durham and Blyth operations managers to inform them of the issue

11.45 After taking guidance from the BCP, *** REDACTED*** has asked the team leader to contact *** REDACTED*** and inform them of the issue

12.00 Both Durham and Blyth managers have contacted all crews and all of the contracted hospitals to inform them of the issue

12.30 2 mobile phones have been allocated to each site to be used until the issue can be resolved

12.45 The team leaders have been asked to contact all staff on shift and give them the mobile numbers for each respective site

13.00 All hospitals have ben contacted and given the mobile numbers and have been advised that contracted hospitals will take priority until the issue is resolved

13.15 All local non- contracted hospitals that we think may need to contact site have been contacted and given alternative mobile numbers

13.30 *** REDACTED*** have contacted site with an update, they are aware of what the problem is and it appears only to be affecting the north east. They are hoping to have the problem resolved within the next 2 hours

13.45 The team leaders have been asked to contact the hospitals with and update on the expected time frame for repairs

14,00 Dean Laws has made a call to the mobile phones to ensure the calls are coming through ok

14.30 All staff that are on rest days have been contacted to let them know of the issue in case they need to contact the office with any concerns prior to there next shift

14.45 *** REDACTED*** has emailed all ERS sites to let them know if they need to contact Durham or Blyth sites could they do it via email as we are experiencing some technical issues with the phone system

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15.00 *** REDACTED*** have contacted site and advised that the landline phones are now up and running

15.15 *** REDACTED*** has asked team leaders to contact all hospitals and staff to let them know the the phone issue has now been rectified

15.30 *** REDACTED*** has also asked if Durham and Blyth can keep the mobile phones in place for the rest of the shift until we are fully confident that the issue is totally resolved

16.00 An email has been sent to all ERS sites to let them know that the phone lines are now up and running

Exercise finished 16.00

Was the BC Plan Enacted / Referred to:	
BC Exercise Rating:	Please Select

Recommendations & Lessons Learnt:

After completion of the site BC exercise send the completed form to the Head of Care Standards for further action and publishing to RADAR.

Head of Care Standards Actions Only

Date Received:		**Published to *** REDACTED***:**	
Unique Ref:	**BC EX/ / /**	**Name:**	

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PART1	
Date:	27/09/2019
Time Alerted:	11.00
Alerter Name:	*** REDACTED***
Site Location:	Durham/ Blyth
Contact Number:	*** REDACTED***
Time Response Coordinator(or if unavailable On-Call Manager Notified:	11.00
Name of Response Coordinator (or if unavailable) On-Call Manager:	*** REDACTED***
Contact Number:	*** REDACTED***

PART2			
Emergency Incident is:		STAND-BY / DECLARED (please delete one)	
Type of Incident:		Service Disruption	
Location of Incident:		North East	
Number of People Affected:		North East Sites	
Time Incident Occurred:		11.00	
Other Organisations Involved:			
Any Hazards (Biological/ Chemical/ Radiation/ Other):			
Other Details:			
Useful Contact Numbers:		Durham manager 07983893577 Blyth manager 07985347952 Durham T/L 07985369872	
Your Name:	*** REDACTED***	Contact Number:	*** REDACTED***

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	Ref No:

From:	To:
11.00	16.00

Time (24 hour clock):	Date:	Taken By:
	27/09/2019	*** REDACTED***

MESSAGE/ INSTRUCTIONS:
11.30 Team Leader contacted Durham and Blyth Managers to make them aware of the issues
11.45 Team leader to contact *** REDACTED***
12.00 All staff and contracted hospitals contacted by Ops Managers
12.45 Team Leaders contacted all staff with alternative contact numbersfor each site
13.00 All hospitals contacted with the alternative contact details and to inform them that contracted hospitals take priority
13.45 Team Leaders to contact allcrews and hospitals with an update received from *** REDACTED***
14.40 All staff on rest days contacted to inform them of the issue
15.50 All hospitals and staff to be contacted by team leaders to inform them that the issue has now been fixed

ACTIONS TAKEN/ REASONS FOR ACTIONS:

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Location:	Bowburn Durham	**Time Started:**	09.00
Date:	26/08/2019	**Time Completed:**	15.30
Conducted by:	*** REDACTED***		

BC Exercise Type:	Please Select (other: Loss of Staff)
Resources Compromised:	Site Bowburn Durham

Narrative Summary of Exercise:

09.00 *** REDACTED*** Bowburn site supervisor has informed *** REDACTED*** (site operations manager) that a number of staff have called site this morning to inform him that they are uable to attend work due to suffering from D&V

09.15 *** REDACTED*** has reviewed the Business Continuity plan and has asked the supervisor to make a count on how many staff have phoned in and what contracts they should be on also which other services may be affected

09.30 The site supervisor has made a count and up to now there has been 7members of staff that have phoned in sick, he has also made the operations manager that one of the contracted hospitals have reported ward closures due to an outbreak of D&V and to be aware that more staff could be affected

09.45 Due to the nature of the report from the hospital and the fact that a nuber of staff have already gone sick, *** REDACTED*** (site clinical lead) has contacted all staff to ensure that they take full IPC precautions

10.00 *** REDACTED*** has contacted the site supervisor and asked him to contact all staff who are on the rota for today to ensure that they will be attending work for their shift

10.15 The supervisor has confirmed that all staff have been contacted and no other staff are suffering from D&V symptoms at present

11.00 *** REDACTED*** has checked the rota and has moved adhoc crews to cover te contracted hospitals and all contracts will take priority until further notice

11.15 *** REDACTED*** has contacted all contracted hospitals and advised them of the situation and to assure the bed management that any adverse affects on transfers will be kept to a minimum also they will be updated throughout the day

11.30 *** REDACTED*** has asked the supervisor to contact all staff that are on their day off if they are able to support and also to contact Blyth operations manager to see if he has any staff available to support Durham for the interim

12.00 The supervisor has been informed that may beed to cover the rota with extra staff for the next 2 days due to D&V lasting 48 hours

12.30 Blyth operations manager has contacted *** REDACTED*** and advised him that he has two members of staff available to support Durham for the next 2 days

13.00 *** REDACTED*** has contacted all contracted hospitals with an update of the measures that are currently in place

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14.00 We have received conformation from 4 members of staff that are currently on their days off that they are able to cover shifts for the next 2 days and they will be on shift within the hour

14.30 Up to now 6 of the 7 staff off sick have now been covered for the next 2 days, both Durham supervisors have made available to cover any gaps in the rota, also *** REDACTED*** will be available for the next 2 days if required

15.00 All contracted hospitals have been updated again and to assure them that all measures have been put in place for the next 2 days

15.30 Exercise Complete

Was the BC Plan Enacted / Referred to:	
BC Exercise Rating:	Please Select

Recommendations & Lessons Learnt:

After completion of the site BC exercise send the completed form to the Head of Care Standards for further action and publishing to RADAR.

Head of Care Standards Actions Only

Date Received:		**Published to *** REDACTED***:**	
Unique Ref:	**BC EX/ / /**	**Name:**	

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PARTI	
Date:	26/08/2019
Time Alerted:	09.00
Alerter Name:	*** REDACTED***
Site Location:	Durham
Contact Number:	*** REDACTED***
Time Response Coordinator(or if unavailable On-Call Manager Notified:	09.15
Name of Response Coordinator (or if unavailable) On-Call Manager:	*** REDACTED***
Contact Number:	*** REDACTED***

PART2			
Emergency Incident is:		STAND-BY / DECLARED (please delete one)	
Type of Incident:		Staffing (Loss of Staff)	
Location of Incident:		ERS Medical Durham	
Number of People Affected:		Site	
Time Incident Occurred:		09.00	
Other Organisations Involved:			
Any Hazards (Biological/ Chemical/ Radiation/ Other):			
Other Details:			
Useful Contact Numbers:		*** REDACTED***	
Your Name:	*** REDACTED***	Contact Number:	*** REDACTED***

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	Ref No:

From:	To:
*** REDACTED***	Durham Supervisor

Time (24 hour clock):	Date:	Taken By:
	26/08/2019	

MESSAGE/ INSTRUCTIONS:
09.45 *** REDACTED*** to contact all staff tomake them aware of their IPC
10.15 Site supervisor to contact all staff to confirm that they will be attending shift
11.15 *** REDACTED*** to contact all contracted hospitals
11.30 Site Supervisor to contact Blyth operations manager for any possible support
13.00 *** REDACTED*** to contact all contracted hospitals with an update
15.00 *** REDACTED*** to contact all contracted hospitals with a final update

ACTIONS TAKEN/ REASONS FOR ACTIONS:

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For use during activation or testing of the sites **FS.04.02** - Business Continuity Plan.

Date	Time	Information / Decisions/ Actions	Initials
26/08/2019	09.00	contact site manager	*** REDACTED***
26/08/2019	09.45	contact all staff	*** REDACTED***
26/08/2019	10.15	contact all staff	*** REDACTED***
26/08/2019	11.15	contact all contracted hospitals	*** REDACTED***
26/08/2019	11.30	contactBlth operations manager	*** REDACTED***
26/08/2019	13.00	contact all contracted hospitals with an update	*** REDACTED***
26/08/2019	15.00	contact all contracted hospitals with a final update	*** REDACTED***

This form must be kept when the incident is over and kept at site level as part of the Business Continuity Plan activation record.

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Site BC Exercise Record

Location:	Durham	**Time Started:**	9.00
Date:	15/07/2019	**Time Completed:**	19.00
Conducted by:	*** REDACTED***		

BC Exercise Type:	Other (please specify) (other: NHS MAJOR INCIDENT)
Resources Compromised:	

Narrative Summary of Exercise:

9.00 *** REDACTED*** has been informed *** REDACTED*** Assistant Service Manager James Cook Urgent and Emergency Care Centre Hospital that an explosion has occurred at the Wilton energy plant Middlesbrough. At this time, it is not believed this is an act of terrorism.

9.15 *** REDACTED*** has contacted Durham ops manager *** REDACTED*** to advise.

9.30 After taking guidance from the BCP Dean has asked *** REDACTED*** to contact the police for update on any road closures or restrictions in the area

9.40 At this time all contracts have priority and all adhoc crews are to remain at base until further notice

10.00 *** REDACTED*** has been advised that all hospitals in the area are accessible however surrounding areas of the energy plant cannot be accessed

10.15 *** REDACTED*** has contacted *** REDACTED*** who has advised all discharges south of the hospital have been cancelled until further notice as this is the area of the incident. All other discharges are to go ahead to free the beds up for any incoming patients from the incident.

10.30 *** REDACTED*** has updated all staff on site and also those on a rest day. A request has been made for any crews available that can come to site to support. The team leader on rest has also been contacted and is heading to site

11.00 James Cook hospital have advised that they have been in contact with North Tees hospital and patients will be transferred across from James Cook to free up beds

11.15 The ERS Blyth manager has been contacted for support and has agreed to travel to North Tees hospital and will liaise with North Tees Transport Scheduler to support with patient transfers.
A team leader will also travel to James Cook to support bed management.

11.30 *** REDACTED*** has requested a direct line for both James Cook and North tees to minimise any delays

12.00 North East ambulance have contacted site to request support with transfers of non-urgent patients from the site of the incident to the dedicated hospitals.

12.15 A vehicle has been dedicated to NEAS however they have been informed that this is a PTS vehicle and only non-urgent patients are to travel. The vehicle will be controlled directly by a NEAS coordinator

13.00 *** REDACTED*** has contacted James Cook hospital for an update from the team leader on site. They have advised transfers are going ahead however not as quick as they would like. An extra adhoc vehicle is to be made ready and sent from ERS Durham to support in the transfers

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14.00 All contractual hospitals and ERS staff have been contacted with an update on the ongoing incident. We have also contacted the police for further updates which has also been passed on to the crews

14.30 The extra PTS vehicle isnow on site and will begin transfers from James Cook to North Tees hospital

16.00 *** REDACTED*** has made contact with the Blyth manager currently supporting North Tees and the team leader supporting James Cook. Both have updated site and movement of patients is now going well

17.00 All transfers from James Cook to North Tees Hospital are now completed. All extra vehicles used in the transfers are to stand down and return to site. The contracted vehicles at James Cook are to continue as normal for the remainder of the shifts

17.30 *** REDACTED*** has agreed to keep night shift on standby for any unexpected patient movement through the night

18.15 The crew currently working with NEAS have informed site that all non-emergency transfers from the site of the incident have now taken place. The NEAS coordinator has stood the crew down and they are to return to site

19.00 The major incident officer has contacted *** REDACTED*** and informed him that ERS are not required any further. All crews are to return to site and contracted vehicles will continue transferring any remaining PTS patients .The incident officer has been provided with the operations manager contact number if any further assistance is required

Was the BC Plan Enacted/ Referred to:	
BC Exercise Rating:	Please Select

Recommendations & Lessons Learnt:

After completion of the site BC exercise send the completed form to the Head of Care Standards for further action and publishing to RADAR.

Head of Care Standards Actions Only

Date Received:

Published to * REDACTED***:**

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Unique Ref: **BC EX/** *I* *I* **Name:**

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PARTI	
Date:	15/07/2019
Time Alerted:	9.00
Alerter Name:	*** REDACTED***
Site Location:	Durham
Contact Number:	*** REDACTED***
Time Response Coordinator(or if unavailable On-Call Manager Notified:	9.15
Name of Response Coordinator (or if unavailable) On-Call Manager:	*** REDACTED***
Contact Number:	*** REDACTED***

PART2	
Emergency Incident is:	STAND-BY / DECLARED (please delete one)
Type of Incident:	NHS Major incident
Location of Incident:	North Tees Hospital
Number of People Affected:	Hospital site
Time Incident Occurred:	9.00
Other Organisations Involved:	NEAS,Police,Fire
Any Hazards (Biological/ Chemical/ Radiation/ Other):	yes
Other Details:	
Useful Contact Numbers:	North Tees Transport Scheduler *** REDACTED*** James Cook hospital dedicated line 01642850850 neas coordinator *** REDACTED***

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Your Name:	*** REDACTED***	Contact Number:	*** REDACTED***

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ERS Medical

BC Message Form

Ref No:

From:	To:
ERS Durham	

Time (24 hour clock):	Date:	Taken By:
9.15	15/07/2019	

MESSAGE/ INSTRUCTIONS:
9.15 Team leader to make contact with ops manager
9.30 Team leader to contact local police for update
10.15 *** REDACTED*** to make contact with James Cook hospital
10.30 Team leader to contact all ERS staff to inform of incident
11.15 *** REDACTED*** to contact Blyth ops manager for support
13.00 *** REDACTED*** to contact James Cook hospital for update
14.00 Team leader to update all contracted hospitals
16.00 *** REDACTED*** contact Blyth manager and team leader for update at hospitals

ACTIONSTAKEN/ REASONSFOR ACTIONS:

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ERS Medical

F5.04.02 Business Continuity & EPRR Plan ERS Medical East - Norwich; King's Lynn; Snetterton; High Kelling.

Version: 4.4

Copy: 1

Location:

Date Published: 19th July 2019

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
Version No:	4.4	**Date Active:**	20/09/2019	**Revision Date:**	29.01.2020

Revision / Amendment Information						
Revision No.	Section / Paragraph / Page No.			Date	Amended By	Comments
2.0	13	.6 to .9	18	07.06.18	[redacted]	Revision post x2 Cleric failures in May 18
3.0	All	All	All	01.09.18	[redacted]	Review of whole plan
3.1	9	13	15	11.10.18	[redacted]	Addition of Telephone Numbers
4.0	All	All	All	29.01.19	[redacted]	Splitting of BC and EPRR Requirements & SitRep Section
4.1	All	All	All	07.05.19	[redacted]	Minor changes for Norwich CCG
4.2	All	All	All	11.07.19	[redacted]	Cleric & Norfolk CCG Changes
4.3	All	All	All	19.07.19	[redacted]	Update at request of Norwich CCG
4.4	28	All	39	20.09.19	[redacted]	Addition of support statement NHS Trusts

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Business Continuity Plan

ERS Medical East –

Norwich

[redacted]

King's Lynn

[redacted]

Snetterton

[redacted]

High Kelling

[redacted]

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02

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3. Responsibilities

3.1	**Strategic Lead (Senior Management Team)**	Have overall responsibility for the control of the Company resources upon the enactment of the business continuity plan. They may not necessarily be at site, but will direct, at the strategic level, formulating a strategy for dealing with the event and committing wider Company resources to better manage and sustain normal operations.
3.2	**Tactical Lead (Regional Manager)**	Normally a senior member of the operational management team, excluding the Strategic Lead if present, who is on site, upon the enactment of the business continuity plan. They will decide at the local level how best to implement the business continuity plan and the use of available resources to achieve the strategic aims set by the Strategic Lead. They will work and cooperate with other organisation's Tactical Leads at the site level and could be embedded within these organisations command centres, in order to communications between agencies. Additionally, they should also ensure that communications from Strategic Lead and the Operational Lead remain regular and effective.
3.3	**Operational Lead (Operations Manager / Compliance Manager / Advisor)**	The on-site manager who is directly controlling Company resources upon the enactment of the business continuity plan, taking instructions from the Tactical Lead. If the business continuity plans cause for actions to be taken over or affecting a wide geographical area, possibly with multiple site locations, there may be occasions when multiple Operational Leads are reporting into the Tactical Lead. Additionally, they are responsible for ensuring effective communication with other Tactical Leads or equivalent and their operational staff resources and this may include directly liaising with external agencies such as Police, Fire, Ambulance, EA, Local Authorities etc.
3.4	**All Personnel**	Are responsible for ensuring they understand the Business Continuity Plan and associated procedures and follow the processes at all times.

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4. Definitions

4.1 **Activity** – Process or set of processes undertaken by the Company (or on its behalf) that produces or supports one of more of its services.

4.2 **Business Continuity** – Capability of the organisation to continue delivery of products or services at acceptable predefined levels following disruptive incident.

4.3 **Business Continuity Event (BCE)** – An occurrence or change of a particular set of circumstances, such as an event, which can be one or more and have several causes. An event can also consist of something not happening, which causes a failing in operational delivery. It is sometimes also referred to as an incident or accident, but for the purposes of the Business Continuity Plan, will be referred to as either a BC Event or BCE.

4.4 **Business Continuity Management System (BCMS)** – Part of the overall management system that establishes implements, operates, monitors, reviews, maintains and improves business continuity.

4.5 **Business Continuity Plan (BCP)** – Documented procedures that guide staff to respond recover and restore, to a predefined level the capability and enable the Company to maintain its services and operations, during and following a business continuity event.

4.6 **Business Continuity Risk Assessments (BCRA)** – The process of identification and analysing business continuity risks, arising from a hazard, taking into account any existing control measures and deciding whether or not the residual risks are acceptable.

4.7 **Business Impact Analysis (BIA)** – Process of analysing activities and the effect that a business disruption might have upon them.

4.8 **Emergency Preparedness Resilience and Response [EPRR]** - The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.
This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR). New arrangements for local health EPRR form some of the changes the Health and Social Care Act 2012 is making to the health system in England.

4.9 **Exercise / Testing** – Is a process to train for, assess, practice and improve within the Company.

4.10 **Interested Party / Stakeholder** – Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.

4.11 **Maximum Tolerable Period of Disruption (MTPD)** – Time it would take for adverse impacts, which might arise as a result of not providing service/product or performing an activity, to become unacceptable.

4.12 **Operational Lead** – For the purposes of business continuity the term operational lead will denote either the Operations Manager or the Compliance Advisor for the specific site.

4.13 **Requirement** – need or expectation that is stated, generally implied or obligatory.

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4.14 **Resources** – All assets, people, skills, information, technology (including plant and equipment), premises and supplies and information (whether electronic or not) that the Company has available to use, when needed, in order to operate and meets its objectives.

4.15 **Risk** – Combination of the impact of an event and the associated likelihood.

4.16 **Strategic Lead** – For the purposes of business continuity strategic lead will denote the Senior Management Team.

4.17 **Tactical Lead** – For the purposes of business continuity the term tactical lead will denote the Regional or General Manager responsible for the specific site.

4.18 **Recovery Time Objective (RTO)** – Period of time following a business continuity event in which services or products must be resumed or activities must be resumed, or resources must be recovered.

4.19 **Risk Assessment** – Overall process of risk identification, risk analysis and risk evaluation.

4.20 **Risk Management** – Co-ordinated activities to direct and control an organisation with regard to risk.

4.21 **Testing** – Procedure for evaluation; a means of determining the presence, quality, or veracity of something.

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5. Business Continuity Impact Assessment Summary

5.1 The information contained within the below table has been taken directly from the sites **F1.07.02** – **Business Impact Analysis (BIA).**

Service Priorities

5.2 In order to ensure that we prioritise both the needs of our patients and those of our contracted partners, ERS Medical as collaborated with its major stake holders and determined the priorities of service should be:

- **RENAL DIALYSIS PATIENTS;**
- **ONCOLOGY PATIENTS;**
- **ON THE DAY DISCHARGES.**

Service Priority Rating	Service Activity
SP1	Non Emergency Patient Transport Services (NEPTS) including HDU - Contracted Services for the [redacted]
SP2	ADHOC tasking booked on behalf of the [redacted], outside of the contract specifications for NEPTS and HDU
SP3	Escalation duties for the [redacted]
SP4	Private ADHOC NEPTS, HDU and Mental Health Taskings

Impact Analysis Rating Key

1 = Minor	2 = Moderate	3 = Serious	4 = Major

5.3 For more detail on business continuity impact analysis rating scores please refer to **WI/1.07.02** – Business Impact Analysis.

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6. What to Do

WHAT TO DO

If you have been notified of, or suspect there to be an Business Continuity Event (BCE)

Please note- Exercise messages will always contain the prefix 'EXERCISE'

CONTACT YOUR LINE MANAGER / SUPERVISOR ON-CALL IMMEDIALTELY

ON

[redacted] - Operations Manager

[redacted] – Senior Operations Manager

Then please complete **F5.04.09** – **BC Alert Form** available from the BMS.

If you have difficulties in contacting either your line manager or supervisor, please contact your Operations Manager on

[redacted] – Regional Manager East and South

[redacted] – Managing Director

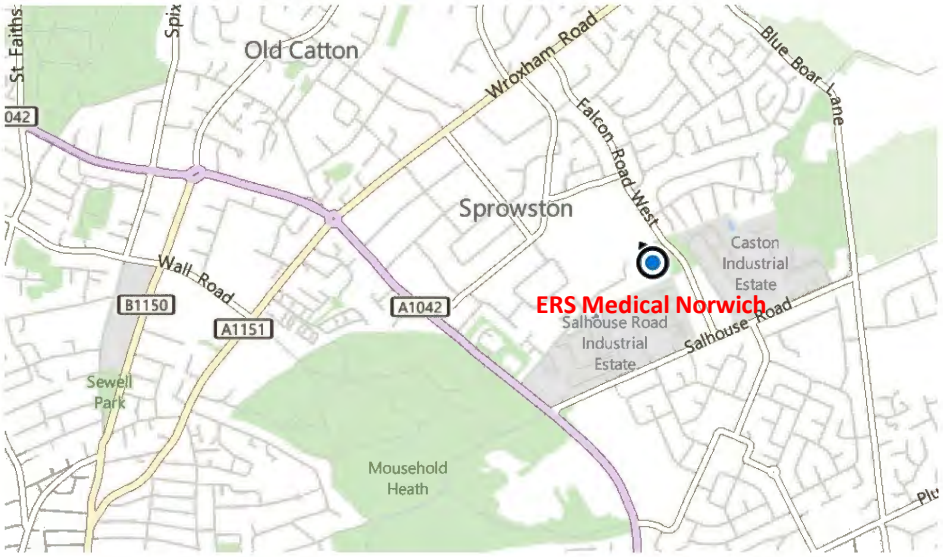
Alternatively, during normal working hours report the issue direct to your direct line manager.

IF YOU ARE ON-CALL

Use **F5.04.13** – **BC Response Checklist**, assess the BCE and notify all necessary personnel. Start an **F5.04.16** – **BC Log Sheet** for all actions and decisions taken. All forms can be found in either the Business Continuity Folder or on the BMS if still available.

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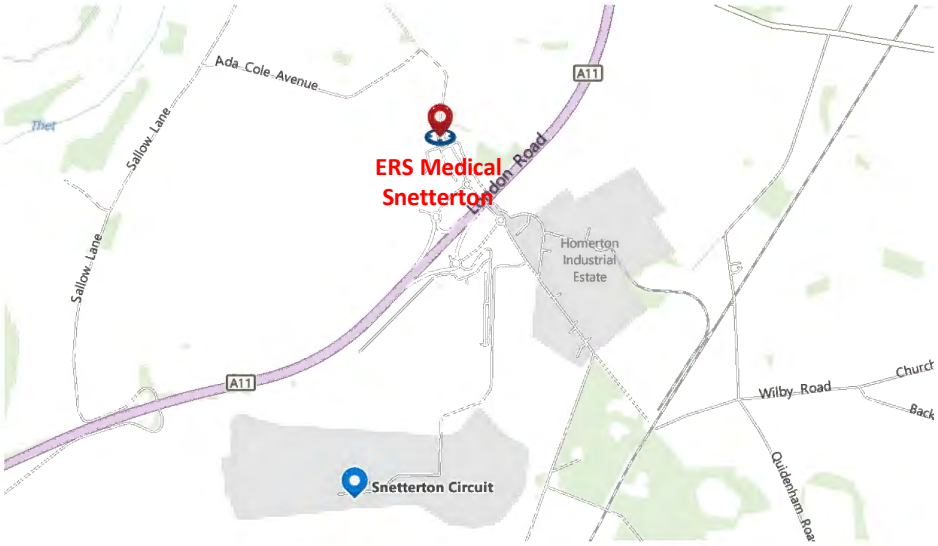
7. Site Location Maps





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Site Location Maps





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8. Immediate BC Response

Declaring a Business Continuity Event (BCE) and Call-Out

8.1 If a Business Continuity Event (BCE) occurs, part 1 of the **F5.04.09** - **BC Alert Form** should be completed by the person who receives the alert (the 'Alerter').

8.2 The On-Call Tactical or Strategic Lead will need to be contacted in first instance, by the Operational Lead.

Contractual, Operations and Senior Management Escalation (Operational, Tactical & Strategic)

8.3 To facilitate the escalation of a BC event or incident to higher authority within the ERS Medical, that is logged and recorded the Operational Leads should call the either their Tactical or Strategic Lead for further guidance**.**

8.4 This escalation process is also available to the [redacted] and the [redacted] to enable them to rapidly communicate, at the appropriate level any internal business continuity event that has the potential to affect the delivery of ERS Medical's service to them.

8.5 The On-Call Tactical or Strategic Lead will have the responsibility for deciding the status of the ERS Medical's response to any BCE that has the potential to interfere with routine activity and the continuation of normal service delivery.

8.6 The On-Call Tactical or Strategic Lead must then initiate the appropriate BCE status:

- **Business Continuity Event-'Stand-by'**; when it is believed that a serious event has occurred, which has potential to escalate. The Company will respond to a "Stand-by" message by preparing to activate this Business Continuity Plan. The Alerter will notify the On-Call Tactical or Operational Lead, who will inform the Alerter which Event Control Centre, will be used, if applicable. The Alerter will then be advised when and if any other staff are to be notified.

This alert is then followed by either of the following:

- **Business Continuity Event- 'Declared';** when either the On-Call Tactical or Operational Lead or the Emergency Services believe the BCE requires special arrangements to be implemented in part or in full. In these circumstances, the Company will fully activate this Business Continuity Plan. Part 2 of the **F5.04.09** – BC Alert Form should now be completed and the **F5.04.13** - BC Response Checklist should be started from this point;
- **Business Continuity Event - 'Cancelled';** when it becomes apparent that the situation is not as serious as initially thought. Any further response is deemed unnecessary and any completed paperwork is collated and sent to the BMS Manager. Staff members may return to normal duties. Services remain normal.

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Finally:

- **Business Continuity Event – 'Stand Down';** occurs when the Company's response to the BCE is complete. Having ascertained this to be the case, the On-Call Tactical or Operational Lead will notify the Strategic Lead with a recommendation to stand down Company resources deployed in support of the event;
- Once the Strategic Lead has authorised the 'stand down' resources can be returned to a normal operational footing and the debrief process commences.

9. Buildings and Facilities

Long Term or Short-Term Loss of Access

Immediate Actions to be Considered (ONLY IF SAFE TO DO SO)

9.1 Record actions on either **F5.04.07** – BC Action Delegation or **F5.04.08** – BC Action Delegation Summary forms:

- The location Regional Manager (tactical lead) and the Managing Director (strategic lead) must be notified as soon as possible so that the landlord can be officially notified and make any necessary arrangements with either their / our ERS Medical's buildings insurers or both.
- Notify through the management structure the Senior Management Team so that our insurers can be contacted in the event of loss or damage to ERS Medical resources (building contents, IT equipment, vehicles etc) ***details of our insurers can be found on the radar compliance system in documents***;
- Notify the key stakeholders within the [redacted] Trusts (this should be a concurrent activity, with the previous actions if any loss of hard facility impacts on service delivery);
- The Operational Lead is to notify both the tactical and strategic leads to assist in the process of identifying and providing suitable premises and facilities, either on temporary, long term and potentially permanent basis.
- Evacuate the building, if in working hours staff should attempt to take their personal belongings with them;
- Lock record cabinets and remove the keys from the site and hand to the senior person on scene;
- Close off access to the site car parks if possible;
- Make contact with (other) member(s) of the Senior Management Team i.e. Head of Care Standards (***there may be a requirement to make a statutory notification to the CQC***);
- Ring the Police / Fire / Ambulance Services as required;
- Turn off the electricity and water supplies if possible and appropriate;
- Ensure that all access and egress points are secured, and security systems remain active, if electrical supplies are still available;
- Allocate a responsible member of staff to remain close to the site, if appropriate, to guide and deal with emergency and support services as required. Ensure that the staff member has charged mobile communications available.

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Additional actions to be considered

9.2 Record actions on either **F5.04.07** – BC Action Delegation or **F5.04.08** – BC Action Delegation Summary forms:

- Contractors / Visitors should remove their vehicles from the site (if possible);
- Instruct Royal Mail to hold all Company mail at the local sorting office until it can be collected by an authorised Manager and redirect deliveries to alternate Company locations;
- Post information signs on access doors;
- Senior Managers (Tactical or Operational Lead) are to reconvene at the designated 'BCE Control Centre'. (Refer to Establishing a BCE Control Centre at Section 9);
  - Set the internal telephone system to call divert (this can be completed by contacting [redacted] on [redacted] or by raising a ticket with them [redacted] if needed);
- Staff should remove all Company vehicles from the site (if possible);
- Staff should remove their private motor vehicles from the site (if possible);
- Staff will be informed, as appropriate by the site Operational Lead or authorised person of any designated rendezvous location. If sent home staff should wait for update information.

9.3 See the relevant site BIA for information relating to the RTO and MTPD. (BIA ref: BIA/NOR/01).

Evacuation of Buildings and the Co-operation with the Emergency Services

9.4 The evacuation of buildings should be completed in a calm and controlled manner and directed by the Tactical and Operational Leads in accordance with predefined routes.

9.5 When evacuating resources from any of the sites detailed within this plan, consideration should be given to the access and egress of emergency service vehicles. Access roads should be kept clear and flowing if at all possible.

9.6 The removal of equipment and or records will be implemented and directed depending on the scale and nature of the BCE and available resources to facilitate their safe removal.

9.7 Control Room and Office based staff will normally be relocated in the first instance to the BCE Control Centre to wait for further information and instructions. Control Room functions will either be transferred immediately to one of the other main sites within the location (Norwich or King's Lynn) or the CCO in Leeds.

9.8 In the event of receiving a bomb alert, mobile telephones **Must Not** be used, and evacuation will be by word of mouth.

9.9 If time and the situation permits refer to Section 14 of this BCP (Essential Equipment & Documentation) for their removal.

9.10 Section 14 (Status) should be annotated as a record of all removed items of essential equipment and documentation. This should be retained for the duration of the BCE.

9.11 A replacement Section 14 page should be inserted into the BCP at the termination of BCE.

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10. Establishing a BC Control Centre and Notifying Stakeholders

10.1 For purposes of BCE meeting and planning, Senior Management will convene at one of the main ERS Medical sites within the location [redacted] which is not affected by the BC Event, with suitable facilities as soon as possible following the BC event, if required.

10.2 If both locations are affected, then a sub-site can be used (Snetterton or High kelling). If all sites are affected, then another suitable location must be identified by the local tactical or operational lead and communicated to Senior Management.

10.3 This will be designated as the '**BCE Control Centre'**, until a suitable alternative facility has been identified and secured if needed.

10.4 Additional IT equipment will be made available at alternate site locations and until this has been established CAD or Operational Control (if applicable) will be diverted to next main site in the location or if needed back to the CCO in Leeds or by Company Laptops remotely.

10.5 A BCE control box will be stored at each operational site for use during activation and testing of the business continuity plan. It shall include;

- Latest version of the site **F5.04.02** – **Business Continuity Plan**;
- Latest versions of **F5.04.03** – **Post BC Recover Plans**;
- Site Vehicle Fleet List;
- Torch (including spare batteries);
- Marker pens, paper, normal pens, highlighters, sticky tape (to make signs and notices);
- 2 High visibility vests;
- Hazard / Cordon tape to prevent access and egress to dangerous or unsafe areas.

10.6 Operational Leads are responsible for ensuring that their BCE control box is kept updated with the necessary information and resources. There will be a check on the contents of the BCE Control Box on a monthly basis using the **F5.04.14** – BC Box Contents and **F5.04.15** - **BC Box Contents Checklist**. All deficiencies will be recorded and replaced.

10.7 Any outstanding action(s) from the 'Immediate Action' section above, may be taken at this time and recorded, using the templates published in the BMS. Replacement forms will be issued, if necessary, for use by staff to ensure continued service provision.

10.8 Additional Business Continuity Plans are available by accessing the Radar Compliance System / Documents / Business Continuity.

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Immediate Communication Issues

10.9 Once the BCE Control Centre has been established, the following should be advised, if not already, of the emergency:

- Emergency Services;
- Staff not initially involved but who will be affected;
- All relevant Stakeholders (Internal & External), (SMT (Strategic Leads), HR, Regulatory Compliance Team, Clinical Team, Fleet, Facilities Management & Information Services). See **F5.04.21** – **BC Key Contacts Sheet** for more details;
- Company Insurers.

Notifying Stakeholders

10.10 If a Business Continuity Event occurs it may be necessary to notify ERS Medical stakeholders. The decision to make contact with stakeholders can only be authorised by the Strategic Lead or Tactical Lead.

10.11 The only exception to this instruction is in the event of a short-term loss of telephone systems. On these occasions, the Operational Lead does have the authority to notify stakeholders direct.

10.12 All contacts with stakeholders should be recorded on the **F5.04.16** – **BC Log Sheet**.

Stakeholder	Telephone Number	Notification Period
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours

10.13 For further stakeholder information please refer to the sites completed **F5.04.21** – BC Key Contacts Sheet.

Time Frames for Notification of Stakeholders

10.14 Stakeholders should be notified as soon as reasonably practicable and within the defined notification period once the correct level of authorisation has been obtained.

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11. Media Contact

11.1 Staff should not make comments to the media and all enquiries should be referred to the Company Head Office at Hetton Court on **0333 240 4999** in the first instance who will escalate this to the Senior Management.

11.2 If knowledge of the BCE has passed into the public domain, the Tactical Lead may provide the press with an initial holding statement (**F5.04.11 – BC Holding Statement**).

11.3 Record any incoming calls, from the media using the **F5.04.10 – BC Media Calls Report Form** and refer them back to the CCO.

11.4 Remember the following:

- **DO NOT MAKE ANY COMMENT and DO NOT SPECULATE ON THE CAUSE OF THE BCE**;
- Any information updates should be communicated DIRECTLY to Senior Management at the BCE Control Centre;
- Senior Management (Strategic Leads) will lead on all statements issued to the media;
- **DO NOT** confirm that a BCE has occurred unless it is clearly in the public domain;
- Take details of the call and enquiry;
- **DO NOT GIVE OUT THE BCE CONTROL CENTRE PHONE NUMBER TO MEDIA CONTACTS.**

12. Damage Assessment

12.1 If required, the designated Operational or Tactical Lead will liaise with the Emergency Services and other agencies to conduct an initial assessment of the situation and determine the extent and likely duration of the BCE.

12.2 A member of Senior Management Team will liaise with the insurers and other third parties to ensure that swift and correct recovery is supported and achieved, including contact with the possible sources of alternative premises.

12.3 If a building becomes unavailable for use for any reason and a suitable alternative facility needs to be identified, contact either the tactical or strategic leads for guidance.

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12.4 Depending on the scale and impact of any damage ERS Medical will consider all suitable options to ensure continuity of services to the [redacted] This will include, but not be limited to:

- The provision of temporary structures and facilities;
- Additional IT equipment and connectivity to the ERS Medical network and telephone system;
- The provision of power generators;
- Lighting & heating;
- Hard standings for vehicle parking;
- Staff welfare facilities;
- IPC and general waste management.

12.5 In the event that rebuilding is required the SMT or their authorised representative will liaise, through the Regional Manager, with relevant and approved contractors to plan and arrange for all relevant actions.

12.6 Staff will be kept up to date with all relevant decisions to reoccupy or occupy new premises through ERS Medical communication systems.

13. Vehicles

13.1 In the first instance, depending on the nature of loss all relevant breakdown, maintenance, accident or theft processes should be followed.

13.2 Contact will be made with the Managing Director to report any loss. He/She will initially within the first 12 to 48 hrs attempt to provide additional internal resources to site in support their ongoing service delivery, through existing ERS Medical assets.

13.3 If this is not practicable or achievable they will then look to an authorised external 3rd party supplier of vehicles for short to medium term provision of additional vehicles.

13.4 If new vehicles need to be ordered and provided to the site, procedures at **BMS/4.01** will be followed.

13.5 **Current Lead Times for new Vehicles:** 12 weeks

13.6 The Company Fleet Team is contactable as detailed in the below table:

Fleet Title	Telephone Number
Managing Director	[redacted]

13.7 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

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14. Information Technology (IT)

Local Loss of IT

14.1 In the event of a local short-term disruption to service the Operational Lead should contact [redacted] E [redacted] and log a works ticket to remedy the fault.

[redacted] **Contact Number:** [redacted]

Web Site: [redacted]

14.2 Essential services will continue to be provided from other ERS Medical sites within the location or from other reginal locations such as Head Office in Leeds.

14.3 Remote access to the ERS medical servers and system such as CAD (Cleric), Bamboo HR and Radar and will still be possible via:

- 4G Hotspots;
- Portable Wi-Fi Systems.

National Loss of IS

14.4 In the event of a national loss of information services staff should follow as above and fall in line with the national recovery protocols and provisions, put in place by the Senior Management Team and Solve IT.

14.5 These provisions will be:

- Isolated power supplies;
- UPS;
- On site generator (if required and the building is appropriate);
- Redundant server links;
- Back-up data centre network connections;
- Spare hardware;
- Back-up telephone system to support Cisco.

14.6 In addition to the above provisions the following will be undertaken in support of the 'Cleric CAD System' and to ensure that essential data is retrievable, even in the event of a Cleric outage.

- A daily 'Activity Dump' for all journeys and allocated work will be created out of Cleric as a CSV file;
- The 'Activity Dump' CSV file will be automatically downloaded every 45 minutes from 'Cleric' and stored on ERS Medical Servers and uploaded to our SharePoint.

14.7 These additional provisions will ensure that if Cleric is inaccessible, we can still access the pre-booked journey data, via a shared folder on the SharePoint system.

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14.8 In the event of a Cleric failure, the most recent CSV file, download from Cleric will be shared with the relevant Operations Managers and their teams.

14.9 In support of ERS Medical servers, Solve It and Rapid Switch have implemented the following BC provisions:

- Planned monthly testing of the server failover switch;
- Installation of a secondary power supply for the ERS Medical servers;
- Active monitoring and alerts for the ERS Medical SQL1.

Loss of CLERIC CAD System

14.10 If IT systems access is lost contact ERS Medical Systems Support on:

Tel: [redacted]

Email:

[redacted] - Any system apart from Cleric

[redacted] - Cleric loss

15. Telephone System

Short Term Loss (Less than 4 hours)

15.1 In the event of a short-term local fault, which is beyond the control of the Company, the Operational Lead should arrange to have the affected numbers transferred to another suitable phone or site.

Transfer Calls To:	[redacted]
Or CCO Leeds	[redacted]99

Transferring a Call

- CCO number for Norfolk = [redacted]
- Press cfwd on desk phone
- Enter [redacted]
- Wait a second for phone to store number
- Phone will auto forward call
- To stop forwarding, Press -cfwd

15.2 The Operational Lead should arrange to have the fault reported, investigated and repaired by contacting;

Supplier	Contact Name	Telephone Number
[redacted]	HELP DESK	[redacted]

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15.3 The Operational Lead should also contact, if necessary, all stakeholders, as detailed in Section 9 of this BCP and advise them of the temporary fault and to either continue to use the same number, but which has been diverted or provide them with an alternative, such as the number at the Emergency Control Centre.

15.4 When the Operational Lead makes contact with stakeholders to inform them of this temporary problem, they should take care not to formally notify them of any enactment of the Business Continuity Plan as this remains the responsibility of the Strategic Lead.

Long Term Loss (more than 4 hours)

15.5 In the event of a national loss of telephone services staff should follow as above and fall in line with the national recovery protocols and provisions, put in place by the Senior Management Team and [redacted]

15.6 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

15.7 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet.**

15.8 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

Out of Hours Contact for [redacted]

15.9 The use of the [redacted] out of hours service is to be restricted to mission critical issues such as, but not limited to:

- Loss of telephone systems;
- Loss of internet systems;
- Loss of Cleric systems

15.10 [redacted] out of hours details:

From: 17:30 – 09:00

PIN: [redacted]

Number: [redacted] (usual number for [redacted])

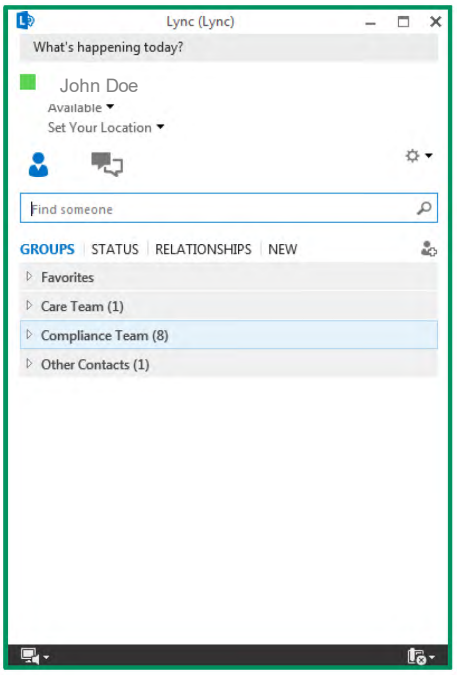
Alternative Methods of Communication

15.11 Operational Lead through to Strategic Lead will ensure that they have '**Skype for Business'** (instant messaging) installed onto their laptops and PC's.

15.12 Skype for Business can be used as a method of communicating in real-time in the event of a loss of either the mobile telephone networks, Cisco telephone system (locally) or both.

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15.13 Any ERS Medical employee (Operational to Tactical Leads) who is required to attend either the [redacted], on enactment of their business continuity plan should request access to that Trusts network systems or enable (if available) a 4G hotspot on their company mobile to enable Skype for Business communication to function.



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16. Essential Equipment - Norwich

16.1 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
Norwich	[redacted]0 PC's (complete)	Various site offices	
Norwich	[redacted] Cisco Telephones	Various site offices	
Norwich	[redacted] Printer / Scanner	Admin & M&C	
Norwich	[redacted] Desks	Various site offices	
Norwich	[redacted] Chairs	Various site offices	
Norwich	[redacted] Extension Leads	Various site locations	
Norwich	[redacted] CAD Tablets & Chargers	Site Ops	
Norwich	[redacted] ECG Monitors	Equipment Room	
Norwich	[redacted] Medicines PODS	Equipment Room	
Norwich	As Required Medical Gases	Gases Store	
Norwich	[redacted] station ChemEx Products	Deep Clean Area	
Norwich	[redacted] of each Mops and Buckets	Various site locations	
Norwich	[redacted] Mail and Courier PDA's	Mail and Courier	
Norwich	[redacted] Mobile Telephones	Various Personnel	
Norwich	[redacted] Kettles	Site	
Norwich	[redacted] Toasters	Site	
Norwich	Water Boiler	Training Room	
Norwich	[redacted] Hospital Training beds	Training Room	
Norwich	[redacted] Projector	Training Room	
Norwich	[redacted] Server and Wi-Fi Systeme	Server Room	
Norwich	[redacted]1 Filling Cabinets	Site	
Norwich	[redacted] Air Conditioning Units	Site	
Norwich	[redacted] ACA's	Site	
Norwich	[redacted] UCA's	Site	
Norwich	[redacted] ECA's	Site	
Norwich	[redacted] Technicians	Site	
Norwich	[redacted] Paramedic	Site	
Norwich	[redacted] Control Room Staff	Control Room	
Norwich	[redacted] Admin Staff	Control Room	
Norwich	[redacted] Team Leaders	Site Ops	
Norwich	[redacted] Hospital Liaison Staff	NNUH	
Norwich	[redacted]1 Trainer	Ops	
Norwich	[redacted] HDU Ambulances	Ops	
Norwich	[redacted] WAV; [redacted] Bariatric [redacted] Seater; [redacted] Stretcher Ambulances	Ops	

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Essential Equipment – king's Lynn

16.2 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
King's Lynn	PC's (complete)	Site offices	
King's Lynn	Cisco Telephones	x3 Offices	
King's Lynn	Printer / Scanner	Site office / Store Rm	
King's Lynn	Desks	Site offices	
king's Lynn	Chairs	Site offices	
King's Lynn	Extension Leads	Site offices	
King's Lynn	CAD Tablets & Chargers		
King's Lynn	SP Services G3H ECG Monitors	Site / HDU	
King's Lynn	Medicines PODS	Storeroom / HDU	
King's Lynn	Cages Medical Gases	Outside of building	
King's Lynn	Station ChemEx Products	Site	
King's Lynn	of Each Colour Mops and Buckets	Deep Clean Area	
King's Lynn	Various Boxes Medical Stores	Store Room	
King's Lynn	Mobile Telephones	Site Management	
King's Lynn	ACA's	Site	
King's Lynn	ECA's	Site	
King's Lynn	UCA's	Site	
King's Lynn	Technicians	Site	
King's Lynn	Hospital Concierge	QEH	
King's Lynn	HDU Ambulances	Site	
King's Lynn	Stretcher Ambulances Bariatric)	Site	
King's Lynn	Seater Ambulances	Site	
King's Lynn	WAV's	Site	
King's Lynn	RRV	Site	
King's Lynn	Keetle	Kitchen	
King's Lynn	Fridge	Kitchem	
King'S Lynn	Freezer	Kitchen	
King's Lynn	Microwave	Kitchen	
King's Lynn	Toaster	Kitchen	
King's Lynn	Power Washer	Deep Clean Area	
King's Lynn	1 Hoover	Deep Clean Area	
King's Lynn	Sluice Sinks	Cleaning Area	
King's Lynn	x1 Medicines Hub	Head of Care Office	

Essential Equipment - Snetterton

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16.3 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
Snetterton	[redacted] PC's (complete)	Office	
Snetterton	[redacted] Cisco Telephones	Office	
Snetterton	[redacted] Printer / Scanner	Office	
Snetterton	[redacted] Desks	Office	
Snetterton	[redacted] Chairs	Office	
Snetterton	NIL ECG Monitors		
Snetterton	NIL Medicines PODS		
Snetterton	[redacted] Dispenser Station ChemEx Products		
Snetterton	[redacted] Mops and Buckets		

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Essential Equipment – High Kelling

16.4 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
Kelling	[redacted] PC's (complete)	Office	
Kelling	[redacted] Cisco Telephones	Office	
Kelling	[redacted] Printer / Scanner	Office	
Kelling	[redacted] Desks	Office	
Kelling	[redacted] Chairs	Office	
Kelling	NIL ECG Monitors	N/A	
Kelling	NIL Medicines PODS	N/A	
Kelling	[redacted] Dispenser Station ChemEx Products	Store	

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17. Security of Company Records and Documentation

17.1 Where time allows and when they can be safely recovered from the premises following an BCE, the following documentation should be recovered and moved to another Company location (see section 14):

- Paper based records, including staff HR and Training Records, Patient identifiable information, financial records, sales and marketing records, fleet transport records;
- Supplier agreements and contracts;
- Letters and correspondence.

17.2 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet.**

17.3 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

18. Utilities

18.1 In the event of a gas supply or power failure within the building, the first thing to check is the main fuse box.

	Norwich	King's Lynn	Snetterton	High Kelling
Main Fuse Box Location:	[redacted] Control	Inside buidling near Ops Managers Office	Cupboard to the right inside front door	Trust Facilities
Gas Isolation Valve:	N/A	N/A	N/A	N/A

18.2 If the fault can't be easily identified and rectified or the fault is external to the site contact the power industry supplier (gas and electrical):

Norwich

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

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King's Lynn

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

Snetterton

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

High Kelling

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

18.3 If the power does fail, cancel or re-schedule all on-site visits and appointments if appropriate until such time as power is restored.

18.4 If the power is going to be off for a protracted period of time and a decision is made to close the building and relocate please refer to Sections 6 and 7 of this plan.

18.5 All power supply sockets should be turned off to prevent damage to equipment when the power is restored.

18.6 If power is going to out for a protracted period and it is not practicable to move to an alternative location, generators should be procured for the site.

18.7 Any installation of a temporary generator should be risk assessed and checked by the Company's Health and Safety Team prior to any use.

Position	Contact Name	Telephone Number
Care Standards Manager	[redacted]	[redacted]

Loss of Water Supply & Local Flooding

18.8 Disruption of clean water supplies to site, for more than 4 hours, would by the nature of the regulated activity undertaken by The Company, requires the implementation of the business continuity plan.

18.9 In the event of flooding it may be necessary to implement the arrangement contained within Sections 6 & 7 of this BCP.

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18.10 In the event of a localised flood due to a failure of the internal or external buildings water supply pipes the stop valve should be shut off.

Water Stop Valve Location:	Norwich	King's Lynn	Snetterton	High Kelling
	[redacted]	Garage Area	First Toilet Cubicle	Trust Facilities

18.11 The affected section(s) of the building should be cordoned off (use the hazard/cordon tape) and work activities will be restricted to areas not affected by the flood.

18.12 If required bulk supplies of bottled water should be provided until such time as the water supply can be restored.

18.13 While the water supply is disrupted, all water should be conserved. Bottled water should be placed at key locations within the building to ensure that hygiene requirements for Infection Prevention and Control (Outcome 8 of CQC Care Guidance) are maintained. These should include:

- Bottled water and disinfectant available in all toilets for flushing;
- Separate Bottled water and soap available at in all toilets for hand hygiene;
- Bottled Water and soap available at all hand basins for hand hygiene;
- Bottled water provided to staff for drinking water.

18.14 For small and localised internal flooding, a contract plumber should be called to repair the fault. Contact;

	Norwich	King's Lynn	Snetterton	High Kelling
Water Supplier:	[redacted]			
Contact Details:	[redacted]			

18.15 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

19. Security

19.1 The Norfolk sites are not manned 24 hours a day but do have a site security alarm system. In some cases, they use CCTV and access control systems as added levels of physical security.

19.2 In the event of the site or building security systems failure contact:

	Norwich	King's Lynn	Snetterton	High Kelling
Security System Supplier:	[redacted]			
Contact Details:	[redacted]			

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19.3 In certain circumstances i.e. receipt of a bomb threat, enhanced physical security measures may need to be taken to ensure site security such as but not limited to:

- Lock and restrict access to buildings (do not compromise any existing evacuations measures);
- Enhanced Physical ID verification of all personnel entering Company premises;
- Restrict and control vehicle access and movement into and around the site.

19.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

20. Personnel

20.1 In the event of a key member(s) of staff being unavailable (due to death, disability, critical illness, illness, accident or injury etc), the sharing or critical knowledge, systems, procedures and documentation should ensure that all routine and essential administrative and management functions can be performed.

20.2 Should further support be required, the following should be contacted:

Position	Name	Telephone Number
Regional Manager	[redacted]	
Head of HR and Training	[redacted]	[redacted]
Managing Director	[redacted]	[redacted]

20.3 Situations may arise where staffing issues may present a significant impact to our ability to run a service to minimum service level required. These situations can be either site based, region based or a national issue. Types of situations where staffing availability can be affected can be:

- Seasonal sickness rates – Flu;
- Healthcare Associated Illness – C-Diff, Nora Virus etc;
- Pandemics;
- Industrial Actions;
- Retention and Recruitment issues.

20.4 Where ERS Medical Operations find that staffing number are or could affect the safe and effective running of the service, they **MUST** escalate internally within ERS Medical as soon as possible.

20.5 The Head of HR and Training will hold responsibility, with the Managing Director for the identification and provision of relief staff from other ERS Medical operations (if available) in order to support and bolster the Norfolk operation.

20.6 All operational support staff **WILL** meet the same training and compliance standards for deployment in support of the Norfolk operation as Norfolk based staff.

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20.7 In addition to sourcing additional staff in support for the Norfolk PTS contract from internal resources, Operations, with the approval of the Strategic Commander (SLT) may also approach the following, for support:

- Approved 3rd party ambulance providers (this can include staff only and staff and ambulance resources) (see note);
- Healthcare agency (ambulance) staff.

20.8 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

Note: 3rd Party Providers must have undergone the ERS Medical Due-Diligence process and have been notified to the [redacted], prior to use.

21. Fire

21.1 Fire will be dealt with in accordance with standard fire procedures as detailed within the buildings fire risk assessment.

21.2 Thereafter the provisions detailed with Sections 6 and 7 of this plan will apply, depending on the nature, type and extent of the fire and the damage caused.

21.3 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

21.4 Where ERS Medical has staff embedded within sites in support contracted local NHS Trusts contract:

- [redacted]
- [redacted]

It will be and remain the responsibility of the respective NHS location to assess the risks associated with flooding and take appropriate control measures and planning to ensure patient, staff and public safety and the continuity of their services.

21.5 ERS Medical will cooperate fully with the respective NHS site in the execution of their control and management of such an event.

21.6 ERS Medical also acknowledges that such an event within such a key stakeholder may require they enactment of our Business Continuity Plan in order to provide suitable and sufficient resources to the Trust to support their aims and objectives.

21.7 It will remain the responsibility of the respective NHS Trusts to notify ERS Medical, through our Operational or Tactical Leads, of the declaration or enactment of their BCP. The Trusts will be responsible for all clinical triaging of patients who require transportation to other facilities and locations, within the specification of the contract.

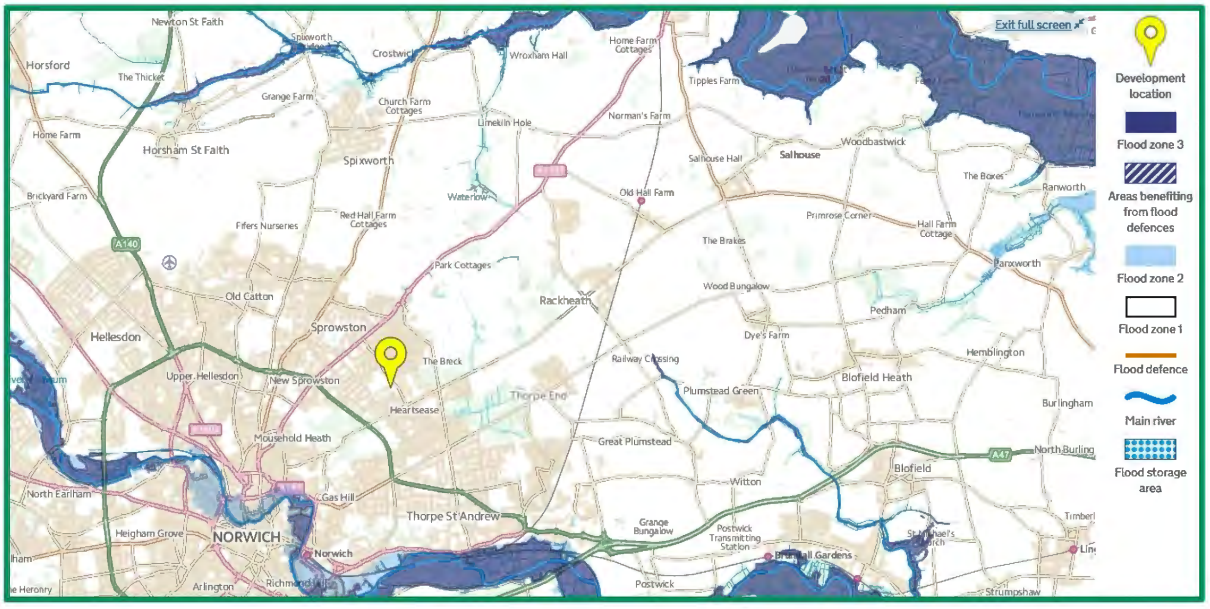
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22. Flooding

22.1 In the event of an external flood, the building will normally be part of a wider externally flooded area and access and egress to the site can either be restricted or totally lost.

22.2 If this is the case the procedures above at Sections 6 & 7 should be followed and in addition, it will be necessary to liaise with the Environment Agency to ensure that the building is hygienically clean in regard to the internal and external site facilities, this will include the supply of clean water and the removal of soiled / foul water.

22.3 The building should not be re-occupied until this has been established and the Regulatory Compliance Team (Environmental and Health and Safety) have deemed the building safe.



Norwich Site Flood Map: Provided from the Environment Agency Website



King's Lynn Site Flood Map: Provided from the Environment Agency Website

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Kelling Site Flood Map: Provided from the Environment Agency Website



Snetterton Site Flood Map: Provided from the Environment Agency Website
https://flood-map-for-planning.service.gov.uk/

22.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

22.5 The King's Lynn site has been assessed as being likely to suffer from flooding. The other sites are not assessed as being in direct of flooding themselves. However, given the geographical area of Norfolk and a history of floods caused by the convergence of spring tides and storms there remains a significant risk of floods affecting service delivery through compromises to local infrastructure.

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22.6 In addition to this is also a risk that such flood could significantly affect other healthcare providers and result in assistance being required to move significant service users from other locations such as, but not limited to:

- NHS Acute and Community Hospitals and Facilities;
- Private Care & Nursing homes;
- Private homes and accommodation for the elderly and vulnerable.

22.7 This request for assistance may come direct from the any of the below organisations and should be coordinated both through ERS Medical and the Norwich CCG:

- Norfolk Police;
- The East of England Ambulance Service NHS Trust;
- The Norfolk Fire Service;
- HM Coastguard;
- The Norfolk County Council;
- Local and Parish Councils.

22.8 ERS Medical will cooperate fully with the respective NHS, private and other government departments when such an event occurs.

23. Supply Chain

23.1 Alternative approved suppliers are detailed within the remit of the Finance Team on the Approved Suppliers List (ASL).

23.2 To add a supplier to the ASL list follow the procedures contained within **BMS/4.01** – Purchasing.

23.3 Where a single supplier exists (e.g. BOC for Oxygen and Entonox) and the supplier is unable to provide the required supplies as expected, arrangements must be made with other stockholders in the local area.

23.4 If the site experiences any difficulties with suppliers, they should in the first instance make contact with the supplier and try and identify what the issues are and resolve them.

23.5 If the issues persist and has or the potential to or has begun to affect the ability of the site to maintain its normal levels of service, contact should be made with the Company's Procurement Team so that they can take the appropriate steps to resolve the issue.

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23.6 These steps may include but not be limited to:

- Working with the supplier to help resolve the issue;
- Issue a warning to the supplier to improve the provision of goods or services;
- Bring on line additional suppliers of goods and services from the ASL as either a temporary measure or on a more permanent basis;
- Redistribute resources i.e. products held at other Company locations to rapidly support the site;
- Terminate the relationship with the supplier causing disruptions to service.

23.7 In addition to these measures ERS Medical, will where required and appropriate conduct due-diligence audits on 3rd party providers and obtain details of their emergency planning measures.

23.8 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

24. Post, Courier and Delivery Services

24.1 In the event that normal post and or courier / delivery service is unavailable, or disruption, invoices and correspondence will be emailed where appropriate.

24.2 If emails are not appropriate then mail will either be hand delivered or the Company will call upon its own Mail and Courier Service or commission a 3rd party approved through the ASL, to deliver its mail.

24.3 If deemed necessary have all site mail and deliveries redirected to one of the other local sites or in extreme circumstances either the site in [redacted].

24.4 Contact should be made with the above address to inform them of this action and to ensure that all site mail, when received is separated for collection or delivery to any alternate site location. This action should be recorded on **F5.04.16 – BC Log Sheet**.

24.5 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

25. Adverse Weather

25.1 There is usually significant notice given with regard to adverse weather conditions that may affect Business Continuity. Notifications can come from news bulletins, weather warnings issued by the Met Office and from colleagues.

25.2 Liaisons will be made to the local police county and district councils to keep informed about the status of local road conditions.

25.3 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet.**

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25.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

26. Bomb Threat

26.1 The threat of terrorism or a bomb has the potential to cause serious disruption to the delivery of the services provided by the Company and significant anxiety for staff.

26.2 In the event of the Company receiving a bomb threat the procedures contained within **F5.04.23** – Bomb Threat Alert procedures will be followed and adhered to and a **F5.04.24** – Bomb Threat Alert From will be completed and actioned accordingly.

26.3 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

26.4 Where ERS Medical has staff embedded within sites in support of contracted services, such as

- [redacted]
- [redacted].

It will be and remain the responsibility of the respective NHS location to assess the risks associated with receiving a bomb threat and take appropriate control measures and planning to ensure patient, staff and public safety and the continuity of their services.

26.5 ERS Medical will cooperate fully with the respective NHS site in the execution of their control and management of such an event.

26.6 ERS Medical also acknowledges that such an event within such a key stakeholder may require they enactment of our Business Continuity Plan in order to provide suitable and sufficient resources to the Trust to support their aims and objectives.

27. Terrorist Attack

27.1 In the event of terrorist attack in Norfolk and potentially a much wider effected area, ERS Medical acknowledges that main arterial transport routes may become severely congested, which in turn may impact on the service it provides to the Trusts and the ability of the Trusts to manage its resources in response to expected casualties.

27.2 It will remain the responsibility of the Trusts to communicate to ERS Medical, in a timely fashion, any changes or cancellations to planned transportation due to the Trust cancelling clinics in order to free up resources to better manage the emergency situation.

27.3 It may also be necessary to respond to specific requests from Trusts, if they declare a major incident, when they become directly or indirectly affected by the terrorist incident. This may mean the rapid relocation of low acuity patients from one NHS location to another, to free up acute bed spaces.

27.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

27.5 Where ERS Medical has staff embedded within sites in support of contracted services, such as

- [redacted]
- [redacted].

27.6 It will be and remain the responsibility of the respective NHS location to assess the risks associated with a terrorist attack and take appropriate control measures and planning to ensure patient, staff and public safety and the continuity of their services.

27.7 ERS Medical will cooperate fully with the respective NHS site in the execution of their control and management of such an event.

27.8 ERS Medical also acknowledges that such an event within such a key stakeholder may require they enactment of our Business Continuity Plan in order to provide suitable and sufficient resources to the Trust to support their aims and objectives.

27.9 ERS Medical also acknowledges that it may require the relocation of its Tactical Lead to a Trust location to ensure robust communication and cooperation with the Trusts internal emergency incident management.

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28. Emergency Preparedness Resilience Response

EPPR Section

[redacted] NHS Foundation Trust

NHS [redacted] NHS Foundation Trust

CCGS Approved Requirement Statement for [redacted]:

Expected support from ERS for providers such as [redacted] or [redacted], commissioners have advised that they would expect ERS to offer support should any of those Trusts be part of a major incident and that their own NEPTS provider could not support the level of demand that may be associated with this. That ERS may also be approached if there was a lack of NEPTS capacity within those local areas.

29. External Major Incident or Business Continuity Event Called by:

[redacted]

28.1 When the [redacted] declares either a Major Incident or activation of their internal Business Continuity Plan, they will communicate this initially to ERS Medical, through the Site Operations Team, in 1 of 4 ways:

1. The will notify the ERS Medical embedded liaison staff to communicate this direct to the Norwich site Management Team;
2. They will call ERS Medical direct at the Norwich Despatch / Control Room to notify the Norwich Site Management Team;
3. They will call the Norwich Management Team Direct;
4. The will call the CCO in Leeds and request that the Norwich Management Team are informed immediately.

28.2 Once a Major Incident or Business Continuity event has been reported to ERS Medical, it will remain the responsibility of the Trust to communicate the measures that they are enacting within their own pre-defined plans.

28.3 This may require a total or partial cancellation of all currently planned PTS journeys into and out of the Trust. The Trust will be responsible for communicating this detail to ERS Medical i.e. what patients or what clinics have been affected if any.

28.4 If there is a cancellation of planned journeys into and out of the Trust, ERS Medical will deploy ambulance resources to the Trust is a tiered approach. This tiered approach will be as follows:

- **Tier 1**: All present crewed and un-assigned ambulances, planned to work for [redacted] patients will immediately deploy to the Trust site (*see Map and notes*);
- **Tier 2**: All currently loaded in-bound vehicles will be contacted and informed to return all identified patients back to the collection addresses. The NNUH will contact them to re-arrange their appointments. ERS Medical staff **MUST NOT** enter into speculation as the reason for the cancellation or make comment upon this to either the patients, the patients carers, NOK or on Social Media or to the media direct if so contacted;
- **Tier 3**: All staff who report for duty after the declaration will initially be held back at Sapphire House, Snetterton or High Kelling, until such time as they are needed or if unaffected by the incident, will be instructed to continue as normal.

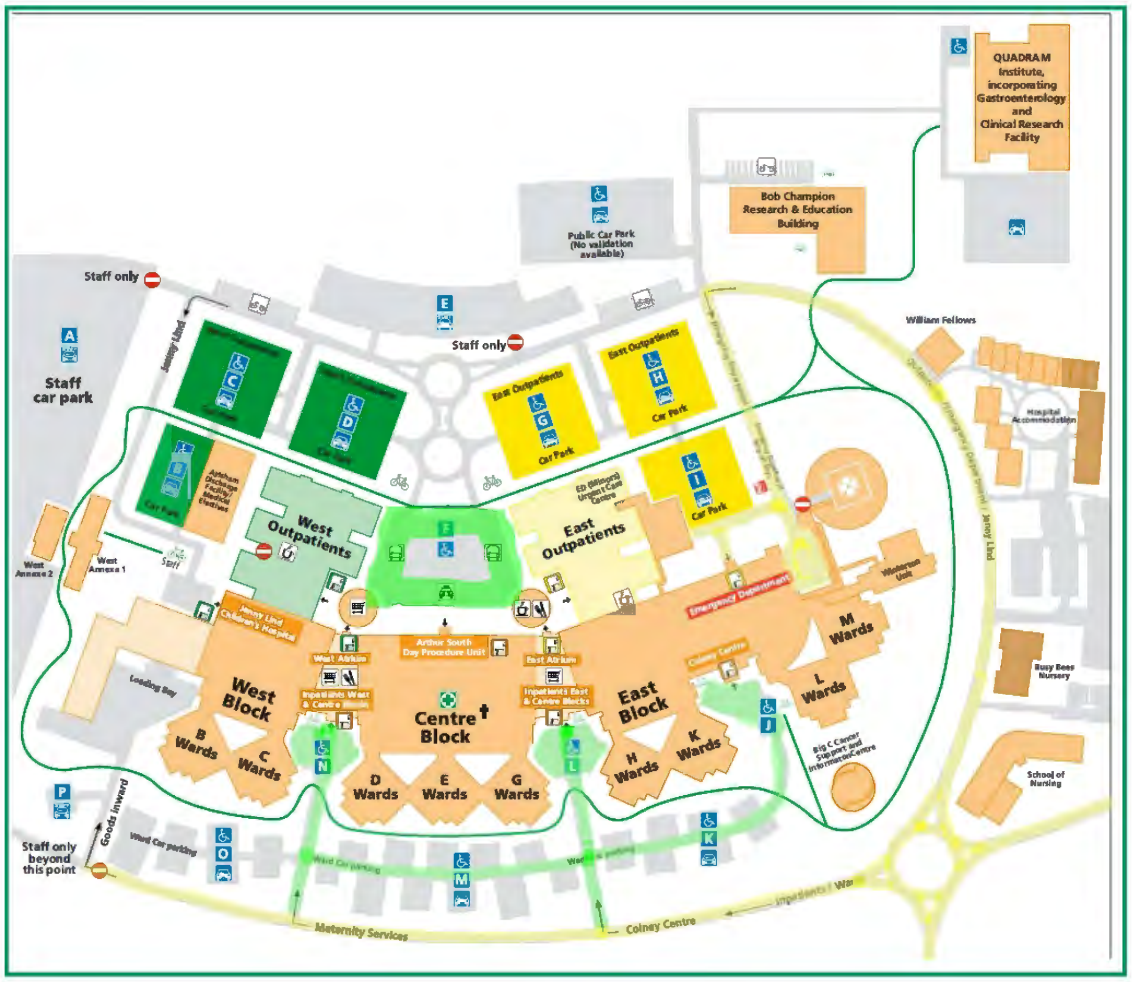
28.5 Under **NO** circumstances should ERS Medical staff make a statement to anyone including the press about the nature of this incident. It will remain the responsibility of the Trusts Communications Team to address this subject.

Deployment to the [redacted]

28.6 When deploying to the [redacted] ERS Medical staff must park their vehicles primarily in the normal locations but can expect some level of disruption depending on the nature or the incident.

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28.7 They must NOT under any circumstances park in and around the A&E Department or any of the approach roads to this area. These must be kept clear for the East of England Ambulance Service and other emergency services as required.



- The Yellow shaded areas MUST be kept clear for emergency services access and egress to the [redacted] site.

- The Green areas are where ERS Medical vehicles may park for all tiers.

28.8 On arrival at the [redacted] all ERS Medical crews must report to the ERS desk situated within the Centre Block. From here the [redacted] Operations team will coordinate all transport requirements.

28.9 It may be necessary for one of the Norfolk Operation Leads (Operations Managers) to deploy to the NNUH and assist in the coordination of ERS Medical resources during this period. This request will be explicit from the [redacted] at the point they declare either a major incident or enact the business continuity plan.

[redacted]

28.10 [redacted]

28.11 [redacted]

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30. BC Situation Calls and Reports

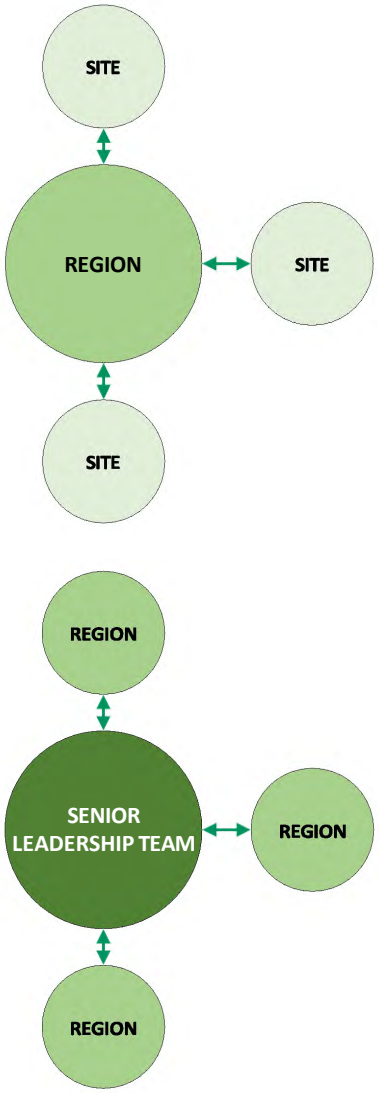
29.1 In the event of a BC event, such as but not limited to 'Adverse Weather', it may become necessary for sites and regions to stage daily BC situation calls.

29.2 The necessity for these calls will be determined at a regional level, by the Regional Manager, who will notify all sites, within his/her region of the call details.

29.3 Sites will formulate their reports for these calls using **F5.04.32 – BC Situation Report Form**. These must be completed prior to the call.

29.4 If the BC event affects more than 1 region, it may be necessary for these calls to be centralised and coordinated by the Managing Director or a member of the Senior Leadership Team. In these instances, the Regional Manager is to coordinate his site reports into a single report, which again will be documented on **F5.04.32 – BC Situation Report Form**.

29.5 All **F5.04.32 – BC Situation Report Forms** must be retained at Region and Site for the purpose of audit and inspection.



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31. BC Recovery

30.1 The On-Call Senior Manager and or Strategic Lead will discuss with other SMT members when to decide a BCE has finished, which may be long after the emergency or support services response is over.

30.2 It may be necessary, before this decision has been taken, to form a strategic group to be tasked with the recovery of routine business. This group will be formed and led by a member of the SMT and or a nominated deputy.

30.3 Alternatively, to, or in conjunction with the formation of this group, recovery tasks will need to be decided and may be delegated for completion (**F5.04.18** – BC Recovery Action Delegation & **F5.04.18** – BC Recovery Action Delegation Summary forms may be used to facilitate this).

30.4 If there are problems encountered when attempting the below detailed actions, use the contacts detailed within the various sections of the Business Continuity Plan to help resolve these problems:

- Conduct an initial survey of the site to determine its suitability for re-occupation. Assistance from the Regulatory Compliance Team will be essential during this process;
- Senior Management will make arrangements for the relocating, rebuilding, cleaning, replacement of equipment;
- Staff will be notified of the relocation, including the cancellation of any designated alternate location;
- Ensure that Company and personal property is removed from any alternate facility;
- Ensure that any alternate facility is left in a condition to which it was originally occupied;
- Re-open the site and its car parks removing any signage or cordon tape that was put in place for the management of the BCE;
- Turn electricity and water supplies back on (when informed it is safe to do so);
- Cancel all telephone diverts when the phone system is confirmed as being up and running;
- Transfer all Company vehicles back to the site;
- Switch on all required equipment (computers, printers, telephone and communications equipment);
- Ensure that all removed Company documentation that was removed the site if returned;
- Return / Replace any equipment or supplies as needed;
- Restock and sign off the contents of the BCE Control Box;
- Contact Royal Mail (if applicable) and arrange for mail to be delivered normally;
- Senior Managers and HR will conduct a staff analysis to ensure that staffing levels remain appropriate to the site operational activities;
- Communication from the SMT to acknowledge the efforts of staff during this period (feedback from the BCE may be used as part of this process);

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- Welfare of staff and their families and bereavement services affecting or involving Company staff will be managed through the HR department;
- Where services have been prioritised the SMT will review and decide how to redistribute resource levels in order to resume normal operations;
- Annual performance KPI's may be analysed to determine the effect the BCE may have had on them;
- Financial implications, remunerations and commissioning agreements will be analysed and determined by the SMT;
- Long term issues as a result of the BCE will be addressed by the SMT accordingly;
- Legal advice may be sought, when necessary, to provide counsel and aide and support the Company's preparations with regard to any public, criminal or other inquiry;
- All logs, records and other details need to be kept and retained by the Head of Care Standards;
- The SMT will debrief the BCE in full to highlight learning points and successes of the Business Continuity Plan.

30.5 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

32. BC Stand Down

31.1 A BCE footing may continue for many hours or days after the initial BCE and scene have been cleared. The decision to stand down resources will rest with the On-Call Senior Manger.

31.2 The Stand Down process is gradual and the On-Call Senior Manager will ensure that appropriate steps are taken, such as:

- Notification to all staff of the Stand Down;
- Re-Stock of Clinical Supplies;
- Complete any reports or forms and submit these to the Head of Care Standards;
- Hot de-brief with staff, providing them with an opportunity to voice any concerns and gauge their immediate reactions to the effectiveness of the Business Continuity Plan and its implementation.

31.3 As no further response action to the BCE are anticipated or required **F5.04.03** – BC Post Site Recovery Plans are initiated at this point and expected to thereafter manage the situation back to recovery with assistance and support of the Emergency Control Centre (if activated).

31.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

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33. Employee Welfare

32.1 An emergency situation is a stressful time and staff may be called upon unexpectedly to come into work and may on occasion be asked to work in unfamiliar environments for possible extended periods of time.

32.2 The Company will do everything within its power to support its staff during this time and guidance can be found by either contacting the HR department or **BMS/2.03 – Employee Health and Wellbeing**.

32.3 During a BCE and afterwards, it is vital that staff consider their own, their colleagues and their patient's welfare and ensure that they are not placed in any unnecessary risk of harm.

32.4 When called upon to assist in an emergency, there are a number of key actions that they should consider before responding:

- Notify their family, partner or significant other that they are involved in the emergency and provide them with a contact number should they need to make contact with them;
- Keep regular contact with their family, partner or significant other, updating them on their welfare but not disclosing sensitive information about the BCE;
- They should advise their family, partner or significant other not to speak to the media;
- Ensure that they have money, debit cards, car keys, house keys, mobile phone & charger with them;
- They may want to take an overnight kit with them (depending on the nature of the BCE);
- Make suitable arrangements for the care of their children, elderly relatives and pets if necessary;
- Ensure that they have a suitable supply of any medications they are taking;
- They should NOT give out their address to anyone outside of the Company except for the Police;
- Ensure that they re-arrange any appointments they have arranged (unless they are of an urgent medical nature);
- Not to work for any longer than 8 -12 hours without a suitable rest period.

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Question 1.24.1

Business Continuity arrangements

Please set out your Business continuity arrangements

We have attached our Business Continuity plan for our Head office and Leeds operational service. During the mobilisation we would develop a bespoke BCP for the Staffordshire contract.

Our Business Continuity Plan sets out how critical business activities will be maintained in the event of any incident/disruption that threatens delivery of core business and organisational priorities. This plan is aligned with ISO-22301 and 22313 and mirrors the requirements of the NHS England's Core Assessment Standards for Emergency Planning Resilience and Response. ERS Medical is also an active partner within local Healthcare Resilience Partnership Working Groups in the East of England.

Executive leadership

We have a defined management structure that supports our business continuity plan and includes clear lines of leadership and accountability within the gold-silver-bronze command structure.

- Gold (Strategic) call – *** REDACTED ***, Managing Director & Senior Leadership Team
- Silver (Tactical) call – Senior Operations and Operational Managers
- Bronze (Operational) call – Team Leaders

Contract Staffing

To ensure we continually have the required number of crews to deliver an effective, safe and efficient NEPTS service we maintain;

- A local/national team of 500 bank staff
- Cross-trained staff that can be deployed to cover all service aspects
- A regional crew network that has the capability to surge where required e.g. Nottingham, Mansfield, Leeds
- Additional administrative staff that can be provided from local, regional or national operational sites
- All systems are cloud based enabling management of a contract from any of our bases.

Vehicles

In the event of breakdown or road traffic accident whilst conveying patients we immediately deploy a replacement vehicle and crew and notify the Authority of the forecast arrival time, which will normally be within the hour. We also have National arrangements in place with the RAC for 24-hour recovery and breakdown assistance across our whole fleet.

We have a contractual relationship with a leading ambulance hire company that can provide resilience vehicles in under four hours.

We have also included within our tender submission a 10% resource resilience that can be called upon when required.

Severe Weather

In the event of severe weather, the Operations Manager will identify staff living closer to operational sites to work over critical periods. We implement the following initiatives:

- Vehicles deployed around the operational area, ensuring they are close to point of use
- The local management team work closely with nominated Authority Officers to determine revised operational requirements if necessary
- Support the Trust with patient communication. Essential journeys are identified, and close attention paid to ensuring these are completed
- ERS works in partnership with NHS England – Emergency Preparedness Resilience Response (EPRR) and therefore has access to 4-wheel drive vehicles allocated on a priority basis.

During the winter months and in periods when severe weather is forecast our vehicles are equipped to ensure they are best prepared for the weather and any delays that may occur. Our severe weather emergency kit includes;

- Jump leads
- Ice scraper and de-icer
- Torch
- Shovel
- Salt
- Additional blankets
- Snow tyres

During these periods we also have additional preparedness checks as part of the driver's daily checks these include checking antifreeze is topped up, correct weather-related tyre pressure, wiper blades in good repair, etc.

Major Incident

Obligations under EPRR are recognised and embraced. To ensure continued compliance ERS engages in NHS or multi-agency emergency preparedness exercises annually as required. Our Major Incident plan is available for review by the Trust.

ERS's escalation plan is fully maintained and operational 24/7. Escalation can start at any point in the business therefore we maintain clear lines of communication to ensure that the correct authority point can be reached in a timely and efficient manner. This includes the Managing Director and Board Members if necessary.

Telecommunications

Facilities are established with full network resilience within compliant environments. In the event of failure of telephone capability at any of our sites we will divert the contact centre to another suitable number. Full details in section 14 of our attached BCP.

IT

ERS utilise a centralised UK data centre environment for all their servers, provided by *** REDACTED ***.

The data centre has 24x7 365 days support service backed with predefined SLA's. The servers are supported by Solve-IT, our IT Technology Partner, who works in conjunction with *** REDACTED *** to support the whole data centre environment on a 24/7 basis.

*** REDACTED *** proactively manage our entire IT environment, looking after our local networks and Internet Infrastructure, mobile PDA platform, workstations, servers, cloud-based phone system and all offsite full image backup's and endpoint security, *** REDACTED *** enable us to ensure we have the highest available up-time.

Pandemic Flu

We will work with the Trust to ensure our plan is compatible with pandemic flu contingency plans. We will:

- Test our plan to ensure solutions documented in BCP meet the business recovery/continuity requirements
- Keep our BCP current and our employees/business resilient, by regular testing schedules
- Resolve problems and determine cause
- Repeat the test with resolutions in place to determine if it is effective in eliminating the problem

Covid-19

Since the COVID-19 outbreak, policies that were currently in place have been checked and altered to align with new government guidelines. We have adhered to the requirements stipulated in the guidance to Ambulance Trusts issued by Public Health England.

Using Care Quality Memos, ERS has been able to keep crews up to date with the latest information about how to prepare their vehicle and themselves from the countless issues raised by the pandemic.

During the peak of the pandemic, we held daily operations and compliance calls with all management staff to ensure that all of our employees were up to date with the latest information during a constantly changing period. ERS Medical also used Microsoft Teams to conduct over 20 site meetings, where road and support staff where able to ask questions and address concerns and anxieties about COVID-19 direct with all the members of the Senior Leadership Team. NHS England recognised this as innovative practice and invited ERS Medical to present to a lessons learnt review of Patient Transport Providers it ran.

Stock Management

The COVID pandemic outlined the importance of maintaining adequate stock levels and to ensure our supplies were maintained we implemented a dedicated stock management strategy, creating a

central hub for fulfilment and distribution to our 19 operational sites across the UK. This enabled us to continue to provide safe and effective services to all of our customers during the pandemics peak.

Effectiveness/Testing

As part of our business continuity plans all sites regularly carry out tabletop exercises and the results of which are recorded on *** REDACTED *** and reviewed by our Head of Care Standards who will provide feedback and improvement planning reports.

By continually testing the effectiveness of our BCP we are able to ensure that when it is required to be put in place, we can give our customers confidence that it will work. An example of this is when, in March 2018, the 'Beast from the East' caused major disruption in East Anglia and throughout the country. Not only were we able to maintain our service delivery to our customers, but we also mobilised a new Courier contract in Ipswich.

IMAGE REDACTED

Risk register

Risk can be identified using various techniques and tools such as:

- Audit and Inspection Reports via *** REDACTED ***
- Trend identification through regular Audits
- Experience
- Discussions with Stakeholders
- Interviews
- Post Incident Reports and Investigations
- Risk Identification Checklists
- Employee and or External Feedback
- Strategic and Business Plans
- Surveys and Questionnaires

Once identified risks are managed using our incident reporting system and our online Risk Register, *** REDACTED ***, which is accessible to all employees to record any serious issues that may impact on patient care, service delivery or the business as a whole.

Business Impact Assessment (BIA) is a process used by ERS to analyse its activities at each location and to establish and understand the effect that a business disruption might have upon them. A work instruction has been devised and implemented, which defines the process to be followed.

Event	Risk	likelihood	Impact	Mitigation
Staff	Med	Med	Severe	Bank staff and trained resource available at other locations

Vehicles	Med	Low	Med	Leasing agreement in place and a Nationwide fleet of 400 vehicles
Weather	Med	Low	Med	Communication with Trusts
Major Incident	Med	Low	Severe	Will assist Trusts where possible
Telecoms	Low	Low	Med	Plans in place for alternatives
IT	Low	Low	Severe	Plans in place for alternatives
Pandemic	Med	Low	Severe	Align ourselves with the CCGs plan

For each activity identified at a location, a BIA will be completed by the Business Continuity subject matter expert, which identifies the following information:

- Site / Service Information
- Specific Employee Numbers and Site Location
- Stakeholders and Dependencies
- Critical Service Function
- Impact Assessment
- Recovery of Service
- Recovery of Service Resource Requirements
- If an Objective and Target is required

Once completed, these documents are uploaded to the BIA Register within the Business Continuity section of the Safety, Health & Compliance page on SharePoint.

ERS Medical

BC Exercise Planner

Location:	[redacted]	Period:	2019

Exercise Type:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Financial (Loss of financial services and support)												X
Health, Safety and Environment (Breach of HSWA 1974)											X	
Information Services (Information service disruption)										X		
Legislative & Regulatory (Breach of legislative or regulatory requirement)									X			
Staffing (Loss of staff)	X							X				
Supply Chain Issues		X										
Fleet Issues (Loss of vehicles, fleet services / maintenance)			X									
Loss of site facilities (Flood, Fire and or loss of utilities / access / egress)				X								
Act of Terrorism					X							
Bomb Threat						X						
NHS Major Incident							X					

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BMS/5.04 Business Continuity & EPRR Plans

Document Author:	***REDACTED***		Head of Care Standards		
Document Owner:	***REDACTED***		Managing Director		
Version:	3.0	**Date Active:**	30.08.2019	**Review Date:**	31.08.2020

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Revision No.	**Section / Paragraph / Page No.**			**Date**	**Amended By**	**Comments**
1.1	2	All	4	20.03.18	***REDACTED***	Addition of F5.04.29 and F5.04.30
2.0	All	All	All	01.08.18	***REDACTED***	Annual Review
2.1	2	All	4	27.11.18	***REDACTED***	Addition of F5.04.31 Action Card
3.0	All	All	All	30.08.19	***REDACTED***	Annual Review

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2. Related Documents

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Action Plans	BMS/1.04
Personal Development and Training	BMS/2.02
Emergency Preparedness and Response	BMS/5.01
Incident Reporting and Investigation	BMS/5.02
Major Incident Investigations	BMS/5.03
Business Impact Analysis (BIA)	WI/1.07.02
Business Continuity Risk Assessment (BCRA)	WI/1.07.03
BC Plan Site Data Capture Form	F5.04.01
Business Continuity Plan	F5.04.02
BC Post Site Recovery Plan	F5.04.03
Building Plan Drawing	F5.04.04
BC Call-Out Log	F5.04.05
BC Cascade Communications Poster	F5.04.06
BC Action Delegation	F5.04.07
BC Action Delegation Summary	F5.04.08
BC Alert Form	F5.04.09
BC Media Calls Report Form	F5.04.10
BC Media Holding Statement	F5.04.11
BC Message Form	F5.04.12
BC Response Checklist	F5.04.13
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BC Log Sheet	F5.04.16
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BC Staff Contacts Sheet	F5.04.22
BC Guidance on Bomb Threat Procedures	F5.04.23
BC Bomb Threat Alert Form	F5.04.24
BC Exercise Test Record	F5.04.25
BC Exercise Planner	F5.04.26
BC Asset Form	F5.04.27
Business Continuity Competency Matrix	F5.04.28
Site Emergency Plan	F5.04.29
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3. Purpose of Procedure

3.1 To ensure a single procedure is defined and utilised at all locations within the Company that provides instruction and guidance to personnel on the devising of an appropriate business continuity and recovery plan.

3.2 To provide clear instruction to personnel on the steps to be taken in response to a Business Continuity Event (BCE) at Company and/or customer premises.

3.3 To define the responsibilities of personnel in relation to business continuity and recovery plans, ensuring consistency is achieved throughout the Company.

4. Scope and Application

4.1 This procedure applies to all Company sites and employees.

4.2 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the Company's Capability and Disciplinary procedures.

5. Policy Statement

5.1 Please refer to the Company's Quality, Environmental, Safety and Health Policy.

5.2 Please refer to the Company's Business Continuity Policy.

5.3 Please refer to the Company's Information Security Policy.

6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety & health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Leadership Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
6.3	**Head of Care Standards**	Is responsible for developing, co-ordinating and implementing quality, environmental, safety & health, business continuity and information security policy, procedures and work instructions. Is responsible for producing business continuity and recovery plans for all Company locations and for communicating the findings to local as well as the Senior Management / Leadership Teams. Additionally, responsible for undertaking the monitoring and review of completed plans, adherence to the testing schedule and any activations.
6.4	**S.I.R.O.**	Are responsible for producing information security risk assessments based on all information assets held by the company at all locations and for communicating the findings to local as well as the Senior Management / Leadership Teams.
6.5	**Health and Safety Managers / Advisors**	Are responsible for producing health and safety risk assessments for all activities undertaken by the Company at all locations and for communicating the findings to local as well as the Senior Management / Leadership Teams.
6.6	**Regional & Operations Managers**	Are responsible for ensuring that all business continuity and recovery plans are present, trained out to employees and tested at the locations or areas for which they are responsible and for communicating the findings to their teams and the BMS Managers. Are additionally responsible for enacting these plans in the event that a BCE occurs.
6.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Activity** – Process or set of processes undertaken by the Company (or on its behalf) that produces or supports one of more of its services.

7.2 **Business Continuity** – Capability of the organisation to continue delivery of products or services at acceptable predefined levels following disruptive incident.

7.3 **Business Continuity Event (BCE)** – An occurrence or change of a particular set of circumstances, such as an event, which can be one or more and have several causes. An event can also consist of something not happening, which causes a failing in operational delivery. It is sometimes also referred to as an incident or accident, but for the purposes of the Business Continuity Plan, will be referred to as either a BC Event or BCE.

7.4 **Business Continuity Management System (BCMS)** – Part of the overall management system that establishes implements, operates, monitors, reviews, maintains and improves business continuity.

7.5 **Business Continuity Plan (BCP)** – Documented procedures that guide staff to respond recover and restore, to a predefined level the capability and enable the Company to maintain its services and operations, during and following a business continuity event.

7.6 **Business Continuity Risk Assessments (BCRA)** – The process of identification and analysing business continuity risks, arising from a hazard, taking into account any existing control measures and deciding whether or not the residual risks are acceptable.

7.7 **Business Impact Analysis (BIA)** – Process of analysing activities and the effect that a business disruption might have upon them.

7.8 **Exercise** – Is a process to train for, assess, practice and improve within the Company.

7.9 **Interested Party / Stakeholder** – Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.

7.10 **Strategic Lead** – For the purposes of business continuity strategic lead will denote the Senior Management / Leadership Team.

7.11 **Tactical Lead** – For the purposes of business continuity the term tactical lead will denote the District or Compliance Manager responsible for the specific site.

7.12 **Operational Lead** – For the purposes of business continuity the term operational lead will denote either the General or Operations Manager or the Compliance Advisor for the specific site.

7.13 **Requirement** – need or expectation that is stated, generally implied or obligatory.

7.14 **Resources** – All assets, people, skills, information, technology (including plant and equipment), premises and supplies and information (whether electronic or not) that the Company has available to use, when needed, in order to operate and meets its objectives.

7.15 **Risk** – Combination of the impact of an event and the associated likelihood.

7.16 **Risk Assessment** – Overall process of risk identification, risk analysis and risk evaluation.

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7.17 **Risk Management** – Co-ordinated activities to direct and control an organisation with regard to risk.

7.18 **Testing** – Procedure for evaluation; a means of determining the presence, quality, or veracity of something.

8. Introduction and General Guidance

8.1 It is vital that the Company has plans in place for business continuity purposes, to ensure that appropriate actions are taken in a timely manner to ensure the recovery of normal service.

8.2 This procedure lays out the processes to be followed for the creation, implementation and testing of plans to be enacted if an event occurs which has the potential to effect the Company's business continuity and its normal service delivery levels.

8.3 Form **F5.04.02 – Business Continuity Plan** and associated forms, have been developed to allow each Company facility to document a site specific plan to achieve this goal.

8.4 Prior to the writing of any Company site Business Continuity Plan (BCP) the BMS Manager should make contact with the General / Operations / Site / Line Managers at the facility and issue them with a copy of **F5.04.01 – BC Plan Site Data Capture Form** template to complete.

8.5 The General / Operations / Site / Line Managers will then populate **F5.04.01** with the required information and once completed, should then return the document to the BMS Manager, who will review the information and if acceptable transfer it to the site specific **F5.04.02.**

8.6 As part of this process the site will have their business activity analysed and assessed for the potential impacts, risks and existing control measure for their normal service delivery.

8.7 This analysis and assessment will be conducted by the BMS Manager in accordance with **BMS/1.07 – Risk Management**, and specifically **WI/1.07.02 – Business Impact Analysis (BIA)** and **WI/1.07.03 – Business Continuity Risk Assessment (BCRA)**.

8.8 Section 4 -of the BCP (Business Continuity Impact Assessment Summary) will take the following from the sites **F1.07.02 – Business Impact Analysis (BIA)** in order to provide both an indication and justification for the prioritisation of service delivery:

- Service Activity;
- Aggregate Priority Impact Score;
- Most Significant Impact Rating.

8.9 The formal writing of the BCP will only occur after these stages are completed and will be co-ordinated by the BMS Manager in conjunction with operational personnel and any other appropriate stakeholders.

8.10 At each stage of this process, the necessary reviews and authorisations must take be completed and only once fully signed off, can the final plan be issued to the site and the Business Continuity section of Steripoint.

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8.11 The following sections of this procedure provide an overview to the content, general guidance and additionally (where appropriate) the information necessary to complete **F5.04.02 – Business Continuity Plan**.

9. Site Location Maps and Building Plan Drawing

9.1 After the initial site data has been entered into the **F5.04.02** (Sections 1 to 4) a site location map should be created and recorded at Section 5 – Location Map.

9.2 In addition to this a detailed buildings plan should be made, highlighting essential business continuity resources, covered in the BCP. This should be documented on **F5.04.04 - Building Plan Drawing**.

9.3 The building plan should include, but not be limited to;

- Fire Doors and Clearways;
- Fire Extinguishers
- Room and Use Identification;
- Mains Water Isolation;
- Electricity Isolation;
- Gas Isolation;
- Waste Facilities;
- IT Equipment Locations, (including Server Location).

10. Immediate BC Response

10.1 This will detail the initial actions required if a Business Continuity Event (BCE) or BC Stand-by is declared that either immediately effects routine activity or has the potential to escalate to a position where this is likely.

10.2 Within this scope it will detail, but may not be limited to;

- The sites Operational Leads declaring a BCE or BC Stand-by;
- The notification, by the Operational Lead to the Tactical Lead, of the BCE or BC Stand-by;

10.3 The notification of a BCE or BC Stand-by should be recorded on **F5.04.08 – BC Alert Form**.

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11. Buildings and Facilities

11.1 In the event that the access, egress and use of Company premises become compromised the Operational Lead should immediately enact the site BCP and follow the guidance provided at Section 7 of the BCP.

11.2 This will include, but not be limited to:

- Conducting an initial survey, only if safe to do so, to ascertain if the loss of access, egress and use will be short or longer term. This should also include an initial estimate on how this will effect normal activities at the site;
- Make contact with the Head of Property & Facilities so that the premises landlord can be officially notified if not already aware.
- Attempt, if practicable to identify other local facilities that could be used as an alternate location for the duration of the BCE.
- Isolate power and water supplies if safe to do so and appropriate at this time;
- Liaise with any emergency services or local agencies as required;
- Ensure that access to the site is controlled and communicated to all employees, with information for any alternate locations;
- Begin the process, if safe to do so and appropriate, of removing essential resources from the site as required and identified by the BIA and BCP.

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12. Establishing a BC Control Centre and Notifying Stakeholders

12.1 Once a BCE has been declared and upon the loss of the local Company premises, either short or long term, a BCE control centre will need to be identified and established.

12.2 The identification of the BCE control centre will follow the same process as defined at Section 9.13 of this procedure and Section 7 of the BCP.

12.3 The BC control centre will provide facilities to enable Company management to manage the ongoing BCE and put into place suitable resources to enable the recovery plan to be enacted and allow normal business activity to be resumed within a reasonable timeframe, dependent upon the nature and type of the BCE.

12.4 As part of BC plan all sites are required to have at least x1 Business Continuity Control Box and for larger more dispersed sites more than 1 may be required.

12.5 The Operational Lead is responsible for ensuring that the Business Continuity Control Boxes are present, stocked in accordance with **F5.04.14 – BC Control Box** and are checked at least once per month which should be recorded on **F5.04.15 – BC Control Box Check Sheet**.

12.6 Further to this they are also responsible for ensuring that all site BC Control Boxes are removed from site and transported to the BCE Control Centre.

12.7 The contents of the BC Control Box will include, but not be limited to:

- The latest version of the site **F5.04.02 – Business Continuity Plan**;
- The latest version of the Head Office Business Continuity Plan, which is available on SteriPoint;
- Hazard / Cordon Tape (x2 rolls);
- Torches with Spare Batteries (x2);
- A Clip Board;
- Marker Pens;
- Plain A4 Paper;
- Sellotape.

Immediate Communication Issues

12.8 The BCP covers immediate issues with communication with:

- Emergency Services;
- Staff who were either not present at the time of the BCE at site;
- All relevant stakeholder and interested parties to the Company's work activities;
- Company Insurers.

12.9 The contact details for these parties should be can be found within the BCP itself or in more detailed form by completing forms **F5.04.21 – Key Contacts Sheet** and **F5.04.22 – Staff Key Contact Sheet.**

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Notifying Stakeholders

12.10 It may be necessary during a BCE for Company stakeholders to be notified. The decision to do so must come from the Strategic Lead.

12.11 The Strategic Lead may wish to delegate the responsibility for making contact with these stakeholders and is all such occasions this decision and a record of any communications made with stakeholders, should be recorded on **F5.04.16 – BC Log Sheet**.

12.12 The most important Stakeholders can be recorded directly within the BCP and others can be found on either the **F5.04.21** or **F5.04.22**.

12.13 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

13. Media Contact

13.1 During the course of a BCE there may be occasions where either local or national media make enquiries with the local site.

13.2 All Managers should direct media enquiries through the Company Head Office (in Leeds) to the Senior Management Team.

13.3 Strategic and Tactical leads are authorised to make an initial holding statement to the media and details of the approved text to use for these can be found at **F5.04.11 – BC Holding Statement**.

13.4 All such communications with the media and contact from the media should be recorded on **F5.04.10 –BC Media Calls Report Form**.

13.5 Whenever interacting with the media the following must be adhered to;

- **Do Not** make any comment and do not speculate on the cause of the BCE;
- **Do Not** confirm a BCE has taken occurred unless it is clearly already in the public domain;
- **Do Not** provide the media with any alternative contact telephone numbers other than Head Office.

14. Damage Assessment

14.1 If the BCE dictates the need the Tactical Lead will liaise with the emergency services and other agencies to conduct an initial assessment of the situation and determine the extent and likely duration of the BCE.

14.2 All such interactions should be recorded on the **F5.04.16 – BC Log Sheet**.

14.3 The Head of Care Standards will make contact with the Company's insurance brokers and any other relevant third parties.

14.4 If the Company premises become unavailable please refer back to the Buildings – Short Term and Long Term Loss section of this procedure for guidance.

14.5 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

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15. Vehicles

15.1 All vehicle losses should be immediately reported back to the Operations Director whose contact details should be entered into the table on Section 11 of the BCP.

15.2 The Company will endeavour in the first instance provide vehicles from within its own internal national fleet resources.

15.3 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

16. Information Services (IS) and Telephone Systems

16.1 Sections 12 and 13 of the BCP deal with losses of IS services or facilities has the potential to impact the Company's ability to deliver a sustainable service to our customers that meets their needs and the Company's contractual and performance obligations.

16.2 Therefore any loss of IS should be dealt with as a potential business continuity event and actions taken in accordance with both the site BCP and the Head Office IS BCP, which is available on SteriPoint.

16.3 Loss of IS will include, but not be limited to:

- Loss of the Company Telephone System;
- Loss of Internet and / or Intranet Access;
- Loss or Damage to critical IS equipment;
- Loss of Connectivity with the Mobile Communications Network (external in origin);
- Loss of Functionality of Critical Company Software (e.g. CAD / CRM).

16.4 All losses of IS should be reported to ***REDACTED***.

or by calling ***REDACTED***out of hours call use the PIN ***REDACTED***.

16.5 Any Compromise of suspected compromise to information security as a result of a BCE should be reported at the earliest opportunity following the Company's incident reporting systems as detailed at **BMS/5.02 – Incident Reporting and Investigation**.

17. Essential Equipment

17.1 All site essential equipment that is portable enough to move safely should be identified and listed within the BCP.

17.2 This listing should be in priority order and readily identify the location and any accessories that are required for its function.

17.3 Equipment should only be removed from site if the site has been classified as safe to enter.

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18. Security of Company Records and Documentation

18.1 Sensitive Company documentation must be safeguarded at all times. If practicable during a BCE event, all such documentation should be moved or removed, as appropriate, to a place of safety where its continued security can be maintained.

18.2 The documentation can include, but is not limited to:

- Paper based records, including staff HR and Training Records, Patient identifiable information, financial records, sales and marketing records, fleet transport records;
- Supplier agreements and contracts;
- Letters and correspondence.

18.3 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

19. Utilities

19.1 The loss of power (gas and electricity) to site can cause a loss of essential services and the Company's ability to sustain normal operations and service delivery. Therefore it is essential the gas and electrical power supplies are resumed as soon as reasonable practicable.

19.2 The BCP requires the identification and location of the main gas isolator valve and the main and support fuse box boxes and isolators at both Section 16 of the BCP and as an output at **F5.04.04 – Building Plan Drawing**.

19.3 It also requires the local sourcing and identification, subject to any existing either national facilities contracts set up by the Company and or landlord provided services, of a local gas or electrical contractor to be able to carry out any needed remedial work.

19.4 In addition to these measures and in case the gas or electrical fault is not a site but supplier issue, details of the gas and electricity supplier should be recorded including a contact telephone number.

19.5 If power supplies are going to be compromised for any prolonged period a local electrical generator supplier should also be identified and details recorded within the BCP.

19.6 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

Water Supply and Discharge

19.7 Disruption of clean water supplies to site, for more than 4 hours, would by the nature of the regulated activity undertaken by The Company, require the implementation of all or part of the BCP.

19.8 The BCP requires the identification and recording of a point of contact with either the local water provider and or facilities management company to contact if there is any disruption to the provision of clean water and or the discharge of foul water to the site drainage system.

19.9 In addition to this the BCP will require the main water supply stop valve to be identified on the site plan.

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19.10 The BCP should also contain provisions and guidance for the Operational Lead to follow in the events of:

- Loss of water supply;
- A significant leak within the premises;
- Contacting an authorised local plumber or Landlord for remedial works to be carried out;
- Details of the local water supplier.

19.11 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet**.

20. Security

20.1 The loss of site and building security systems poses a BC hazard and risk and provisions should be in place to ensure that normal security systems are returned to serviceability as soon as practicable.

20.2 Details of any security systems contractor or landlord / agency contracted providers should be recorded here within the BCP along with any additional physical or non-physical measures taken until the service is restored.

20.3 A record of detailing any additional actions should be made on **F5.04.16 – BC Log Sheet**.

21. Personnel

21.1 Any key member of staff who becomes unavailable has the potential to create a BCE, if their roles and responsibilities cover an essential aspect of continued service delivery that cannot be covered or allocated to another suitable member of staff.

21.2 In these circumstances additional resources may be required from the wider Company. This section of the BCP deals with the internal Company points of contact to be notified in such an event by the local Operational Lead.

21.3 If this event does trigger the enactment of the sites BCP, a record of detailing any such request should be made on **F5.04.16 – BC Log Sheet**.

22. Fire

22.1 Fire will be dealt with in accordance with standard fire procedures as detailed within the buildings fire risk assessment.

22.2 Thereafter the provisions detailed with Sections 6 and 7 of the plan will apply, depending on the nature, type and extent of the fire and the damage caused.

22.3 These actions will also be covered at **BMS/5.01 – Emergency Preparedness and Response**.

22.4 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet**.

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23. Flooding

23.1 In the event of flooding and on its extent, it may be necessary to implement the arrangement contained within Sections 6 and 7 of the plan.

23.2 In the event of a localised flood due to a failure of the internal or external buildings water supply pipes the stop valve should be shut off.

23.3 As part of the BIA and BCRA process as defined in **WI/1.07.02** and **WI/1.07.03**, flood risks and likelihood will be investigated by accessing the relevant Environmental Regulators website.

23.4 The BCP should have a map inserted into it at Section 22 if there is historical evidence of a flood to the sites or surrounding area for:

- Rivers and Sea;
- Reservoirs;
- Surface Water.

24. Supply Chain

24.1 In the event of a supplier failure of service to the Company, which compromises our ability to sustain normal service delivery a BCE may be declared.

24.2 The site Operational Lead should in the first instance follow the procedures at **BMS/4.01 – Purchasing** and identify an alternate supplier through either Proactis or the Company's Approved Suppliers List (ASL).

24.3 If a suitable supplier cannot be identified then the procurement team must be contacted and provided with the details required to identify and secure another supplier as soon as possible.

24.4 If this event does trigger the enactment of the sites BCP, a record of detailing any such request should be made on **F5.04.16 – BC Log Sheet**.

25. Post, Courier and Delivery Services

25.1 In the event that the Postal Service is unavailable or interrupted, invoices and correspondence will be emailed where appropriate.

25.2 If emails are not appropriate then mail will either be hand delivered or the Company will call upon its own Mail and Courier Service or commission a 3rd party approved through the ASL, to deliver its mail.

25.3 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

26. Adverse Weather

26.1 There is usually significant notice given with regard to adverse weather conditions that may affect Business Continuity. Notifications can come from news bulletins, warnings issued by weather agencies and from colleagues.

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26.2 Liaisons will be made to the local police and authorities to keep informed about the status of local major and minor roads.

26.3 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet**.

27. Bomb Threat

27.1 Although unlikely, the Company will take any received bomb threat seriously and recognise the disruption it would cause. Specific guidance is provided at **F5.04.24 – Guidance on Bomb Threat Procedures** and **F5.04.25 – BC Bomb Threat Alert Form**.

27.2 Should a bomb threat be received, then records shall be made of all actions taken on **F5.04.16 – BC Log Sheet.**

28. Terrorist Attack

28.1 Although unlikely, the Company recognises that its ability to deliver services would be disrupted should a terrorist attack take place near one of its facilities.

28.2 In these situations, it may become necessary in conjunction with our approved 3rd party contractors to increase the available resources in attempt to maintain operational levels, declare a BCP and notify stakeholders in accordance with Section 13 of this procedure and Section 8 of the **F5.04.02** – **Business Continuity Plan**.

28.3 A record of detailing any actions taken after a terrorist attack should be made on **F5.04.16 – BC Log Sheet.**

29. External Major Incident

29.1 As part of the BIA and BCRA process the local area should be investigated to ascertain if there is a likelihood of a BC event to occur that may trigger either an internal or external major incident. These could include but not be limited to:

- An emergency at a local airport or involving an aircraft crash or emergency;
- An NHS Trust declaring a major incident;
- Local or national government declaring a major incident;
- A bomb threat and / or an act of terrorism;
- A major road traffic collision that results in large numbers of casualties and blocks traffic infrastructure;
- A public order breach that involves a large crowd (e.g. organised or unorganised event, riot etc);
- A military facility being attacked;
- An internal event that significantly affects large parts of the business, both operationally and in the support services.

29.2 The BCP should contain a narrative that reflects these local and potential national issues.

29.3 A record of detailing any actions taken after a terrorist attack should be made on **F5.04.16 – BC Log Sheet.**

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30. BC Recovery

30.1 The BCP will document the process to the recovery of normal service delivery and will detail the following, but not be limited to;

- The final decision to close a BCE;
- The formation of a working group to expedite a return to normal service delivery;
- The enactment **of F5.04.03 – Post Site Recovery Plan**, if still applicable;
- The identification and taking possession of new premises if required;
- The formal request of additional Company operational and support services;
- Arrangements for the cleaning and or repair of the existing facility;
- The notification to stakeholders;
- The provision of new or replacement equipment;
- A review of existing processes including training;
- The reinstatement of power, water, communications and mail resources;
- The relocation of all resources previously removed from the site;
- A debrief to all staff;
- Any other actions required to ensure an effective and efficient return to normal operations.

31. BC Stand Down

31.1 The BCP will contain details on how managers should close a BCE event down and the subsequent actions required, such as but not limited to;

- Notifying all staff that the BCE has been terminated (pending the actions at Section 28 to the BCP);
- Notifying all relevant stakeholders (pending the actions at Section 28 to the BCP);
- Completing the **F5.04.17 – BC Post Event Report** and sending it to the BMS Manager;
- The BMS Manager collating the report, making it available to senior managers and publishing the report to SteriPoint;
- The identification of any lesions learnt and remedial actions plans required as a result of the BCE.

32. Employee Welfare

32.1 The BCP will contain guidance to managers to assist employees after a BCE has occurred.

32.2 It will guide them to us either the services available through the Company HR Department or those provided by our Occupational Health Provider, details of which can be found at **BMS/2.03 – Employee Health and Wellbeing**.

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33. Deployment and Training

33.1 The BCP will be deployed to sites after the completion of BIA's, BCRA's and the writing and authorisation of the plan.

33.2 The BMS Manager will assist local site managers in the training and deployment phase to ensure that all staff are aware of the actions and responsibilities under the BCP.

33.3 All training will be conducted and recorded in accordance with the requirements of **BMS/2.02 – Personal Training and Development**.

34. Monitoring, Testing and Exercising the BCP

34.1 At periods not greater than a year, the BCP must be reviewed and a tested of as part of the process of continual improvement and review.

34.2 These exercises and tests with scheduled by site and documented at **F5.04.26 – BC Exercise Planner**. A central record will be held by the BMS Manager and all completed exercises recorded on SteriPoint.

34.3 The findings of this review and the outcome of the test must be recorded on **F5.04.25 – BC Exercise Test Record**. Once completed this form must be forwarded to the Regulatory Compliance Managers for review.

34.4 The Regulatory Compliance Manager will responsible for collating the report form submission to for the monthly SMT meeting and the publication of the sites **F5.04.25** to SteriPoint.

34.5 Any actions arising from the exercises / test will be entered into the BMS in accordance with **BMS/1.04 – Corrective and Preventive Action (RAP's)**.

34.6 The testing and exercising of the BCP can take numerous forms as detailed, but not limited to:

- **Desktop Exercise** – An exercise designed to discuss the actions and responsibilities of the BCP in a collaborative meeting. This will not require any physical implementation of the BCP;
- **Communications Exercise** – A test purely of the communications requirements of the BCP. This can be for both internal and external stakeholders;
- **Partial Rehearsal** – A partial enactment of the BCP that focuses on a specific requirement of the continuity of the business;
- **Full Rehearsal** – A full enactment that test all the elements of the BCP.

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35. Business Continuity Competency

35.1 In order to have a measureable business continuity competency throughout the Company, a standardised competency matrix has been written to cover BC positions such as, but not limited to:

- Strategic Lead;
- Tactical Lead;
- Operational Lead;
- Team Leaders / Lead Drivers / Site Supervisors;
- Site Administrative Support;
- Site Team Members.

35.2 **F5.04.28 – Business Continuity Competency Matrix** is available from the BMS for sites to ensure that during the initial deployment of BC, team members receive the appropriate level of training and that all such training is documented and recorded in accordance with the requirements of **BMS/2.02 – Personal Training and Development**.

35.3 BC training has been broken down into 2 types which is:

- General awareness of BC;
- Detailed deployment of **BMS/1.07 –Risk Management** and **BMS/5.04 –Business Continuity Plans**.

35.4 All existing team members and new starters must receive BC training relevant to their position within the Company as part of either the initial deployment of BC to site or as part of the initial induction into the Company.

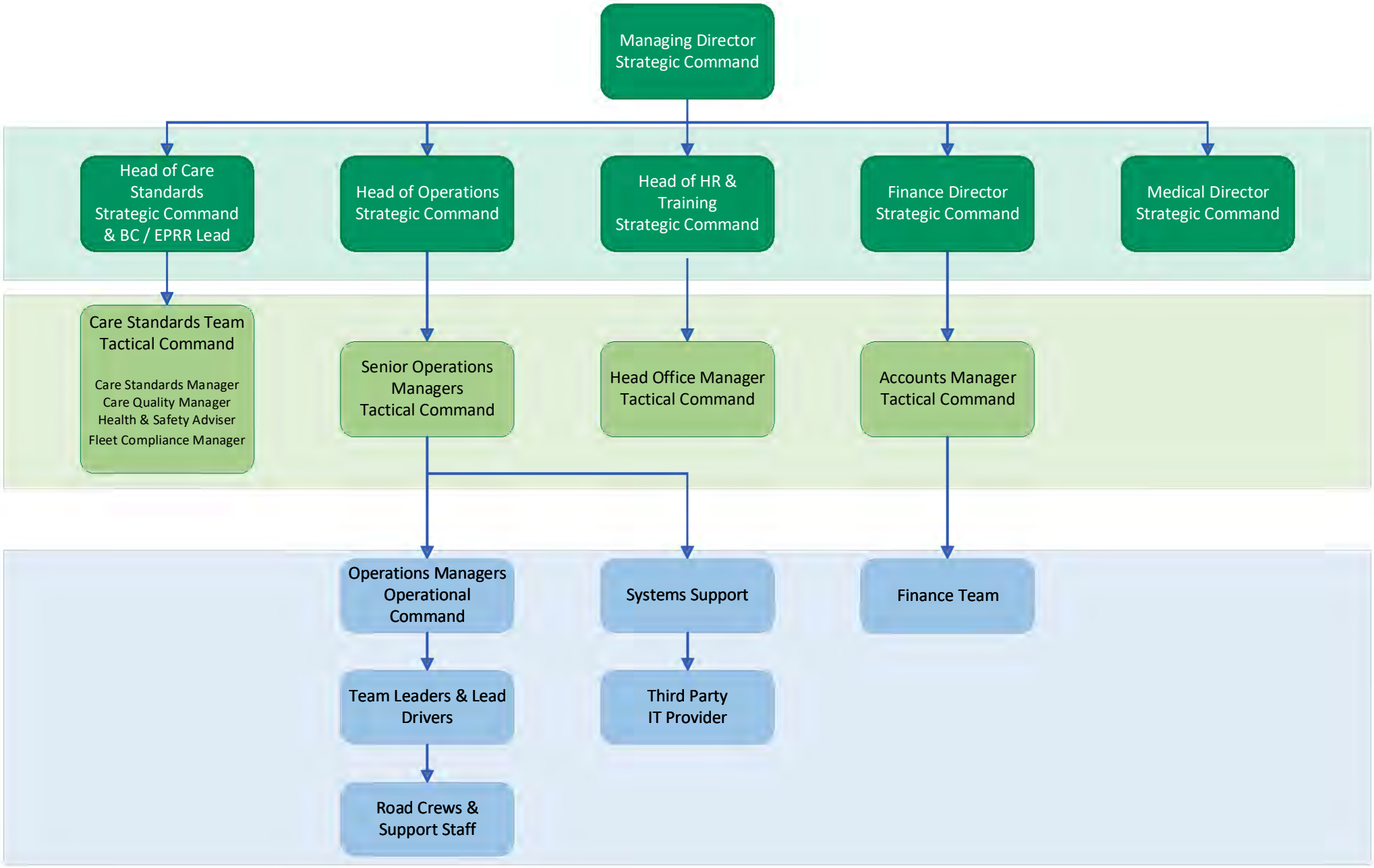
35.5 All training completed must be recorded on the employees training record **F2.02.01(H)** or **F2.02.01(W)** and **F2.02.04(W)** or **F2.02.06(H) – Training and Toolbox Talk Attendance Record**.

35.6 Business Continuity training can be requested by submitting a **F2.02.05(H)** or **F2.02.08(W) – Training and Development Requisition Form** to the Training Department.

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ERS Medical

Business Continuity and EPRR Organisational Chart



ERS Medical

F5.04.02 Business Continuity & EPRR Plan ERS Medical East - Norwich; King's Lynn; Snetterton; High Kelling.

Version: 4.4

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Location:

Date Published: 19th July 2019

Document Author:	[redacted]		Head of Care Standards		
Document Owner:	[redacted]		Managing Director		
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Revision / Amendment Information						
Revision No.	Section / Paragraph / Page No.			Date	Amended By	Comments
2.0	13	.6 to .9	18	07.06.18	[redacted]	Revision post x2 Cleric failures in May 18
3.0	All	All	All	01.09.18	[redacted]	Review of whole plan
3.1	9	13	15	11.10.18	[redacted]	Addition of Telephone Numbers
4.0	All	All	All	29.01.19	[redacted]	Splitting of BC and EPRR Requirements & SitRep Section
4.1	All	All	All	07.05.19	[redacted]	Minor changes for Norwich CCG
4.2	All	All	All	11.07.19	[redacted]	Cleric & Norfolk CCG Changes
4.3	All	All	All	19.07.19	[redacted]	Update at request of Norwich CCG
4.4	28	All	39	20.09.19	[redacted]	Addition of support statement NHS Trusts

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Business Continuity Plan

ERS Medical East –

Norwich

[redacted]

King's Lynn

[redacted]

Snetterton

[redacted]

High Kelling

[redacted]

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2. Related Documents & Legal References

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Planning and Review	BMS/1.05
Communication	BMS/1.06
Risk Management	BMS/1.07
Human Resources	BMS/2.01
Personal Development and Training	BMS/2.02

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3. Responsibilities

3.1	**Strategic Lead (Senior Management Team)**	Have overall responsibility for the control of the Company resources upon the enactment of the business continuity plan. They may not necessarily be at site, but will direct, at the strategic level, formulating a strategy for dealing with the event and committing wider Company resources to better manage and sustain normal operations.
3.2	**Tactical Lead (Regional Manager)**	Normally a senior member of the operational management team, excluding the Strategic Lead if present, who is on site, upon the enactment of the business continuity plan. They will decide at the local level how best to implement the business continuity plan and the use of available resources to achieve the strategic aims set by the Strategic Lead. They will work and cooperate with other organisation's Tactical Leads at the site level and could be embedded within these organisations command centres, in order to communications between agencies. Additionally, they should also ensure that communications from Strategic Lead and the Operational Lead remain regular and effective.
3.3	**Operational Lead (Operations Manager / Compliance Manager / Advisor)**	The on-site manager who is directly controlling Company resources upon the enactment of the business continuity plan, taking instructions from the Tactical Lead. If the business continuity plans cause for actions to be taken over or affecting a wide geographical area, possibly with multiple site locations, there may be occasions when multiple Operational Leads are reporting into the Tactical Lead. Additionally, they are responsible for ensuring effective communication with other Tactical Leads or equivalent and their operational staff resources and this may include directly liaising with external agencies such as Police, Fire, Ambulance, EA, Local Authorities etc.
3.4	**All Personnel**	Are responsible for ensuring they understand the Business Continuity Plan and associated procedures and follow the processes at all times.

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4. Definitions

4.1 **Activity** – Process or set of processes undertaken by the Company (or on its behalf) that produces or supports one of more of its services.

4.2 **Business Continuity** – Capability of the organisation to continue delivery of products or services at acceptable predefined levels following disruptive incident.

4.3 **Business Continuity Event (BCE)** – An occurrence or change of a particular set of circumstances, such as an event, which can be one or more and have several causes. An event can also consist of something not happening, which causes a failing in operational delivery. It is sometimes also referred to as an incident or accident, but for the purposes of the Business Continuity Plan, will be referred to as either a BC Event or BCE.

4.4 **Business Continuity Management System (BCMS)** – Part of the overall management system that establishes implements, operates, monitors, reviews, maintains and improves business continuity.

4.5 **Business Continuity Plan (BCP)** – Documented procedures that guide staff to respond recover and restore, to a predefined level the capability and enable the Company to maintain its services and operations, during and following a business continuity event.

4.6 **Business Continuity Risk Assessments (BCRA)** – The process of identification and analysing business continuity risks, arising from a hazard, taking into account any existing control measures and deciding whether or not the residual risks are acceptable.

4.7 **Business Impact Analysis (BIA)** – Process of analysing activities and the effect that a business disruption might have upon them.

4.8 **Emergency Preparedness Resilience and Response [EPRR]** - The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.
This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR). New arrangements for local health EPRR form some of the changes the Health and Social Care Act 2012 is making to the health system in England.

4.9 **Exercise / Testing** – Is a process to train for, assess, practice and improve within the Company.

4.10 **Interested Party / Stakeholder** – Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.

4.11 **Maximum Tolerable Period of Disruption (MTPD)** – Time it would take for adverse impacts, which might arise as a result of not providing service/product or performing an activity, to become unacceptable.

4.12 **Operational Lead** – For the purposes of business continuity the term operational lead will denote either the Operations Manager or the Compliance Advisor for the specific site.

4.13 **Requirement** – need or expectation that is stated, generally implied or obligatory.

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4.14 **Resources** – All assets, people, skills, information, technology (including plant and equipment), premises and supplies and information (whether electronic or not) that the Company has available to use, when needed, in order to operate and meets its objectives.

4.15 **Risk** – Combination of the impact of an event and the associated likelihood.

4.16 **Strategic Lead** – For the purposes of business continuity strategic lead will denote the Senior Management Team.

4.17 **Tactical Lead** – For the purposes of business continuity the term tactical lead will denote the Regional or General Manager responsible for the specific site.

4.18 **Recovery Time Objective (RTO)** – Period of time following a business continuity event in which services or products must be resumed or activities must be resumed, or resources must be recovered.

4.19 **Risk Assessment** – Overall process of risk identification, risk analysis and risk evaluation.

4.20 **Risk Management** – Co-ordinated activities to direct and control an organisation with regard to risk.

4.21 **Testing** – Procedure for evaluation; a means of determining the presence, quality, or veracity of something.

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5. Business Continuity Impact Assessment Summary

5.1 The information contained within the below table has been taken directly from the sites **F1.07.02** – **Business Impact Analysis (BIA).**

Service Priorities

5.2 In order to ensure that we prioritise both the needs of our patients and those of our contracted partners, ERS Medical as collaborated with its major stake holders and determined the priorities of service should be:

- **RENAL DIALYSIS PATIENTS;**
- **ONCOLOGY PATIENTS;**
- **ON THE DAY DISCHARGES.**

Service Priority Rating	Service Activity
SP1	Non Emergency Patient Transport Services (NEPTS) including HDU - Contracted Services for the [redacted]
SP2	ADHOC tasking booked on behalf of the [redacted], outside of the contract specifications for NEPTS and HDU
SP3	Escalation duties for the [redacted]
SP4	Private ADHOC NEPTS, HDU and Mental Health Taskings

Impact Analysis Rating Key

1 = Minor	2 = Moderate	3 = Serious	4 = Major

5.3 For more detail on business continuity impact analysis rating scores please refer to **WI/1.07.02** – Business Impact Analysis.

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6. What to Do

WHAT TO DO

If you have been notified of, or suspect there to be an Business Continuity Event (BCE)

Please note- Exercise messages will always contain the prefix 'EXERCISE'

CONTACT YOUR LINE MANAGER / SUPERVISOR ON-CALL IMMEDIALTELY

ON

[redacted] - Operations Manager

[redacted] – Senior Operations Manager

Then please complete **F5.04.09** – **BC Alert Form** available from the BMS.

If you have difficulties in contacting either your line manager or supervisor, please contact your Operations Manager on

[redacted] – Regional Manager East and South

[redacted] – Managing Director [redacted]

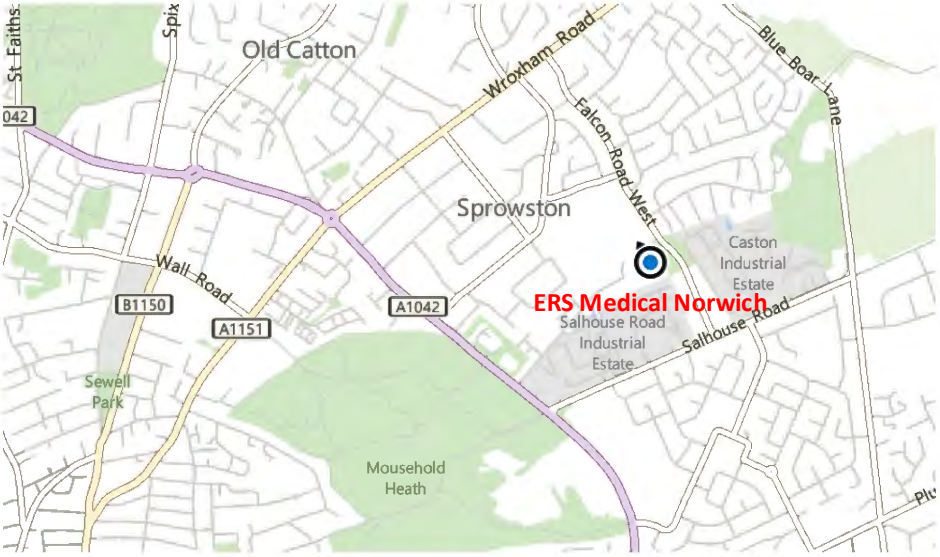
Alternatively, during normal working hours report the issue direct to your direct line manager.

IF YOU ARE ON-CALL

Use **F5.04.13** – **BC Response Checklist**, assess the BCE and notify all necessary personnel. Start an **F5.04.16** – **BC Log Sheet** for all actions and decisions taken. All forms can be found in either the Business Continuity Folder or on the BMS if still available.

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7. Site Location Maps

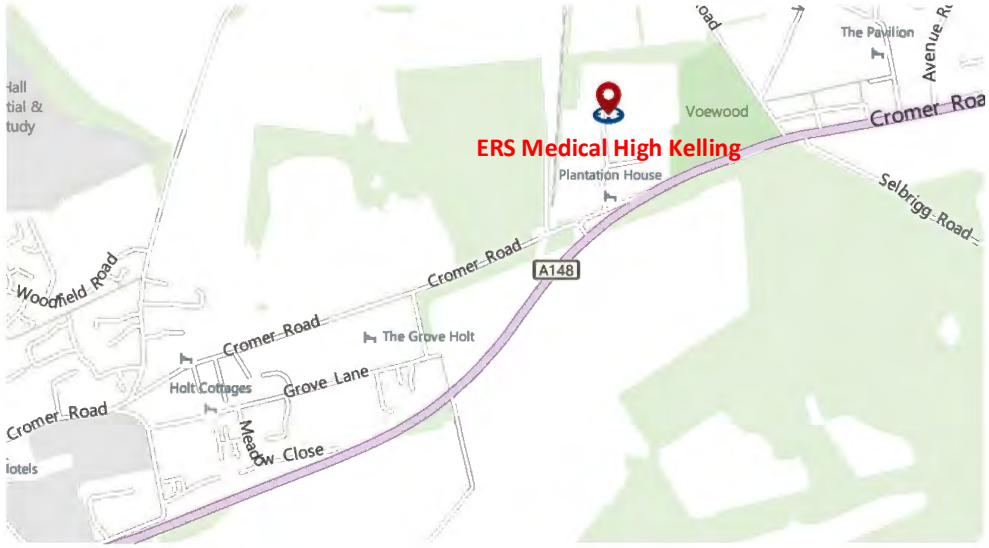




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Site Location Maps





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8. Immediate BC Response

Declaring a Business Continuity Event (BCE) and Call-Out

8.1 If a Business Continuity Event (BCE) occurs, part 1 of the **F5.04.09** - **BC Alert Form** should be completed by the person who receives the alert (the 'Alerter').

8.2 The On-Call Tactical or Strategic Lead will need to be contacted in first instance, by the Operational Lead.

Contractual, Operations and Senior Management Escalation (Operational, Tactical & Strategic)

8.3 To facilitate the escalation of a BC event or incident to higher authority within the ERS Medical, that is logged and recorded the Operational Leads should call the either their Tactical or Strategic Lead for further guidance**.**

8.4 This escalation process is also available to the [redacted] and the [redacted] to enable them to rapidly communicate, at the appropriate level any internal business continuity event that has the potential to affect the delivery of ERS Medical's service to them.

8.5 The On-Call Tactical or Strategic Lead will have the responsibility for deciding the status of the ERS Medical's response to any BCE that has the potential to interfere with routine activity and the continuation of normal service delivery.

8.6 The On-Call Tactical or Strategic Lead must then initiate the appropriate BCE status:

- **Business Continuity Event-'Stand-by'**; when it is believed that a serious event has occurred, which has potential to escalate. The Company will respond to a "Stand-by" message by preparing to activate this Business Continuity Plan. The Alerter will notify the On-Call Tactical or Operational Lead, who will inform the Alerter which Event Control Centre, will be used, if applicable. The Alerter will then be advised when and if any other staff are to be notified.

This alert is then followed by either of the following:

- **Business Continuity Event- 'Declared';** when either the On-Call Tactical or Operational Lead or the Emergency Services believe the BCE requires special arrangements to be implemented in part or in full. In these circumstances, the Company will fully activate this Business Continuity Plan. Part 2 of the **F5.04.09** – BC Alert Form should now be completed and the **F5.04.13** - BC Response Checklist should be started from this point;
- **Business Continuity Event - 'Cancelled';** when it becomes apparent that the situation is not as serious as initially thought. Any further response is deemed unnecessary and any completed paperwork is collated and sent to the BMS Manager. Staff members may return to normal duties. Services remain normal.

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Finally:

- **Business Continuity Event – 'Stand Down';** occurs when the Company's response to the BCE is complete. Having ascertained this to be the case, the On-Call Tactical or Operational Lead will notify the Strategic Lead with a recommendation to stand down Company resources deployed in support of the event;
- Once the Strategic Lead has authorised the 'stand down' resources can be returned to a normal operational footing and the debrief process commences.

9. Buildings and Facilities

Long Term or Short-Term Loss of Access

Immediate Actions to be Considered (ONLY IF SAFE TO DO SO)

9.1 Record actions on either **F5.04.07** – BC Action Delegation or **F5.04.08** – BC Action Delegation Summary forms:

- The location Regional Manager (tactical lead) and the Managing Director (strategic lead) must be notified as soon as possible so that the landlord can be officially notified and make any necessary arrangements with either their / our ERS Medical's buildings insurers or both.
- Notify through the management structure the Senior Management Team so that our insurers can be contacted in the event of loss or damage to ERS Medical resources (building contents, IT equipment, vehicles etc) ***details of our insurers can be found on the radar compliance system in documents***;
- Notify the key stakeholders within the [redacted] Trusts (this should be a concurrent activity, with the previous actions if any loss of hard facility impacts on service delivery);
- The Operational Lead is to notify both the tactical and strategic leads to assist in the process of identifying and providing suitable premises and facilities, either on temporary, long term and potentially permanent basis.
- Evacuate the building, if in working hours staff should attempt to take their personal belongings with them;
- Lock record cabinets and remove the keys from the site and hand to the senior person on scene;
- Close off access to the site car parks if possible;
- Make contact with (other) member(s) of the Senior Management Team i.e. Head of Care Standards (***there may be a requirement to make a statutory notification to the CQC***);
- Ring the Police / Fire / Ambulance Services as required;
- Turn off the electricity and water supplies if possible and appropriate;
- Ensure that all access and egress points are secured, and security systems remain active, if electrical supplies are still available;
- Allocate a responsible member of staff to remain close to the site, if appropriate, to guide and deal with emergency and support services as required. Ensure that the staff member has charged mobile communications available.

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Additional actions to be considered

9.2 Record actions on either **F5.04.07** – BC Action Delegation or **F5.04.08** – BC Action Delegation Summary forms:

- Contractors / Visitors should remove their vehicles from the site (if possible);
- Instruct Royal Mail to hold all Company mail at the local sorting office until it can be collected by an authorised Manager and redirect deliveries to alternate Company locations;
- Post information signs on access doors;
- Senior Managers (Tactical or Operational Lead) are to reconvene at the designated 'BCE Control Centre'. (Refer to Establishing a BCE Control Centre at Section 9);
  - Set the internal telephone system to call divert (this can be completed by contacting [redacted] on [redacted] or by raising a ticket with them [redacted] if needed);
- Staff should remove all Company vehicles from the site (if possible);
- Staff should remove their private motor vehicles from the site (if possible);
- Staff will be informed, as appropriate by the site Operational Lead or authorised person of any designated rendezvous location. If sent home staff should wait for update information.

9.3 See the relevant site BIA for information relating to the RTO and MTPD. (BIA ref: BIA/NOR/01).

Evacuation of Buildings and the Co-operation with the Emergency Services

9.4 The evacuation of buildings should be completed in a calm and controlled manner and directed by the Tactical and Operational Leads in accordance with predefined routes.

9.5 When evacuating resources from any of the sites detailed within this plan, consideration should be given to the access and egress of emergency service vehicles. Access roads should be kept clear and flowing if at all possible.

9.6 The removal of equipment and or records will be implemented and directed depending on the scale and nature of the BCE and available resources to facilitate their safe removal.

9.7 Control Room and Office based staff will normally be relocated in the first instance to the BCE Control Centre to wait for further information and instructions. Control Room functions will either be transferred immediately to one of the other main sites within the location (Norwich or King's Lynn) or the CCO in Leeds.

9.8 In the event of receiving a bomb alert, mobile telephones **Must Not** be used, and evacuation will be by word of mouth.

9.9 If time and the situation permits refer to Section 14 of this BCP (Essential Equipment & Documentation) for their removal.

9.10 Section 14 (Status) should be annotated as a record of all removed items of essential equipment and documentation. This should be retained for the duration of the BCE.

9.11 A replacement Section 14 page should be inserted into the BCP at the termination of BCE.

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10. Establishing a BC Control Centre and Notifying Stakeholders

10.1 For purposes of BCE meeting and planning, Senior Management will convene at one of the main ERS Medical sites within the location [redacted] which is not affected by the BC Event, with suitable facilities as soon as possible following the BC event, if required.

10.2 If both locations are affected, then a sub-site can be used (Snetterton or High kelling). If all sites are affected, then another suitable location must be identified by the local tactical or operational lead and communicated to Senior Management.

10.3 This will be designated as the '**BCE Control Centre'**, until a suitable alternative facility has been identified and secured if needed.

10.4 Additional IT equipment will be made available at alternate site locations and until this has been established CAD or Operational Control (if applicable) will be diverted to next main site in the location or if needed back to the CCO in Leeds or by Company Laptops remotely.

10.5 A BCE control box will be stored at each operational site for use during activation and testing of the business continuity plan. It shall include;

- Latest version of the site **F5.04.02** – **Business Continuity Plan**;
- Latest versions of **F5.04.03** – **Post BC Recover Plans**;
- Site Vehicle Fleet List;
- Torch (including spare batteries);
- Marker pens, paper, normal pens, highlighters, sticky tape (to make signs and notices);
- 2 High visibility vests;
- Hazard / Cordon tape to prevent access and egress to dangerous or unsafe areas.

10.6 Operational Leads are responsible for ensuring that their BCE control box is kept updated with the necessary information and resources. There will be a check on the contents of the BCE Control Box on a monthly basis using the **F5.04.14** – BC Box Contents and **F5.04.15** - **BC Box Contents Checklist**. All deficiencies will be recorded and replaced.

10.7 Any outstanding action(s) from the 'Immediate Action' section above, may be taken at this time and recorded, using the templates published in the BMS. Replacement forms will be issued, if necessary, for use by staff to ensure continued service provision.

10.8 Additional Business Continuity Plans are available by accessing the Radar Compliance System / Documents / Business Continuity.

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Immediate Communication Issues

10.9 Once the BCE Control Centre has been established, the following should be advised, if not already, of the emergency:

- Emergency Services;
- Staff not initially involved but who will be affected;
- All relevant Stakeholders (Internal & External), (SMT (Strategic Leads), HR, Regulatory Compliance Team, Clinical Team, Fleet, Facilities Management & Information Services). See **F5.04.21** – **BC Key Contacts Sheet** for more details;
- Company Insurers.

Notifying Stakeholders

10.10 If a Business Continuity Event occurs it may be necessary to notify ERS Medical stakeholders. The decision to make contact with stakeholders can only be authorised by the Strategic Lead or Tactical Lead.

10.11 The only exception to this instruction is in the event of a short-term loss of telephone systems. On these occasions, the Operational Lead does have the authority to notify stakeholders direct.

10.12 All contacts with stakeholders should be recorded on the **F5.04.16** – **BC Log Sheet**.

Stakeholder	Telephone Number	Notification Period
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours
[redacted]	[redacted]	0 to 2 hours

10.13 For further stakeholder information please refer to the sites completed **F5.04.21** – BC Key Contacts Sheet.

Time Frames for Notification of Stakeholders

10.14 Stakeholders should be notified as soon as reasonably practicable and within the defined notification period once the correct level of authorisation has been obtained.

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11. Media Contact

11.1 Staff should not make comments to the media and all enquiries should be referred to the Company Head Office at Hetton Court on **0333 240 4999** in the first instance who will escalate this to the Senior Management.

11.2 If knowledge of the BCE has passed into the public domain, the Tactical Lead may provide the press with an initial holding statement (**F5.04.11 – BC Holding Statement**).

11.3 Record any incoming calls, from the media using the **F5.04.10 – BC Media Calls Report Form** and refer them back to the CCO.

11.4 Remember the following:

- **DO NOT MAKE ANY COMMENT and DO NOT SPECULATE ON THE CAUSE OF THE BCE**;
- Any information updates should be communicated DIRECTLY to Senior Management at the BCE Control Centre;
- Senior Management (Strategic Leads) will lead on all statements issued to the media;
- **DO NOT** confirm that a BCE has occurred unless it is clearly in the public domain;
- Take details of the call and enquiry;
- **DO NOT GIVE OUT THE BCE CONTROL CENTRE PHONE NUMBER TO MEDIA CONTACTS.**

12. Damage Assessment

12.1 If required, the designated Operational or Tactical Lead will liaise with the Emergency Services and other agencies to conduct an initial assessment of the situation and determine the extent and likely duration of the BCE.

12.2 A member of Senior Management Team will liaise with the insurers and other third parties to ensure that swift and correct recovery is supported and achieved, including contact with the possible sources of alternative premises.

12.3 If a building becomes unavailable for use for any reason and a suitable alternative facility needs to be identified, contact either the tactical or strategic leads for guidance.

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12.4 Depending on the scale and impact of any damage ERS Medical will consider all suitable options to ensure continuity of services to the [redacted]
This will include, but not be limited to:

- The provision of temporary structures and facilities;
- Additional IT equipment and connectivity to the ERS Medical network and telephone system;
- The provision of power generators;
- Lighting & heating;
- Hard standings for vehicle parking;
- Staff welfare facilities;
- IPC and general waste management.

12.5 In the event that rebuilding is required the SMT or their authorised representative will liaise, through the Regional Manager, with relevant and approved contractors to plan and arrange for all relevant actions.

12.6 Staff will be kept up to date with all relevant decisions to reoccupy or occupy new premises through ERS Medical communication systems.

13. Vehicles

13.1 In the first instance, depending on the nature of loss all relevant breakdown, maintenance, accident or theft processes should be followed.

13.2 Contact will be made with the Managing Director to report any loss. He/She will initially within the first 12 to 48 hrs attempt to provide additional internal resources to site in support their ongoing service delivery, through existing ERS Medical assets.

13.3 If this is not practicable or achievable they will then look to an authorised external 3rd party supplier of vehicles for short to medium term provision of additional vehicles.

13.4 If new vehicles need to be ordered and provided to the site, procedures at **BMS/4.01** will be followed.

13.5 **Current Lead Times for new Vehicles:** 12 weeks

13.6 The Company Fleet Team is contactable as detailed in the below table:

Fleet Title	Telephone Number
Managing Director	[redacted]

13.7 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

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14. Information Technology (IT)

Local Loss of IT

14.1 In the event of a local short-term disruption to service the Operational Lead should contact [redacted] and log a works ticket to remedy the fault.

[redacted] **Contact Number:** [redacted]

Web Site: [redacted]

14.2 Essential services will continue to be provided from other ERS Medical sites within the location or from other reginal locations such as Head Office in Leeds.

14.3 Remote access to the ERS medical servers and system such as CAD (Cleric), Bamboo HR and Radar and will still be possible via:

- 4G Hotspots;
- Portable Wi-Fi Systems.

National Loss of IS

14.4 In the event of a national loss of information services staff should follow as above and fall in line with the national recovery protocols and provisions, put in place by the Senior Management Team and Solve IT.

14.5 These provisions will be:

- Isolated power supplies;
- UPS;
- On site generator (if required and the building is appropriate);
- Redundant server links;
- Back-up data centre network connections;
- Spare hardware;
- Back-up telephone system to support Cisco.

14.6 In addition to the above provisions the following will be undertaken in support of the 'Cleric CAD System' and to ensure that essential data is retrievable, even in the event of a Cleric outage.

- A daily 'Activity Dump' for all journeys and allocated work will be created out of Cleric as a CSV file;
- The 'Activity Dump' CSV file will be automatically downloaded every 45 minutes from 'Cleric' and stored on ERS Medical Servers and uploaded to our SharePoint.

14.7 These additional provisions will ensure that if Cleric is inaccessible, we can still access the pre-booked journey data, via a shared folder on the SharePoint system.

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14.8 In the event of a Cleric failure, the most recent CSV file, download from Cleric will be shared with the relevant Operations Managers and their teams.

14.9 In support of ERS Medical servers, Solve It and Rapid Switch have implemented the following BC provisions:

- Planned monthly testing of the server failover switch;
- Installation of a secondary power supply for the ERS Medical servers;
- Active monitoring and alerts for the ERS Medical SQL1.

Loss of CLERIC CAD System

14.10 If IT systems access is lost contact ERS Medical Systems Support on:

Tel: [redacted]

Email:

[redacted] - Any system apart from Cleric

[redacted] - Cleric loss

15. Telephone System

Short Term Loss (Less than 4 hours)

15.1 In the event of a short-term local fault, which is beyond the control of the Company, the Operational Lead should arrange to have the affected numbers transferred to another suitable phone or site.

Transfer Calls To:	[redacted]
Or CCO Leeds	[redacted]**99**

Transferring a Call

- CCO number for Norfolk = [redacted]
- Press cfwd on desk phone
- Enter [redacted]
- Wait a second for phone to store number
- Phone will auto forward call
- To stop forwarding, Press -cfwd

15.2 The Operational Lead should arrange to have the fault reported, investigated and repaired by contacting;

Supplier	Contact Name	Telephone Number
[redacted]	HELP DESK	[redacted]

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15.3 The Operational Lead should also contact, if necessary, all stakeholders, as detailed in Section 9 of this BCP and advise them of the temporary fault and to either continue to use the same number, but which has been diverted or provide them with an alternative, such as the number at the Emergency Control Centre.

15.4 When the Operational Lead makes contact with stakeholders to inform them of this temporary problem, they should take care not to formally notify them of any enactment of the Business Continuity Plan as this remains the responsibility of the Strategic Lead.

Long Term Loss (more than 4 hours)

15.5 In the event of a national loss of telephone services staff should follow as above and fall in line with the national recovery protocols and provisions, put in place by the Senior Management Team and [redacted]

15.6 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

15.7 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet.**

15.8 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

Out of Hours Contact for [redacted]

15.9 The use of the [redacted] out of hours service is to be restricted to mission critical issues such as, but not limited to:

- Loss of telephone systems;
- Loss of internet systems;
- Loss of Cleric systems

15.10 [redacted] out of hours details:

From: 17:30 – 09:00

PIN: [redacted]

Number: [redacted] (usual number for [redacted])

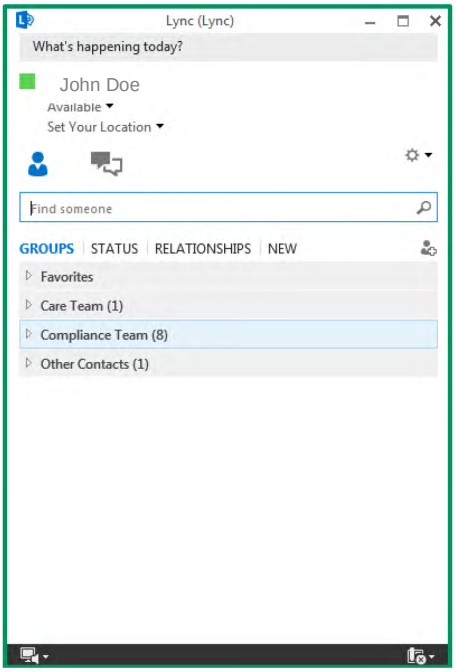
Alternative Methods of Communication

15.11 Operational Lead through to Strategic Lead will ensure that they have '**Skype for Business'** (instant messaging) installed onto their laptops and PC's.

15.12 Skype for Business can be used as a method of communicating in real-time in the event of a loss of either the mobile telephone networks, Cisco telephone system (locally) or both.

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15.13 Any ERS Medical employee (Operational to Tactical Leads) who is required to attend either the [redacted], on enactment of their business continuity plan should request access to that Trusts network systems or enable (if available) a 4G hotspot on their company mobile to enable Skype for Business communication to function.



16. Essential Equipment - Norwich

16.1 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
Norwich	[redacted]0 PC's (complete)	Various site offices	
Norwich	[redacted] Cisco Telephones	Various site offices	
Norwich	[redacted] Printer / Scanner	Admin & M&C	
Norwich	[redacted] Desks	Various site offices	
Norwich	[redacted] Chairs	Various site offices	
Norwich	[redacted] Extension Leads	Various site locations	
Norwich	[redacted] CAD Tablets & Chargers	Site Ops	
Norwich	[redacted]ECG Monitors	Equipment Room	
Norwich	[redacted] Medicines PODS	Equipment Room	
Norwich	As Required Medical Gases	Gases Store	
Norwich	[redacted] station ChemEx Products	Deep Clean Area	
Norwich	[redacted] of each Mops and Buckets	Various site locations	
Norwich	[redacted] Mail and Courier PDA's	Mail and Courier	
Norwich	[redacted] Mobile Telephones	Various Personnel	
Norwich	[redacted] Kettles	Site	
Norwich	[redacted] Toasters	Site	
Norwich	Water Boiler	Training Room	
Norwich	[redacted] Hospital Training beds	Training Room	
Norwich	[redacted] Projector	Training Room	
Norwich	[redacted] Server and Wi-Fi Systeme	Server Room	
Norwich	[redacted]1 Filling Cabinets	Site	
Norwich	[redacted] Air Conditioning Units	Site	
Norwich	[redacted] ACA's	Site	
Norwich	[redacted] UCA's	Site	
Norwich	[redacted] ECA's	Site	
Norwich	[redacted] Technicians	Site	
Norwich	[redacted] Paramedic	Site	
Norwich	[redacted] Control Room Staff	Control Room	
Norwich	[redacted] Admin Staff	Control Room	
Norwich	[redacted] Team Leaders	Site Ops	
Norwich	[redacted] Hospital Liaison Staff	NNUH	
Norwich	[redacted]1 Trainer	Ops	
Norwich	[redacted] HDU Ambulances	Ops	
Norwich	[redacted] WAV; [redacted] Bariatric [redacted] Seater; [redacted] Stretcher Ambulances	Ops	

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Essential Equipment – king's Lynn

16.2 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
King's Lynn	PC's (complete)	Site offices	
King's Lynn	Cisco Telephones	x3 Offices	
King's Lynn	Printer / Scanner	Site office / Store Rm	
King's Lynn	Desks	Site offices	
king's Lynn	Chairs	Site offices	
King's Lynn	Extension Leads	Site offices	
King's Lynn	CAD Tablets & Chargers		
King's Lynn	SP Services G3H ECG Monitors	Site / HDU	
King's Lynn	Medicines PODS	Storeroom / HDU	
King's Lynn	Cages Medical Gases	Outside of building	
King's Lynn	Station ChemEx Products	Site	
King's Lynn	of Each Colour Mops and Buckets	Deep Clean Area	
King's Lynn	Various Boxes Medical Stores	Store Room	
King's Lynn	Mobile Telephones	Site Management	
King's Lynn	ACA's	Site	
King's Lynn	ECA's	Site	
King's Lynn	UCA's	Site	
King's Lynn	Technicians	Site	
King's Lynn	Hospital Concierge	QEH	
King's Lynn	HDU Ambulances	Site	
King's Lynn	Stretcher Ambulances Bariatric)	Site	
King's Lynn	Seater Ambulances	Site	
King's Lynn	WAV's	Site	
King's Lynn	RRV	Site	
King's Lynn	Keetle	Kitchen	
King's Lynn	Fridge	Kitchem	
King'S Lynn	Freezer	Kitchen	
King's Lynn	Microwave	Kitchen	
King's Lynn	Toaster	Kitchen	
King's Lynn	Power Washer	Deep Clean Area	
King's Lynn	1 Hoover	Deep Clean Area	
King's Lynn	Sluice Sinks	Cleaning Area	
King's Lynn	x1 Medicines Hub	Head of Care Office	

Essential Equipment - Snetterton

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16.3 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
Snetterton	[redacted] PC's (complete)	Office	
Snetterton	[redacted] Cisco Telephones	Office	
Snetterton	[redacted] Printer / Scanner	Office	
Snetterton	[redacted] Desks	Office	
Snetterton	[redacted] Chairs	Office	
Snetterton	NIL ECG Monitors		
Snetterton	NIL Medicines PODS		
Snetterton	[redacted] Dispenser Station ChemEx Products		
Snetterton	[redacted] Mops and Buckets		

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Essential Equipment – High Kelling

16.4 Where time allows and when they can be safely recovered from the premises following a BCE, the following equipment should be recovered and moved to another Company or temporary location if practicable and safe to do so;

Site	Equipment	Location	Status (removed of left)
Kelling	[redacted] PC's (complete)	Office	
Kelling	[redacted] Cisco Telephones	Office	
Kelling	[redacted] Printer / Scanner	Office	
Kelling	[redacted] Desks	Office	
Kelling	[redacted] Chairs	Office	
Kelling	NIL ECG Monitors	N/A	
Kelling	NIL Medicines PODS	N/A	
Kelling	[redacted] Dispenser Station ChemEx Products	Store	

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17. Security of Company Records and Documentation

17.1 Where time allows and when they can be safely recovered from the premises following an BCE, the following documentation should be recovered and moved to another Company location (see section 14):

- Paper based records, including staff HR and Training Records, Patient identifiable information, financial records, sales and marketing records, fleet transport records;
- Supplier agreements and contracts;
- Letters and correspondence.

17.2 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet.**

17.3 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

18. Utilities

18.1 In the event of a gas supply or power failure within the building, the first thing to check is the main fuse box.

	Norwich	King's Lynn	Snetterton	High Kelling
Main Fuse Box Location:	[redacted] Control	Inside buidling near Ops Managers Office	Cupboard to the right inside front door	Trust Facilities
Gas Isolation Valve:	N/A	N/A	N/A	N/A

18.2 If the fault can't be easily identified and rectified or the fault is external to the site contact the power industry supplier (gas and electrical):

Norwich

	Supplier	Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

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King's Lynn

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

Snetterton

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

High Kelling

Supplier		Contact Name	Telephone Number
Gas:	N/A	N/A	N/A
Electricity:	[redacted]	Customer Services	[redacted]

18.3 If the power does fail, cancel or re-schedule all on-site visits and appointments if appropriate until such time as power is restored.

18.4 If the power is going to be off for a protracted period of time and a decision is made to close the building and relocate please refer to Sections 6 and 7 of this plan.

18.5 All power supply sockets should be turned off to prevent damage to equipment when the power is restored.

18.6 If power is going to out for a protracted period and it is not practicable to move to an alternative location, generators should be procured for the site.

18.7 Any installation of a temporary generator should be risk assessed and checked by the Company's Health and Safety Team prior to any use.

Position	Contact Name	Telephone Number
Care Standards Manager	[redacted]	[redacted]

Loss of Water Supply & Local Flooding

18.8 Disruption of clean water supplies to site, for more than 4 hours, would by the nature of the regulated activity undertaken by The Company, requires the implementation of the business continuity plan.

18.9 In the event of flooding it may be necessary to implement the arrangement contained within Sections 6 & 7 of this BCP.

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18.10 In the event of a localised flood due to a failure of the internal or external buildings water supply pipes the stop valve should be shut off.

Water Stop Valve Location:	Norwich	King's Lynn	Snetterton	High Kelling
	[redacted]	Garage Area	First Toilet Cubicle	Trust Facilities

18.11 The affected section(s) of the building should be cordoned off (use the hazard/cordon tape) and work activities will be restricted to areas not affected by the flood.

18.12 If required bulk supplies of bottled water should be provided until such time as the water supply can be restored.

18.13 While the water supply is disrupted, all water should be conserved. Bottled water should be placed at key locations within the building to ensure that hygiene requirements for Infection Prevention and Control (Outcome 8 of CQC Care Guidance) are maintained. These should include:

- Bottled water and disinfectant available in all toilets for flushing;
- Separate Bottled water and soap available at in all toilets for hand hygiene;
- Bottled Water and soap available at all hand basins for hand hygiene;
- Bottled water provided to staff for drinking water.

18.14 For small and localised internal flooding, a contract plumber should be called to repair the fault. Contact;

	Norwich	King's Lynn	Snetterton	High Kelling
Water Supplier:	[redacted]			
Contact Details:	[redacted]			

18.15 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

19. Security

19.1 The Norfolk sites are not manned 24 hours a day but do have a site security alarm system. In some cases, they use CCTV and access control systems as added levels of physical security.

19.2 In the event of the site or building security systems failure contact:

	Norwich	King's Lynn	Snetterton	High Kelling
Security System Supplier:	[redacted]			
Contact Details:	[redacted]			

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19.3 In certain circumstances i.e. receipt of a bomb threat, enhanced physical security measures may need to be taken to ensure site security such as but not limited to:

- Lock and restrict access to buildings (do not compromise any existing evacuations measures);
- Enhanced Physical ID verification of all personnel entering Company premises;
- Restrict and control vehicle access and movement into and around the site.

19.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

20. Personnel

20.1 In the event of a key member(s) of staff being unavailable (due to death, disability, critical illness, illness, accident or injury etc), the sharing or critical knowledge, systems, procedures and documentation should ensure that all routine and essential administrative and management functions can be performed.

20.2 Should further support be required, the following should be contacted:

Position	Name	Telephone Number
Regional Manager	[redacted]	
Head of HR and Training	[redacted]	[redacted]
Managing Director	[redacted]	[redacted]

20.3 Situations may arise where staffing issues may present a significant impact to our ability to run a service to minimum service level required. These situations can be either site based, region based or a national issue. Types of situations where staffing availability can be affected can be:

- Seasonal sickness rates – Flu;
- Healthcare Associated Illness – C-Diff, Nora Virus etc;
- Pandemics;
- Industrial Actions;
- Retention and Recruitment issues.

20.4 Where ERS Medical Operations find that staffing number are or could affect the safe and effective running of the service, they **MUST** escalate internally within ERS Medical as soon as possible.

20.5 The Head of HR and Training will hold responsibility, with the Managing Director for the identification and provision of relief staff from other ERS Medical operations (if available) in order to support and bolster the Norfolk operation.

20.6 All operational support staff **WILL** meet the same training and compliance standards for deployment in support of the Norfolk operation as Norfolk based staff.

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20.7 In addition to sourcing additional staff in support for the Norfolk PTS contract from internal resources, Operations, with the approval of the Strategic Commander (SLT) may also approach the following, for support:

- Approved 3rd party ambulance providers (this can include staff only and staff and ambulance resources) (see note);
- Healthcare agency (ambulance) staff.

20.8 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

Note: 3rd Party Providers must have undergone the ERS Medical Due-Diligence process and have been notified to the [redacted], prior to use.

21. Fire

21.1 Fire will be dealt with in accordance with standard fire procedures as detailed within the buildings fire risk assessment.

21.2 Thereafter the provisions detailed with Sections 6 and 7 of this plan will apply, depending on the nature, type and extent of the fire and the damage caused.

21.3 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

21.4 Where ERS Medical has staff embedded within sites in support contracted local NHS Trusts contract:

- [redacted]
- [redacted]

It will be and remain the responsibility of the respective NHS location to assess the risks associated with flooding and take appropriate control measures and planning to ensure patient, staff and public safety and the continuity of their services.

21.5 ERS Medical will cooperate fully with the respective NHS site in the execution of their control and management of such an event.

21.6 ERS Medical also acknowledges that such an event within such a key stakeholder may require they enactment of our Business Continuity Plan in order to provide suitable and sufficient resources to the Trust to support their aims and objectives.

21.7 It will remain the responsibility of the respective NHS Trusts to notify ERS Medical, through our Operational or Tactical Leads, of the declaration or enactment of their BCP. The Trusts will be responsible for all clinical triaging of patients who require transportation to other facilities and locations, within the specification of the contract.

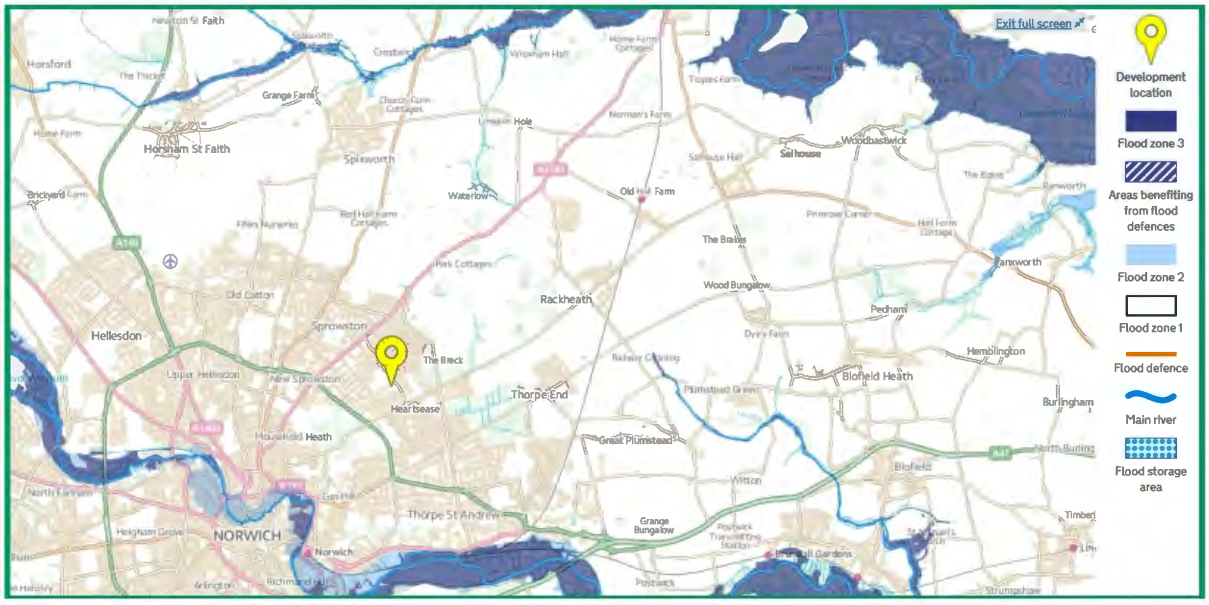
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22. Flooding

22.1 In the event of an external flood, the building will normally be part of a wider externally flooded area and access and egress to the site can either be restricted or totally lost.

22.2 If this is the case the procedures above at Sections 6 & 7 should be followed and in addition, it will be necessary to liaise with the Environment Agency to ensure that the building is hygienically clean in regard to the internal and external site facilities, this will include the supply of clean water and the removal of soiled / foul water.

22.3 The building should not be re-occupied until this has been established and the Regulatory Compliance Team (Environmental and Health and Safety) have deemed the building safe.



Norwich Site Flood Map: Provided from the Environment Agency Website

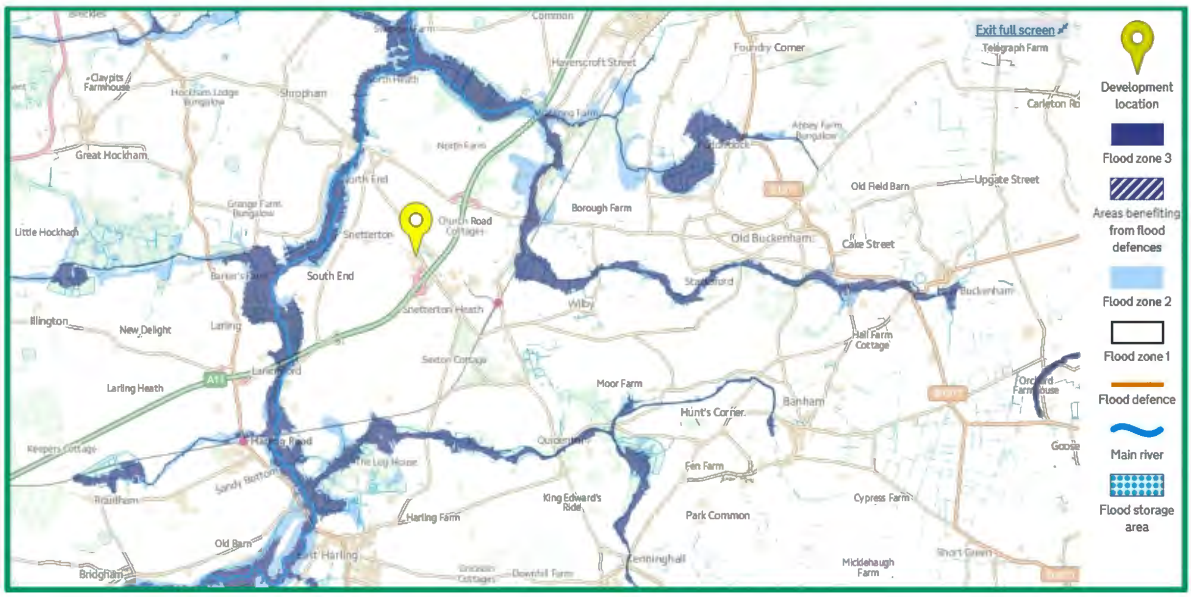


King's Lynn Site Flood Map: Provided from the Environment Agency Website

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Kelling Site Flood Map: Provided from the Environment Agency Website



Snetterton Site Flood Map: Provided from the Environment Agency Website
https://flood-map-for-planning.service.gov.uk/

22.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

22.5 The King's Lynn site has been assessed as being likely to suffer from flooding. The other sites are not assessed as being in direct of flooding themselves. However, given the geographical area of Norfolk and a history of floods caused by the convergence of spring tides and storms there remains a significant risk of floods affecting service delivery through compromises to local infrastructure.

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22.6 In addition to this is also a risk that such flood could significantly affect other healthcare providers and result in assistance being required to move significant service users from other locations such as, but not limited to:

- NHS Acute and Community Hospitals and Facilities;
- Private Care & Nursing homes;
- Private homes and accommodation for the elderly and vulnerable.

22.7 This request for assistance may come direct from the any of the below organisations and should be coordinated both through ERS Medical and the Norwich CCG:

- Norfolk Police;
- The East of England Ambulance Service NHS Trust;
- The Norfolk Fire Service;
- HM Coastguard;
- The Norfolk County Council;
- Local and Parish Councils.

22.8 ERS Medical will cooperate fully with the respective NHS, private and other government departments when such an event occurs.

23. Supply Chain

23.1 Alternative approved suppliers are detailed within the remit of the Finance Team on the Approved Suppliers List (ASL).

23.2 To add a supplier to the ASL list follow the procedures contained within **BMS/4.01** – Purchasing.

23.3 Where a single supplier exists (e.g. BOC for Oxygen and Entonox) and the supplier is unable to provide the required supplies as expected, arrangements must be made with other stockholders in the local area.

23.4 If the site experiences any difficulties with suppliers, they should in the first instance make contact with the supplier and try and identify what the issues are and resolve them.

23.5 If the issues persist and has or the potential to or has begun to affect the ability of the site to maintain its normal levels of service, contact should be made with the Company's Procurement Team so that they can take the appropriate steps to resolve the issue.

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23.6 These steps may include but not be limited to:

- Working with the supplier to help resolve the issue;
- Issue a warning to the supplier to improve the provision of goods or services;
- Bring on line additional suppliers of goods and services from the ASL as either a temporary measure or on a more permanent basis;
- Redistribute resources i.e. products held at other Company locations to rapidly support the site;
- Terminate the relationship with the supplier causing disruptions to service.

23.7 In addition to these measures ERS Medical, will where required and appropriate conduct due-diligence audits on 3rd party providers and obtain details of their emergency planning measures.

23.8 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

24. Post, Courier and Delivery Services

24.1 In the event that normal post and or courier / delivery service is unavailable, or disruption, invoices and correspondence will be emailed where appropriate.

24.2 If emails are not appropriate then mail will either be hand delivered or the Company will call upon its own Mail and Courier Service or commission a 3rd party approved through the ASL, to deliver its mail.

24.3 If deemed necessary have all site mail and deliveries redirected to one of the other local sites or in extreme circumstances either the site in [redacted].

24.4 Contact should be made with the above address to inform them of this action and to ensure that all site mail, when received is separated for collection or delivery to any alternate site location. This action should be recorded on **F5.04.16 – BC Log Sheet**.

24.5 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

25. Adverse Weather

25.1 There is usually significant notice given with regard to adverse weather conditions that may affect Business Continuity. Notifications can come from news bulletins, weather warnings issued by the Met Office and from colleagues.

25.2 Liaisons will be made to the local police county and district councils to keep informed about the status of local road conditions.

25.3 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet.**

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25.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

26. Bomb Threat

26.1 The threat of terrorism or a bomb has the potential to cause serious disruption to the delivery of the services provided by the Company and significant anxiety for staff.

26.2 In the event of the Company receiving a bomb threat the procedures contained within **F5.04.23** – Bomb Threat Alert procedures will be followed and adhered to and a **F5.04.24** – Bomb Threat Alert From will be completed and actioned accordingly.

26.3 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

26.4 Where ERS Medical has staff embedded within sites in support of contracted services, such as

- [redacted]
- [redacted].

It will be and remain the responsibility of the respective NHS location to assess the risks associated with receiving a bomb threat and take appropriate control measures and planning to ensure patient, staff and public safety and the continuity of their services.

26.5 ERS Medical will cooperate fully with the respective NHS site in the execution of their control and management of such an event.

26.6 ERS Medical also acknowledges that such an event within such a key stakeholder may require they enactment of our Business Continuity Plan in order to provide suitable and sufficient resources to the Trust to support their aims and objectives.

27. Terrorist Attack

27.1 In the event of terrorist attack in Norfolk and potentially a much wider effected area, ERS Medical acknowledges that main arterial transport routes may become severely congested, which in turn may impact on the service it provides to the Trusts and the ability of the Trusts to manage its resources in response to expected casualties.

27.2 It will remain the responsibility of the Trusts to communicate to ERS Medical, in a timely fashion, any changes or cancellations to planned transportation due to the Trust cancelling clinics in order to free up resources to better manage the emergency situation.

27.3 It may also be necessary to respond to specific requests from Trusts, if they declare a major incident, when they become directly or indirectly affected by the terrorist incident. This may mean the rapid relocation of low acuity patients from one NHS location to another, to free up acute bed spaces.

27.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

27.5 Where ERS Medical has staff embedded within sites in support of contracted services, such as

- [redacted]
- [redacted].

27.6 It will be and remain the responsibility of the respective NHS location to assess the risks associated with a terrorist attack and take appropriate control measures and planning to ensure patient, staff and public safety and the continuity of their services.

27.7 ERS Medical will cooperate fully with the respective NHS site in the execution of their control and management of such an event.

27.8 ERS Medical also acknowledges that such an event within such a key stakeholder may require they enactment of our Business Continuity Plan in order to provide suitable and sufficient resources to the Trust to support their aims and objectives.

27.9 ERS Medical also acknowledges that it may require the relocation of its Tactical Lead to a Trust location to ensure robust communication and cooperation with the Trusts internal emergency incident management.

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28. Emergency Preparedness Resilience Response

EPPR Section

NHS [redacted] NHS Foundation Trust

NHS [redacted] NHS Foundation Trust

CCGS Approved Requirement Statement for [redacted]:

Expected support from ERS for providers such as [redacted] or [redacted], commissioners have advised that they would expect ERS to offer support should any of those Trusts be part of a major incident and that their own NEPTS provider could not support the level of demand that may be associated with this. That ERS may also be approached if there was a lack of NEPTS capacity within those local areas.

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29. External Major Incident or Business Continuity Event Called by:

[redacted]

28.1 When the [redacted] declares either a Major Incident or activation of their internal Business Continuity Plan, they will communicate this initially to ERS Medical, through the Site Operations Team, in 1 of 4 ways:

1. The will notify the ERS Medical embedded liaison staff to communicate this direct to the Norwich site Management Team;
2. They will call ERS Medical direct at the Norwich Despatch / Control Room to notify the Norwich Site Management Team;
3. They will call the Norwich Management Team Direct;
4. The will call the CCO in Leeds and request that the Norwich Management Team are informed immediately.

28.2 Once a Major Incident or Business Continuity event has been reported to ERS Medical, it will remain the responsibility of the Trust to communicate the measures that they are enacting within their own pre-defined plans.

28.3 This may require a total or partial cancellation of all currently planned PTS journeys into and out of the Trust. The Trust will be responsible for communicating this detail to ERS Medical i.e. what patients or what clinics have been affected if any.

28.4 If there is a cancellation of planned journeys into and out of the Trust, ERS Medical will deploy ambulance resources to the Trust is a tiered approach. This tiered approach will be as follows:

- **Tier 1**: All present crewed and un-assigned ambulances, planned to work for [redacted] patients will immediately deploy to the Trust site (*see Map and notes*);
- **Tier 2**: All currently loaded in-bound vehicles will be contacted and informed to return all identified patients back to the collection addresses. The NNUH will contact them to re-arrange their appointments. ERS Medical staff **MUST NOT** enter into speculation as the reason for the cancellation or make comment upon this to either the patients, the patients carers, NOK or on Social Media or to the media direct if so contacted;
- **Tier 3**: All staff who report for duty after the declaration will initially be held back at Sapphire House, Snetterton or High Kelling, until such time as they are needed or if unaffected by the incident, will be instructed to continue as normal.

28.5 Under **NO** circumstances should ERS Medical staff make a statement to anyone including the press about the nature of this incident. It will remain the responsibility of the Trusts Communications Team to address this subject.

Deployment to the [redacted]

28.6 When deploying to the [redacted] ERS Medical staff must park their vehicles primarily in the normal locations but can expect some level of disruption depending on the nature or the incident.

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28.7 They must NOT under any circumstances park in and around the A&E Department or any of the approach roads to this area. These must be kept clear for the East of England Ambulance Service and other emergency services as required.



- The Yellow shaded areas MUST be kept clear for emergency services access and egress to the [redacted] site.

- The Green areas are where ERS Medical vehicles may park for all tiers.

28.8 On arrival at the [redacted] all ERS Medical crews must report to the ERS desk situated within the Centre Block. From here the [redacted] Operations team will coordinate all transport requirements.

28.9 It may be necessary for one of the Norfolk Operation Leads (Operations Managers) to deploy to the NNUH and assist in the coordination of ERS Medical resources during this period. This request will be explicit from the [redacted] at the point they declare either a major incident or enact the business continuity plan.

[redacted]

28.10 [redacted]

28.11 [redacted]

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30. BC Situation Calls and Reports

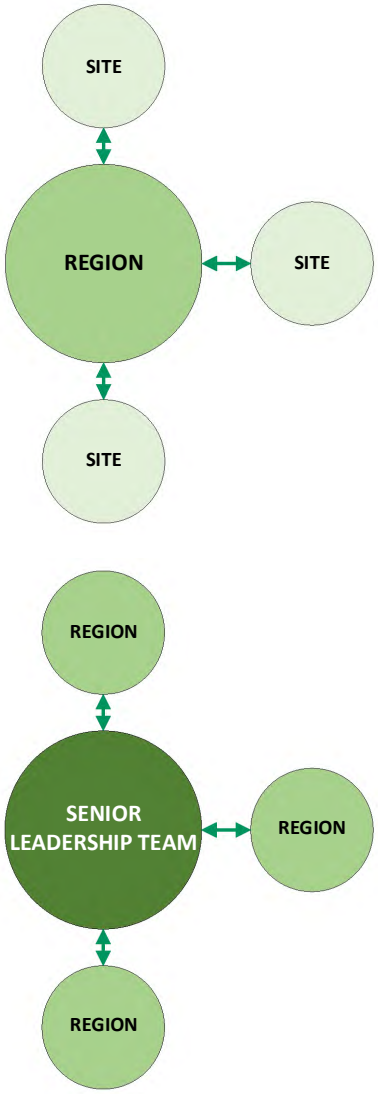
29.1 In the event of a BC event, such as but not limited to 'Adverse Weather', it may become necessary for sites and regions to stage daily BC situation calls.

29.2 The necessity for these calls will be determined at a regional level, by the Regional Manager, who will notify all sites, within his/her region of the call details.

29.3 Sites will formulate their reports for these calls using **F5.04.32 – BC Situation Report Form**. These must be completed prior to the call.

29.4 If the BC event affects more than 1 region, it may be necessary for these calls to be centralised and coordinated by the Managing Director or a member of the Senior Leadership Team. In these instances, the Regional Manager is to coordinate his site reports into a single report, which again will be documented on **F5.04.32 – BC Situation Report Form**.

29.5 All **F5.04.32 – BC Situation Report Forms** must be retained at Region and Site for the purpose of audit and inspection.



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31. BC Recovery

30.1 The On-Call Senior Manager and or Strategic Lead will discuss with other SMT members when to decide a BCE has finished, which may be long after the emergency or support services response is over.

30.2 It may be necessary, before this decision has been taken, to form a strategic group to be tasked with the recovery of routine business. This group will be formed and led by a member of the SMT and or a nominated deputy.

30.3 Alternatively, to, or in conjunction with the formation of this group, recovery tasks will need to be decided and may be delegated for completion (**F5.04.18** – BC Recovery Action Delegation & **F5.04.18** – BC Recovery Action Delegation Summary forms may be used to facilitate this).

30.4 If there are problems encountered when attempting the below detailed actions, use the contacts detailed within the various sections of the Business Continuity Plan to help resolve these problems:

- Conduct an initial survey of the site to determine its suitability for re-occupation. Assistance from the Regulatory Compliance Team will be essential during this process;
- Senior Management will make arrangements for the relocating, rebuilding, cleaning, replacement of equipment;
- Staff will be notified of the relocation, including the cancellation of any designated alternate location;
- Ensure that Company and personal property is removed from any alternate facility;
- Ensure that any alternate facility is left in a condition to which it was originally occupied;
- Re-open the site and its car parks removing any signage or cordon tape that was put in place for the management of the BCE;
- Turn electricity and water supplies back on (when informed it is safe to do so);
- Cancel all telephone diverts when the phone system is confirmed as being up and running;
- Transfer all Company vehicles back to the site;
- Switch on all required equipment (computers, printers, telephone and communications equipment);
- Ensure that all removed Company documentation that was removed the site if returned;
- Return / Replace any equipment or supplies as needed;
- Restock and sign off the contents of the BCE Control Box;
- Contact Royal Mail (if applicable) and arrange for mail to be delivered normally;
- Senior Managers and HR will conduct a staff analysis to ensure that staffing levels remain appropriate to the site operational activities;
- Communication from the SMT to acknowledge the efforts of staff during this period (feedback from the BCE may be used as part of this process);

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- Welfare of staff and their families and bereavement services affecting or involving Company staff will be managed through the HR department;
- Where services have been prioritised the SMT will review and decide how to redistribute resource levels in order to resume normal operations;
- Annual performance KPI's may be analysed to determine the effect the BCE may have had on them;
- Financial implications, remunerations and commissioning agreements will be analysed and determined by the SMT;
- Long term issues as a result of the BCE will be addressed by the SMT accordingly;
- Legal advice may be sought, when necessary, to provide counsel and aide and support the Company's preparations with regard to any public, criminal or other inquiry;
- All logs, records and other details need to be kept and retained by the Head of Care Standards;
- The SMT will debrief the BCE in full to highlight learning points and successes of the Business Continuity Plan.

30.5 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

32. BC Stand Down

31.1 A BCE footing may continue for many hours or days after the initial BCE and scene have been cleared. The decision to stand down resources will rest with the On-Call Senior Manger.

31.2 The Stand Down process is gradual and the On-Call Senior Manager will ensure that appropriate steps are taken, such as:

- Notification to all staff of the Stand Down;
- Re-Stock of Clinical Supplies;
- Complete any reports or forms and submit these to the Head of Care Standards;
- Hot de-brief with staff, providing them with an opportunity to voice any concerns and gauge their immediate reactions to the effectiveness of the Business Continuity Plan and its implementation.

31.3 As no further response action to the BCE are anticipated or required **F5.04.03** – BC Post Site Recovery Plans are initiated at this point and expected to thereafter manage the situation back to recovery with assistance and support of the Emergency Control Centre (if activated).

31.4 The site should adhere to the stakeholder notification periods as detailed within Section 9 of this BCP.

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33. Employee Welfare

32.1 An emergency situation is a stressful time and staff may be called upon unexpectedly to come into work and may on occasion be asked to work in unfamiliar environments for possible extended periods of time.

32.2 The Company will do everything within its power to support its staff during this time and guidance can be found by either contacting the HR department or **BMS/2.03 – Employee Health and Wellbeing**.

32.3 During a BCE and afterwards, it is vital that staff consider their own, their colleagues and their patient's welfare and ensure that they are not placed in any unnecessary risk of harm.

32.4 When called upon to assist in an emergency, there are a number of key actions that they should consider before responding:

- Notify their family, partner or significant other that they are involved in the emergency and provide them with a contact number should they need to make contact with them;
- Keep regular contact with their family, partner or significant other, updating them on their welfare but not disclosing sensitive information about the BCE;
- They should advise their family, partner or significant other not to speak to the media;
- Ensure that they have money, debit cards, car keys, house keys, mobile phone & charger with them;
- They may want to take an overnight kit with them (depending on the nature of the BCE);
- Make suitable arrangements for the care of their children, elderly relatives and pets if necessary;
- Ensure that they have a suitable supply of any medications they are taking;
- They should NOT give out their address to anyone outside of the Company except for the Police;
- Ensure that they re-arrange any appointments they have arranged (unless they are of an urgent medical nature);
- Not to work for any longer than 8 -12 hours without a suitable rest period.

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Met Office Weather warning

Amber weather warning— Norfolk and Suffolk

Heavy Snow and High Winds

Between 10:00 Mon 17 Dec and 18:00 Wed 19 Dec



Headline

Heavy snowfall is expected across the East of England of the country from Monday which may lead to significant travel disruption.

What to expect

Heavy snowfall will continue in the East of the country with the high winds causing significant drifting in all exposed areas. Accumulations of between 6 to 8 cm are expected with drifting to 2 feet.

Temperatures in exposed areas are expected to reach a minimum of –15°C. With the wind chill this will feel more like –25°C. The snow is expected to freeze and turn to ice on all untreated surfaces.

The advice from the Police and Highways Agency is that all unnecessary travel should be avoided.

As the weather improves to the back end of the week and temperatures rise localised flooding is Expected.

Question 1.24.2

Emergency Preparedness, Resilience and Response (EPRR)

Please provide your EPRR policy, an organisational chart showing your EPRR structure, a copy of your most recent board approved annual emergency planning report and your EPRR plan. Please ensure each attachment references this question number.

We have provided the following attachments as evidence of our Emergency Preparedness, Resilience and Reponses (EPRR):

- ERS BC & EPRR Procedure – BMS/5.04
- ERS BC Structure / Org Chart
- Example BC / EPRR Plan [redacted]
- BC Exercise Cold Weather Scenario 2018 East
- BC Exercise Planner

We do not have a single Board approved annual emergency planning report. This is because all of our EPRR plans are bespoke to each site. Each plan is approved and signed off by our Senior Leadership Team and we have attached a redacted plan from one of our sites.

All plans are developed and approved by our EPRR Lead, ***** REDACTED *****, who is strategically trained by the NHS and ISO 22301 certified.

ERS Medical

Question 1.24.3

EPRR Core Standards (Y/N)

Have you been assessed as substantially or fully compliant against NHS EPRR core standards in 2019. If YES please include evidence. IF YES Then 1.25.4 need not be answered just enter N/A to that question. Word count 250. If you have answered No then please complete question 1.25.4 EPRR Core Standards Self Assessment.

- [Please note that that there will be a mandatory cores standards self-assessment and confirm and challenge process annually throughout the contract]

Yes

Please select type of organisation:	Patient Transport Services

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	10	7	3	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	1	1	0	0
Business Continuity	9	9	0	0
CBRN	0	0	0	0
Total	41	38	3	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

ERS Medical

Overall assessment	Substantially compliant

Instructions
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Produce Action Plan (Populate Action Plan tab)

Question 1.24.4

Scoring. If YES answer then this question will be scored up to a maximum of 5 and next question 1.24.4 will be allocated a 0 score. If answered NO, then this question will be given a score of 0 and the answer in 1.24.4 will be scored up to a maximum score of 5.

N/A

Question 1.24.5

EPRR Case study

Please submit

• a major incident case studies outlining as an illustration how the bidder will respond to

•very severe prolonged snow preventing use of motorways and trunk roads for 24 hours and smaller roads for a further 72 hours

Word count 1500

Total Word Count: 765

We have interpreted this question to mean that we are unable to use any road to deliver patient transport include any use of 4 wheeled driver vehicles.

We understand that it is vital that as a company we have plans in place for business continuity purposes to ensure that appropriate actions are taken in a timely manner to ensure minimal disruption and a swift return to normal service.

As part of our winter preparedness plan which is enacted yearly between November – March ensures that all of our vehicles, crews, customers and 3rd party providers are prepared for the potential disruption that may occur during the winter months. This plan includes:

- Procurement and supply of items such as vehicle deicer, rock salt, snow shovels, bottled water and allocate to vehicles as appropriate.
- Liaison with 3rd Party Providers to implement parallel requirements for their vehicles as appropriate.
- Identify and Establish, where reasonable, local arrangements with 3rd Party Providers & external companies regarding the provision of additional resources e.g. additional capacity, 4x4 vehicles.
- Co-operate and coordinate activity with NHS Resilience & Emergency Planning Teams and structures such as the Local Health and Resilience Partnership Working Groups (LHRPWP) and NHS England.
- Appropriate support mechanisms in place for the issue and receipt of alerts and warnings (MET Office).
- Promote awareness and train on the site / location BC / EPRR plan.
- Contribute and coordinate planning (internal & external) around severe weather events as required.
- Review and update all plans from identified lessons and share with key stakeholders.

Having this preparedness in place ensures that all of our operational management teams are aware of what to do in the event of snow disruption service.

There is usually significant notice given with regard to adverse weather conditions that may affect Business Continuity. Notifications can come from news bulletins, weather warnings issued by the Met Office and from colleagues.

When severe weather is predicted we will work in partnership with the commissioners in line with their Cold Weather action plan.

This will include the identification of the most vulnerable patients and ensure a plan is put in place for any transport requirements prior to the adverse weather having an impact on transport.

Once the adverse weather takes hold and the Highways Agency close all roads we will continually liaise with the local police, County Councils and District Councils to keep informed about the road conditions and the plans for opening them up. We will arrange for regular calls to be set up between key individuals within the Trusts to ensure that all parties have the latest information and a holistic plan is put in place for when the roads become passable again.

We will also facilitate regular call at each level of the Command Structure:

- Operation Lead (Bronze) – Our Team Leaders
- Tactical Lead (Silver) – Our Senior Operations and Operational manager
- Strategic Lead (Gold) – Our Managing Director and Senior Leadership Team

As part of our winter resilience we have access to 4x4 ambulances to enable us to safely deliver any critical journey requirements as soon as the Highways Agency reopen roads.

After 24 hours when the trunk roads reopen, we will work in partnership with the individual Trusts to identify patients who are now able to be transported and focus on making sure they are able to make their required journeys. We will also begin to plan the phasing of the service back normality and plan in the journeys for when the smaller roads will be accessible.

Recovery phase

When the adverse weather event is over, we will continue to work in partnership with the Trusts to prioritise all critical journeys and assist in easing the back log of journeys to minimise the impact this has on patients. To assist with this, we will call in additional staff from our resilience and bank staff. We will also provide additional vehicles using our resilience fleet and national network of vehicles. This will allow us to maximise the efficiency of our service and get it back to normal service delivery as soon as practically possible.

Following the event when the service has returned to its normal schedule we will liaise with the Trusts and conduct a full debrief. We will discuss areas that went well and areas that could be improved.

Example

An example of our effective utilisation of our Business Continuity Plan was when, in March 2018, the ‘Beast from the East’ caused major disruption in East Anglia and throughout the country. Not only were we able to maintain our service delivery to our customers, but we were also able to mobilise a new contract.

ERS Medical

BMS/5.04 Business Continuity Plans

Document Author:	***REDACTED****		Head of Care Standards		
Document Owner:			Managing Director		
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1.1	2	All	4	20.03.18	***REDACTED****	Addition of F5.04.29 and F5.04.30
2.0	All	All	All	01.08.18	***REDACTED****	Annual Review
2.1	2	All	4	27.11.18	***REDACTED****	Addition of F5.04.31 Action Card

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2. Related Documents

BMS Manual	
Document Control	BMS/1.01
Record Retention, Storage and Disposal	BMS/1.02
Audit	BMS/1.03
Corrective and Preventive Action (RAP's)	BMS/1.04
Personal Development and Training	BMS/2.02
Emergency Preparedness and Response	BMS/5.01
Incident Reporting and Investigation	BMS/5.02
Major Incident Investigations	BMS/5.03
Business Impact Analysis (BIA)	WI/1.07.02
Business Continuity Risk Assessment (BCRA)	WI/1.07.03
BC Plan Site Data Capture Form	F5.04.01
Business Continuity Plan	F5.04.02
BC Post Site Recovery Plan	F5.04.03
Building Plan Drawing	F5.04.04
BC Call-Out Log	F5.04.05
BC Cascade Communications Poster	F5.04.06
BC Action Delegation	F5.04.07
BC Action Delegation Summary	F5.04.08
BC Alert Form	F5.04.09
BC Media Calls Report Form	F5.04.10
BC Media Holding Statement	F5.04.11
BC Message Form	F5.04.12
BC Response Checklist	F5.04.13
BC Control Box	F5.04.14
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BC Exercise Test Record	F5.04.25
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3. Purpose of Procedure

3.1 To ensure a single procedure is defined and utilised at all locations within the Company that provides instruction and guidance to personnel on the devising of an appropriate business continuity and recovery plan.

3.2 To provide clear instruction to personnel on the steps to be taken in response to a Business Continuity Event (BCE) at Company and/or customer premises.

3.3 To define the responsibilities of personnel in relation to business continuity and recovery plans, ensuring consistency is achieved throughout the Company.

4. Scope and Application

4.1 This procedure applies to all Company sites and employees.

4.2 Failure to comply with the requirements of this procedure may result in investigation and subsequent formal action in line with the Company's Capability and Disciplinary procedures.

5. Policy Statement

5.1 Please refer to the Company's Quality, Environmental, Safety and Health Policy.

5.2 Please refer to the Company's Business Continuity Policy.

5.3 Please refer to the Company's Information Security Policy.

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6. Responsibilities

6.1	**Managing Director**	Has overall responsibility for setting and directing: quality, environmental, safety & health, business continuity and information security policy and for ensuring the appropriate resources are available.
6.2	**Senior Management Teams**	Are responsible for ensuring that all BMS requirements are established, implemented, maintained and continually improved in accordance with the standards to which the Company subscribes and the legislation relative to the Company's operations.
6.3	**Head of Care Standards**	Is responsible for developing, co-ordinating and implementing quality, environmental, safety & health, business continuity and information security policy, procedures and work instructions. Is responsible for producing business continuity and recovery plans for all Company locations and for communicating the findings to local as well as the Senior Management / Leadership Teams. Additionally, responsible for undertaking the monitoring and review of completed plans, adherence to the testing schedule and any activations.
6.4	**S.I.R.O.**	Are responsible for producing information security risk assessments based on all information assets held by the company at all locations and for communicating the findings to local as well as the Senior Management / Leadership Teams.
6.5	**Health and Safety Managers / Advisors**	Are responsible for producing health and safety risk assessments for all activities undertaken by the Company at all locations and for communicating the findings to local as well as the Senior Management / Leadership Teams.
6.6	**General & Operations Managers**	Are responsible for ensuring that all business continuity and recovery plans are present, trained out to employees and tested at the locations or areas for which they are responsible and for communicating the findings to their teams and the BMS Managers. Are additionally responsible for enacting these plans in the event that a BCE occurs.
6.7	**All Personnel**	Are responsible for ensuring they understand Company policy and procedures and follow the processes at all times.

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7. Definitions

7.1 **Activity** – Process or set of processes undertaken by the Company (or on its behalf) that produces or supports one of more of its services.

7.2 **Business Continuity** – Capability of the organisation to continue delivery of products or services at acceptable predefined levels following disruptive incident.

7.3 **Business Continuity Event (BCE)** – An occurrence or change of a particular set of circumstances, such as an event, which can be one or more and have several causes. An event can also consist of something not happening, which causes a failing in operational delivery. It is sometimes also referred to as an incident or accident, but for the purposes of the Business Continuity Plan, will be referred to as either a BC Event or BCE.

7.4 **Business Continuity Management System (BCMS)** – Part of the overall management system that establishes implements, operates, monitors, reviews, maintains and improves business continuity.

7.5 **Business Continuity Plan (BCP)** – Documented procedures that guide staff to respond recover and restore, to a predefined level the capability and enable the Company to maintain its services and operations, during and following a business continuity event.

7.6 **Business Continuity Risk Assessments (BCRA)** – The process of identification and analysing business continuity risks, arising from a hazard, taking into account any existing control measures and deciding whether or not the residual risks are acceptable.

7.7 **Business Impact Analysis (BIA)** – Process of analysing activities and the effect that a business disruption might have upon them.

7.8 **Exercise** – Is a process to train for, assess, practice and improve within the Company.

7.9 **Interested Party / Stakeholder** – Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.

7.10 **Strategic Lead** – For the purposes of business continuity strategic lead will denote the Senior Management / Leadership Team.

7.11 **Tactical Lead** – For the purposes of business continuity the term tactical lead will denote the District or Compliance Manager responsible for the specific site.

7.12 **Operational Lead** – For the purposes of business continuity the term operational lead will denote either the General or Operations Manager or the Compliance Advisor for the specific site.

7.13 **Requirement** – need or expectation that is stated, generally implied or obligatory.

7.14 **Resources** – All assets, people, skills, information, technology (including plant and equipment), premises and supplies and information (whether electronic or not) that the Company has available to use, when needed, in order to operate and meets its objectives.

7.15 **Risk** – Combination of the impact of an event and the associated likelihood.

7.16 **Risk Assessment** – Overall process of risk identification, risk analysis and risk evaluation.

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7.17 **Risk Management** – Co-ordinated activities to direct and control an organisation with regard to risk.

7.18 **Testing** – Procedure for evaluation; a means of determining the presence, quality, or veracity of something.

8. Introduction and General Guidance

8.1 It is vital that the Company has plans in place for business continuity purposes, to ensure that appropriate actions are taken in a timely manner to ensure the recovery of normal service.

8.2 This procedure lays out the processes to be followed for the creation, implementation and testing of plans to be enacted if an event occurs which has the potential to effect the Company's business continuity and its normal service delivery levels.

8.3 Form **F5.04.02 – Business Continuity Plan** and associated forms, have been developed to allow each Company facility to document a site specific plan to achieve this goal.

8.4 Prior to the writing of any Company site Business Continuity Plan (BCP) the BMS Manager should make contact with the General / Operations / Site / Line Managers at the facility and issue them with a copy of **F5.04.01 – BC Plan Site Data Capture Form** template to complete.

8.5 The General / Operations / Site / Line Managers will then populate **F5.04.01** with the required information and once completed, should then return the document to the BMS Manager, who will review the information and if acceptable transfer it to the site specific **F5.04.02.**

8.6 As part of this process the site will have their business activity analysed and assessed for the potential impacts, risks and existing control measure for their normal service delivery.

8.7 This analysis and assessment will be conducted by the BMS Manager in accordance with **BMS/1.07 – Risk Management**, and specifically **WI/1.07.02 – Business Impact Analysis (BIA)** and **WI/1.07.03 – Business Continuity Risk Assessment (BCRA)**.

8.8 Section 4 -of the BCP (Business Continuity Impact Assessment Summary) will take the following from the sites **F1.07.02 – Business Impact Analysis (BIA)** in order to provide both an indication and justification for the prioritisation of service delivery:

- Service Activity;
- Aggregate Priority Impact Score;
- Most Significant Impact Rating.

8.9 The formal writing of the BCP will only occur after these stages are completed and will be co-ordinated by the BMS Manager in conjunction with operational personnel and any other appropriate stakeholders.

8.10 At each stage of this process, the necessary reviews and authorisations must take be completed and only once fully signed off, can the final plan be issued to the site and the Business Continuity section of Steripoint.

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8.11 The following sections of this procedure provide an overview to the content, general guidance and additionally (where appropriate) the information necessary to complete **F5.04.02 – Business Continuity Plan**.

9. Site Location Maps and Building Plan Drawing

9.1 After the initial site data has been entered into the **F5.04.02** (Sections 1 to 4) a site location map should be created and recorded at Section 5 – Location Map.

9.2 In addition to this a detailed buildings plan should be made, highlighting essential business continuity resources, covered in the BCP. This should be documented on **F5.04.04 - Building Plan Drawing**.

9.3 The building plan should include, but not be limited to;

- Fire Doors and Clearways;
- Fire Extinguishers
- Room and Use Identification;
- Mains Water Isolation;
- Electricity Isolation;
- Gas Isolation;
- Waste Facilities;
- IT Equipment Locations, (including Server Location).

10. Immediate BC Response

10.1 This will detail the initial actions required if a Business Continuity Event (BCE) or BC Stand-by is declared that either immediately effects routine activity or has the potential to escalate to a position where this is likely.

10.2 Within this scope it will detail, but may not be limited to;

- The sites Operational Leads declaring a BCE or BC Stand-by;
- The notification, by the Operational Lead to the Tactical Lead, of the BCE or BC Stand-by;

10.3 The notification of a BCE or BC Stand-by should be recorded on **F5.04.08 – BC Alert Form**.

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11. Buildings and Facilities

11.1 In the event that the access, egress and use of Company premises become compromised the Operational Lead should immediately enact the site BCP and follow the guidance provided at Section 7 of the BCP.

11.2 This will include, but not be limited to:

- Conducting an initial survey, only if safe to do so, to ascertain if the loss of access, egress and use will be short or longer term. This should also include an initial estimate on how this will effect normal activities at the site;
- Make contact with the Head of Property & Facilities so that the premises landlord can be officially notified if not already aware.
- Attempt, if practicable to identify other local facilities that could be used as an alternate location for the duration of the BCE.
- Isolate power and water supplies if safe to do so and appropriate at this time;
- Liaise with any emergency services or local agencies as required;
- Ensure that access to the site is controlled and communicated to all employees, with information for any alternate locations;
- Begin the process, if safe to do so and appropriate, of removing essential resources from the site as required and identified by the BIA and BCP.

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12. Establishing a BC Control Centre and Notifying Stakeholders

12.1 Once a BCE has been declared and upon the loss of the local Company premises, either short or long term, a BCE control centre will need to be identified and established.

12.2 The identification of the BCE control centre will follow the same process as defined at Section 9.13 of this procedure and Section 7 of the BCP.

12.3 The BC control centre will provide facilities to enable Company management to manage the ongoing BCE and put into place suitable resources to enable the recovery plan to be enacted and allow normal business activity to be resumed within a reasonable timeframe, dependent upon the nature and type of the BCE.

12.4 As part of BC plan all sites are required to have at least x1 Business Continuity Control Box and for larger more dispersed sites more than 1 may be required.

12.5 The Operational Lead is responsible for ensuring that the Business Continuity Control Boxes are present, stocked in accordance with **F5.04.14 – BC Control Box** and are checked at least once per month which should be recorded on **F5.04.15 – BC Control Box Check Sheet**.

12.6 Further to this they are also responsible for ensuring that all site BC Control Boxes are removed from site and transported to the BCE Control Centre.

12.7 The contents of the BC Control Box will include, but not be limited to:

- The latest version of the site **F5.04.02 – Business Continuity Plan**;
- The latest version of the Head Office Business Continuity Plan, which is available on SteriPoint;
- Hazard / Cordon Tape (x2 rolls);
- Torches with Spare Batteries (x2);
- A Clip Board;
- Marker Pens;
- Plain A4 Paper;
- Sellotape.

Immediate Communication Issues

12.8 The BCP covers immediate issues with communication with:

- Emergency Services;
- Staff who were either not present at the time of the BCE at site;
- All relevant stakeholder and interested parties to the Company's work activities;
- Company Insurers.

12.9 The contact details for these parties should be can be found within the BCP itself or in more detailed form by completing forms **F5.04.21 – Key Contacts Sheet** and **F5.04.22 – Staff Key Contact Sheet.**

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Notifying Stakeholders

12.10 It may be necessary during a BCE for Company stakeholders to be notified. The decision to do so must come from the Strategic Lead.

12.11 The Strategic Lead may wish to delegate the responsibility for making contact with these stakeholders and is all such occasions this decision and a record of any communications made with stakeholders, should be recorded on **F5.04.16 – BC Log Sheet**.

12.12 The most important Stakeholders can be recorded directly within the BCP and others can be found on either the **F5.04.21** or **F5.04.22**.

12.13 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

13. Media Contact

13.1 During the course of a BCE there may be occasions where either local or national media make enquiries with the local site.

13.2 All Managers should direct media enquiries through the Company Head Office (in Leeds) to the Senior Management Team.

13.3 Strategic and Tactical leads are authorised to make an initial holding statement to the media and details of the approved text to use for these can be found at **F5.04.11 – BC Holding Statement**.

13.4 All such communications with the media and contact from the media should be recorded on **F5.04.10 –BC Media Calls Report Form**.

13.5 Whenever interacting with the media the following must be adhered to;

- **Do Not** make any comment and do not speculate on the cause of the BCE;
- **Do Not** confirm a BCE has taken occurred unless it is clearly already in the public domain;
- **Do Not** provide the media with any alternative contact telephone numbers other than Head Office.

14. Damage Assessment

14.1 If the BCE dictates the need the Tactical Lead will liaise with the emergency services and other agencies to conduct an initial assessment of the situation and determine the extent and likely duration of the BCE.

14.2 All such interactions should be recorded on the **F5.04.16 – BC Log Sheet**.

14.3 The Head of Care Standards will make contact with the Company's insurance brokers and any other relevant third parties.

14.4 If the Company premises become unavailable please refer back to the Buildings – Short Term and Long Term Loss section of this procedure for guidance.

14.5 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

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15. Vehicles

15.1 All vehicle losses should be immediately reported back to the Operations Director whose contact details should be entered into the table on Section 11 of the BCP.

15.2 The Company will endeavour in the first instance provide vehicles from within its own internal national fleet resources.

15.3 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

16. Information Services (IS) and Telephone Systems

16.1 Sections 12 and 13 of the BCP deal with losses of IS services or facilities has the potential to impact the Company's ability to deliver a sustainable service to our customers that meets their needs and the Company's contractual and performance obligations.

16.2 Therefore any loss of IS should be dealt with as a potential business continuity event and actions taken in accordance with both the site BCP and the Head Office IS BCP, which is available on SteriPoint.

16.3 Loss of IS will include, but not be limited to:

- Loss of the Company Telephone System;
- Loss of Internet and / or Intranet Access;
- Loss or Damage to critical IS equipment;
- Loss of Connectivity with the Mobile Communications Network (external in origin);
- Loss of Functionality of Critical Company Software (e.g. CAD / CRM).

16.4 All losses of IS should be reported to ***REDACTED****.

or by calling ***REDACTED****out of hours call use the PIN ***REDACTED****.

16.5 Any Compromise of suspected compromise to information security as a result of a BCE should be reported at the earliest opportunity following the Company's incident reporting systems as detailed at **BMS/5.02 – Incident Reporting and Investigation**.

17. Essential Equipment

17.1 All site essential equipment that is portable enough to move safely should be identified and listed within the BCP.

17.2 This listing should be in priority order and readily identify the location and any accessories that are required for its function.

17.3 Equipment should only be removed from site if the site has been classified as safe to enter.

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18. Security of Company Records and Documentation

18.1 Sensitive Company documentation must be safeguarded at all times. If practicable during a BCE event, all such documentation should be moved or removed, as appropriate, to a place of safety where its continued security can be maintained.

18.2 The documentation can include, but is not limited to:

- Paper based records, including staff HR and Training Records, Patient identifiable information, financial records, sales and marketing records, fleet transport records;
- Supplier agreements and contracts;
- Letters and correspondence.

18.3 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

19. Utilities

19.1 The loss of power (gas and electricity) to site can cause a loss of essential services and the Company's ability to sustain normal operations and service delivery. Therefore it is essential the gas and electrical power supplies are resumed as soon as reasonable practicable.

19.2 The BCP requires the identification and location of the main gas isolator valve and the main and support fuse box boxes and isolators at both Section 16 of the BCP and as an output at **F5.04.04 – Building Plan Drawing**.

19.3 It also requires the local sourcing and identification, subject to any existing either national facilities contracts set up by the Company and or landlord provided services, of a local gas or electrical contractor to be able to carry out any needed remedial work.

19.4 In addition to these measures and in case the gas or electrical fault is not a site but supplier issue, details of the gas and electricity supplier should be recorded including a contact telephone number.

19.5 If power supplies are going to be compromised for any prolonged period a local electrical generator supplier should also be identified and details recorded within the BCP.

19.6 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

Water Supply and Discharge

19.7 Disruption of clean water supplies to site, for more than 4 hours, would by the nature of the regulated activity undertaken by The Company, require the implementation of all or part of the BCP.

19.8 The BCP requires the identification and recording of a point of contact with either the local water provider and or facilities management company to contact if there is any disruption to the provision of clean water and or the discharge of foul water to the site drainage system.

19.9 In addition to this the BCP will require the main water supply stop valve to be identified on the site plan.

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19.10 The BCP should also contain provisions and guidance for the Operational Lead to follow in the events of:

- Loss of water supply;
- A significant leak within the premises;
- Contacting an authorised local plumber or Landlord for remedial works to be carried out;
- Details of the local water supplier.

19.11 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet**.

20. Security

20.1 The loss of site and building security systems poses a BC hazard and risk and provisions should be in place to ensure that normal security systems are returned to serviceability as soon as practicable.

20.2 Details of any security systems contractor or landlord / agency contracted providers should be recorded here within the BCP along with any additional physical or non-physical measures taken until the service is restored.

20.3 A record of detailing any additional actions should be made on **F5.04.16 – BC Log Sheet**.

21. Personnel

21.1 Any key member of staff who becomes unavailable has the potential to create a BCE, if their roles and responsibilities cover an essential aspect of continued service delivery that cannot be covered or allocated to another suitable member of staff.

21.2 In these circumstances additional resources may be required from the wider Company. This section of the BCP deals with the internal Company points of contact to be notified in such an event by the local Operational Lead.

21.3 If this event does trigger the enactment of the sites BCP, a record of detailing any such request should be made on **F5.04.16 – BC Log Sheet**.

22. Fire

22.1 Fire will be dealt with in accordance with standard fire procedures as detailed within the buildings fire risk assessment.

22.2 Thereafter the provisions detailed with Sections 6 and 7 of the plan will apply, depending on the nature, type and extent of the fire and the damage caused.

22.3 These actions will also be covered at **BMS/5.01 – Emergency Preparedness and Response**.

22.4 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet**.

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23. Flooding

23.1 In the event of flooding and on its extent, it may be necessary to implement the arrangement contained within Sections 6 and 7 of the plan.

23.2 In the event of a localised flood due to a failure of the internal or external buildings water supply pipes the stop valve should be shut off.

23.3 As part of the BIA and BCRA process as defined in **WI/1.07.02** and **WI/1.07.03**, flood risks and likelihood will be investigated by accessing the relevant Environmental Regulators website.

23.4 The BCP should have a map inserted into it at Section 22 if there is historical evidence of a flood to the sites or surrounding area for:

- Rivers and Sea;
- Reservoirs;
- Surface Water.

24. Supply Chain

24.1 In the event of a supplier failure of service to the Company, which compromises our ability to sustain normal service delivery a BCE may be declared.

24.2 The site Operational Lead should in the first instance follow the procedures at **BMS/4.01 – Purchasing** and identify an alternate supplier through either Proactis or the Company's Approved Suppliers List (ASL).

24.3 If a suitable supplier cannot be identified then the procurement team must be contacted and provided with the details required to identify and secure another supplier as soon as possible.

24.4 If this event does trigger the enactment of the sites BCP, a record of detailing any such request should be made on **F5.04.16 – BC Log Sheet**.

25. Post, Courier and Delivery Services

25.1 In the event that the Postal Service is unavailable or interrupted, invoices and correspondence will be emailed where appropriate.

25.2 If emails are not appropriate then mail will either be hand delivered or the Company will call upon its own Mail and Courier Service or commission a 3rd party approved through the ASL, to deliver its mail.

25.3 A record of detailing these actions should be made on **F5.04.16 – BC Log Sheet**.

26. Adverse Weather

26.1 There is usually significant notice given with regard to adverse weather conditions that may affect Business Continuity. Notifications can come from news bulletins, warnings issued by weather agencies and from colleagues.

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26.2 Liaisons will be made to the local police and authorities to keep informed about the status of local major and minor roads.

26.3 A record of detailing any actions taken should be made on **F5.04.16 – BC Log Sheet**.

27. Bomb Threat

27.1 Although unlikely, the Company will take any received bomb threat seriously and recognise the disruption it would cause. Specific guidance is provided at **F5.04.24 – Guidance on Bomb Threat Procedures** and **F5.04.25 – BC Bomb Threat Alert Form**.

27.2 Should a bomb threat be received, then records shall be made of all actions taken on **F5.04.16 – BC Log Sheet.**

28. Terrorist Attack

28.1 Although unlikely, the Company recognises that its ability to deliver services would be disrupted should a terrorist attack take place near one of its facilities.

28.2 In these situations, it may become necessary in conjunction with our approved 3rd party contractors to increase the available resources in attempt to maintain operational levels, declare a BCP and notify stakeholders in accordance with Section 13 of this procedure and Section 8 of the **F5.04.02 – Business Continuity Plan**.

28.3 A record of detailing any actions taken after a terrorist attack should be made on **F5.04.16 – BC Log Sheet.**

29. External Major Incident

29.1 As part of the BIA and BCRA process the local area should be investigated to ascertain if there is a likelihood of a BC event to occur that may trigger either an internal or external major incident. These could include but not be limited to:

- An emergency at a local airport or involving an aircraft crash or emergency;
- An NHS Trust declaring a major incident;
- Local or national government declaring a major incident;
- A bomb threat and / or an act of terrorism;
- A major road traffic collision that results in large numbers of casualties and blocks traffic infrastructure;
- A public order breach that involves a large crowd (e.g. organised or unorganised event, riot etc);
- A military facility being attacked;
- An internal event that significantly affects large parts of the business, both operationally and in the support services.

29.2 The BCP should contain a narrative that reflects these local and potential national issues.

29.3 A record of detailing any actions taken after a terrorist attack should be made on **F5.04.16 – BC Log Sheet.**

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30. BC Recovery

30.1 The BCP will document the process to the recovery of normal service delivery and will detail the following, but not be limited to;

- The final decision to close a BCE;
- The formation of a working group to expedite a return to normal service delivery;
- The enactment **of F5.04.03 – Post Site Recovery Plan**, if still applicable;
- The identification and taking possession of new premises if required;
- The formal request of additional Company operational and support services;
- Arrangements for the cleaning and or repair of the existing facility;
- The notification to stakeholders;
- The provision of new or replacement equipment;
- A review of existing processes including training;
- The reinstatement of power, water, communications and mail resources;
- The relocation of all resources previously removed from the site;
- A debrief to all staff;
- Any other actions required to ensure an effective and efficient return to normal operations.

31. BC Stand Down

31.1 The BCP will contain details on how managers should close a BCE event down and the subsequent actions required, such as but not limited to;

- Notifying all staff that the BCE has been terminated (pending the actions at Section 28 to the BCP);
- Notifying all relevant stakeholders (pending the actions at Section 28 to the BCP);
- Completing the **F5.04.17 – BC Post Event Report** and sending it to the BMS Manager;
- The BMS Manager collating the report, making it available to senior managers and publishing the report to SteriPoint;
- The identification of any lesions learnt and remedial actions plans required as a result of the BCE.

32. Employee Welfare

32.1 The BCP will contain guidance to managers to assist employees after a BCE has occurred.

32.2 It will guide them to us either the services available through the Company HR Department or those provided by our Occupational Health Provider, details of which can be found at **BMS/2.03 – Employee Health and Wellbeing**.

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33. Deployment and Training

33.1 The BCP will be deployed to sites after the completion of BIA's, BCRA's and the writing and authorisation of the plan.

33.2 The BMS Manager will assist local site managers in the training and deployment phase to ensure that all staff are aware of the actions and responsibilities under the BCP.

33.3 All training will be conducted and recorded in accordance with the requirements of **BMS/2.02 – Personal Training and Development**.

34. Monitoring, Testing and Exercising the BCP

34.1 At periods not greater than a year, the BCP must be reviewed and a tested of as part of the process of continual improvement and review.

34.2 These exercises and tests with scheduled by site and documented at **F5.04.26 – BC Exercise Planner**. A central record will be held by the BMS Manager and all completed exercises recorded on SteriPoint.

34.3 The findings of this review and the outcome of the test must be recorded on **F5.04.25 – BC Exercise Test Record**. Once completed this form must be forwarded to the Regulatory Compliance Managers for review.

34.4 The Regulatory Compliance Manager will responsible for collating the report form submission to for the monthly SMT meeting and the publication of the sites **F5.04.25** to SteriPoint.

34.5 Any actions arising from the exercises / test will be entered into the BMS in accordance with **BMS/1.04 – Corrective and Preventive Action (RAP's)**.

34.6 The testing and exercising of the BCP can take numerous forms as detailed, but not limited to:

- **Desktop Exercise** – An exercise designed to discuss the actions and responsibilities of the BCP in a collaborative meeting. This will not require any physical implementation of the BCP;
- **Communications Exercise** – A test purely of the communications requirements of the BCP. This can be for both internal and external stakeholders;
- **Partial Rehearsal** – A partial enactment of the BCP that focuses on a specific requirement of the continuity of the business;
- **Full Rehearsal** – A full enactment that test all the elements of the BCP.

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35. Business Continuity Competency

35.1 In order to have a measureable business continuity competency throughout the Company, a standardised competency matrix has been written to cover BC positions such as, but not limited to:

- Strategic Lead;
- Tactical Lead;
- Operational Lead;
- Team Leaders / Lead Drivers / Site Supervisors;
- Site Administrative Support;
- Site Team Members.

35.2 **F5.04.28 – Business Continuity Competency Matrix** is available from the BMS for sites to ensure that during the initial deployment of BC, team members receive the appropriate level of training and that all such training is documented and recorded in accordance with the requirements of **BMS/2.02 – Personal Training and Development**.

35.3 BC training has been broken down into 2 types which is:

- General awareness of BC;
- Detailed deployment of **BMS/1.07 –Risk Management** and **BMS/5.04 –Business Continuity Plans**.

35.4 All existing team members and new starters must receive BC training relevant to their position within the Company as part of either the initial deployment of BC to site or as part of the initial induction into the Company.

35.5 All training completed must be recorded on the employees training record **F2.02.01(H)** or **F2.02.01(W)** and **F2.02.04(W)** or **F2.02.06(H) – Training and Toolbox Talk Attendance Record**.

35.6 Business Continuity training can be requested by submitting a **F2.02.05(H)** or **F2.02.08(W) – Training and Development Requisition Form** to the Training Department.

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Question 1.24.6

Business continuity plan

Please provide your proposed Business Continuity plans for the service being delivered.

Word count 500

Total Word Count: 500

When developing a new site specific Business Continuity Plans and EPRR plans, our lead seeks to engage with CCG's and NHS Trust so that our plans align to the requirement of each organisation. This step is vital in identifying if measures such as embedding an Operational or Tactical lead would be appropriate if required and how ERS Medical resources are deployed in support of Trust so that surges are not encountered and create additional issues such as traffic flow and access and egress issues.

Our combined Business Continuity and EPRR Plan (attached) sets out how critical business activities will be maintained in the event of any incident/disruption that threatens delivery of core business and organisational priorities. This plan is aligned with ISO-22301 and 22313 and mirrors the requirements of the NHSE's Core Assessment Standards for EPRR.

Pandemic flu - COVID-19

Since the COVID-19 outbreak, policies that were currently in place have been checked and altered to align with new government guidelines. We have adhered to the requirements stipulated in the guidance to Ambulance Trusts issued by PHE.

Using Care Quality Memos, ERS has been able to keep crews up to date with the latest information about how to prepare their vehicle and themselves from the countless issues raised by the pandemic.

Vehicles

In the event of breakdown or road traffic accident whilst conveying patients we immediately deploy a replacement vehicle and crew and notify the Authority of the forecast arrival time, which will normally be within the hour. We also have National arrangements in place with the RAC for 24-hour recovery and breakdown assistance across our whole fleet.

We have a contractual relationship with several leading ambulance hire companies that can provide resilience vehicles in under four hours as well as 10% fleet resilience.

Severe Weather

In the event of severe weather, the Operations Manager will identify staff living closer to operational sites to work over critical periods. We implement the following initiatives:

- Vehicles deployed around the operational area, ensuring they are close to point of use

- The local management team work closely with nominated Authority Officers to determine revised operational requirements if necessary
- Support the Trust with patient communication. Essential journeys are identified, and close attention paid to ensuring these are completed
- ERS works in partnership with NHSE

Major Incident

Obligations under EPRR are recognised and embraced. To ensure continued compliance ERS engages in NHS or multi-agency emergency preparedness exercises annually as required.

Telecommunications

Facilities are established with full network resilience within compliant environments. In the event of failure of telephone capability at any of our sites we will divert the contact centre to another suitable number.

IT

ERS utilise a centralised UK data centre environment for all their servers, provided by *** REDACTED *** supported 24x7 365.

*** REDACTED *** proactively manage our entire IT environment, looking after our local networks and Internet Infrastructure, mobile PDA platform, workstations, servers, cloud-based phone system and all offsite full image backup's and endpoint security, *** REDACTED *** enable us to ensure we have the highest available up-time.

Question 1.25.1

IT Systems

Please describe the IT systems and software you propose to use, to deliver and manage the service and why these systems are appropriate for the Services being delivered.

Where relevant, please include your proposed method of integration, with the relevant NHS and Social Care organisations and their systems?

Word count 1000

Total Word Count: 710

We have invested heavily in our Information Management & Technology infrastructure that supports the delivery of our services. We have developed a fully integrated cloud-based system that includes:

- Scheduling
- Communication and tracking for vehicles
- Data reporting and real-time information
- Call recording
- Vehicle Compliance
- Regulatory Compliance

Our systems have been recognised by the CQC in our latest report.



Below is a snapshot of the systems we will utilise in the delivery of this contract:

IMAGE REDACTED

*** REDACTED***

Inherent to the ERS Medical value proposition is *** REDACTED***, our integrated system that plans, operates, manages and reports on our operations. It includes a frontend booking portal that our customers can access to book journeys directly into the system and feeds through to our back-end operations. It feeds journeys either directly into the PDA's for the drivers to pick up or into the despatch control room that allocates the journeys to the vehicles.

All journeys are given a unique job reference and are then timestamped from patient being ready, to the vehicle receiving the transfer details, arrival at pick up, patient on the vehicle, arrival at destination, patient clear and end of transfer time.

It also includes pick up and drop off addresses and post-codes, patient NHS number, mobility type, escort numbers and any relevant notes.

All of this is a minimum data set, that is then pulled through into the KPI pack and delivered to our customers. We will also provide all backing data with the KPI packs to you to ensure an open and honest culture.

We also report on cancelled and aborted journeys and the system provides dropdown reasons for the cancellation of a journey. This report can be further analysed to show the hospital and ward to see if there are any patterns to aborted or cancelled journeys which may need to be managed as well as filtering into patient details to see if any patients regularly cancel their journeys, to better manage transport requirements.

IMAGE REDACTED

*** REDACTED***

*** REDACTED*** is a comprehensive GPS vehicle tracking solution, giving real-time visibility of our remote workforces. Accessed via a secure web-based platform, *** REDACTED*** displays "live" vehicle locations with continual traffic updates on *** REDACTED*** detailed mapping solution - which incorporates satellite, street level and hybrid views. It also offers a comprehensive reporting suite with business intelligence to help reduce costs, improve productivity and enhance customer service.

Should there be any incidents, the onboard camera records the environment, and the sophisticated tracking system records all data for example location and speed. This is then automatically uploaded to specific personnel within ERS Medical and our insurers.

We can also use this system to record driver behaviours and we are able to report any issues or positive effects of driver behaviours to you at the contract review meetings.

IMAGE REDACTED

*** REDACTED***

*** REDACTED*** is our internal HR system, which holds all employee data in one secure location which collates healthcare data, contact information for the employee directory and also customised data to record any relevant information on our employees including training files and driving license checks. Reports on training records etc will be produced via *** REDACTED*** and reported at contract review meetings as requested.

IMAGE REDACTED

It is also an internal registration of all personal development plans, holiday allowances and trackers. Bamboo also holds all of our policies and procedures which can be provided on request.

IMAGE REDACTED

*** REDACTED*** also allows us to advertise all vacancies and records applicant's CVs, which can be star rated to provide an easy record.

IMAGE REDACTED

*** REDACTED***

ERS Medical uses the *** REDACTED*** compliance software for its management of clinical and other regulatory governance. This system has been designed specifically with the healthcare market in mind by *** REDACTED*** solutions and it allows us to quickly and efficiently capture and record some of the main aspects required for evidencing compliance with the requirements of regulated activity.

All comments, complaints and compliments are recorded on radar and will be reported to you within 24 hours. We will also provide reports during the contract review meeting which will show the number of complaints and their status on a cumulative basis.

IMAGE REDACTED

*** REDACTED***

*** REDACTED*** is our invoicing and accounting system. All invoices will be electronically produced via *** REDACTED*** and emailed to your relevant accounts department with the relevant backing data once agreed with the Trust.

IMAGE REDACTED

Question 1.25.2

IT Disaster Recovery plan

Please provide your proposed Information systems Business Continuity and Disaster Recovery plan. The content will be evaluated and scored.

Word count 500 plus a plan as a separate attachment

Total Word Count: 500

Within our BCP we have identified our full IM&T plan, processes and Disaster Recovery Plan.

Information Technology

Local Loss of IT

In the event of a local short-term disruption to service the Operational Lead will contact our IT department and log a works ticket to remedy the fault.

All essential services will continue to be provided from other sites within the location or from other regional locations such as Head Office in Leeds.

Remote access to the ERS medical servers and systems such as *** REDACTED ***, *** REDACTED *** and *** REDACTED *** and will still be possible via 4G Hotspots.

National Loss of IS

In the event of a national loss of information services staff will follow as above and fall in line with the national recovery protocols and provisions, put in place by the Senior Management Team and *** REDACTED SYSTEM/SOFTWARE TITLE***.

These provisions will be:

- Isolated power supplies
- UPS
- On site generator
- Redundant server links
- Back-up data centre network connections
- Spare hardware
- Back-up telephone system to support 8X8

In addition to the above provisions the following will be undertaken in support of the *** REDACTED *** System and to ensure that essential data is retrievable, even in the event of a *** REDACTED *** outage:

- A daily 'Activity Dump' for all journeys and allocated work will be created out of *** REDACTED *** as a CSV file
- The 'Activity Dump' CSV file will be automatically downloaded every 45 minutes from *** REDACTED *** and stored on ERS Medical Servers and uploaded to our SharePoint

These additional provisions will ensure that if Cleric is inaccessible, we can still access the pre-booked journey data, via a shared folder on the SharePoint system.

In support of ERS Medical servers, *** REDACTED *** and *** REDACTED *** have implemented the following BC provisions:

- Planned monthly testing of the server failover switch
- Installation of a secondary power supply
- Active monitoring and alerts for the ERS Medical SQL1

Telephone System

Short-Term Loss (Less than 4 hours)

In the event of a short-term local fault, which is beyond the control of the Company, the Operational Lead will arrange to have the affected numbers transferred to another suitable phone or site. They will report the fault to our IT department.

The Operational Lead will also contact all stakeholders and advise them of the temporary fault and to how to make booking during this period.

Long-Term Loss (more than 4 hours)

In the event of a national loss of telephone services staff will follow as above and fall in line with the national recovery protocols and provisions, put in place by the Senior Management Team.

A record of detailing these actions will be made.

The site should adhere to the stakeholder notification periods as detailed within Section 10 of this BCP.

Alternative Communication

Operational Lead through to Strategic Lead will ensure that they have *** REDACTED *** installed onto their laptops and PC's.

Teams for Business can be used as a method of communicating in real-time in the event of a loss of either the mobile telephone networks, 8X8 telephone system (locally) or both.

Question 1.25.3

Interoperability of IT systems

Is your booking system capable of becoming interoperable with NHS systems to support direct booking by wards and patient readiness notification etc. and capable of becoming interoperable with Staffordshire STP developing digital infrastructure. If so please summarise how this will be achieved.

Word count 500

Total Word Count:

We have a fully operational online booking portal that is accessible through the internet and via a phone application (currently being rolled out across the business). The online booking portal will not accept any bookings until all of the eligibility questions have been successfully answered by the booker.

Sample question: *Question creation within criteria as an example:*

IMAGE REDACTED

We will provide all Clinic/Authority locations with full training to allow staff to book patients 'ready to travel'. Our system provides Clinic/Authority staff with a simple but effective means of booking and amending patient transport. It uses the latest internet technology and can be used by any authorised person with access to the system over a secure online network. The online booking service streamlines the booking process for Authority staff, allowing them not only to quickly and easily arrange transport for their eligible patients, but to also make alterations to their bookings should it be required. Further to this we also have a dedicated Call Centre that is available to take bookings directly from authorised staff. The combination of our Call Centre and our online booking service ensures we deliver a comprehensive service to the Authority.

All of the bookings are managed and processed using our *** REDACTED*** system which allows us to run comprehensive reports, which we will provide to the Authority on a monthly basis. Further to this we can run ad hoc performance reports as an when required.

We are able to monitor who books each journey and coupled with feedback from our crews and the Authority identify any inappropriate booking such as wrong mobility type, wrong time, wrong destination, etc. From this we can then deliver targeted refresher training for the individuals/wards/departments identified.

Interoperability

Following meetings with *** REDACTED*** and *** REDACTED*** we are able to confirm that our Booking portal has the potential to deliver interoperability with *** REDACTED*** in the following areas:

- Ability to upload bookings made so that these can be verified by clinical teams
- Ability to receive patient information relevant to NEPTS bookings
- Ability for clinical teams to book journeys electronically subject to eligibility
- Ability for patients to book journeys electronically subject to eligibility
- Ability to use *** REDACTED*** portals to view bookings including for clinical teams pick up and estimated time of arrival.

*** REDACTED*** have already developed a public interface (API) that allows 3rd party users to insert journeys directly into the booking system and would undertake an implementation project to develop and secure the integration moving forward. During the mobilisation period we will begin the implementation project and following initial talks we would set out a plan to deliver the project within a specified timeframe.

Question 1.26.1

Equality and diversity embedding

Please describe how equality and diversity shall be embedded by your organisation in terms of service delivery (to service users/patients) and for internal operations (workforce).

Word Count 1500

Total Word Count: 583

Promoting and supporting diversity in the workplace is an important aspect of good people management - it's about valuing everyone in the organisation as an individual. However, to reap the benefits of a diverse workforce it's vital to have an inclusive environment where everyone feels able to participate and achieve their potential. While UK legislation – covering age, disability, race, religion, gender and sexual orientation among others – sets minimum standards, an effective diversity and inclusion strategy goes beyond legal compliance and seeks to add value to an organisation, contributing to employee well-being and engagement.

The moral case for building fairer and more inclusive labour markets and workplaces is indisputable: people matter, and organisations must ensure their people management approaches do not put any group at a disadvantage. Regardless of our identity or background, we all deserve the opportunity to develop our skills and talents to our full potential, work in a safe, supportive and inclusive environment, be fairly rewarded and recognised for our work and have a meaningful voice on matters that affect us.

It's also vital for the sustainability of businesses and economies. Everyone stands to benefit when we embrace and value the diversity of thoughts, ideas and ways of working that people from different backgrounds, experiences and identities bring to an organisation. It helps people grow and learn, tackles under-utilisation of skills by enabling people to reach their full potential, improves decision-making, boosts engagement and innovation, and enables businesses to better meet the needs of a diverse customer base. This applies to the individuals we employ and how our staff interact with service users and patients.

To ensure our approach to equality and diversity is embedded within our organisation it is contained within the following policies and working practices:

- Employee handbook
- Recruitment Policy
- Training
- Corporate Social Responsibility Policy

In 2020 we will be launching several initiatives to promote Equality and Diversity in ERS Medical. These include:

Dementia friendly vehicles

We are partnering with the Alzheimer's Society to assess the working practices of our operations and to implement Dementia Friendly processes and vehicles across the business. Our dementia friendly vehicles will look to include:

- Window covers – The window nearest the patients seat will be covered with a scene that contains key points to talk and reminisce about, including children playing to remind people of their youth and animals for patients to guess what they are
- Music provision – Our crews will have the ability to play music for the patients to help deliver positive reactions and memories.
- Provision of 'Twiddlemuffs' – a knitted hand muff, decorated with internal and external items, such as buttons and ribbons.
- Communication guide for staff – dementia friendly training for all staff had been rolled out throughout the company. The guide this guide provides advise to staff on how to use the changes to the vehicles to prompt conversation and communications styles for patient who may not be able to communicate verbally.

Becoming Dementia Friends

Dementia Friends is about learning more about dementia and the small ways we can help. We are encouraging our employees to become Dementia Friends to raise awareness and understanding, so that people living with dementia can continue to live the way they want.

Mental Health Advocates

We are rolling out a training scheme across the business, to train key personnel including Managers and Team leaders to be Mental Health Advocates. Giving them the skills to recognise the signs of someone struggling with their mental well-being and the training and tools available to help our employees.

Question 1.26.2

Please confirm how you will evidence service improvements and good outcomes for seldom heard users and people protected under the Equality Act 2010, via equality feedback from service users and their cares in terms of 'You said, we listened, we did'.

Word Count 1500

Total Word Count: 675

The term 'seldom-heard users' refers to under-represented people who use or might potentially use our transport services and who are less likely to be heard by service professionals and decision-makers. Many factors can contribute to people who use services being seldom heard, including:

- Disability
- Ethnicity
- Sexuality
- Communication impairments
- Mental health problems
- Homelessness
- Geographical isolation

We will engage with Seldom Heard User Groups and those specialist healthcare organisations who facilitate these. We are committed to working with all stakeholders within the local population to identify ongoing continuous improvement to our service. To engage directly with stakeholders including those identified as vulnerable or seldom heard we utilise the following methods:

- Attending stakeholder meeting groups
- Establishing service user groups
- Social media groups to allow those that may not attend user groups to have their say
- Working with Healthwatch
- Marketing leaflets at CCG and Trust facilities not only outlining the services we deliver, but also how to provide feedback on our services.
- Work with PALS and commissioners to implement a forum to engage with vulnerable and seldom heard patients

Attending stakeholder meetings

We will attend stakeholder meetings to ensure that all of the key stakeholders are kept fully up to date of our service offering, upcoming developments and to obtain any feedback on our service. This

two-way transfer of information will not only ensure that all parties are happy with the service, but it will also lead to the continual development of our service offering throughout the contract.

Setting up user groups

ERS are happy to facilitate new user groups to enable us to work with regular users of our service to understand how we can make it better and what changes service users would like to see in the future.

Set up social media groups

To make our service all-inclusive and ensure that all patients voices are heard we will set up social media groups on the main social media networks. This allows patients who are unable to attend user groups to have the ability to discuss our service and voice improvements or developments they would like to see.

Work with Healthwatch

Healthwatch talk to local people to build a better understanding of health and social care systems as they are experienced. We will work in partnership with Healthwatch Staffordshire to develop specific consultations and share information regarding the local NHS transport service. We will also actively encourage their representation at our user group and stakeholder meetings to allow them to maximise the amount of information at their disposal to ensure they have the best overview of the whole services delivered by and on the behalf of the NHS.

We will also have regular meetings with them to provide any feedback that they may have received directly or broadly referring to the services we deliver. This ensures we capture as much feedback as possible to allow us to best develop our services.

Marketing materials

During the mobilisation of the service and throughout the contract we will provide marketing materials to be used and displayed throughout the NHS network to ensure that all patients have the ability to access the information they require. This will include:

- An A4 tri-fold leaflet to communicate the criteria which patients must meet to be eligible for a PTS service. The document contains all relevant contact details to signpost each type of enquiry from patients to the relevant department such as PALS. A PDF of the publication will also be provided to the communications team at the hospital
- A condensed informative flyer to direct patients to the booking office and explaining the system in place step by step to guide a patient through the process.
- TV screens, posters and pull up banners will be designed for display within entrance areas of hospitals to communicate change of provider information to those passing through or in waiting room areas

Example of engagement

At our Steeper contract we conduct biannual patient engagement days through having a pop-up stand in the reception area of the hospital. This allows patients to provide us with direct feedback on our services.

Question 1.26.3

Service Improvements

Please tell us how you will evidence any service improvements and reasonable adjustments for people protected under the Equality Act 2010 and other vulnerable groups. Examples may include lessons learnt, service users and carers feedback, embedded processes, ongoing monitoring, other approaches or an example of where a reasonable adjustment has been made.

Word Count 1500

Total Word Count: 394

The Equality Act 2010 protects people from discrimination in the workplace and in wider society. The UK legislation covers the following outlined protected characteristics:

- Age
- Disability
- Gender reassignment
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage and civil partnership
- Pregnancy and maternity

ERS understands the principles of protected characteristics and all staff receive training on it to ensure we treat all patients equally with dignity and respect.

embedded processes

To ensure the processes we have in place to meet the requirements of the Equality Act 2010, they form part of our induction training and annual refresher training to all staff. The training includes explaining the Act and what it means for our employees and providing a full definition of Equality and Diversity and our policies and how they are to be applied in a day to day work environment. Our employees understanding is assessed at the end of the session.

To ensure our approach to equality and diversity is embedded within our organisation it is contained within the following policies and working practices;

- Employee handbook
- Recruitment Policy
- Corporate Social Responsibility Policy

Should any service improvements or adjustments be made for people protected under the Equality Act 2010 it will be captured in the above documentation and policies and also reflected in the training moving forward. This ensures that all staff are made aware of any improvements or adjustments are adhered to from the implementation.

Ongoing monitoring

Our compliance to the Equality Act is maintained through our HR partner Peninsular. Along with our annual internal review of our policies and Employee Handbook. Peninsular conduct a full audit to ensure we are compliant with the latest legislation and have implemented any required changes.

To ensure that Equality and Diversity is fully embedded into our service our Operational teams conduct staff ride-a-longs and staff shadowing as part of their ongoing PDP assessments.

Service users and carers feedback

At ERS we are committed to working with all service users and stakeholders to identify ongoing continuous improvement to our service through feedback, staff and patient engagement and steering groups. An on-board survey is provided to patients on every journey (excluding regular service users) for them to complete and return. Feedback from these surveys is discussed at our monthly Governance and Patient Safety meeting. These meetings are used to discuss the feedback we receive to develop and improve our service.

(2) NOTES ON COMPLETION OF MODEL

All Bidders must complete the Financial Model Template (FMT) in full to ensure a Compliant Bid. Failure to do so could result in a non-Compliant Bid and elimination as a potential Bidder.

It is the responsibility of the bidder to ensure the information submitted in the FMT is accurate, complete and correct.

The FMT provided to the Bidders has been prepared in Microsoft Excel 2010. Bidders are requested to save their electronic submission copy under this version or in a lower version of Excel with their name in the title and the date of submission.

VAT will not be chargeable to the Commissioner, the individual bidder will be responsible for any VAT incurred and therefore will need to ensure they can cover all appropriate costs within the pricing options shown.

Colour Guide to Cells and tabs

	This is a bidder input cell
	This cell is a Commissioner input cell
	These tabs are summaries no Input Required
	No entry required

All monetary values must be quoted in £'s sterling

The FMT comprises a series of tabs, which are listed in the table below, providing the tab references within the workbook, together with a brief description of their content and the Bidder requirements, i.e. actions required of the Bidders for the relevant tab.

WORKSHEET NO.	TAB TITLE	NOTES	Purpose of workbook		
			BIDDER INPUT	CCG INPUT	SUMMARY
1	**Title**	Title of procurement and date of submission	☑		☑
2	**Completion Notes**	Instructions for Bidders on how to complete the model		☑	☑
3	**General Assumptions**	General assumptions used/ or to be used and description of pricing methodology		☑	☑
4	**Bidder Costs**	Inputs to be completed by the Bidder for any Staff costs including any relevant TUPE costs, and for all Non Staff Costs, including all setup and mobilisation costs.	☑		
5	**Financial Summary**	A summary of the Revenues, Costs and Profits over the contract period			☑
6	**Financial Structure**	Bidders must complete the table with details of how cash flow requirement identified within the FMT will be funded	☑		

7	**Narrative and Assumptions**	Allows the bidder to provide full details and disclosure of any key assumptions made in the FMT.	☑		

Worksheet	***BIDDER INPUT -FURTHER DETAILS***
	Title
1	There are four items that need to be entered in this section C5 - Enter your organisation's name C7 - Enter the date of submission of the model. This will be used to differentiate versions of the model. C9 - Enter the name of the person responsible for the submission. C11 - Enter the email address from which the submission is made.
4	**Bidder Costs:-** **Staff Cost Calculations** **Staff Costs should include TUPE Staff where appropriate - refer to the tupe information on "Tupe (5)"** **Whole Time Equivalent (WTE)** **-** Bidders must enter details of all the staff they intend to employ and categorise as either Medical & Nursing or Non Medical & Nursing and further categorise using the staff band - The definition of a standard working week is 37.5 hrs. Bidders are required to provide the number of WTE's per category of staff. - For example a part time member of staff employed on 20hrs per week would be classfied as 0.53 WTE (20/37.5) **Staffing Costs** - Bidders are required to enter the full cost of all the staff they intend to employ as detailed in the WTE section. - Costs must include all the cost consequences of Pensions and National Insurance. - Staff costs must include the Tupe staff, if the bidder anticipates any redundancy costs these must be included. **Non Staffing Costs** This section allows the bidder to enter the full Non Staffing costs expected to be incurred on an annual basis over the lifetime of the contract. All costs should be input inclusive of VAT where applicable. **Bidder Profit** Enter the expected bidder profit of the service if applicable.
	Financial Summary
	This sheet requires no Bidder input but the Bidder should review to ensure that it correctly summarises their proposal.

5	This tab reflects a summary of the Bidder's proposal as follows: • Bidder total revenue • Bidder total expenture • Bidder profitability and margins

	Financial Structure
6	This sheet asks Bidders to evidence how Opening Cash balance will be funded and also how any periods of negative cash flow will be managed. The sheet gives examples of the types of funding which could be included. The analysis of cash flow and cash flow management forms part of the overall Financial Evaluation and Bidders must be aware that supporting evidence should be provided of any stated sources of funding.
	Narrative and Assumptions & Cashflow
7	"Bidders should include as much detail as possible to explain key assumptions made in the FMT. For example Bidders should include a full explaination if they have deviated from using the estimated levels of activity. Bidders can explain treatment of pay on costs, the level of depreciation included, rationale for the staffing numbers. Enter as much detailed as necessary to allow the reader to understand the finances included within the model. The bidder is required to highlight any cash flow assumptions they have made in tendering the bid in the cash flow assumptions section of tab 7 "Narrative and Assumptions (7)

NHS Stafford and Surrounds CCG, NHS Cannock Chase CCG, NHS East Staffordshire CCG, NHS South East Staffordshire and Seisdon Peninsular CCG, NHS North Staffordshire CCG, NHS Stoke on Trent CCG, NHS Midlands Partnership Foundation Trust

Annex 5

ITT769 Non-Emergency Patient Transport Services across Staffordshire

Financial Model Template

Non-Emergency Patient Transport Services (NEPTS) across Staffordshire ITT 769

NHS Stafford and Surrounds CCG
NHS Cannock Chase CCG
NHS East Staffordshire CCG
NHS South East Staffordshire and Seisdon Peninsular CCG
NHS North Staffordshire CCG
NHS Stoke on Trent CCG
NHS Midlands Partnership Foundation Trust (Associate Commissioner)

Organisation	
Submission Date	
Submitted by	
E-Mail Address	

Organisation	0

Submission Date	0

NHS Stafford and Surrounds CCG, NHS Cannock Chase CCG, NHS East Staffordshire CCG, NHS South East Staffordshire and Seisdon Peninsular CCG, NHS North Staffordshire CCG, NHS Stoke on Trent CCG, NHS Midlands Partnership Foundation Trust

General Assumptions	
Model Start Date	
Service Commencement	01/08/2021
Contract End	31/07/2026
Optional two year extension end	31/07/2028
Bidders are required to submit information for the full term of the contract plus the two year extension	
Inflation	
The model assumes no inflation rate but from 01 April 2023 and each year after that the NHS inflation and efficiency assumptions for ambulance services will be applied to the contract value.	
Financial Value	
Financial values in Real Terms (ie excluding inflation)	YES
Financial Value to be in £ sterling	YES
Cost are to be based on financial year ending March	2022

Financial envelope - Maximum annual contract value EXCLUDING the journeys to and from Birmingham Hospitals from 01 August 2021 to 31 March 2022.	
Financial envelope - Maximum annual contract value INCLUDING the journeys to and from Birmingham Hospitals from 01 April 2022.	

Taxation Assumptions
Costs where VAT is charged are to include the VAT element
Sates / Revenue charges are VAT Exempt
Activity Data
Insert activity data (to follow)
Block Contract
Payment is not linked to Outcomes.
Annual Contract Value will remain fixed between 01 August 2021 and 31 March 2023

From Year 2 and each year thereafter until Year 4 the bidder must reduce its annual contract value by at least 0.5% as an efficiency saving. (Three annual reductions)

The bidder may choose to apply an annual efficiency saving of greater than 0.5% each year

The bidder efficiency adjustments MUST BE included in the bidders costs and financial summary tabs.

Between 01 August 2021 and 31 March 2022 the bidders costs and financial summary should reflect total costs EXCLUDING activity involving journeys to and from the University Hospital Birmingham sites.

From 01 April 2022 the bidders costs and financial summary should reflect total costs INCLUDING activity involving journeys to and from the University Hospital Birmingham sites.

From 01 April 2023 and each year after that the NHS inflation and efficiency assumptions for ambulance services will be applied to the contract value. This will be applied in addition to the bidder proposed efficiency adjustments.

The NHS inflation and efficiency assumptions MUST NOT BE ESTIMATED OR INCLUDED in the bidders costs and financial summary tabs.

There are no extra-contractual journeys. All journeys covered with the service specification are contractual .

Full CQUIN Payments are to be included within the annual contract value. No additional CQUIN payments will be due and no CQUIN submissions are required from the provider.

Only those journeys expressly identified in the service specification and listed below will be eligible for additional payment above the annual contract value.

The maximum additional journey payment in each financial year will be capped at 1% of the total contract value for that financial year.

Journeys Eligible for Additional Payment are limited to the following categories of journey:

Repatriation of patients undergoing emergency treatment at centres beyond the central England zone (the West Midlands, East Midlands, Cheshire, Merseyside, Greater Manchester, South or West Yorkshire) because of the location the patient found themselves when they became ill / were injured and required treatment.

Journeys to or from centres beyond the central England zone (the West Midlands, East Midlands, Cheshire, Merseyside, Greater Manchester, Yorkshire) to enable the patient choice where the services being accessed would be available much closer to home.

Journeys to or from centres beyond the central England zone (the West Midlands, East Midlands, Cheshire, Merseyside, Greater Manchester, South and West Yorkshire) because of lack of local capacity and immediate or urgent clinical need

Journeys involving repatriation of patients in disproportionate numbers from outside Staffordshire. Stoke-on-Trent or its immediate neighbouring CCGs where these patients have been admitted to or moved to more distant secondary care facilities because of a major incident which limited access to normal the facilities normally used by Staffordshire and Stoke-on-Trent. Note that these repatriations will not be counted as Journeys eligible for additional payment during the incident response and recovery phase until normal NEPTS activity has resumed, but would apply to repatriations of patients who could not be repatriated within the recovery phase for example for clinical reasons.

The bidder will set out within Tab 7 (Narrative & Assumptions) the method for calculating the cost of such journeys. This must be commensurate with the 2021 market rate for such journeys.

Where journeys eligible for additional payment are requested, if the total additional payment exceeds £1000, commissioner approval will be requested in advance (without detriment to the patient).

The provider will audit and provide reports on journeys eligible for additional payment

Additional Payments made for journeys subsequently found not to be eligible will be repayable to the relevant commissioner.

No other adjustments to annual contract value will be permissible up to 31 July 2026 (or 31 July 2028 if the option to extend is activated) except as required by the NHS standard contract in place at the time.

Definitions	

Premises Costs
All premises and associated costs are the responsibility of the provider This includes but is not limited to, IT software and hardware, administration costs, facilities maintenance etc

Reference	Description	Event Type	Region	Location	Event Date	Closed Date
IG-004	****** A Transport patient was waiting in the main patient waiting area to be collected and taken to ***** Hospital. Transport arrived and took the patient and returned the public wheelchair to the main wheel chair area outside. The patients note were later found by another member of the public on the wheel chair and handed in to reception. Hospitals Actions: Contacted patient transport and made them aware of the breach of patient data. Tried to arrange a collection from transport to pick the notes up and return to the patient at***** Hospital. However, transport made me aware that the notes could not be collected until after 6pm when the department is closed, and therefore transport could not help. I then raised the issue with my Line Manager who approved costing to send the notes using a public taxi. Contacted ***** Hospital to make them aware of the issue and that the notes will be arriving separately to the patient	Information Governance/Security	East	Norwich	04/10/2018	04/11/2018
IG-006	***** VDI'd his vehicle this morning and came across a folder containing patient information. It was brought directly to me and I ascertained the patient was discharged yesterday evening and the crew member responsible was *****. Along with ***** we spoke to ***** who recalled the patient and circumstances surrounding her transport and was aware of the seriousness of leaving patient identifiable information on his vehicle. ***** was apologetic and has said he will be more careful in the future. This was ***** last Job of the day so on this occasion no other member of the public would of had access to this folder. We discussed with ***** doing a thorough check of the vehicle when arriving with a patient to their address and also at the end of his shift to avoid this situation reoccurring.	Information Governance/Security	East	Kings Lynn	14/11/2018	30/11/2018

IG-007	Norfolk KPI MDS sent to CSU in error. This contains patient identifiable information and should have been sent to the DSCRO. STEIS number is 2018/******	Information Governance/Security	East	Norwich	12/11/2018	10/01/2019
IG-012	As part of the Monthly PRF Audit there were two PRFs missing from the 18th and 19th March 2019 - ***** and *****. After a primary search of the offices at ****** the HDU vehicle ***** was searched and the missing PRFs were found on board. The vehicle was used on 20th, 21st and 28th March when the PRFs would have been on board. The PRFs were in a folder with the supply of blank PRFs inside a draw in the vehicle.	Information Governance/Security	East	Kings Lynn	08/04/2019	30/04/2019
IG-015	I received a call from ****** at Norfolk CSU to advise that she had received a strange email from ***** that contained PID and that this didn't appear to be a Norfolk Patient I had a look at this and realised that ***** had been assisting to send the ***** booking forms as she had a NHS.net account and with the email address being very similar this had been sent in error Update** The same email was sent on two separate occasions in error on the same day **	Information Governance/Security	North	Leeds - CCO (Not Operations)	05/06/2019	10/06/2019
IG-016	Picked pt up from a care home and they've given us the DNAR, which I put it somewhere on my person or on the wheelchair as I was sorting the patient out in the ambulance. We got to the hospital and we didn't have the DNAR, we couldn't find it at all. We've looked all over the ambulance, went back to care home, retraced our steps and it is nowhere to be found. We've searched everywhere and with other patients on the vehicle and it's nowhere to be found. The ambulance was locked when nobody was in it so we just cannot fathom where it has gone.	Information Governance/Security	East	Kings Lynn	13/06/2019	24/06/2019

IG-017	Received an email on bookings mail box with patient information on, regarding a death. *** has notified the people who have sent the email.	Information Governance/Security	North	Leeds - CCO (Not Operations)	24/06/2019	10/07/2019
IG-021	Member of the transport crew took photograph of TEP form on EPR prior to taking patient home.	Information Governance/Security	South	Homerton	08/10/2019	22/10/2019
IG-022	On Thursday at 17.31 an e-mail with regards to the payroll communication was sent out and rather than bcc everyone in the e-mail addresses were in the to box and this wasnt picked up until after the e-mails had gone out. An apology e-mail is currently been sent out to all involved	Information Governance/Security	Head Office	Hetton - Head Office	07/11/2019	22/11/2019
IG-024	An email has been sent out to which included a group in the recipients, the individuals in the group were not blind copied as such personal email addresses were accessible.	Information Governance/Security	North	Manchester	15/11/2019	03/12/2019
IG-025	Notified by Norfolk CSU of PID (TRN-297) within the October 19 *** Compliance report, submitted as part of the KPI pack.	Information Governance/Security	East	Norwich	19/11/2019	22/11/2019
IG-026	A Reference Request that had been completed was Scanned to Email via Copier and the Email address attached to the name in the address book did not match meaning that the completed form was sent to wrong email internal address	Information Governance/Security	Head Office	Hetton - Head Office	21/11/2019	22/11/2019
IG-027	As part of a current Disciplinary Appeal, I was speaking to the Ops Manager at site when it became apparent that an individual that was part of the original Disciplinary/Complaint had actually applied for PI information in relation to a lettings reference under his company. The company is logged on companies House but as of 4.30pm last night - it is our belief that this information was obtained fraudulently and we gave the information, which now forms a breach.	Information Governance/Security	South	Eastleigh	21/11/2019	06/12/2019

IG-033	The crew had two wheelchair patients allocated to them and took the wheelchair to collect the first patient. When arriving to collect the first patient she was in fact a stretcher patient therefore, they went to collect the other patient first and got her on board the vehicle. Before leaving the vehicle the crew member moved her bag to a safer spot on the vehicle. The crew then went to collect the stretcher patient and on returning noticed that the bag had moved and upon inspection the sat nav that was in there was missing. When arriving at the destination hospital there were two police officers stood outside and the crew member driving approached them and explained the situation. The officers then came to the vehicle and questioned the patient who denied it at first but then pulled the sat nav and some cables, which the crew had not noticed were missing, out from underneath her top. She returned them to the crew member and the officers asked if the crew wanted to press charges. They decided not to and explained that they just wanted to get the patient into the hospital. On arrival at the ward the crew informed the nurse in charge of what had happened and handed the patient over to them. The crew then called the OOH team and informed them of what had happened and the details were logged on the patients notes so that the incident was documented.	Information Governance/Security	North	Leeds - Teaching	31/08/2020	09/09/2020
IG-034	I was picking up a patient from****** discharge suite. I was given a plastic wallet containing some paperwork and notes. I accidentally left in the rear holder of the Hospitals wheelchair. I realised this when Dispatch contacted us at 16:23. Another Crew were at the Hospital and were asked to go look for the paperwork but during that time Dispatch contacted me to tell me that the ***** had found the paperwork.	Information Governance/Security	East	Norwich	27/09/2020	

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Public Interest Test

Request for FOI/1224/1107 Information	
FOIA Exemption, S.43 (1) and (2) – Commercial Interests	
Factors supporting disclosure	***Factors supporting non-disclosure***
• There is a clear public interest test in the work of government being closely examined to encourage the discharging of public functions in the most efficient and effective way; • There is an important public interest in the work of public bodies being transparent and open to scrutiny to increase diligence and to protect the public purse; • There is a public interest test in disclosing information about transparency in the spending of public money and that public bodies are getting value for money when entering into contracts.	• The procurement process must be seen to be fair and that commercial interests of the suppliers of services are not unduly prejudiced by the release of commercially sensitive information. It is important to maintain the confidence of our suppliers in order to achieve best value for the tax payer; • The pricing aspects outlined in the existing contract may be construed as a "trade secret" in that it is a strategy owned and developed by the contractors. If the pricing was made available to competitors in the marketplace it would undermine the commercial interests of the contractors when bidding for other contracts by reducing their competitive edge; • To reveal the details of the cost would seriously undermine our ability to negotiate the best value for money for the public purse on future contracts as the rates and methodology are still current; • The contractor adopts a unique approach to the build-up of its rates prices and percentages which gives it a competitive advantage. This would undoubtedly prejudice its competitive position in future tender competitions. The public disclosure of this and other information would make available to competitors commercially sensitive information and, as a result, would undermine and prejudice the contractor's financial status by undermining its ability to win future tenders and future negotiations in respect of such fees.
Conclusion: there are compelling arguments which support withholding the information which outweigh those supporting release.	

Staffordshire and Stoke-on-Trent Integrated Care Board

PIT Members: Vasileia Pitarokoili, Tracey Revill, Matthew Gollins and Lee Squire.

Date of Public Interest Test: 21st January 2025