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| **Developed by:** | Head of Safety, Security and Risk  Emergency Planning Adviser |
| **Director leads:** | Associate Director of Estates and Facilities |
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| **1.** | **INTRODUCTION** | | |
|  | The **Civil Contingencies Act 2004 (CCA)** and associated Regulations and Guidance that came into force on 14 November 2005, form the legal background that requires South West Yorkshire Partnership Foundation Trust (SWYPFT) to produce and maintain comprehensive Business Impact Assessments (BIA) and Continuity arrangements. This policy provides instruction and guidance on how SWYPFT can comply with the CCA. | | |
| **2.** | **PURPOSE & SCOPE** | | |
|  | The purpose of this policy is to: | | |
|  |  | Enable SWYPFT to comply with the requirements of the CCA 2004 and associated Regulations; | |
|  |  | Enable SWYPFT to comply with NHS England’s EPRR Core Standards Assurance Framework; <https://www.england.nhs.uk/ourwork/eprr/gf> | |
|  |  | Ensure SWYPFT provide instruction and guidance to ensure their critical and essential functions can continue to operate in the event of an emergency or critical incident; | |
|  |  | Provide a structure to enable comprehensive business continuity management systems to be established and maintained, in the event of an emergency or critical incident; | |
|  |  | Identify key services, together with their critical activities, processes and resources that need to be maintained in the event of an emergency or critical incident. | |
|  | **2.1**  **2.2** | **Organisational Wide Business Continuity Risk Matrix**  The organisational wide Business Continuity Risk Matrix identifies a range of issues that could affect the Trust. Individual service and directorate plans provide information of how the Trust will manage business continuity in the event of a major /critical event (see 3.3 for definitions). The invocation of an organisation wide response will most probably run in conjunction with an emergency and the activation of the [Trust’s Major/Critical Incident plan](http://nww.swyt.nhs.uk/emergency-planning/Pages/Policies-and-Procedures.aspx) and Business Continuity Plan.  **Flow Chart of Procedure**  The successful implementation and flow of effective business continuity processes is everyone’s responsibility. The diagram below identifies key stakeholder groups whose duties are set out in Section 3. | |
| **3.** | **DEFINITIONS** | | |
|  | 3.1 | **Employees** | |
|  |  | Employees are: | |
|  |  | * Direct employees of SWYPFT; * Employees of other organisations but directly managed by SWYPFT;   **N.B.** Direct employees of SWYPFT that are directly managed by another organisation (e.g. Local Authority) will work to that organisation’s policy and procedures, unless specific agreement is reached to the contrary;   * Agency staff, apprentices, cadets, volunteers and any other staff on placement with SWYPFT. | |
|  | 3.2 | **Emergency**  An emergency is as defined in Section 1 of the CCA and means:   * an Event or Situation which threatens serious damage to human welfare in a place in the UK, * an Event or Situation which threatens serious damage to the environment in the UK, * war or terrorism, which threatens serious damage to the security of the UK.   In responding to an incident, the Trust will aim to:     * save life; * prevent the escalation of the situation; * relieve suffering; * safeguard the environment; * protect property; * facilitate criminal investigation and judicial, public, technical or other inquiries; * inform the public; * promote self-help and recovery; * restore normality as soon as possible. | |
|  | 3.3 | **Incident Types**  **Major incident** – this is defined as ‘An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.’ For Health Service purposes a Major Incident is:  “*Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations”.*  **Critical incident** is any significant event that causes disruption to normal business activities. It may threaten staff, buildings, vehicles, surrounding area or the operational structure of the Trust and could be caused by:   * fire; * floods or storms; * technical or mechanical failure (loss of essential services e.g. power, IM&T failure); * sabotage or vandalism (including arson); * events involving staff; * accidents or carelessness; * terrorism; * loss of supplier; * communicable disease outbreak i.e. Pandemic Influenza; * chemical spillages /HAZMAT incident; * serious building damage.   N.B. These examples are not exhaustive.  **Business continuity incident** is an event or occurrence that disrupts, or might disrupt, an organisation’s normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed) all definitions are available at <https://www.england.nhs.uk/wp-content/uploads/2015/11/eprr-framework.pdf> , page 8-9.  There are 4 levels of incidents that may affect SWYPFT: | |
|  |  | * **‘Level 1 incident’** – an unplanned event that requires an assessment with a view to deciding possible response. It may have the potential to develop into a level 2 or 3 incident; (An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners. * **‘Level 2 incident’** – a potentially dangerous situation requiring an immediate response. The consequence of declaring a level 2 incident is that the first priority is the safeguarding of human life; (An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.) * **‘Level 3 incident’** – An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level. * **‘Level 4 incident’** -An incident that requires NHS England National Command and Control to support the NHS response.   NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.  *NHS England Emergency Preparedness, Resilience and Response Framework, p9.* | |
|  | 3.4 | **Business Continuity Management (BCM)**  Business Continuity Management is a process that identifies potential threats to an organisation and the impact to business operations that those threats may cause.  Chapter 6 of the Emergency Planning (Civil Contingencies Act Enhancement Programme Cabinet Office 2012, page 7) considers that BCM is a flexible framework designed to help organisations to continue operating in the face of a wide range of different types of disruptions right the way along the spectrum of severity. BCM does not however embrace all dimensions of an organisation’s resilience, and one important distinction is between BCM and crisis management.  Crisis management (major/critical incident or emergency response) deals with the immediate strategic and wide ranging response to an emergency which is likely to be events or situations that threaten serious damage to the human welfare, environment or security of a place in the United Kingdom or when the incident overwhelms existing response arrangements, and cannot be dealt with within existing resources or procedures.  While BCM is an important response in the context of an emergency in ensuring that the trust can continue to provide critical and essential services during an emergency, BCM also adds to the overall resilience of the Trust in responding to disruptive challenge that is not at the level of an emergency. | |
|  | 3.5 | **Business Continuity Plan (BCP)**  A [Business Continuity Plan](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) is a collection of documented procedures and information that is developed and maintained in readiness of an incident to enable the Trust/individual team to continue to deliver its functions. | |
|  |  | **Overview of Requirements in the Business Continuity Process**  All services and directorates have available a template and pro-forma plan. This is to ensure all business continuity work is carried out in a consistent manner across the Trust.  **Business Impact Analysis**  Managers need to identify their critical and essential services/functions by reference to dependencies with other services. These services represent those services that will be maintained during an emergency.  To identify which services are critical and essential, staff should use the following broad criteria:   * + Direct and indirect impact on the health and wellbeing of service users, staff and visitors;   + Legal and regulatory obligations;   + Financial impacts on loss of services – compensation, penalties, contracts;   + Loss of reputation and public confidence;   + Impact on partners and other dependent services;   + Impact on the environment.   As a part of this process other services/functions may have been identified that could be stood down if necessary to enable the staff and resources usually employed in these areas to support the maintenance of critical and essential services or functions.  **Recovery Time**  Managers need to calculate the time that any service or function which has ceased as a result of an emergency must be recommenced to prevent serious harm occurring. This is called the recovery time objective for this service or function.  **Impact of Risk**  Managers need to consider how emergencies happening through specific risks (both from the Trust’s own risk register and community risk registers) would affect their services or functions and how they can take steps to reduce the probability of the emergency occurring and how they would mitigate the impacts.  **Understanding Resources and Dependencies**  All business continuity plans have been designed to**:**   * Identify possible accommodation that may be used to support other displaced critical and essential services; * Identify staffing whose normal service or function could be stood down and may either support the directorate’s own critical services or in a wider incident, other Trust critical services; * Identify dependent services which would be at risk of ceasing operation if other services ceased or were running at unacceptable levels. | |
|  | 3.6 | **Incident Control Centre (ICC)**  There are two main locations where an ICC can be established:  **The Boardroom, Conference Centre, Kendray Hospital, Barnsley, Doncaster Road, S70 3RD.** This is the site that has the best layout and equipment for the control centre but the **Directors suite in block 7 at Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP** would be the first place to convene; should an event require a control centre. Other locations can be used as required around the Trust dependant on who is needed and the type of incident. Refer to the [Trust’s Major/Critical Incident Plan](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Policies-and-Procedures.aspx). | |
|  | 3.7 | **Emergency Preparedness, Resilience and Response (EPRR)**  EPRR is defined by a series of statutory responsibilities under the CCA (2004). This requires NHS funded organisations to maintain a robust capability to plan for, and respond to, incidents or emergencies that could impact on health or services to patients. | |
|  | 3.8 | **Operational Pressures Escalation Levels (OPEL) Framework**  OPEL levels provide a structured set of arrangements when ‘normal’ operating functions are challenged, either through loss of staff, resources, or external factors including periods of high demand. The Trust will have a variety of strategic and tactical options in their plans that are most suitable to deal with situations that may arise and as such the OPEL level may need to be routinely shared with the nominated leads across the local health community, who understand their impact.  Since November 2016, 4 terms have been used (steady state, moderate pressure, severe pressure and extreme pressure) and depending on the Organisations normal activity, the level will be dependent on how we escalate any issues. BDU’s have their own local plan but the outcomes are Trust wide. They are embedded in to the Bed Management protocol and Trustwide Business Continuity Plan and OPEL reporting system on Sharepoint.  <https://swyt.sharepoint.com/sites/Policy-Documents/Shared%20Documents/1051.docx> | |
| **4.** | **DUTIES** | | |
|  | 4.1 | **The Trust Board** | |
|  |  | The Trust Board will ensure, so far as is reasonably practicable, that appropriate structures are in place to implement effective Business Continuity Arrangements. | |
|  | 4.2 | **Chief Executive** | |
|  |  | The Chief Executive has overall responsibility for all business continuity matters of SWYPFT. | |
|  | 4.3 | **Associate Director of Estates and Facilities** | |
|  |  | It is the responsibility of the Associate Director of Estates and Facilities, so far as reasonably practicable to: | |
|  |  |  | Act as the Accountable Emergency Officer (AEO) for the Trust; |
|  |  |  | Co-ordinate all business continuity matters across SWYPFT; |
|  |  |  | Ensure a fit for purpose Business Continuity procedure that reflects all safety aspects of the SWYPFT organisation is in place; |
|  |  |  | Ensure financial resources are available, in conjunction with the Director of Finance and colleagues in order to implement relevant Business Continuity Plans; |
|  |  |  | Establish a Safety & Resilience Trust Action Group (TAG) that reflects the structures, operating framework of the Trust and discuss Business Continuity Management, policies and procedures across the Trust; |
|  |  |  | Ensure appropriate arrangements are in place to periodically monitor the business continuity performance of the organisation; |
|  |  |  | Report to the Trust Board on an annual basis the business continuity performance of SWYPFT; |
|  |  |  | Provide periodic assurances to external stakeholders on the Trust EPRR position by attending the Quarterly Local Health Resilience Partnership (LHRP) meeting or sending a suitable nominated deputy. |
|  | 4.4 | **Directors and Deputy Directors** | |
|  |  | It is the responsibility of the Directors and Deputy Directors, so far as reasonably practicable to: | |
|  |  |  | Delegate the responsibility for Emergency Preparedness to a suitable nominated senior member of staff (a Business Continuity lead) who will be a key liaison with the Emergency Preparedness Team. |
|  |  |  | Ensure that staff within their control attend appropriate EPRR training as required by following Training Needs Analysis. |
|  |  |  | Ensure that local procedures relating to EPRR are monitored, managed and maintained. |
|  |  |  | Ensure the Information, Management & Technology (IM&T) Priority Sheet Template is reviewed regularly with updates provided to IM&T to enable clear communication with all pertinent staff within their area of control in the event of an incident/emergency situation. |
|  |  |  | Ensure areas of concern are raised at the Safety & Resilience TAG. |
|  |  |  | Prioritise and allocate resources or request additional resources as required relating to EPRR.  Where an event has occurred in their respective areas, ensure a nominated person provides timely information to be supplied to the [Emergency Planning Team](mailto:emergency.resilience@swyt.nhs.uk?subject=Activation%20of%20Business%20Continuity%20Plans) and where required, a report or other documentation submitted. |
|  |  |  | Establish local arrangements for operational resilience. |
|  |  |  | Ensure strategic BDU BCP’s are undertaken, monitored, practiced and managed within their areas of responsibility. |
|  | 4.5 | **Head of Safety, Security and Risk** | |
|  |  | It is the responsibility of the Head of Safety, Security and Risk to: | |
|  |  |  | Bring to the attention of the Associate Director of Estates and Facilities any matter that has a bearing on the EPRR arrangements of the Trust. |
|  |  |  | Keep up to date with EPRR developments and new legislation so as to advise SWYPFT on actions to take. |
|  |  |  | Provide assurance to the Associate Director of Estates and Facilities following assessment of the Trust against the NHS national assurance framework agreement. |
|  |  |  | Liaise with the local Clinical Commissioning Group’s (CCG’s) and local agencies as required. |
|  |  |  | Attendance at Regional EPRR meetings, deputising for the Associate Director of Estates and Facilities, as appropriate at the LHRP meeting. |
|  | Ensure the Trust has a robust plan to ensure that the EPRR framework is adequately resourced. |
|  | 4.6 | **Emergency Planning Adviser** | |
|  |  | It is the responsibility of the Emergency Planning Adviser to: | |
|  |  |  | Assess the Trust against the NHS England Core Standards for Emergency, Preparedness, Resilience and Response framework. |
|  |  |  | Provide assistance to managers in the development of Business Continuity Management Systems and control strategies, including training, so as to ensure that they meet legislative requirements in addition to NHS England EPRR standards. |
|  |  |  | Plan and co-ordinate Training Needs Analysis of Emergency Preparedness Awareness across all levels of staff within the Trust to ensure needs are met with the assistance of Learning & Development centre. |
|  |  |  | Arrange and support testing arrangements for the Trust. |
|  | 4.7 | **Business Continuity Lead/Departmental/Ward/Team Managers** | |
|  |  | It is the responsibility of BC lead/Departmental/Ward/Team Managers, so far as reasonably practicable to: | |
|  |  |  | Report to their BDU (Directors/Deputy Directors), any matters that are a concern to them but for which they do not feel capable of acting upon, including critical events. |
|  |  |  | Create, implement and monitor local BCP’s and control measures on an annual basis or sooner if there is reason to do so, i.e. when a plan has been utilised and lesson learnt needs to be implemented. |
|  |  |  | Organise and conduct Table Top exercises within their areas on an annual basis; seeking guidance and support from the Emergency Planning Team as appropriate. These exercises must cover all the services that they operate. |
|  |  |  | Provide a written report of what has been tested and lessons learnt to the [Emergency Planning Team](mailto:icc@swyt.nhs.uk) once complete. |
|  |  |  | Ensure relevant and identified staff are released as appropriate to attend training as stipulated via Training Needs Analysis training  and keep their training up to date and relevant  **On-call staff**  The Trust is responsible for ensuring appropriate leadership during emergencies and other times of pressure. Incidents, emergencies and peaks in demand can occur at any time of day or night, so the whole organisation must have an appropriate out of hours on call system. A Director should always be available to make strategic decisions for the organisation; other staff may also be on call to provide support.  If the severity of an incident dictates it, the on call manager should attend the Trust site and if required, request the assistance of the on-call Director.  Staff should be appropriately trained relevant to their role within the organisational response. Further guidance is in the Major/Critical incident plan. |
|  | 4.8 | **Employees** | |
|  |  | It is the responsibility of Employees, so far as reasonably practicable to: | |
|  |  |  | Co-operate with any person who has EPRR responsibilities. |
|  |  |  | Be familiar with local BCP’s and their actions to undertake should a BCP be activated. |
|  | Ensure they attend relevant business continuity and emergency planning training as directed by their manager. |
| 4.9 | **Incident Loggists** | |
|  | NHS funded organisations must have appropriately trained and competent loggists to support the management of an incident. Loggists are an integral part in any incident management team. It is essential that all those tasked with logging do so to best practice standards and understand the importance of logs in the decision making process, in evaluation and identifying lessons and as evidence for any subsequent inquiries. Following an incident a number of internal investigations or legal challenges may be made. These may include Coroner’s inquests, public inquiries, criminal investigations and civil action.  When planning for and responding to an incident it is essential that any decisions made or actions taken are recorded and stored in a way that can be retrieved at a later date to provide evidence. It may be necessary to provide all documentation, therefore robust and auditable systems for documentation and decision making must be maintained. The organisation’s Document Retention policies and procedures should cover the requirements of EPRR.  For a current list of loggists click [here.](\\\\swyt-fhh-fs02.xswyt.xswy.nhs.uk\\Shared\\Business Continuity Planning\\Trained Loggists within SWYPFT.docx)  4.10 **Procurement**  The procurement team will monitor supply chains to ensure continuity of products and where failure is anticipated, put in place suitable contingency arrangements to meet departmental needs, where possible. Should an alternative not be available, Business Continuity Plans should be activated and immediate discussions with relevant parties undertaken. A report to the [EPRR Team](mailto:emergency.resilience@swyt.nhs.uk?subject=Loss%20of%20Supplier/Failure%20of%20Supply%20Chain) should be provided within 2 weeks. | | |
| **5** | **PROCEDURE/PROCESS – BUSINESS CONTINUITY PLANS (BCP)** | | |
|  | Each BDU will have service/function specific BCPs. The maintenance, review and testing of these is the responsibility of their respective business continuity leads and the relevant District or Deputy Director or head of service is accountable for ensuring well developed and up to date plans are in place.  The Trust’s EPRR Leads will support the BDU business continuity leads in their development of BCP’s including assisting in desktop exercises and further development of plans as new risks are identified. | | |
|  | 5.1 | **Activating the Plan** | |
|  |  | A BCP may be activated as a result of:   * A Major/Critical Incident – (*see 3.3*). The Incident Director will ask for relevant BDU’s (or all Trust services) to implement their business continuity arrangements to ensure that they are able to maintain or restart critical/essential services, if these have ceased or being severely affected due to an incident. * Surge and escalations in demand – departments and clinical services may have to enact their plans to meet challenges caused by greater calls on their services and this may mean standing down some services to maintain critical and essential services. * Other disruptive challenge such as adverse weather, fuel disruption, industrial action etc. may require services to enact their BCP’s. (Please see appendices).   The responsibility for activating the BCP rests with the most senior member of staff on duty at the time of the incident or challenge arising.  The decision making process should consider:   * The nature of the disruptive challenge; * Whether the disruptive challenge can be managed within normal day to day responses; * The risks posed to service provision; * The potential impact on dependent services and functions; * The additional resources needed to meet the challenge.   As part of the decision making process, staff should always consider if the incident or challenge is so significant that they need to escalate to Director level (either during office hours or via on-call) for consideration if the incident is so serious that activating the Major/Critical Incident plan is needed.  As soon as practical after enacting the BCP the senior member of staff should alert the relevant Director/Deputy Director and the [Emergency Planning Team](mailto:emergency.resilience@swyt.nhs.uk).  Section 9.2.2 of the [EPRR framework v2](https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwiN0d7b8ejOAhXHaRQKHcK5A2EQFggjMAA&url=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2015%2F11%2Feprr-framework.pdf&usg=AFQjCNG1ZPKdNAZsu4zNIXGHlSA1RlTFAA&bvm=bv.131286987,d.d24) states **Mental health and learning disability secure services** providers “must have in place evacuation plans which provide for relocation of service users to alternative secure premises in the event of any incident and how that relocation is to be effected in such a way as to maintain public safety and confidence”. | |
|  | 5.2 | **Overview of Action** | |
|  |  | Each plan will detail the critical services identified and how these are affected by risks and include specific actions to reduce the likelihood of a disruptive event or mitigate the events impact. Action taken will be based on:   * Supporting critical services to continue at a suitable level (but potentially reduced level compared to normality); * Ensuring these critical and essential services are appropriately resourced in terms of staff, provisions, infrastructure and accommodation, making use of prompt sheets and previously identified solutions.   The Director/ Head of Service will monitor the situation and ensure:   * Any deterioration in the ability to provide services is assessed and escalated if this poses a risk to the organisation, service users and staff; * All critical and essential services are operating and that the level of service meets at least minimum agreed levels for the service during a period of disruptive challenge; * Any services stood down are being restarted within their Recovery Time Objective; * A clear line of communication is maintained with staff and the wider Trust and key stakeholders/ dependent services; * Any request for additional resources are forwarded to the appropriate manager promptly; * Incidents must be promptly reported on Datix, and plans must also consider an assessment ensuring safe working practices are maintained, even in an emergency as the health, safety and welfare of all involved has to be considered. | |
|  | 5.3 | **Recovery**  The recovery phase from an incident should be planned at the start of the response. In terms of recovery in the context of business continuity threat the planning should consider:   * Develop a recovery plan aimed at restarting any services stood down and recovering activity to normal levels (or a new normality); * Recommencement of stood down services; * Re-engagement of displaced staff and those working to support critical services elsewhere in the Trust; * Estimation of any resources and support required to recover service provision. | |
|  | 5.4 | **Debrief** | |
|  |  | A key aspect to debrief is the support and communication with and from colleagues.  Technical debrief is an important and essential element of recovery which SWYPFT takes seriously. Immediately following ‘stand down’ provision will be made for a ‘*hot debrief’* to identify:  Any immediate actions required:   * Any support required for staff and service users; * What we can learn from this; * What was good and what could have been done better; * Precise times and chronology of events.   Within 14 days of the incident the Trust will begin the process to undertake a full internal debrief. Those involved will consider the various accounts and agree an incident report. Other appropriate members of staff should be involved in the debrief as required.  The report will include good practice and lessons identified; actions and leads, to ensure the best possible response to similar incidents in the future.  This will be supported by further debrief sessions to include staff as they wish. Again support for staff will be offered as well as the on-going monitoring and support offered by line managers. The progress of those actions will be monitored and evaluated by the Safety & Resilience TAG. SWYPFT will also partake in multi-agency debriefings, as required.  It is important that learning is gathered from any activation of a business continuity plan. Immediately after the end of the period of disruptive challenge, the staff involved should be debriefed in a timely manner.  Some areas to consider are:   * Considering what worked well; * What aspect of the plan didn’t work and needs revision; * How well staff followed the plan; * How effective the plan was at mitigating the worst effects of the incident; * Any identified training or knowledge gaps?   Following this, the relevant business continuity leads should discuss the incident and any points for wider discussion and complete a lessons learnt template (see Section 12).  Every BCP activation should be reported to the Safety & Resilience TAG where learning, performance and any other issues will be considered. | |
|  | 5.5 | **Communications and Coordination** | |
|  | **Internal**  It is essential that clear and authoritative communication messages are in place during periods of disruptive challenge. It is the responsibility of managers within each service to maintain contact with staff and use the contact lists they are asked to maintain as part of their own business continuity plans.  Directors and Deputy Directors have a responsibility to ensure they are up to date with service provision, risks and pressures in any period of disruptive challenge.  If a major/critical incident is declared, one Director within the ICC will have specific responsibilities for maintaining continuity of services and will report to the Incident Director.  Communication is two way, so information should flow to bronze (operational) command via silver (tactical) to gold (strategic) command and back down again (see Major/Critical Incident Plan).  **External**  The activation of a business continuity plan will mean that the Trust is obliged to inform its relevant commissioner of the activation within the required number of days stipulated by the commissioner.    In addition, the wider NHS community, some identified as dependencies in the planning stage, will also need to be notified that the Trust, as a whole or services within the Trust are working in accordance with BCP’s and therefore:   * Services may be stood down if non critical; * Critical and essential services may be operating at reduced activity levels. | | |
| **6** | **PRINCIPLES** | | |
|  | SWYPFT will take all steps, so far as is reasonably practicable, to pursue the following principles: | | |
|  |  | Ensure that suitable Business Continuity Plans and contingency arrangements are in place in order to achieve its strategic aims and objectives. | |
|  |  | The provision of appropriate information, instruction, training and supervision, including exercise testing is available to support contingency planning for employees. | |
|  |  | The provision of suitable funding and resources to implement Business Continuity Plans in accordance with this policy. | |
| **7.** | **THE RISKS OF NOT HAVING THIS POLICY IN PLACE** | | |
|  | Failure to comply with this policy may result in the following corporate risks arising: | | |
|  |  | The health, safety and welfare of staff, service users and visitors may not be adequately managed and controlled. | |
|  |  | Breach of Regulations, specifically those detailed in the Civil Contingencies Act 2004. | |
|  |  | Contingency arrangements may not be achieved and implemented in a consistent manner across the organisation. | |
|  |  | SWYPFT may not meet its legal and contractual obligations and standards set by such organisations as the CQC, Health and Social Care Act 2012, NHS Improvement, Public Health England, NHS England etc. | |
|  |  | Potential loss of reputation both as a provider of care and employer. | |
| **8.** | **PROCEDURES** | | |
|  | **8.1** | **Training** | |
|  |  | The EPRR training needs of employees will vary depending upon their role and responsibilities and when exposed to new risks.  EPRR training will be determined on the basis of assessment and a test of understanding and/or competency will be applied where applicable.  Training staff that have a response role for incidents is of fundamental importance. NHS organisations are familiar to responding to routine everyday challenges by following usual business practices, yet very few respond to incidents on a frequent basis. If staff are to respond to an incident in a safe and effective manner they require the tools and skills to do so in line with their assigned role.  Training should be focussed on the specific roles and requirements assigned to the individual, aligned to a Training Needs Analysis (TNA) and ensure training objectives and outcomes are met and recorded. In addition to covering all aspects of the response role, training should also highlight wider organisational and multi-agency response structures, as appropriate to the role. Training can comprise of dealing with a real or simulated event or attending formal training.  Standards for NHS incident training are contained within the Skills for Justice National Occupational Standards (NOS) framework and should be referred to when identifying staff training needs.  Training needs to be an on-going process to ensure skills are maintained; it is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning. | |
| **9.** | **MONITORING THE COMPLIANCE AND EFFECTIVENESS OF THIS POLICY** | | |
|  | This will be achieved by: | | |
|  |  | The Safety & Resilience Trust Action Group will provide periodic exception reports to the Clinical Governance & Clinical Safety Group. | |
|  |  | The Clinical Governance & Clinical Safety Group will review the Corporate Risk Register which includes reference to the Community Risk Register and National Risk Registers as referred to in the NHS England Standards for EPRR. | |
|  |  |  | |
| **10.** | **REVIEW OF THIS POLICY** | | |
|  | This policy will be reviewed three years from the date of Board and Executive Management Team approval or sooner if there is a requirement to meet legal, statutory or good practice standards. | | |
| **11.** | **REFERENCES** | | |
|  | * The Civil Contingencies Act 2004. * NHS England Assurance Core Standards Framework Agreement | | |
|  |  | | |
| **12.** | **DOCUMENTS TO BE READ/UTILISED IN CONJUCTION WITH THIS POLICY** | | |
|  |  | | |
|  | All documents can be located on the Trust EPRR Intranet pages and/or by selecting the links below:   * [Business Continuity Plan Template](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [Pandemic Influenza Plan](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Policies-and-Procedures.aspx) * [Major/Critical Incident Plan](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Policies-and-Procedures.aspx) * [HAZMAT Procedure](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Documents/SWYPFT%20FINAL%20HAZMAT%20Procedures%20updated%202020.docx) * [Adverse Weather Plan](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Policies-and-Procedures.aspx) * [Exercising of Plans including Template Form](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [Table Top Exercise Report Template](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [Business Continuity Management Procedure](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Policies-and-Procedures.aspx) * [Joint Decision Model (JDM)](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [Joint Emergency Services Interoperability Programme (JESIP)](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [METHANE](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [Lessons Learned Template](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Useful-Forms-and-Information.aspx) * [Organisational Business Continuity Risks](https://swyt.sharepoint.com/sites/Intranet/emergency-planning/Pages/Risk-Assessments.aspx) | | |

**Appendix 1**

# Policy Consultation Process

|  |  |  |
| --- | --- | --- |
| Trust Board & Executive Management Team |  | Approves the main policies for Trust wide implementation |
|  |  |  |
| Clinical Governance & Clinical Safety Committee |  | Approves all subordinate policies. |
|  |  |  |
| **Safety & Resilience Trust Action Group** |  | Formal consultation mechanism on corporate policies. |
|  |
| **Trade Union Safety Representatives And document author** |  | Meet with the document author to consider the issues raised and identify the correct forum for them to be discussed |
|  |  |  |
|  |  |  |

# Appendix 2

**EQUALITY IMPACT ASSESSMENT TOOL**

As a trust wide policy, the assessment includes demographics’ for the four areas covered by the trust as below.

**Race Equality**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | White | Asian | Black | Mixed | Chinese & Other |
| England % av. | 85.5 | 5.1 | 3.4 | 2.2 | 1.7 |
| **Kirklees** |  |  |  |  |  |
| % average | 79.1 | 15.7 | 1.9 | 2.3 | 0.7 |
| **Barnsley** |  |  |  |  |  |
| % average | 97.9 | 0.7 | 0.5 | 0.7 | 0.2 |
| **Calderdale** |  |  |  |  |  |
| % average | 89.6 | 7 | 0.9 | 1.3 | 0.6 |
| **Wakefield** |  |  |  |  |  |
| % average | 95.4 | 2.6 | 0.77 | 0.9 | 0.29 |

Taken from Census 2011 for each area

Assessment of The Emergency Preparedness, Resilience and Response Policy has not highlighted any Equality Impact issues

**Date of assessment: 06 June 2019**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Equality Impact Assessment Questions:** | | **Evidence based answers & actions:** |
| **1** | **Name of the document that you are Equality Impact Assessing** | | Emergency Preparedness, Resilience and Response Policy |
| **2** | **Describe the overall aim of your document and context?**  **Who will benefit from this policy/procedure/strategy?** | | The overall aim of the policy is to describe the Trust’s approach to providing, managing and monitoring Business Continuity Management Systems.  All staff, service users & visitors. |
| **3** | **Who is the overall lead for this assessment?** | | Associate Director of Estates and Facilities |
| **4** | **Who else was involved in conducting this assessment?** | | Emergency Preparedness team and the Safety & Resilience TAG |
| **5** | **Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?**  **What did you find out and how have you used this information?** | | The Safety & Resilience Trust Action Group was consulted during the original development and review of the Policy.  It was identified that there was a need for clearer information and relevant documentation to be embedded within the policy. |
| **6** | **What equality data have you used to inform this equality impact assessment?** | | Equality Dashboard  Staff Satisfaction Survey  Annual Workforce Report  Datix Reports  On Call Reports  Business Continuity Table Top Exercises |
| **7** | **What does this data say?** | | Inclusion and Access is considered. |
| **8** | **Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:** | **Yes** | **Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.** |
| **8.1** | **Race** | **No** |  |
| **8.2** | **Disability** | **No** | **Suitable aids and adaptations needs to be taken into account during a major/critical incident, all of which will be considered in departmental Business Continuity Plans and care plans.** |
| **8.3** | **Gender** | **No** |  |
| **8.4** | **Age** | **No** |  |
| **8.5** | **Sexual orientation** | **No** |  |
| **8.6** | **Religion or belief** | **No** | **Impact to food provision/deliveries can affect religious groups, following a major/critical incident. Business Continuity Plans are in place and consider these potential impacts.** |
| **8.7** | **Transgender** | **No** |  |
| **8.8** | **Maternity & Pregnancy** | **No** |  |
| **8.9** | **Marriage & civil partnerships** | **No** |  |
| **8.10** | **Carers (Our Trust requirement)** | **No** |  |
| **9** | **What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-** | | **The Emergency Preparedness, Resilience and Response policy promotes and encourages good safe working practices for everyone.** |
| **9a** | **Promotes equality of opportunity for people who share the above protected characteristics;** | | **Yes, the procedure is none discriminative and applies to everyone.** |
| **9b** | **Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;** | | **As above** |
| **9c** | **Promotes good relations between different equality groups;** | | **As above** |
| **9d** | **Public Sector Equality Duty – “Due Regard”** | | **As above** |
| **10** | **Have you developed an Action Plan arising from this assessment?** | | **No** |
| **11** | **Assessment/Action Plan approved by** | |  |
|  | **(Director Lead)** | | **Sign: Date:**  **Title:** **Associate Director of Estates and Facilities** |
| **12** | ***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:***  [**partnerships@swyt.nhs.uk**](mailto:partnerships@swyt.nhs.uk)  **Please note that the EIA is a public document and will be published on the web.**  **Failing to complete an EIA could expose the Trust to future legal challenge.** | |  |

**Appendix 3**

**Checklist for the Review and Approval of Procedural Document**

|  | **Title of document being reviewed:** | **Yes/No/ Unsure** | **Comments** |
| --- | --- | --- | --- |
| **1.** | **Title** |  |  |
|  | Is the title clear and unambiguous? | Yes |  |
|  | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes |  |
|  | Is it clear in the introduction whether this document replaces or supersedes a previous document? | Yes |  |
| **2.** | **Rationale** |  |  |
|  | Are reasons for development of the document stated? | Yes |  |
| **3.** | **Development Process** |  |  |
|  | Is the method described in brief? | Yes |  |
|  | Are people involved in the development identified? | Yes |  |
|  | Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? | Yes |  |
|  | Is there evidence of consultation with stakeholders and users? | Yes | Safety & Resilience TAG and sharing with Local Health Resilience Partnerships |
| **4.** | **Content** |  |  |
|  | Is the objective of the document clear? | Yes |  |
|  | Is the target population clear and unambiguous? | Yes |  |
|  | Are the intended outcomes described? | Yes |  |
|  | Are the statements clear and unambiguous? | Yes |  |
| **5.** | **Evidence Base** |  |  |
|  | Is the type of evidence to support the document identified explicitly? | Yes |  |
|  | Are key references cited? | Yes |  |
|  | Are the references cited in full? | Yes |  |
|  | Are supporting documents referenced? | Yes |  |
| **6.** | **Approval** |  |  |
|  | Does the document identify which committee/group will approve it? | Yes |  |
|  | If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | N/A |  |
| **7.** | **Dissemination and Implementation** |  |  |
|  | Is there an outline/plan to identify how this will be done? | Yes |  |
|  | Does the plan include the necessary training/support to ensure compliance? | Yes |  |
| **8.** | **Document Control** |  |  |
|  | Does the document identify where it will be held? | Yes |  |
|  | Have archiving arrangements for superseded documents been addressed? | Yes |  |
| **9.** | **Process to Monitor Compliance and Effectiveness** |  |  |
|  | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | Yes |  |
|  | Is there a plan to review or audit compliance with the document? | Yes |  |
| **10.** | **Review Date** |  |  |
|  | Is the review date identified? | Yes |  |
|  | Is the frequency of review identified?  If so is it acceptable? | Yes |  |
| **11.** | **Overall Responsibility for the Document** |  |  |
|  | Is it clear who will be responsible implementation and review of the document? | Yes |  |

**Appendix 4**

**VERSION CONTROL SHEET**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment / changes** |
| 1 | July 2014 | Martin Brandon | Draft | Version 1 to be presented to Emergency Preparedness TAG July 2014 |
| 2 | September 2014 | Martin Brandon | Draft | Version 2 incorporates consultation comments. To progress to EMT October 2014. |
| 3 | August 2016 | Steve Amos/Emma Hilton | Draft | Version 3 – update to incorporate changes to roles, responsibilities, meetings and additions relating to all appendices. |
| 4 | August 17 | Steve Amos/Emma Hilton | Draft | Version 4 – updates to reflect change to major incident plan, roles/responsibilities, telephone numbers and organisational BC risk identification |
| 5 | May 19 | Emma Hilton | Draft | Version 5 – general review in line with timescales identified within document. Appendices updated and links to associated documents added. |
| 6 | September 2021 | Emma Hilton | Draft | Version 6 – updated to include Trustwide BCP reference and check meets EPRR Core Standard Requirements. Added Procurement section in roles and responsibilities |
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