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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:

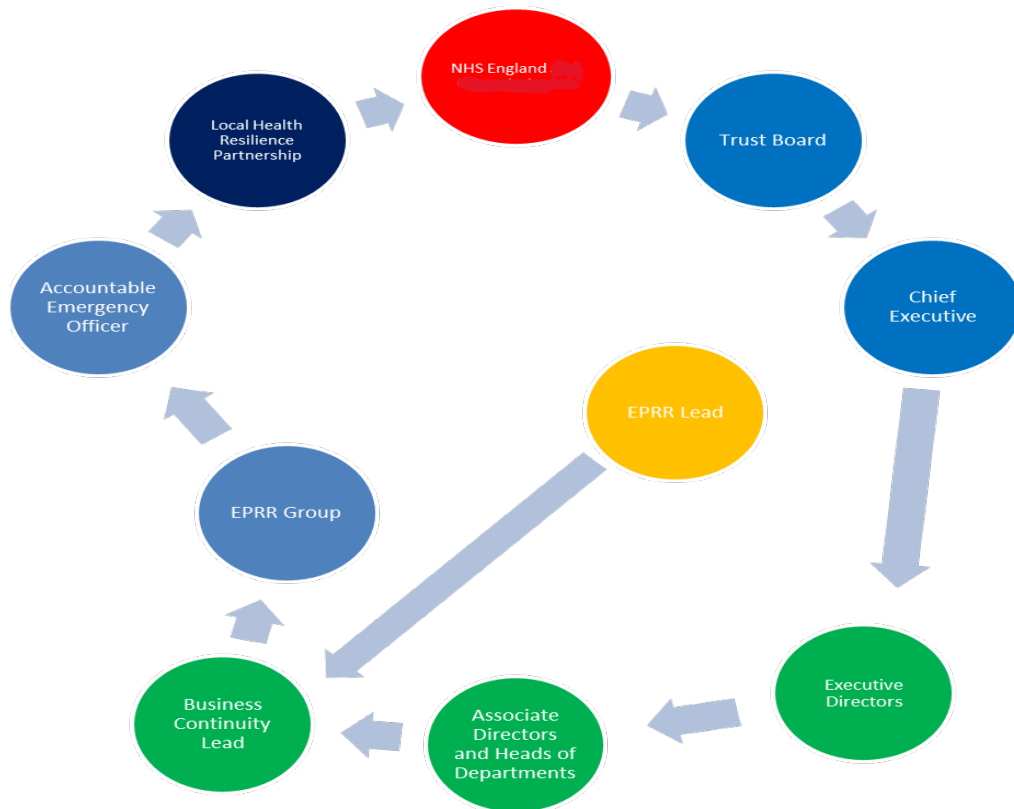
- Enable SWYPFT to comply with the requirements of the CCA 2004 and associated Regulations;
- Enable SWYPFT to comply with NHS England's EPRR Core Standards Assurance Framework; <https://www.england.nhs.uk/ourwork/epr/gf>
- Ensure SWYPFT provide instruction and guidance to ensure their critical and essential 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 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 plans and strategic 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](#) and Business Continuity Plan.

2.2 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, bank 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/epr-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 Integrated Care Boards (ICBs) 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 an NHS England region. NHS England regional teams to coordinate the NHS response in collaboration with ICBs 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](#) 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 have available a template BCP and guidance. 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)

The location where an ICC can be established is at The Small Conference Centre, Learning and Development, Fieldhead Hospital, Ouchthorpe Lane, WF1 3SP. Should this room be unavailable any other room within Learning and Development and the main block can be utilised. If the site is unavailable a virtual ICC can also be established. Refer to the [Trust's Major/Critical Incident Plan](#).

Following on from lessons learned from the COVID-19 pandemic, the Trust also have the option to operate a virtual ICC via MS Teams. The method of convening the Incident Management Team is decided by the Incident Commander.

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.

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. Care Groups have their own local plan, but the outcomes are Trust wide. They are embedded in to the Bed Management protocol and Trust wide Business Continuity Plan and OPEL reporting system on SharePoint.

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 Director of Finance and Resources, Accountable Emergency Officer (AEO)

It is the responsibility of the AEO to:

- Be accountable for the Trusts Emergency Preparedness;
- 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;
- Escalate any risks and concerns to the ICBs, via approved channels, at the earliest opportunity;
- Ensure financial resources are available, in order to implement relevant Business Continuity Plans;
- Report to the Trust Board on an annual basis the business continuity performance of SWYPFT;
- In the absence of the AEO, a nominated executive level director will be nominated to act on their behalf.

4.4 Deputy Director of Estates and Facilities

It is the responsibility of the Deputy Director of Estates and Facilities, so far as reasonably practicable to:

- 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;
- 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;
- Act as deputy for the AEO, when the AEO is unable to attend the LHRP meetings (maximum 3 out of 4 meetings).

4.5 Directors of Services and Associate Directors

It is the responsibility of the Directors of Services and Associate 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 via the dedicated EPRR email account of the Trust EPRR Network.
- 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](#) and where required, a report or other documentation submitted.

- Establish local arrangements for operational resilience.
- Ensure departmental BCP's are undertaken, monitored, practiced and managed within their areas of responsibility.

4.6 **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 Deputy Director of Estates and Facilities any matter that has a bearing on the EPRR arrangements of the Trust.
- Provide assurance to the Deputy Director of Estates and Facilities following assessment of the Trust against the NHS national assurance framework agreement.

- Liaise with the local ICC's and local agencies as required.
- Ensure the Trust has a robust plan to ensure that the EPRR framework is adequately resourced.

4.7 **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 a Training Needs Analysis of Emergency Preparedness Awareness, linked in with the National Minimum Occupational Standards for EPRR (MOS), 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.
- Provide reports to appropriate governing meetings on Business Continuity/EPRR status, including, training, exercising, testing, business continuity management, business impact analysis and BCP status.
- Undertake EPRR risk assessments, linking into the North East & Yorkshire Risk Register, ensuring that they are appropriately reviewed and signed off through appropriate governance structures.
- Liaise with wider system partners and EPRR colleagues to consult on internal and external plans, policies, exercises, incidents and lessons learned.
- Receive and cascade updates from the Local Resilience Forum (LRF), which is attended by the West Yorkshire ICB on behalf of all regional Trusts.
- Undertake annual testing and exercising of business continuity plans, utilising various methods including:
 - A live exercise (1 every 3 years);
 - Discussion based exercises;
 - Scenario exercises;
 - Simulation exercises.
- Keep up to date with EPRR developments and new legislation so as to advise SWYPFT on actions to take.

4.8 Business Continuity (BC) Lead/Managers

It is the responsibility of BC lead/Managers, so far as reasonably practicable to:

- Report to their Care Group (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.
- Conduct Table Top exercises within their areas on an annual basis; utilising scenarios and scripts provided by the Emergency Planning Adviser. These exercises must cover all the services that they operate. The exercises must be completed with wider team members, not in isolation.
- Provide a written report of what has been tested and lessons learnt to the [Emergency Planning Team](#) once complete.
- Attend the Trust EPRR Network to provide feedback on incidents/exercises and to raise any matters of concern.
- Ensure relevant and identified staff are released as appropriate to attend training as stipulated via Training Needs Analysis and keep their training up to date and relevant.

4.9 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 on call guidance is in the Major/Critical incident plan.

4.10 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.

4.11 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](#).

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](#) should be provided within 2 weeks.

In addition to this, the Procurement team will review and audit and provider assurance regarding provider and supplier Business Continuity plans, seeking advice from the Emergency Planning Adviser as and when necessary. An audit report will be provided to the Safety and Resilience TAG annually to highlight any risks and resolutions identified from audits undertaken.

5 PROCEDURE/PROCESS – BUSINESS CONTINUITY PLANS (BCP)

Each Care Group 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 Lead will support the Care Group 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 Care Group'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](#).

Section 9.2.2 of the [EPRR framework v2](#) 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 is 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 EPRR Team and 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 partner i.e. ICB's of the activation within the required number of days stipulated by the organisation.

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, UK Health Security Agency, 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 the National Minimum Occupational Standards for EPRR (MOS). These 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.

8.2 Reporting Arrangements

The EPRR Team will provide an annual report, detailing information relating to incidents, training, exercising, lessons learned and compliance against the NHSE Core Standards for EPRR. The report will be submitted to the Safety & Resilience TAG, along with work programmes and action plans, which will then escalate through governance to the Trust Board.

The work programme will contain both actions identified from the Core Standards for EPRR self-assessment, and actions from incidents/exercises. Progress against all actions will be monitored via the Safety & Resilience TAG.

Where relevant lessons learned and debrief reports will be shared with wider partners at LHRP and EPRR specialist meetings.

8.3 Risk Assessment

The Emergency Planning Adviser will regularly review EPRR related risks in line with the North East and Yorkshire (NEY) Risk Register. The NEY Risk Register is derived from the National Risk Register, Community Risk Registers and local partner risks that have been escalated to NHS England, which also takes into account climate change and adaptation planning.

These risk assessments will be considered and approved at the Safety & Resilience TAG. Any risk that scores over 15 will be forwarded to the Estates TAG for discussion. If approved the risk will be added to the Estates and Facilities Risk Register, which feeds directly into the Corporate Risk Register.

Those risks added to the Risk register will be added to the Datix Risk Management system where all updates and changes are automatically noted and audited.

8.4 Mass casualty events

If a Mass casualty event occurs notification will normally come from the ICB, NHS England or the Police.

A mass casualty event will be a declared major incident may result from an accident or as a deliberate; terror related act or series of acts and will be sudden and unexpected.

A Mass casualty incident may involve hundreds or thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and require further measures to appropriately deal with the casualty numbers. *NHS England issued its Concept of Operations for Managing Mass Casualties* in November 2017, and this gave details of expectations for various NHS bodies in a mass casualty event.

Service Provision Issues in a Major Incident Involving Mass Casualties

There is an expectation that the Trust will play its part in delivery of emergency type care to those affected by the incident. Mutual aid requests are likely from other parts of the system and in particular from the acute hospitals. In such situations elements of care provision may need to be increased.

Immediate impacts may be:

- Requests for assistance from Barnsley Hospital Foundation Trust, Pinderfields Hospital, Calderdale Royal Hospital, Huddersfield Royal Infirmary or Dewsbury District Hospital. Particularly for staff

to assist in emergency departments and increased liaison psychiatry provision.

- Service users involved in the incident and/or requiring additional support and re-assurance.
- Impacts on staff - involved in the incident or affected by the incident.

All the potential consequences of a major incident involving mass casualties will need rapid and dynamic risk assessment at the outset and during the response by Trust incident commanders.

Specific Duties (from the NHS Concept of Operations for Managing Mass Casualties)

The obligations on mental health service providers are detailed in this document and are given as immediate, medium and long term obligations. In addition, acute partners Mass Casualty Plans also define mutual aid needs in the event of a mass casualty incident with the Trust.

Immediate action

Ensure adequate mental health liaison resources are made available to responding care settings if requested. Ensure the discharge areas are supported with suitable staff able to give advice on where to seek treatment and support.

Receiving providers should ensure they are supported by suitable staff who are able to:

- Give advice to everyone who visits the care setting on where to seek support and psychosocial care for distress.
- Make referrals to specialist mental health services for people who require immediate assessment and treatment immediately after events.

Responding providers should liaise with the NHS England DCO teams to ensure that arrangements for psychosocial care and mental healthcare are made, coordinated and signposted across the agencies.

They should ensure adequate mental health liaison resources are made available to those care providers which have responded to the incident.

Medium term action

Everyone involved is likely to benefit from social support after a mass casualty event and most people are likely to receive it from their families and a range of agencies. Assumptions about which agencies are to provide social support should not be made.

Mental health services providers should work with local agencies to design and deliver an appropriate mechanism that is able to identify people who continue to need supporting and welfare arrangements beyond those that their families can provide. It should signpost them to

agencies and facilities that are able to offer the enhanced psychosocial support they require.

They should escalate the need to commission specialist mental health services from specific organisations for the projected numbers of persons who are likely to need specialist assessment and treatment. They should work with commissioners to identify processes to recover normal business after the incident.

Long Term actions

People who develop new episodes of psychiatric disorders or exacerbations of previous disorders may require specialist care in the medium and long-term. A minority of people may require them for several years.

Mental health service providers should work with ICB's and partners to build referral, assessment and treatment processes for people who need further or extended care. They should identify methods to continue to deliver assessment and treatment for patients in the long-term before these facilities are absorbed into their ordinary business.

They should work across sectors of care to identify patients who require monitoring or may present later in need of specialist care. They should consider likely triggers for patients who might need intervention during similar or subsequent events or at specific times of the year. Some of these services may be provided by other mental health organisations.

Acute Trusts

If a mass casualty event occurs within the Trusts geographical footprint, Acute Trusts will bear the main responsibility of managing casualties.

This will place an extreme strain on service continuity within the acute hospitals and all partners will be expected to support the response. As well as actions specified above in this section, Acute Trusts will assist with logistical support. This will be based on mutual aid requests or as directed by coordinating groups at strategic or tactical level.

- Pharmacy support
- Transport support
- Activation of bank staff systems to seek additional staff
- Cascade call out to seek Trust staff to support Acute Trusts
- Provision of staff to assist in counselling and psychological debrief (if required)

Support for Those Affected by the Incident

In addition to arrangements required under section 8.4, support arrangements for those affected by the incident must be put in place before the Incident Coordination Centre stands down. These are likely to be:

- Telephone line for relatives and carers

- Psychological and counselling support for staff and service users involved in the incident
- Guidance for managers in terms of assisting staff to return to normality

A critical or major incident has the potential to produce effects on those victims and survivors that require further consideration.

NHS guidance (Planning for the psychosocial and mental health care of people affected by major incidents and disasters: Interim national strategic guidance NHS 2009) indicates that the main response for caring for those experiencing psychological will be from unofficial support networks such as workplace, family, community and voluntary assistance. Smaller numbers will require psychological first aid – mainly primary care based/ IAPT but with access to secondary care assessment. A yet smaller number may develop difficulties requiring secondary, specialised mental health care.

The potential impact on healthcare needs should be a significant planning consideration for relevant staff in the incident coordination centre and should feature in outline assessment of likely impacts as part of the immediate debrief.

Nice guidance is also relevant relating to post traumatic stress disorder (Clinical Guideline 26 - The management of PTSD in adults and children in primary and secondary care 2005).

As part of recovery planning the Trust should assess the patients and members of staff likely to have been affected by the incident and ensure any counselling or support is available as required. Wider support for those affected, e.g. in any community wide incident will be a consideration as part of the recovery process and will be requested from primary care as and when necessary.

8.5 Excess Deaths and Mass Casualties

The Cabinet Office's *Guidance on Dealing with Fatalities in Emergencies* identifies responsibility across sectors for the management of mass fatality events. The definition of a mass casualty incident is: Any incident where the number of fatalities is greater than normal local arrangements can manage.

The NHS main priority in any major incident will to save lives and to treat casualties. The ambulance service will co-ordinate the NHS response at the scene of an incident through the ambulance incident officer (AIO) and provide casualty assessment.

The role of a mental health Trust in mass fatality incidents is very limited and overall coordination is the role of local authorities. However, as with a mass casualty incident support for the bereaved and those dealing with the transport and recovery of the deceased may be required and hence the Trust's clinical staff may need to work across partners to support this process.

8.6 Mass Vaccination

In the event of a major incident occurring involving the need for Mass Vaccination, the Trust would link into the wider provider network, providing support as necessary/requested via the ICB/NHS England. To support any requests for mass vaccination a command structure would be enabled to ensure effective decision making and timely response. All relevant training and record keeping would be put in place at the time of incident.

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 Audit Committee.
- The Audit Committee 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.
- Annual internal audits will be undertaken to ensure compliance against this and associated policy documents. Reports will be provided to the Safety & Resilience TAG and Audit Committee.
- Three yearly external audits will be undertaken to ensure compliance against policy and standards. Reports will be provided to Safety & Resilience TAG and Audit Committee.

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

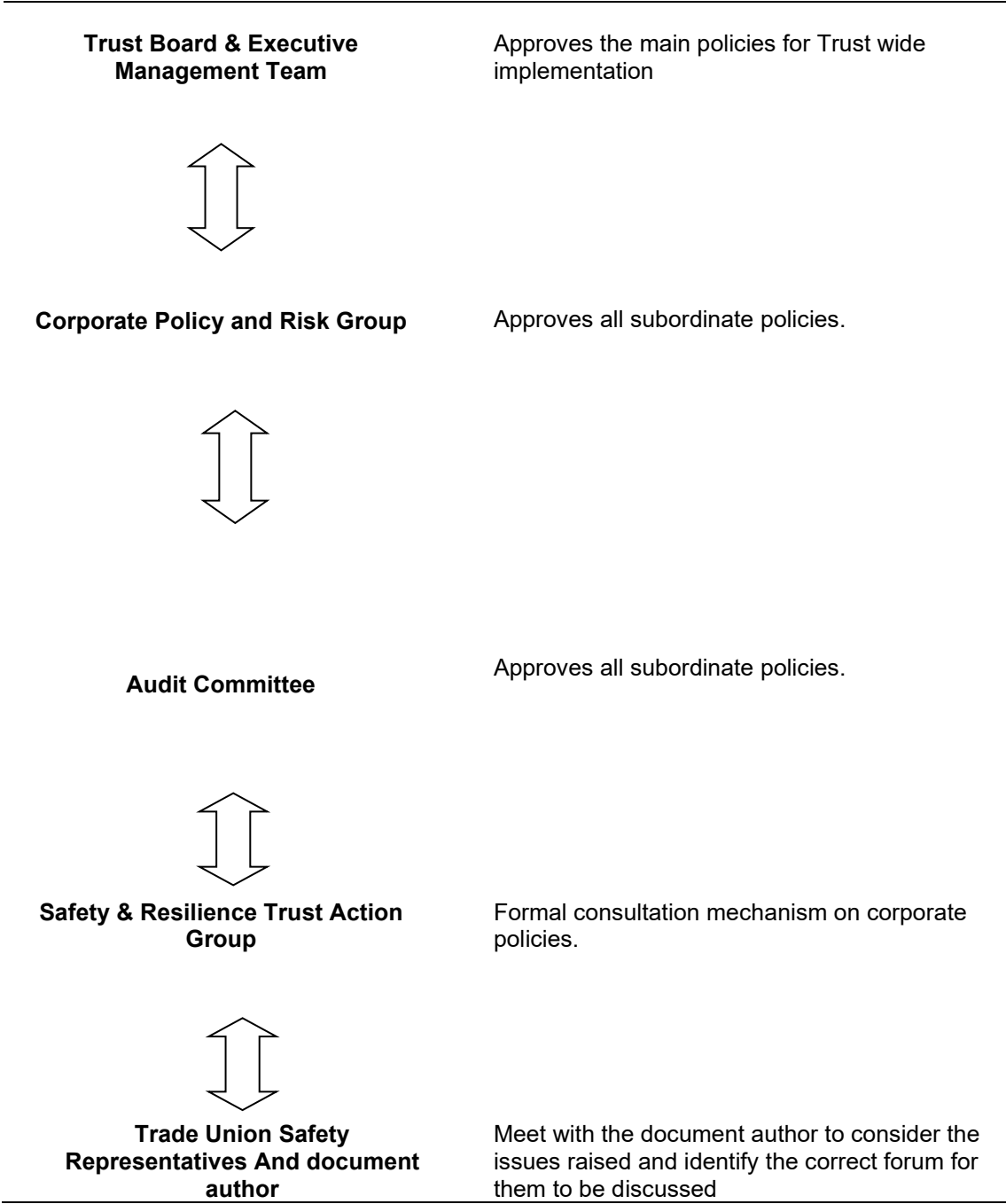
12. DOCUMENTS TO BE READ/UTILISED IN CONJUNCTION WITH THIS POLICY

All documents can be located on the Trust EPRR Intranet pages and/or by selecting the links below:

- Business Continuity Plan Template
- Pandemic Influenza Plan
- Major/Critical Incident Plan
- HAZMAT Procedure
- Adverse Weather Plan
- Exercising of Plans including Template Form
- Table Top Exercise Report Template

- Business Continuity Management Procedure
- Joint Decision Model (JDM)
- Joint Emergency Services Interoperability Programme (JESIP)
- METHANE
- Lessons Learned Template
- Organisational Business Continuity Risks

Policy Consultation Process



Equality Impact Assessment

Date of EIA: August 2023

Review Date: July 2026

Completed By: Emma Hilton

	QUESTIONS	ANSWERS AND ACTIONS
1	What is being assessed? Prompt: what is the function of this document (new or revised)	Emergency Preparedness, Resilience & Response Policy (EPRR) 2023
2	Description of the document Prompt: What is the aim of this document	<p>The policy aims to support a consistent and positive approach to Emergency Preparedness, Resilience & Responses for the benefit of service users, staff, and visitors within South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). It aims to support staff to promote best practice to effectively manage untoward incidents with the aim of reducing the number and severity of subsequent incidents and near misses.</p> <p>The policy is in line with the Civil Contingencies Act 2004 (CCA) and associated guidance related to Emergency Planning as this affects clinical and non-clinical activities within South West Yorkshire Partnership NHS Trust.</p>
3	Lead contact person for the Equality Impact Assessment	Emma Hilton, Emergency Planning Adviser
4	Who else is involved in undertaking this Equality Impact Assessment	Roland Webb, H&S Manager
5	Sources of information used to identify barriers etc Prompts: service delivery equality data – refer to equality dashboards (BI Reporting - Home (sharepoint.com)) satisfaction surveys, complaints, local demographics, national or local research & statistics, anecdotal. Contact InvolvingPeople@swyt.nhs.uk for insight What does your research tell you about the impact your proposal will have on the following equality groups?	Sources of information Data in relation to our communities We have considered population statistics for our localities in respect of race equality, disability, gender, age and sexual orientation, religion and belief, marriage, and civil partnership from census data. UK census data - Office for National Statistics (ons.gov.uk) Census 2021 took place in England, Wales, and Northern Ireland in March 2021. This data is not yet available. SWYFPT. Equality Impact Assessment. Quality Strategy. January 2023. A recent review of Datix figures between 1 August 2020 and 31 July 2023 highlighted that most incidents detailed clinical pathway issues due to loss of resource such as 136 suites, and assessment and treatment issues. All incidents were effectively managed and resulted in appropriate treatment of all patients. Other incidents include low level evacuation in non-patient areas and adverse weather impacts to trust property, staff and patients. Again all incidents were managed in accordance with Trust policy and procedure.
5a	Disability Groups: Prompt: Learning Disabilities or	Reasonable adjustments, for any person affected by their impairment or special needs will be covered by risk assessments and work procedures to ensure their safety needs are met and to reduce the risk

	Difficulties, Physical, Visual, Hearing disabilities and people with long term conditions such Diabetes, Cancer, Stroke, Heart Disease etc. Accessible information standard	<p>of or impact the need for Emergency Planning measures in the workplace, wherever this is and in line with local EPRR plans.</p> <p>Data in relation to our communities</p> <p>Day to day activities limited by disability, taken from 2011 census for each area.</p> <p>Disability groups</p> <table><tr><th></th><th colspan="3">Day to day activities limited by disability</th></tr><tr><th></th><th>Not at all</th><th>A little</th><th>A lot</th></tr><tr><td>England % av.</td><td>47.2</td><td>13.2</td><td>4.2</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>45.5</td><td>12.5</td><td>13.7</td></tr><tr><td>Barnsley</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>76.1</td><td>11.3</td><td>12.6</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>56.5</td><td>12.2</td><td>13.8</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td></tr><tr><td>% average</td><td>77.93</td><td>9.33</td><td>8.31</td></tr></table> <p>This data indicates that we have a higher than national average proportion of people whose day-to-day activities are limited ‘a lot’ by their disability.</p> <p>There appears to be minimal impact from investigation in incidents with Disability Groups identified from the lifetime of the previous policy. (See action EIA plan to improve this information moving forward)</p> <p>The Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to reduce the number and severity of incidents, whether Emergency Plans have to be implemented</p>		Day to day activities limited by disability				Not at all	A little	A lot	England % av.	47.2	13.2	4.2	Kirklees				% average	45.5	12.5	13.7	Barnsley				% average	76.1	11.3	12.6	Calderdale				% average	56.5	12.2	13.8	Wakefield				% average	77.93	9.33	8.31
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	QUESTIONS	ANSWERS AND ACTIONS																																												
5b	<p>Gender:</p> <p>Prompt: Female & Male issues should be considered</p>	<p>Data in relation to our communities</p> <table><tr><th></th><th>Male</th><th>Female</th></tr><tr><td>England % av.</td><td>49.2</td><td>50.8</td></tr><tr><td>Kirklees</td><td></td><td></td></tr><tr><td>% average</td><td>49.4</td><td>50.6</td></tr><tr><td>Barnsley</td><td></td><td></td></tr><tr><td>% average</td><td>49.1</td><td>50.9</td></tr><tr><td>Calderdale</td><td></td><td></td></tr><tr><td>% average</td><td>48.9</td><td>51.1</td></tr><tr><td>Wakefield</td><td></td><td></td></tr><tr><td>% average</td><td>49</td><td>51</td></tr></table> <p>Taken from 2011 Census data.</p> <p>Gender identity was requested as a new topic on the 2021 Census topic consultation. This information is not yet available.</p> <p>There appears to be minimal impact from investigation in incidents with specific gender groups throughout the lifetime of the previous policy. (See action EIA plan to improve this information moving forward)</p>		Male	Female	England % av.	49.2	50.8	Kirklees			% average	49.4	50.6	Barnsley			% average	49.1	50.9	Calderdale			% average	48.9	51.1	Wakefield			% average	49	51														
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		<p>The Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person from either gender, for all stakeholders including service users, visitors and staff</p>																																																												
5c	<p>Age:</p> <p>Prompt: Older people & Young People issues should be considered</p>	<p>Data in relation to our communities</p> <table><tr><td></td><td>0-15</td><td>16-29</td><td>30-44</td><td>45-64</td><td>65+</td></tr><tr><td>England % av.</td><td>18.9</td><td>18.6</td><td>20.3</td><td>22.4</td><td>16.9</td></tr><tr><td>Kirklees</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>15.8</td><td>18.5</td><td>20.3</td><td>22.2</td><td>15.8</td></tr><tr><td>Barnsley (2011 data)</td><td></td><td>16-24</td><td>25-44</td><td>45-59</td><td>60+</td></tr><tr><td>% average</td><td>18.5</td><td>10.8</td><td>26</td><td>20.9</td><td>23.8</td></tr><tr><td>Calderdale</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>19.6</td><td>16.4</td><td>20.1</td><td>24.2</td><td>16.6</td></tr><tr><td>Wakefield</td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>% average</td><td>18.4</td><td>17.2</td><td>19.6</td><td>24.2</td><td>17.6</td></tr></table> <p>Taken from 2011 Census data.</p> <p>It is difficult to identify impacts to older people & Young People from investigation in incidents identified from the lifetime of the previous policy. (See action EIA plan to improve this information moving forward)</p> <p>Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person from any group.</p>		0-15	16-29	30-44	45-64	65+	England % av.	18.9	18.6	20.3	22.4	16.9	Kirklees						% average	15.8	18.5	20.3	22.2	15.8	Barnsley (2011 data)		16-24	25-44	45-59	60+	% average	18.5	10.8	26	20.9	23.8	Calderdale						% average	19.6	16.4	20.1	24.2	16.6	Wakefield						% average	18.4	17.2	19.6	24.2	17.6
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5d	<p>Sexual Orientation:</p> <p>Prompt: Heterosexual, Bisexual, Gay, Lesbian groups are included in this Category</p>	<p>Research has shown that people who consider themselves heterosexual are more likely to report better levels of health. While bisexual respondents had the worst. Gay and lesbian respondents reported poorer health than heterosexuals, specifically with regards to mental functioning, distress, and illness status.</p> <p>Impacts to people of various Sexual Orientations from investigation in incidents identified from the lifetime of the previous policy is not clear. (See action EIA plan to improve this information moving forward)</p> <p>Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person from any Sexual Orientation</p>																																																												
5e	<p>Religion & Belief:</p> <p>Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered</p>	<p>Data in relation to our communities is taken from 2011, and shows a large Christian faith, second are people who report no religion. Muslim religion shows as the third largest belief system.</p> <p>The latest data on religious affiliation from NatCen’s British Social Attitudes survey reveals that the proportion of people in Britain who describe themselves as having no religion is at its highest ever level.</p> <p>More than half (53%) of the British public now describe themselves as having “no religion”, up from 48% in 2015. The proportion of non-</p>																																																												

believers has increased gradually since the survey began in 1983, when the proportion saying they had no religion stood at 31%.

	Christian	Buddhist	Hindu	Jewish	Sikh	Muslim	Other	No religion
England % av.	71.8	0.3	1	0.5	0.7	10.1	0.2	15.1
Kirklees								
% average	67.2	0.2	0.3	0.1	0.7	10.1	0.2	14
Barnsley								
% average	59.4	0.5	1.5	0.5	0.8	5	0.4	24.7
Calderdale								
% average	60.6	0.3	0.3	0.1	0.2	7.8	0.4	30.2
Wakefield								
% average	66.4	0.16	0.25	0.04	0.12	2.0	0.3	24.4

Taken from 2011 Census data.

General impacts to people of various religions & beliefs from investigation in incidents identified during the previous policy is not clear. *(See action EIA plan to improve this information moving forward)*

Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates, and reduces any risk that may affect any person from any Religion & Belief.

5f Marriage and Civil Partnership

Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category

Data in relation to our communities

	Married	Single	In a [registered] civil partnership	Divorced	Widowed	Separated
England % av.	46.6	34.6	0.2	9.0	6.9	2.7
Kirklees						
% average	48.4	32.4	0.2	9.3	6.8	2.8
Barnsley						
% average	46.6	34.6	0.2	9	6.9	2.7
Calderdale						
% average	46.7	32.1	0.3	10.5	7.3	3.0
Wakefield						
% average	48.2	30.9	0.18	10.5	7.5	2.6

Taken from 2011 Census data.

Older adults who are widowed or divorced are more likely to present with increased symptoms of depression and poorer physical functioning, as well as to face a greater mortality risk than their married counterpart.

		<p>Broad impacts to people from differing marriage or civil Partnerships from investigation in incidents during the previous policy are not clear. <i>(See action EIA plan to improve this information moving forward)</i></p> <p>Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person from any Marriage or Civil Partnership although this is thought to be highly unlikely.</p>
5g	<p>Pregnancy and Maternity</p> <p>Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered</p>	<p>Reasonable adjustments for pregnant/nursing mothers will be covered by processes covering risk assessments and work procedures.</p> <p>Broader impacts to people experiencing pregnancy and or general maternity episodes from investigation in incidents during the previous policy are difficult to ascertain as these could have physical as well as psychological impacts and are judged clinically <i>(See action EIA plan to improve this information moving forward)</i></p> <p>Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures mitigates and reduces any risk that may affect any person who is either pregnant or have been pregnant in the last 12 months.</p>
5h	<p>Gender Re-assignment</p> <p>Prompt: Transgender issues should be considered</p>	<p>Age is the biggest risk factor for falls and frailty. Poor experiences with healthcare providers act to deter trans people from accessing medical treatment and support when they need it. This can lead to poor mental and physical health outcomes.</p> <p>Stonewall LGBT in Britain - Trans Report (2017)</p> <p>Impacts to people having gone through, or currently going through gender re-assignment at the time of an incident from investigations during the previous policy are difficult to ascertain as these could have physical as well as psychological impacts and are judged clinically <i>(See action EIA plan to improve this information moving forward)</i></p> <p>The Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person who has or is undergoing through any Gender Re-assignment.</p>
5i	<p>Carers</p> <p>Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered</p>	<p>Within the local footprint of South West Yorkshire Partnership NHS Foundation Trust, there is an estimated 160,000 unpaid carers and around 7 million carers in the UK.</p> <ul style="list-style-type: none"> • Carers who care for more than 50 hours a week reported poorer health with 25% reporting bad or very bad physical health and 29% reporting bad or very bad mental health. • Carers who have been caring for over 15 years were more likely to report poorer health with 28% describing their physical health as bad or very bad and 27% describing their mental health as bad or very bad. • The most recent GP Patient survey in England found that carers are more likely to report having a long-term condition, disability or illness. <p>Impacts to carers at the time of an incident from investigations during the previous policy are difficult to ascertain as these are likely to have physical as well as psychological impacts and judged clinically <i>(See action EIA plan to improve this information moving forward)</i></p>

Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person, including staff who have Caring responsibilities whether paid or unpaid.

Data in relation to our communities
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 2011 Census data.

Broader race impacts to people from incidents during the previous policy are difficult to ascertain as these could have physical as well as psychological impacts and are judged clinically (*See action EIA plan to improve this information moving forward*)

Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 aims to have a positive and proactive approach to ensure any preventative measures, mitigates and reduces any risk that may affect any person of any race.

All managers are expected to raise and deal robustly with any concerns immediately from incidents involving emergency plans in operation

Prompt: Indigenous population and BME Groups such as Black African and Caribbean, Mixed Heritage, South Asian, Chinese, Irish, new Migrant, Asylum & Refugee, Gypsy & Travelling communities.)

5j

Race

Action Plan

EIAs are now reviewed using a grading approach which is in line with our Equality Delivery System (EDS). This rates the quality of the EIA. This means that the team can review the EIA and make recommendations only. The rating and suggested standards are set out below:

- **Under-developed** – red – **No data. No strands** of equality
- **Developing** – amber – **Some census data plus workforce. Two strands** of equality addressed
- **Achieving** – green – **Some census data plus workforce. Five strands** of equality addressed
- **Excelling** – purple – **All the data and all the strands** addressed

Potential themes for actions: Geographical location, built environment, timing, costs of the service, make up of your workforce, stereotypes and assumptions, equality monitoring, community relations/cohesion, same sex wards and care, specific issues/barriers.

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	✓	<p>All individuals and groups will be encouraged and empowered to ensure safe working practices in their workplace where this supports safe effective service delivery for everyone and to report any concerns from acts or omissions noted.</p> <p>Action 1 (below) covers all individuals and groups to ensure a comprehensive inclusive approach.</p> <p><i>Rigorously & proactively interrogate DATIX reports and report back to the Safety & Resilience TAG any exceptional reports and/or trends affecting any particular individuals or groups to share learning and practices.</i></p>	Emma Hilton	July 2026	July 2026	Developing
Disability	✓					
Gender reassignment	✓					
Marriage and civil partnership	✓					
Race	✓					
Religion or belief	✓					
Sex	✓					
Sexual Orientation	✓					
Pregnancy maternity	✓					
Carers	✓					

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update -outcome	RAG
Age	✓	<p>All individuals and groups will be encouraged and empowered to ensure safe working practices in their workplace where this supports safe effective service delivery for everyone and to report any concerns from acts or omissions noted.</p> <p>Action 2 (below) covers all individuals and groups to ensure a comprehensive inclusive approach.</p> <p><i>Commit time and resources to work even more closely with all Trust individuals and groups on a regular basis when reviewing policies, procedures and general learning from incidents to ensure a comprehensive inclusive approach and avoid any unintended marginalisation.</i></p>	Emma Hilton	July 2026	July 2026	Developing
Disability	✓					
Gender reassignment	✓					
Marriage and civil partnership	✓					
Race	✓					
Religion or belief	✓					
Sex	✓					
Sexual Orientation	✓					
Pregnancy maternity	✓					
Carers	✓					

Involvement & Insight: New or Previous (please include any evidence of activity undertaken in the box below)

This Equality Impact Assessment has been completed after a very informative Cultural awareness and cultural change session with Zahida Mallard, Equality & Involvement Manager on Tuesday, 21st March 2023. Furthermore in line with the proposed action plan, the Trust's Equality Team and other staff minority groups have specially been invited to comment on both the overarching Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 along with Equality Impact Assessment to demonstrate our commitment to an inclusive approach.

7 Methods of Monitoring progress on Actions

Progress on actions will be monitored through the Safety & Resilience & RRPI TAGs along with monitoring trends via DATIX.

8 Publishing the Equality Impact Assessment

The Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 Equality Impact Assessment has been incorporated into the Emergency Preparedness, Resilience & Response Policy (EPRR) 2023 policy as an important & integral element of the document.

9 Signing off Equality Impact Assessment:

Nick Phillips

Associate Director of Estates and Facilities



**Once approved, you must forward a copy of this
Assessment/Action Plan by email to:
InvolvingPeople@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.**

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 Disability Network REACH LGBT SCN Involving People Equality and Inclusion EPRR Network Audit Committee
4.	Content		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	

	Title of document being reviewed:	Yes/No/Unsure	Comments
	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	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	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	

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment / changes
1	July 2014	Martin Brandon	Final	Version 1 to be presented to Emergency Preparedness TAG July 2014
2	September 2014	Martin Brandon	Final	Version 2 incorporates consultation comments. To progress to EMT October 2014.
3	August 2016	Steve Amos/Emma Hilton	Final	Version 3 – update to incorporate changes to roles, responsibilities, meetings and additions relating to all appendices.
4	August 2017	Steve Amos/Emma Hilton	Final	Version 4 – updates to reflect change to major incident plan, roles/responsibilities, telephone numbers and organisational BC risk identification
5	May 2019	Emma Hilton	Final	Version 5 – general review in line with timescales identified within document. Appendices updated and links to associated documents added.
6	September 2021	Emma Hilton	Final	Version 6 – updated to include Trust wide BCP reference and check meets EPRR Core Standard Requirements. Added Procurement section in roles and responsibilities
7	Oct 2023	Emma Hilton	Final	Version 7 – updated to bring into line with reviewed NHSE Core Standard requirements.