Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Business Continuity Strategy and Policy

This Procedural Document replaces: CORP/RISK 9 v.5 – Business Continuity Policy and Strategy

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Target audience:	Doncaster and Bassetlaw Teaching Hospitals NHS FT; Local Partners; Local Health Resilience Partnership (information)

Amendment Form

Version	Date Issued	Summary of Changes	Author
Version 6	27 June 2018	<u>Full revision of document</u> • Renamed 'Strategy and Policy' (formerly 'Policy and Strategy'); • Restructured and reorganised; • Removed duplication and repetition; • Simplified and shortened; • Updated Trust name and logo throughout; • Updated job titles throughout; • Standardised references to ED throughout; • Removal of references to BS 25999 (replaced by ISO 22301). • Replaced references to Monitor's Compliance Framework with NHS Improvement's Single Oversight Framework; • Replaced Care Quality Commission's Essential Standards of Quality and Safety with Care Quality Commission's Fundamental Standards; • Removed Appendix 2 – (Was Model for Business Resilience); • Appendix 2 – (Previously Appendix 3) - Updated with latest terms of reference for BRSG.	Jeannette Reay, Emergency Planning Officer

Version 5	15 December 2015	Minor amendment made: Page 18: Risk assessment grid changed to reflect the updated version as declared in the National Risk Guidance. This adds another red box indicating that the combination of likelihood and impact determining that the risk rating moves from High to Very High. No other changes.	Jean Yates Emergency Planning Lead
Version 4	October 2014	• The Policy and Strategy have been revised in line with organisational restructure. • Revised Terms of Reference in line with organisational restructure • Addition of NHS England Core Standards for EPRR and compliance requirements • Reference to ISO 22301 and the links to BS NHS 25999 • Added a Scope to the document • Added a section on communication responsibilities • Reinforcement of Care Group and Department ownership of business continuity planning • Added the range across which Care Group/Department plans should be risk assessed • Additional sections added on risk assessment and management • Added the requirement to ensure all new service development is risk assessed for business resilience and documented through business case development • Added Resilience Model to confirm the links between the Business Resilience Steering Group and Care Group/Department resilience structures.	Jean Yates, Emergency Planning Lead
Version 3	March 2013	• Full revision of policy document in line with recommendations of Internal Audit report 2011. • Full revision of the Strategy section in line with BS25999. • Amended change of name of business continuity steering group to Business Resilience Steering Group (BRSG). • Roles and responsibilities of the BRSG • Executive Lead change.	Jean Yates, Emergency Planning Lead

CONTENTS

1. INTRODUCTION

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) provides a wide range of healthcare services to the public.

There is an expectation that DBTH services are provided to its communities without interruption.

There are however uncertainties, events, incidents and emergencies that can expose a service or services to disruptions that could prevent business as usual.

DBTH's strategy is to have business continuity planning (BCP) that ensures the maintenance of its most critical services in the event of any disruption to business as usual.

2. REGULATORY FRAMEWORK

The driving forces for the delivery of DBTH's services are statutory and regulatory, under:

- The Health and Social Care Act 2012 S.46 & 47;
- The National Standard Contract S.30;
- The Independent Regulator NHS Improvement - Single Oversight Framework for NHS Foundation Trusts;
- The Care Quality Commission – Essential standards of quality and safety.

Duties for BCP and the production and maintenance of the contingency plans is a statutory requirement for DBTH (as a Category 1 responder) under:

- The Civil Contingencies Act 2004.

The international standard for BCP is:

- ISO 22301.

DBTH is also required to comply with/take account of statute/guidance under:

- The Corporate Manslaughter and Corporate Homicide Act 2007;
- NHS England Emergency preparedness, Resilience and Response (EPRR) 2013;
- NHS England National Core Standards for EPRR;
- Publically Available Specification (PAS) 2015.

ISO 22301 provides a framework for resilience for organisations and outlines the process for BCP. The standard specifies the requirements to plan, establish, implement, operate, monitor, review, maintain and continually improve a documented management system to protect against, reduce the likelihood of occurrence, prepare for, respond to, and recover from disruptive incidents when they arise.

PAS 2015 was written in 2010. The NHS is advised to use it for reference purposes until an updated version is released.

DBTH's Strategy and Policy is intentionally aligned with the principles within ISO 22301 and uses PAS 2015 as a reference document.

3. AIM AND OBJECTIVES

The aim of BCP is to enhance the resilience of DBTH to significant service disruptions and to maintain its most critical services at agreed acceptable levels until normal business as usual may be resumed.

DBTH will have BCP in place to:

- Reduce the likelihood of a disruption to services;
- Minimise impacts if a disruption occurs;
- Reduce financial losses to DBTH;
- Prevent loss of business to competitors;
- Enhance DBTH's reputation and build customer confidence;
- Build staff confidence;
- Ensure that DBTH meets legislative and regulatory requirements where appropriate.

4. ROLES AND RESPONSIBILITIES

4.1 Chief Executive (CE)

The Chief Executive is responsible for ensuring that DBTH has in place a BC Strategy and Policy which meets statutory and regulatory requirements.

The Chief Executive will ensure that the Trust Board receives assurance that DBTH is compliant with the National Standard Contract S.30 and NHS England National Core Standards for EPRR. The Chief Executive is responsible for setting up an Incident Control Room and team in accordance with the command and control arrangements detailed in the Major Incident Plan - REF: CORP/RISK 1. This role will be delegated to an on call executive officer in the absence of the CE.

The Chief Executive will be supported by

- The Accountable Emergency Officer; and,
- The Emergency Planning Officer.

4.2 The Accountable Emergency Officer (AEO)

The Accountable Emergency officer is responsible for ensuring that all plans associated with business resilience are linked to the organisations arrangements for ensuring BC as required by the Civil Contingencies Act 2004 and other regulatory bodies. The AEO supports the CE and provides managerial support and guidance for the Emergency Planning Officer. The AEO is the Chief Operating Officer.

4.5 Emergency Planning Officer (EPO)

The Emergency Planning Officer is responsible for ensuring that DBTH has compliant BCPs which are developed using the methodology promoted within ISO 22301. This work will be undertaken through the Business Resilience Steering Group.

The EPO is responsible for supporting Care Groups and Departments in the development of BC Plans and ensuring that appropriate training and updates in BCP are provided to relevant staff.

4.5 Emergency Planning Support Officer (EPSO)

The Emergency Planning Support Officer supports the EPO to deliver DBTH's BCP agenda, with particular reference to the training and exercise programme.

The EPSO is responsible for ensuring accurate records of staff attendance are collated and stored on the organisation's electronic training record.

4.5 Care Group and Department Management Teams

Local BCPs are owned by the relevant Care Groups and Support Departments. It is the responsibility of Care Group Directors and relevant Executive Directors to ensure that their Care Groups and Support Departments teams have developed appropriate and effective BC arrangements.

Care Groups and Departments must identify all their services, decide which of these are business critical, and identify the resources and infrastructure required to support them.

They must ensure that all staff are aware of and understand their role within the BCPs and that plans are regularly reviewed, tested and updated as necessary - at least annually and following every activation.

All service plans will be agreed by the Care Groups and Departments management team prior to submission to the BRSG.

4.6 Business Resilience Steering Group (BRSG)

BCP and arrangements will be organised through the Business Resilience Steering Group (BRSG), on which each Care Group and Department will have an appropriate representative. The group is required to provide reports, both written and verbal as necessary:

- The Chair of the BRSG will ensure standard reports on business resilience (which includes emergency preparedness) are provided to the Accountable Emergency Officer as required but as a minimum, annually, in order to inform the relevant Boards.

- Management Board will be made aware of all activities identified as critical, for which current BCPs are not in place.

- DBTH's Assurance Framework will be updated six monthly on progress with compliance and risk relating to business resilience.

The BRSG members have the following roles and responsibilities to ensure that DBTH is compliant with the statutory requirements of Category 1 responders under the Civil Contingencies Act 2004 and the National Core Standards for EPRR:

- Undertake appropriate training in BCP in order to be able to understand the BCP process and be able to apply it to their Care Group or Department.

- Develop BCPs and emergency preparedness plans.

- Act as link personnel within their own Care Group or Department ensuring that Clinical Management Teams and Departmental Management Teams are kept appraised of the actions and functions of the group.

- Be responsible for implementing BCP within their local management structure.

- Actively facilitate training and exercising throughout the Care Group or Department, working with the EPSO, keeping a record of such training and exercising, on DBTH's Oracle Learning Management System (OLN), locally and on the designated electronic B drive folder.

- Ensure that all plans relating to BCP and emergency preparedness are reviewed on an annual basis, as a minimum.

5. TYPES OF INCIDENTS AND BUSINESS CONTINUITY PLANS

5.1 Types of issues

The issues which can lead to business disruption include:

- Loss of staff (eg Industrial action; pandemic influenza)
- Denial of access to premises (eg flood; police crime scene; high risk of building collapse)
- Electricity supply failure
- IT failure
- Loss of telecommunications
- Severe weather
- Major transport failure (eg fuel shortage)
- Water supply failure
- Supply chain disruption
- Excessive demand

DBTH should also give consideration to the South Yorkshire Local Health Resilience Partnership Risk Register which documents current healthcare system wide risk issues.

5.2 Contexts

There are three possible contexts within which a BC incident could occur and would need to be managed. These are:

- An internal incident, affecting a part, one or all sites of DBTH (eg failure of part of IT system, partial loss of power). This type of incident may begin in one service area and may then escalate to affect several other services.

  This type of incident would initially be dealt with by general managers using their local BCPs. Depending on the extent, severity and likely duration of the incident, managers would be required to escalate the disruption and it may then be appropriate to set up the Hospital Incident Control Team.

- A civil emergency within, or affecting, the locality (eg failure of local infrastructure, loss of power, adverse weather). The response from DBTH could involve activating the Major Incident Plan.

  This would necessitate diverting resources internally to manage the major incident, but would ultimately impact on the ability to continue to deliver normal services, depending on the duration of the emergency response.

  Whilst the actual response to the emergency would be managed as detailed in the Major Incident Plan, DBTH may be required to activate BCPs to manage the longer term impact on service delivery. The consequences on the provision of normal services would be managed by General Managers following their BCPs.

- A national emergency affecting DBTH's ability to function normally (eg a fuel interruption, pandemic influenza or industrial action).

  Co-ordination of the consequences of this type of emergency would need to be carried out by the Hospital Incident Control Team, modified to suit the type of event and with full partnership co-operation.

5.3 Types of Business Continuity Plans

The preparation of plans at Care Group and Department level are a crucial first step in the BCP process, as it is at this level that critical services are identified and problems related to the preparation of contingency plans identified.

The following plans will be developed:

- Care Groups.
- Support Departments.
- Corporate Trust plan.

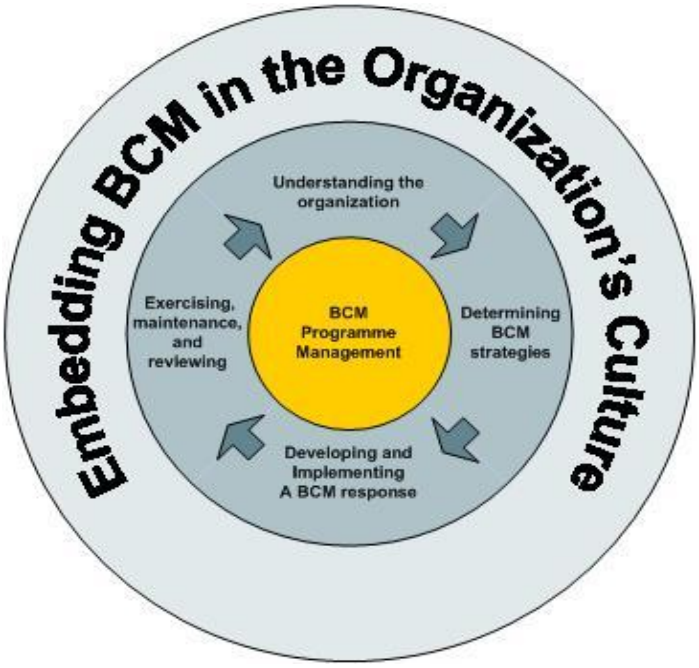
BCPs should be prepared by Care Groups and Departments from within their own resources. Where this is not possible for an identified risk, escalation will be through the Business Resilience Steering Group (BRSG) for consideration and resolution at Management Board.

The Corporate Trust plan addresses interruptions and emergencies that need corporate co-ordination or are too widespread to be addressed by individual services.

6. BUSINESS CONTINUITY PLANNING PROCESS

6.1 The Business Continuity Planning Lifecycle

The process within ISO 22301 and PAS 2015 describes BCP as a lifecycle which should be embedded into the organisation to be effective.



6.2 Objectives of Business Continuity Planning

The following objectives are identified as stages in the planning process:

- Identify the most critical services, and the infrastructure and resources to support them;
- Consider ways of reducing the risk to delivery of the most critical services;
- Prepare contingency plans to ensure continuity of provision of the most critical services;
- Identify any critical services for which no local risk mitigation measures are possible or affordable and addressing these areas on a corporate basis;
- Produce a corporate plan that contains management information and specific corporate contingency plans;

- Identify key areas in terms of criticality and vulnerability and therefore assist in the decision making process concerning the allocation of available funds for resilience measures; and,

- Validate generic and specific plans by exercise and challenge.

6.3 Business Impact Analysis (BIA)

All Care Groups and Departments are required to understand their core business. This is achieved by undertaking a BIA which is the first step in BCP.

The BIA is conducted in two parts:

- Part 1 which identifies the service's *critical services,* and

- Part 2 which provides a *dependency analysis.*

The dependencies are those essential services and resources needed to run the critical services to the 'agreed acceptable level'.

BIA enables the team to:

- List services and identify those critical services that must continue;
- Identify the impact any service disruption will have on these services;
- Identify the essential resources needed to maintain these critical services, and agree what the *minimum acceptable level of service* is;
- Document the impact in terms of time eg first 24 hours;
- Identify the maximum length of time that a service can manage at a *minimum acceptable level of service* for each key service;
- Identify and set a point that services would need to be resumed;
- Identify the risk - an impact score and a probability score for a range of service disruptions; and,
- Produce a CBP which identifies contingencies for each critical service, across a range of common service disruptions (see 5.1).

Following the BIA, Care Group/Departmental leads will be able to rank the risks and develop BCPs for those which score high or very high on the risk matrix.

6.4 Definition of a Critical Service

This is a service which, if not delivered, could have significant detrimental consequences for the patients or for DBTH. The levels of criticality are dependant on what the consequences of NOT delivering that service would be, based on the amount of time that the service could not be provided, eg loss of IT systems could have a catastrophic effect on the organisation, depending on the length of time the service was down.

The following levels of criticality are recognised nationally through BCM models and these are the definitions which must be used for all classification and assessment of services:

Priority	Definition
1	A service, if not provided, would have an immediate detrimental effect on: (a) the patients; (b) on other service providers; (c) cause significant financial loss, or (d) could incur a potential threat of litigation or other penalties
2	Services that cannot be suspended beyond **24 hours** without incurring the potential penalties identified at priority 1 above
3	Services that cannot be suspended beyond **48 hours** without incurring potential penalties as at priority 1 above
4	Services that cannot be suspended beyond **5 days** without incurring potential penalties as at priority 1 above
5	All other services

Services will be assessed using these priority classifications, and any impact of service disruption measured against the relative likelihood of an event occurring. This will produce a relative likelihood score for each critical function/service. The aim is to reduce the likelihood of a service disruption, shorten the period of disruption and limit the impact of a disruption on the DBTH's key services:

Relative Likelihood:

Low	Not known to have occurred previously. It is a conceivable but highly remote possibility
Medium low	Not known to have occurred previously but it is capable of happening
Medium	Is known to have occurred on a single occasion and is capable of happening again
Medium high	Is known to have occurred on multiple occasions and is capable of happening again
High	Is known to have occurred on multiple occasions and is expected to occur again

Relative Impact

5 Catastrophic	Major disruption to all operational functions
4 Significant	Major disruption to many functions
3 Moderate	Major disruption to some operational functions
2 Minor	Minor disruption to some operational services
1 Limited	Minimal disruption to the organisation.

6.5 Assessing the Risk

By planning to deal with the *most likely risks*, DBTH will be better able to deal with the less likely and difficult to predict events.

Care Groups and Departments will need to endorse recommendations as to the criticality and vulnerability of functions, the allocation of resources for risk reduction, determining what is an acceptable level of risk for individual functions and approving contingency plans where these are necessary. As a guide, the strategy for response can range from:

Risk Level	Priority	Treatment / Action
Very High & High Risks	1 &2	Reduce the risk(s) Prepare contingency plan(s)
Medium Risks	3	Attempt to reduce the risk(s) Prepare contingency plans for the highest risk(s)
Medium Low Risk	4	Accept the risk(s) (if not easily be reduced) Consider the preparation of a contingency plan There will be up to 5 days available to prepare alternative arrangements
Low Risk	5	Accept the risk(s) (if not easily reduced)

A "cost / benefit analysis" should be undertaken in situations where the cost of mitigating a given risk is likely to prove significant eg the provision of critical functions on more than one site.

(See Appendix 1 - Risk Assessment Guidance)

6.6 Generic Plans

Generic plans overarch specific plans. They contain information about the overall service, such as what the service is, how many staff it has, contact details, the type of premises and resources it uses. In the event of a significant emergency, for example the loss of, or loss of access to, a major DBTH building, certain planning information will be extremely valuable:

- The critical services that are conducted from that building/section.
- The number of staff required to continue to provide these services.
- Any special equipment needed to continue the service from another location.
- The availability of alternative emergency office space.
- How long it may take to make alternative arrangements.

6.7 Business Continuity Plans

As a minimum, all plans should contain the following:

- Purpose and scope of the plan;
- The document owner and maintainer with a version control panel identifying key revisions;
- Roles and responsibilities of members of the Care Group/department within the plan;
- How the plan will be invoked;
- How and at what point, the service disruption will be escalated to the Executive Team;
- A list of critical services to be recovered approved by the Clinical/Service Management Team;
- Specific service plans for each service priority risk assessed as high or very high;
- Action cards for key staff within the CSU/department;
- Key contact details (roles not names);
- How service team will manage the incident(s);
- Communications structure; and
- De-escalation and recovery.

A standard approach has been developed for DBTH – located at *B:\DBTH Document Library\Business Continuity\BC Template.*

6.8 Exercising, Reviewing and Maintaining BCM Arrangements

Exercising:
DBTH is obliged to ensure plans are fit for purpose and that they are tested and reviewed as a minimum annually. Care Groups/ Heads of Department must ensure their staff receive training on local plans as:

- It is the best way to ensure that the plan is effective;
- It permits errors or omissions to be identified and subsequently rectified; and,
- It is an excellent way of ensuring that the whole management team understands the plan.

An exercise can constitute:

- An actual event requiring a plan to be invoked. This should be followed by a debrief and the plan amended according to any lessons or actions identified if required;
- A discussion – this will meet a training element if staff are able to listen to a presentation of the plan and ask questions about key roles;
- A table top exercise – more complex, requires scenario planning and is best utilised to test a group of Care Group/departmental plans together to ensure each understands the other departments' roles within BCM; and,
- Live exercises – these are usually run with a number of partner organisations to test a whole series of plans, eg a bad weather scenario or significant power outage affecting a large grid area.

Any local exercises are best kept simple, relevant and realistic to the critical service being tested.

Post exercise reporting:
It is good practice to carry out a post exercise debrief following any training/exercise opportunity.

Care Group and Department leads will produce a short report, noting lessons and making recommendations for improvements and changes as necessary. Debriefs should be presented to the BRSG and any issues and actions arising from such exercises will be taken forward through the BRSG.

Reviewing:
Reviewing of plans will be undertaken through either formal audit, peer group or self – assessment. The BRSG will undertake to ensure that plans are reviewed annually as a minimum, a documentary record is maintained and plans meet current standards including ISO 22301.

Following the activation of any Care Group or Department plan as a result of a service disruption, the responsible manager will undertake a review of the circumstances leading to the disruption and actions taken. The purpose will be to determine whether the disruption could have been avoided and whether the Care Group or Department response was appropriate and effective in returning the service to business as usual within an optimal time frame.

This review will be brought to the BRSG for discussion and shared learning. Any serious issues arising will be escalated to the Accountable Emergency Officer and to Management Board. BCPs may need to be amended following this review and should be done so at the earliest opportunity.

Maintenance:
Plans which are out of date are ineffective and unsafe. All plans must be kept up to date and it is the responsibility of the Care Group and General Manager or Department Head to ensure a maintenance programme for their BCPs is in place, identifying a nominated lead.

As a minimum, plans must be updated whenever:

- There are organisational changes;
- There are changes to the external environment in which DBTH operates, eg transitional changes as a result of the NHS reconfiguration;
- Following a real incident, incorporating lessons learned;
- Staff changes; contact details; role changes; retraction or changes to service delivery; and,
- Following the addition of a new service or essential infrastructure (Business Cases must include a statement which assures that DBTH's BC resilience arrangements have been considered as part of this new development).

Storage of Business Impact Analyses (BIA) and associated business continuity plans
The Care Group or Department Lead will provide copies of BIA's and associated BCPs to the EPO to be lodged, electronically on the Trust's B:\.

7. COMMUNICATION

In the event of a significant service disruption and/or where any incident escalates to the point where DBTH invokes its Command and Control structure, the Incident Director will decide what it the most appropriate method to communicate with staff within the organisation and with key partners.

Messages from the Incident Control Room will be sent without delay and will be in a standard format containing agreed key messages - including the type of incident and its impact on DBTH services.

Once the message is agreed, staff must not change the message before passing on to their teams.

8. COSTS

The main costs relating to this policy are staff time taken to:

- Preparing effective plans based on risk identification;
- Mitigate identified risks;
- Review and test plans; and,
- Undertake and provide training to develop plans in line with ISO 22301.

The most critical services will be identified through the BCP process, and subsequent action including allocation of any available resource, will be focused on planning for these.

9. STRATEGIC IMPLICATIONS

DBTH is required to have a strategy and policy in place to provide for the delivery of services to the public, in the event of BC disruption.

The consequences of failure to respond positively to the requirements of the Civil Contingencies Act 2004, and subsequently the NHS Core Standards for EPRR , could adversely affect DBTH's compliance ratings with NHS Improvement, and the Care Quality Commission (CQC).

Business discontinuity can also present severe financial challenges through loss of income, recovery activity and continuity reasons.

10. TRAINING

In order for DBTH to have appropriate generic and specific BCPs, staff who are required to develop them need to have the knowledge and skills and time to do so. Current best practice is that key staff should undertake foundation training and this should be updated every two years as a minimum, or as requirements around effective BC planning changes.

It is a requirement for all members of the BRSG to undergo foundation training and it is the responsibility of Care Group Directors, and Executive Directors to ensure that their Care Group or Department representative attends.

In general, foundation training will be provided in house through the EPO and EPSO. Ad hoc and update training and support will be delivered by the EPO and or EPSO.

The EPO will also maintain a register of staff who have received BC training but it remains the responsibility of the Care Group or Department management team to ensure staff are put forward for updates as is necessary.

11. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (Appendix 3).

12. GLOSSARY

AEO	The Accountable Emergency Officer is the board-level director responsible for EPRR and has executive authority and responsibility for ensuring the organisation complies with legal and policy requirements. They should be a highly visible, senior and authoritative individual who provides assurance to the board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response from DBTH in the event of a major incident or civil contingency event
Agreed acceptable levels	The minimum level that a service can operate at during a significant service disruption or emergency. The level is agreed as acceptable by the service operator, but a plan must be in place to ensure the service is restored at the earliest possible time, and within an agreed timeframe
BC	Business Continuity
BCP	Business Continuity Planning – the process used to determine service priorities, undertaking risk assessments and developing business continuity plans (BCPs) to enable DBTH to deliver business critical service during a significant service disruption or emergency
BCPs	Business Continuity Plans
BIA	Business Impact Analysis – significant first step in the BCP process, which identifies DBTH's critical priorities and the resources needed to ensure these are maintained TO AN AGREED LEVEL in a significant service disruption or emergency
BRSG	Business Resilience Steering Group – DBTH focus group for EPRR assurance and compliance
	A vital function of the organisation without which it would not be able to

Business Critical also Critical priority	operate effectively. As a result, the organisation could suffer serious financial, legal and reputational penalties. The earliest possible restoration and maintenance of such functions is the main focus of BCP
Business as usual	Operating at normal levels
CCA 2004	The Civil Contingencies Act 2004 (c 36) and its associated revisions is an Act of Parliament of the UK that establishes a coherent framework for emergency planning and response ranging from local to national level. There were revisions and guidance documents produced in 2012 which interpret the Act. It replaces former Civil Defence and Emergency Powers legislation of the 20th century
CE	Chief Executive
Category 1 Responder	Defined by the CCA 2004 as organisations at the core of the response to most emergencies (the emergency services, local authorities, some NHS bodies). Category 1 responders are subject to the full set of civil protection duties
Command and Control	A national structure through which significant service disruptions and emergencies are managed. There are three levels of Control and Command: Strategic, Tactical and Operational. The structure is replicated throughout the whole of the response from local to national levels
Debrief	A specific process of gathering information following a significant service disruption or emergency to enable lessons to be identified, actions to be agreed and taken culminating in the production of a report. A HOT debrief is carried out immediately after the event whilst issues are fresh, followed by a formal cold debrief and report production
EPRR	Emergency preparedness, resilience and response – NHS England's Framework supporting the Health response in planning for, responding to and recovering from a significant service disruption or emergency, enabling the Health providers and commissioners to meet the statutory duties under the CCA 2004 and the Health and Social care Act 2012 S.46 & 47
EPO	Emergency Planning Officer – supports the AEO in achieving DBTH compliance against the CCA 2004 responder duties and the national Core Standards for EPRR
EPSO	Emergency Planning Support Officer – supports the EPO by developing and delivering an annual training and exercise programme , working with Care Groups and Department leads
Emergency	The NHS defines an emergency as "A significant incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or a local authority". However, in relation to differentiating between major incidents and business continuity incidents, emergency in general describes a major incident or incident of that type

Incident Control Room (DBTH) Incident Co-ordination Centre	Each NHS organisation has the responsibility to provide a suitable environment for managing an emergency. This is known as an Incident Coordination Centre (DBTH refers to this as an Incident Control Room). It provides a functional space for making decisions and collecting and sharing information quickly and efficiently. Large organisations with several sites will need an ICC at each location where tactical and operational functions can be coordinated. This should be supported by a separately located strategic ICC The Incident Control Room for DBTH is based at DRI in the Education Centre Rooms 1&2 and would be set up to manage either an emergency incident or a significant business continuity incident
Incident	In terms of EPRR, the term 'incident' is often interchangeable with 'emergency'
NHS England Core Standards for EPRR	The Core Standards form the assurance and for EPRR for Health. The standards are framed around the CCA 2004 Responder duties and DBTH is required to undertake a self-assessment against the standards and provide a compliance statement for the Board of Directors and for NHS England via the South Yorkshire and Bassetlaw Area Team. The Core Standards relate to both emergency preparedness and to BCP
OLM	Oracle Learning Management system
Risk Assessment	The process of determining and prioritising the risks to an organisation of a hazard or threat. Risk is the product of likelihood and impact. The process determines the impact or consequences of a hazard or threat occurring against the likelihood of such an event occurring. A risk rating is generated, and depending on the plans/processes in place to manage the risk, a risk priority is determined
Relative Impact	This is the effect that a hazard or threat can have on an organisation if it is untreated
Relative likelihood	The probability of an event occurring, based on a range of known circumstances and evidence
Significant service disruption	This relates specifically to a business continuity incident and generally describes such an issue as a power outage, flooding, any incident which results in loss of staff eg pandemic influenza, industrial action

APPENDIX 1: RISK ASSESSMENT GUIDANCE

Risk Definition

Risk is the probability of an event or action or inaction that will affect DBTH's ability to achieve its overall objectives and the successful execution of its strategies.

Risk management is the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events. In ideal risk management, a prioritisation process is followed whereby the risks with the greatest loss (or impact) and the greatest probability of occurring are handled first, and risks with lower probability of occurrence and lower loss are handled in descending order. Interruption to business continuity in a large, diverse organisation like DBTH can be a major risk for some services, but less significant for others.

Risk Mitigation or reduction is the application of measures to reduce the impact of the known risk, before it occurs eg putting in place checks to make sure critical equipment is protected during a power outage; having in place processes to replace staff who are temporarily unable to get in to work due to, say, flooding or a major transport failure.

Risk assessment is an essential part of the BCP process and will focus managers on which of their services are most at risk, and what can be done to reduce the impact of the risk. Some risks are so small that no action is required, but others have the potential to have a significant impact on the operational business of DBTH and need to be identified and managed

Each Care Group and Support Department therefore needs to consider what is required to ensure that their essential services are resilient to disruption and are therefore always available to enable operational service, even though that may temporarily be at *an agreed acceptable level* to that which it normally runs at. (see Appendix 1 - Risk Guidance).

Risk Assessment

(CCA 2004 'Local Risk Assessment Guidance 2012').

Risk is defined as the product of likelihood and impact and Table 1 below relates these to risk rating terms to identify the priority of identified risks within Care Group and Department:

Likelihood X Impact = Risk rating

Likelihood Assessment descriptions refer to the **chances or probability** of the incident either occurring in or impacting on the services provided by DBTH.

Impact Assessment descriptions refer to the **potential scale** of each hazard and are not predictions relating to particular incidents or sites, but indicate the potential maximum scale of problems relating to that hazard, based upon the principle of a "reasonable worst case scenario". It should be noted that where the descriptor "limited" or "minor" is used, this refers to the level of impact on an overall basis. It is not intended to diminish the scale of any impact on the lives of individuals.

RISK ANALYSIS – ASSESSING RELATIVE IMPACT AND LIKELIHOOD

Table 1. Risk matrix

RELATIVE IMPACT	Catastrophic (5)	MEDIUM	**VERY HIGH**	**VERY HIGH**	**VERY HIGH**	**VERY HIGH**
	Significant (4)	MEDIUM	HIGH	**VERY HIGH**	**VERY HIGH**	**VERY HIGH**
	Moderate (3)	MEDIUM	HIGH	HIGH	HIGH	HIGH
	Minor (2)	LOW	MEDIUM	MEDIUM	MEDIUM	MEDIUM
	Limited (1)	LOW	LOW	LOW	LOW	LOW
		Low (1)	Medium Low (2)	Medium (3)	Medium High (4)	High (5)
	RELATIVE LIKELIHOOD					

The following definitions of the risk ratings are used to help us decide the relative priority of a given risk and refer to the shaded areas in the matrix:

Very High	These are classed as primary or critical risks requiring immediate attention. They may have a high or low likelihood of occurrence, but their potential consequences are such that they must be treated as a high priority. This may mean that strategies should be developed to reduce or eliminate the risks, but also that mitigation in the form of (multi-agency) planning, exercising and training for these hazards should be put in place and the risk monitored on a regular frequency. Consideration should be given to planning being specific to the risk rather than generic.
High	These risks are classed as significant. They may have a high or low likelihood of occurrence, but their potential consequences are sufficiently serious to warrant appropriate consideration after those risks classed as 'very high'. Consideration should be given to the development of strategies to reduce or eliminate the risks. Mitigation in the form of at least (multi-agency) generic planning, exercising and training should be put in place and the risk monitored on a regular frequency.
Medium	These risks are less significant, but may cause upset and inconvenience in the short term. These risks should be monitored to ensure that they are being appropriately managed under generic emergency planning arrangements.
Low	These risks are both unlikely to occur and not significant in their impact. They should be managed using normal or generic planning arrangements and require minimal monitoring and control unless subsequent risk assessments show a substantial change, prompting a move to another risk category.

IMPACT SCORING SCALE – QUALITATIVE MEASURES

Level	Descriptor	Categories of Impact	Description of impact
1	Limited	Health	Insignificant number of injuries or impact on health.
		Social	Insignificant number of persons displaced and insignificant personal support required. Insignificant disruption to community services, including transport services and infrastructure.
		Economic	Insignificant impact on local economy.
		Environment	Insignificant impact on environment.
2	Minor	Health	Small number of people affected, no fatalities, and small number of minor injuries with first aid treatment.
		Social	Minor damage to properties. Minor displacement of a small number of people for up to 24 hours and minor personal support required. Minor localised disruption to community services or infrastructure for up to 24 hours.
		Economic	Negligible impact on local economy and cost easily absorbed.
		Environment	Minor impact on environment with no lasting effects.
3	Moderate	Health	Sufficient number of fatalities with some casualties requiring hospitalisation and medical treatment and activation of MAJAX procedures in one or more hospitals.
		Social	Damage that is confined to a specific location, or to a number of locations, but requires additional resources. Localised displacement of up to 100 people for 1–3 days. Localised disruption to infrastructure and community services.
		Economic	Limited impact on local economy with some short-term loss of production, with possible additional clean-up costs.
		Environment	Limited impact on environment with short-term or long-term effects.
4	Significant	Health	Significant number of people in affected area impacted with multiple fatalities, multiple serious or extensive injuries, significant hospitalisation and activation of MAJAX procedures across a number of hospitals.

Level	Descriptor	Categories of Impact	Description of impact
		Social	Significant damage that requires support for local responders with external resources. 100 to 500 people in danger and displaced for longer than 1 week. Local responders require external resources to deliver personal support. Significant impact on and possible breakdown of delivery of some local community services.
		Economic	Significant impact on local economy with medium-term loss of production. Significant extra clean-up and recovery costs.
		Environment	Significant impact on environment with medium- to long-term effects.
5	Catastrophic	Health	Very large numbers of people in affected area(s) impacted with significant numbers of fatalities, large number of people requiring hospitalisation with serious injuries with longer-term effects.
		Social	Extensive damage to properties and built environment in affected area requiring major demolition. General and widespread displacement of more than 500 people for prolonged duration and extensive personal support required. Serious damage to infrastructure causing significant disruption to, or loss of, key services for prolonged period. Community unable to function without significant support.
		Economic	Serious impact on local and regional economy with some long-term, potentially permanent, loss of production with some structural change. Extensive clean-up and recovery costs.
		Environment	Serious long-term impact on environment and/or permanent damage.

LIKELIHOOD SCORING SCALE

Level	Descriptor	Likelihood over 5 years	Description of Likelihood over 5 years
1	Low	Estimated at 0.005%	It is a conceivable but highly remote possibility.
2	Medium Low	Estimated at 0.05%	No significant incidents of this type have occurred in/at DBTH, but it is capable of happening.
3	Medium	Estimated at 0.5%	Has occurred in/at DBTH and is capable of happening again.
4	Medium High	Estimated at 5%	Has occurred on multiple occasions in/at DBTH and is capable of happening again.
5	High	Estimated at 50%	Has occurred on multiple occasions in/at DBTH and is expected to occur in the future.

APPENDIX 2: BRSG TERMS OF REFERENCE

Name	Business Resilience Steering Group (BRSG)
Purpose	To ensure coordination across Care Groups and Departments to enable DBTH: - To prepare and respond to any emergency or service interruption impacting on DBTH's key functions; - To fulfil its role as a Category 1 Responder under the Civil Contingencies Act 2004 (CCA 2004). - To provide assurance and evidence of compliance to demonstrate that DBTH is a resilient organisation (as defined by the CCA 2004 and NHS England's Emergency Preparedness Framework 2013).
Responsible to	Management Board which will assess the BRSG to ensure that it is acting in accordance with these terms of reference.
Chair	The Emergency Planning Officer will provide the agenda and papers and will chair the meetings.
Secretary	The Emergency Planning Support Officer will take minutes and keep a record of matters arising.
Membership	Emergency Planning Officer (Chair) Emergency Planning Support Officer <u>Business Continuity Lead* for</u> - Children and Families Care Group - Diagnostic and Pharmacy Care Group - Emergency Care Group - MSK and Frailty Care Group - Speciality Service Care Group - Surgical Care Group - Information Technology - Estates - Facilities - People and Organisational Development - Finance - Communications - Procurement - Clinical Therapies
	Representative from Heads of Nursing** Education Centre Patient Safety and Quality Lead Security Manager Fire Officer Health and Safety Advisor CBRNe Lead *The business continuity lead will be the General Manager, Head of Nursing, Head of Service, or a direct report – as agreed with the meeting Chair. **If not covered by a business continuity lead.

In attendance	The Non-Executive Director leading on Emergency Planning will be extended an invite to attend all meetings. Representatives may be sent in the place of a member when apologies are given – by agreement with the Chair.
Quorum	Eight members, including two from care groups.
Frequency of meetings	Quarterly (plus extraordinary meetings called as required)
Attendance requirements	Committee members must attend at least 75% of meetings.
Delegated Authority	The Group has delegated authority through the Accountable Emergency Officer to;
Duties and work programme	• Have business continuity planning (BCP) in member job descriptions or have delegated authority from the General Manager of the Care Group and understand the process of BCP as it applies to this organisation; • Understand and support the wider Emergency Preparedness Resilience and Response (EPRR) agenda and DBTH's statutory and regulatory obligations within this; • Facilitate EPRR and BCP risk assessments to identify key risks and assist in risk mitigation; • Facilitate the development, review and maintenance of resilience plans within the organisation, monitoring Care Group and Department progress and compliance through the BRSG; • Review and sign off all plans and policies relating to EPRR (and BCP) before being approved by the relevant Trust Board; • Discuss, agree and take forward actions from the BRSG work plan; • Represent Care Groups and Departments and ensure that information and actions from the BRSG are cascaded through appropriate Care Group management teams and actioned within local resilience group; • Enable escalation of local issues back to the BRSG for discussion and advice/action; • Ensure that Care Groups and Departments are compliant by having current appropriate business continuity and emergency plans and action cards in place; • Work with the Emergency Planning Officer in the provision of assurance and compliance statements for the Trust Board, NHS England Area Team and Doncaster and Bassetlaw CCGs;
	• Work with the Emergency Planning Support Officer to develop and deliver a robust training and exercise programme which is representative of the requirements of the National Core Standards for EPRR ; • Facilitate the cascade of the Annual Training and Exercise programme into Care Groups and Departments, ensuring participation of Care Groups and Departments in desk top exercises, communications exercises and real life incidents, providing post-event analysis back to the BRSG so that any issues or actions can be addressed and emergency and action plans amended in light of the outcomes.
Papers	The agenda and supporting papers will be distributed seven days in advance of the meeting.

Permanency	The Group has been set up on a permanent basis.
Minutes	The minutes will be circulated within four weeks of the meetings for distribution to Members and the Management Board. The minutes will also be copied to Care Group Directors, General Managers, Heads of Nursing and Heads of Service.

Date approved by the committee:	16 November 2017
Date approved by Management Board:	12 February 2018
Committee review date:	October 2018
Review date (for approval by Management Board):	November 2019

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Business Continuity Strategy and Policy	David Purdue, Chief Operating Officer	Jeannette Reay	Existing revised	May 2018

1) Who is responsible for this policy? Name of Care Group/Directorate: The Lead Director for Emergency Preparedness, Resilience and Response (EPRR) and the Emergency Planning Officer who has delegated responsibilities.

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? The purpose of the Strategy and Policy is to enable the Trust to meet its statutory obligations under the Civil Contingencies Act 2004 to be prepared for and plan to respond effectively to any emergency or incident which may affect the Trust's capability of service provision. This could be any service disruption affecting service delivery, ranging from a major incident or significant power outage (examples only). It is also to protect staff, patients and the public in the event of any incident affecting the service and provides for protecting core service priorities.

3) Are there any associated objectives? Legislation, targets national expectation, standards - Statutory requirements under the CCA 2004; NHS Improvement's Single Oversight Framework; CQC fundamental Standards; NHS England Core Standards; NHS England EPRR Framework; National Standard Contract Compliance.

4) What factors contribute or detract from achieving intended outcomes? None known

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [eg Monitoring, consultation]

6) Is there any scope for new measures which would promote equality? Non known

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form

Date for next review: June 2019

Checked by: Neil Colton, Emergency Planning Support Officer **Date:** 14 May 2018