Trust Policy	NHS University Hospitals Plymouth NHS Trust

Emergency Planning, Resilience and Response Policy

Issue Date	Review Date	Version
August 2020	August 2023	3

Purpose

This policy describes how the wider Emergency Planning, Resilience and Response agenda is addressed and delivered, across the Trust. This policy covers key responsibilities and arrangements for how the Trust plans for and recovers from significant incidents including training and exercising requirements.

Who should read this document?

All staff and contracted service providers who may become involved in responding to an emergency.

Key messages

The response to challenging incidents will differ dependent upon the incident and disruption that may be experienced as a result eg major incident or internal disruption to critical functions.

All staff should be familiar with the plans relevant to their area of work and able to undertake designated roles, detailed in the action cards contained within the emergency response plans.

Accountabilities

Production	Miriam Smith, Emergency Planning & Liaison Officer
Review and approval	Emergency Planning Resilience and Response Committee
Ratification	Chief Operating Officer / Accountable Emergency Officer
Dissemination	Emergency Planning & Liaison Officer
Compliance	Emergency Planning Resilience and Response Committee

Links to other policies and procedures

Major Incident Plan
Service Line Business Continuity Plans
Critical Services Disruption Guide
IT Outage Self Help Guide

Version History

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2	May 2016	Reviewed and updated
3	August 2020	Reviewed and updated

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

1   Introduction

1.1   The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health and patient care. These could be anything from extreme weather conditions to an infectious disease outbreak, major transport accident or a terrorist act.

1.2   This work is referred to in the health service as emergency preparedness, resilience and response (EPRR).

2   Purpose, including legal or regulatory background

2.1   This policy describes the Trust's approach to the emergency preparedness resilience and response agenda and how elements are delegated.

2.2   Emergency arrangements are planned around the following objectives:

- ❑ To prepare for the common consequences of emergencies rather than for every individual emergency scenario
- ❑ To have flexible arrangements for responding to emergencies, which can be scalable and adaptable to meet the wide-range of scenarios
- ❑ To supplement this with specific planning and capability building for the most concerning risks held in the National Risk Register
- ❑ To ensure that plans are in place to recover from incidents and provide appropriate support to the local communities affected

3   Definitions

3.1   **Emergency –** under Section 1 of the CCA 2004 and emergency is defined as:

"(*a*)   *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*
(b)   *an event or situation which threatens serious damage to the environment of a place in the United Kingdom;*
(c)   *war or terrorism, which threatens serious damage to the security of the United Kingdom*"

3.2   **Major Incident –** any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an 'emergency' – as defined above

3.3   **Business Continuity Incident** – an event or occurrence that disrupts, or might disrupt an organisation's normal service delivery, below acceptable pre-defined 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.

3.4   **Critical Incident –** any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services,

patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

4	**Duties**

4.1 Accountable Emergency Officer

The Chief Nurse/director of Integrated Professions as Designated Accountable Executive Officer (AEO), is the Board level director responsible for EPRR and has executive responsibility for ensuring that the organisation complies with the legal and policy requirements. The AEO will provide assurance to the Board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response for the Trust in the event of an incident.

Specifically the AEO is responsible for:

❑ Chairing the EPRR Committee and the Executive representative of the Local Health Resilience Partnership

❑ Accountable to the Trust Board for the implementation of EPRR arrangements and provides assurance to the Board via an annual report. Periodically up-dates the Quality Assurance Committee on the wider EPRR agenda.

❑ Ensuring the Trust and any sub-contractors is compliant with the EPRR requirements as set out in the CCA2004, the NHS Act 2006 (as amended) and the NHS Standard Contract, including the NHS England EPRR Framework and Core Standards for EPRR

❑ Ensuring that the organisation is properly prepared and resourced for dealing with an incident

❑ Ensuring that the Trust, any commissioned providers and sub-contractors have robust business continuity arrangements in place which are aligned to ISO 22301 or subsequent guidance

❑ Ensuring that the Trust has robust surge capacity plan that provides an integrated organisational response and that has been tested with other providers and partner organisation

❑ Ensuring that the organisation complies with any requirements of NHS England, or agents of NHS England, in respect of monitoring compliance

❑ Providing NHS England with such information as it may require for the purpose of discharging its functions.

4.2 On-call Director
The Trust is responsible for ensuring appropriate leadership during emergencies and other times of pressure. The On-call Director should always be available to make strategic decisions for the Trust - other staff may also be on-call to provide support.

4.3 Emergency Planning and Liaison Officer

- Responsible to the Accountable Emergency Officer for the day-to-day management of the EPRR agenda
- Provides advice, support and guidance to Trust staff on EPRR issues
- Responsible for developing tools to standardise emergency plans across the Trust
- Supports managers in the development and testing incident response plans
- Provides advice and support for staff with responsibility for emergency planning
- Co-ordinates exercises to test the Trust's emergency arrangements
- Reviews the response to incidents to ensure learning points are shared and included in future planning arrangements

4.4 Service Line Leads

- Responsible for ensuring critical functions have resilient arrangements in place, in the event of significant disruption to services
- Responsible for ensuring that emergency response plans are reviewed annually and any changes to Trust-wide plans are communicated to the Emergency Planning & Liaison Officer
- For areas that provide Trust-wide services that others are reliant upon 24/7 or on-call, business continuity plans are to be developed and maintained, using the Trust template, with risks recorded on Datix
- Liaising with suppliers of sub-contracted that provide NHS Services and obtain a copy of their business continuity plan in the event of disruption to their service provision
- Ensure sufficient staff are aware and trained in the requirements detailed in relevant emergency response plans - including business continuity arrangements, Major Incident Plan and relevant emergency response plans

4.5 All Staff

- Familiar with plans relevant to their area of work and able to undertake designated roles, detailed in the action cards contained within the emergency response plans

4.6 Suppliers of Contracted NHS Services

Suppliers have a responsibility to adhere to the NHS Terms and Conditions for the Supply of Goods/Services, Schedule 2, Clause 6 relating to business continuity for their organisation.

As such, suppliers are required to:

- Maintain and comply with a plan for business continuity and disaster recovery (a "Business Continuity Plan") for each of the goods and services it provides to the Trust, in order to mitigate, as far as reasonably possible, the impact of events or circumstances which could detrimentally affect the uninterrupted supply of the goods or provision of the services. These will include circumstances including but not limited to staff and supplies shortages, workload demand, information technology, equipment, energy and utility failures;

- Take steps and secure that their organisation is properly prepared for dealing with an Emergency and complies with the requirements on Services

Providers under Section 46 of the Health and Social Care Act 2012. For the purposes of this exercise, an "Emergency" shall be any emergency which might affect the Trust (whether by increasing the need for the goods or services or in any other way)

❑ Provide a copy of their Business Continuity Plan to the Trust

4.7   Emergency Preparedness Resilience & Response Committee

❑ Reviews the existence and effectiveness of the policy, systems and procedures in place Trust-wide in respect of major incidents and business continuity arrangements to ensure that they are in line with current legislation.

❑ To assess the Trust's ability to respond to risks identified on the Local resilience Forum (LRF) Community risk register.

❑ To coordinate training and exercise opportunities to test and validate, the policy, plans and arrangements.

❑ To undertake post exercise and incident reviews and develop action plans based on the findings

❑ Co-ordinates mitigation measures to manage the consequences of a range of disruptive events that could affect the Trust's ability to deliver patient care

5   Key Elements

5.1   Risk Management
Risk management is covered within the CCA 2004 and is the first step in the emergency planning and business continuity process. It ensures that local responders make plans that are sound and proportionate to risks.

Through the Devon, Cornwall and Isles of Scilly Local Resilience Forum, the Trust participates in multi-agency planning to contribute to the Community Risk Register.

As an NHS funded organisations, the Trust also needs to undertake risk assessments appropriate to our facilities and services provided.

5.2   Local Health Resilience Partnership
The Accountable Emergency Officer is the executive representative on the Local Health Resilience Partnership (LHRP) - the strategic forum for joint planning and preparedness for incidents, supporting the health sector's contribution to multi-agency planning and preparation. Members of the LHRP are executives able to provide strategic direction and commit resources for health EPRR in this area.

5.3   Major Incident Plan
The Major Incident Plan and supplementary arrangements detail response arrangements and action cards for services involved in a major incident response, where casualties from an incident overwhelm normal resources.

5.4   Generic Business Continuity Plan
The Generic Business Continuity Plan contains a framework for response to an emergency, including the command and control arrangements in place to manage

the response and sufficient operational procedures to enable responders to manage an incident.

The Incident Control Centre will be established to provide an enhanced level of operational support and will lead on:
- ❑ Co-ordination – matching capabilities to demands
- ❑ Policy making – decisions pertaining to the response
- ❑ Operations – managing as required to directly meet the demands of the incident
- ❑ Information gathering – determining the nature and extend of the incident ensuring shared situational awareness
- ❑ Dispersing public information – informing the community, news media and partner organisations

5.4 Business Continuity Arrangements

All Service Lines/Corporate Leads are required to produce Business Continuity Plans –detailing their response to a disruption in service provision, actions to resolve the problem and advice and support to staff affected.

Business continuity plans should be developed using the Business Continuity Plan Template, with guidance provided on developing arrangements detailed in the Business Continuity Guide – available on Trust Documents.

Specific tried and tested resilience plans are also held on Trust Documents including:
- ☐ Critical Services Disruption Guide
- ☐ IT Outage Self Help guide
- ☐ Emergency Telephone Directory

5.6 Information Sharing

Under the CCA 2004 responders have a duty to share information with partner organisations. This is seen as a crucial element of civil protection work, underpinning all forms of cooperation.

Further guidance can be obtained from the *Data protection and Sharing Guidance for Emergency Planners and Responders* here:

file:///G:\MajorIncident\Business%20Continuity%20Plans\data%20protection%20and%20sharing.pdf

5.7 Legal Frameworks, Public Inquiries, Coroners inquests and Civil Action

The day to day management of people and patients in the NHS is subject to legal frameworks, duty of care, candour and moral obligation. This does not change when responding to an incident however these events can lead to greater public and legal scrutiny.

5.8 Logging and record keeping

Plymouth University Hospitals NHS Trust must have appropriately trained and competent Loggists to support the management of an accident. 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 Coroners inquests, public enquiries, 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.

5.9 **Decision Making**

Decision making, especially during an incident, is often complex and decisions are open to challenge. Decision makers will be supported in all instances where they can demonstrate that their decisions were assessed and managed reasonably in the circumstances existing at a particular point in time. Use of decision support models and processes assist in providing this evidence, particularly in conjunction with decision logs.

The Joint Decision Model (see Diagram 1) is suitable for all decisions and has been adopted by JESIP in the joint doctrine to practically support decision makers working under difficult circumstances. It is organised around the three primary considerations: situation, direction, action.

It is expected that decision makers will use their judgement and experience in deciding what additional questions to ask and considerations to take into account to reach a decision. The Joint Decision Model is used to support the decision making process in achieving the desired outcomes.

Diagram 1

5.10 **Recovery**

Recovery from any incident is imperative and requires a coordinated approach from the affected organisation(s) and multi-agency partners, depending upon the type and scale of the incident.

The national Emergency Response and Recovery Guidance provides detailed advice for organisations; https://www.gov.uk/emergency-response-and-recovery. It may also offer opportunities for service redesign and changes to operational practice.

The recovery phase should begin at the earliest opportunity following the start of an incident and should be run in parallel with the response. The recovery phase does not end until all disruption has been rectified, demands on services have returned to normal levels and the physical and psychosocial needs of those involved have been met.

5.11 **Post Incident Review**

In order to identify lessons from any incident it is important to capture as much detail about the incident and the experiences of those involved as soon as is reasonably practicable. A series of debriefs post incident is seen as good practice.

The post incident reports should be supported by action plans, with timescales and accountable owners, and recommendations in order to update any relevant plans or procedures and identify any training or exercising required.

5.12 **Training**

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 need 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 and highlight wider organisational and multi-agency response structures, as appropriate to the role. The EPRR Committee will annually review the Training Needs Analysis, detailing training priorities, in addition to ad-hoc training undertaken at ward/department level.

5.13 **Exercising**

Plans developed to allow the Trust to respond efficiently and effectively must be tested regularly using a variety of processes. Roles within the plan, not individuals, are exercised to ensure they are fit for purpose and cover all the necessary functions and actions to be carried out during an incident response.

The outcome of testing and exercising must identify and record whether it worked and what needs changing. The log must also identify what has changed. This information provides an audit tool that lessons have been identified and action taken and is key evidence during any enquiry process.

Through the exercising process individuals have the opportunity to practice their skills and increase their confidence, knowledge and skill base in preparation for responding in a live incident.

The Trust should consider exercising with partner agencies and contracted services where the identified risks and the involvement of partner organisations is appropriate. Learning from exercises must be cultivated into developing a method that supports personal and organisational goals and is part of an annual plan validation and maintenance programme.

- ❏ Communications exercise – every six months
- ❏ Table top exercise – every 12 months
- ❏ Live play exercise - every three years
- ❏ Command post exercise - every 3 years

5.14 **Assurance**

The minimum requirements which NHS funded organisations must meet are set out in the Core Standards. University Hospitals Plymouth NHS Trust is asked to provide evidence of compliance and for their Board to issue a Statement of EPRR Conformity to our Commissioners. NHS England will ensure that CCG compliance forms part of the annual CCG Assurance Framework.

| 6 | **Overall Responsibility for the Document** |

6.1 Overall responsibility for this document rests with the Accountable Emergency Officer and Emergency Planning and Liaison Officer. Both parties report to the Emergency Preparedness, Resilience and Response Committee, where assurance is provided that this document is being managed and implemented across the Trust.

| 7 | **Consultation and Ratification** |

7.1 The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

7.2 The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

7.3 This document will be approved by the Emergency Preparedness, Resilience and Response Committee and ratified by the Accountable Emergency Officer.

7.4 Non-significant amendments to this document may be made, under delegated authority from the Accountable Emergency Officer, by the nominated author. These must be ratified by the Accountable Emergency Officer and should be reported, retrospectively, to the approving Emergency Preparedness, Resilience and Response Committee.

7.5 Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

| 8 | **Dissemination and Implementation** |

8.1 Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

8.2 Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

8.3 The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the named Accountable Emergency Officer and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9	Monitoring Compliance and Effectiveness

9.1 The Emergency Planning and Liaison Officer provides regular up-dates to the Emergency Preparedness, Resilience and Response (EPRR) Committee including an overview current risks, progress on the development of plans to mitigate risks, training and exercising.

9.2 After each significant incident, a post incident review will be presented to the EPRR Committee and recommendations tracked.

9.3 Care Groups and Corporate Functions will monitor compliance of business continuity arrangements relating to their area of responsibility and report outcomes to the EPRR Committee.

9.4 The EPRR Committee will receive reports on progress and issues highlighted throughout this process.

9.5 Any shortfalls identified through this process will be monitored by the EPRR Committee and addressed through action plans.

9.6 An annual report will be presented to Trust Board, detailing compliance of EPRR Core Standards and associated work plan.

9.7 Learning from any incident will be cascaded by plan amendments, training development of new arrangements to cover any identified gaps in arrangements.

10	References and Associated Documentation

10.1 Emergency planning should be an integral part of how the Trust manages its core business and the Trust is required to have arrangements in place that complies with:

- Civil Contingencies Act 2004 and associated Cabinet Office Guidance
- NHS Act 2006 (as amended)
- NHS Constitution
- Requirements for EPRR as set out in the NHS Standard Contract
- NHS England EPRR guidance and supporting materials including
    - NHS England Core Standards for EPRR
    - NHS England EPRR Framework
    - Business Continuity Management Framework (service resilience)
    - Other guidance available at http://www.england.nhs.uk/ourwork/eprr/
    - National Occupational Standards for Civil Contingencies
    - BS ISO 22301 Societal Security – Business continuity management systems

Dissemination Plan	Appendix 1

Core Information	
Document Title	Emergency Preparedness, Resilience and Response Policy
Date Finalised	August 2020
Dissemination Lead	Miriam Smith
Previous Documents	
Previous document in use?	Business Continuity Plan Major Incident Plan
Action to retrieve old copies.	Remove from Trust Documents folder and email all managers to request removal of old document
Dissemination Plan	

Recipient(s)	When	How	Responsibility	Progress update
All staff		Email	Document Control	
Leads with Designated Responsibilities	Upon publication	Email	Miriam Smith	

Review and Approval Checklist		Appendix 2
Review		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y
Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Equalities and Human Rights Impact Assessment | Appendix 3

Core Information

Manager	Miriam Smith
Directorate	Corporate
Date	August 2020
Title	Emergency Preparedness, Resilience and Response Policy
What are the aims, objectives & projected outcomes?	To ensure that the full spectrum of the emergency preparedness, resilience and response agenda is understood and applied throughout the Trust, to minimise periods of disruption to services.

Scope of the assessment

This assessment considers the full range of activities included in this policy, for all protected characteristics.

Collecting data

Race	During communication re a Major Incident, there will be options for the information to be available in other languages.
Religion	Consideration will be made regarding religious requirements during a major incident, and these will be met where reasonable and practical.
Disability	Reasonable adjustments will be made as reasonable and practical during the activities contained within this policy.
Sex	No impact has been identified re gender, however this will be monitored through patient and workforce data
Gender Identity	No impact has been identified re gender identity, however this will be monitored through patient and workforce data
Sexual Orientation	No impact has been identified re sexual orientation, however this will be monitored through patient and workforce data
Age	No impact has been identified re age, however this will be monitored through patient and workforce data
Socio-Economic	No impact has been identified re socio-economic group, however this will be monitored through patient and workforce data
Human Rights	No impact has been identified re Human Rights, however this will be monitored through patient and workforce data
What are the overall trends/patterns in the above data?	There are possible impacts re Race, Religion and Disability, and adjustments will be made where reasonably practicable
Specific issues and data gaps that may need to be addressed through consultation or further research	No data has been collected during this review

Involving and consulting stakeholders

Internal involvement and consultation	Members of the Trust's Emergency Preparedness, Resilience and Response Committee
External involvement and consultation	NHS England policies and guidance

Impact Assessment				
Overall assessment and analysis of the evidence	There are possible impacts re Race, Religion and Disability and adjustments will be made where reasonably practical.			
Action Plan				
Action	**Owner**	**Risks**	**Completion Date**	**Progress update**
Patient and workforce data will be reviewed for possible impacts during the compliance monitoring of this document	Miriam Smith			