Policy:
Business Continuity OPS 003

Executive Director lead	Executive Director of Nursing, Professions and Quality / Accountable Emergency Officer
Policy Owner	Emergency Planning Manager
Policy Author	Emergency Planning Manager

Document type	Policy
Document version number	V2.1
Date of approval	December 2023
Approved by	Audit & Risk Committee
Date of issue	March 2022 / Mid-term review December 2023
Date for review	March 2025

Summary of policy
Provide a summary description of the policy

Target audience	All Trust Staff

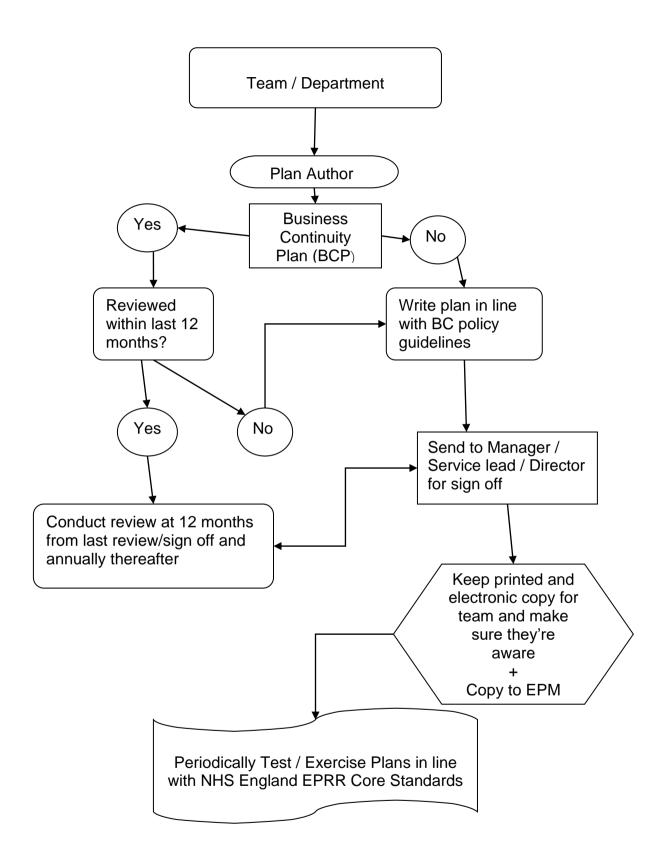| Keywords	Business Continuity Plan

Storage
This policy will be available through the SHSC intranet and extranet platform, JARVIS. This version of the policy supersedes the previous version. Any copies of the previous policy held separately should be destroyed and replaced with this version.

Contents

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
1.0	New draft policy created	01/2019	New policy commissioned by PGG on approval of a Case for Need.
2.0	Policy review	01/2022	Removal of uploading BCP's to Resilience Direct, update terminology e.g., management titles, inclusion of JARVIS internet/extranet platform.
2.1	Mid-term review	12/2023	Amended to show commitment to align with ISO22301, escalation and to reference Business Impact Assessments and Business Continuity Management System.

Flowchart

Team / Department

↓

Plan Author

↓

Yes ← Business Continuity Plan (BCP) → No

Yes path:
Reviewed within last 12 months?

No path:
Write plan in line with BC policy guidelines

Reviewed within last 12 months? → Yes → Conduct review at 12 months from last review/sign off and annually thereafter

Reviewed within last 12 months? → No → Write plan in line with BC policy guidelines

Write plan in line with BC policy guidelines → Send to Manager / Service lead / Director for sign off

Send to Manager / Service lead / Director for sign off ← Conduct review at 12 months from last review/sign off and annually thereafter

Send to Manager / Service lead / Director for sign off → Keep printed and electronic copy for team and make sure they're aware + Copy to EPM

Keep printed and electronic copy for team and make sure they're aware + Copy to EPM → Periodically Test / Exercise Plans in line with NHS England EPRR Core Standards

1   Introduction

This policy sets out the specific requirements for establishing and maintaining effective business continuity plans within our Trust.

2   Purpose

The Civil Contingencies Act 2004 (CCA) and NHS England Emergency Preparedness, Resilience and Response Core Standards requires organisations, including NHS Foundation Trusts to have arrangements for (but not necessarily have a separate plan for) corporate and service level Business Continuity (BC) aligned to current nationally recognised BC standards.

The CCA requires our Trust to maintain plans to ensure that it can continue to exercise its functions in the event of an emergency so far as is reasonably practicable. The CCA also states that the organisation must have regard to assessments of internal and external risks when developing and reviewing business continuity plans.

This policy demonstrates our Trust's intent to undertake business continuity and implement a Business Continuity Management System that aligns with ISO22301.

3   Scope

This policy applies to all Trust staff across all services and teams within our Trust.

The policy is to be read in conjunction with the Major and Critical Incident Plan and other emergency plans on our Trust website (see section 11). It falls under the remit of the Trust Emergency Preparedness, Resilience and Response (EPRR) Policy.

For the purposes of this policy a 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.

Business Continuity incidents will not ordinarily lead to activation of the Major and Critical Incident Plan. They must be escalated through Service Leads to the Accountable Emergency Officer or nominated Deputy, who will determine leadership and response as detailed in the Business Continuity Management System.

4   **Definitions, Responsibilities and Duties**

4.1 Accountable Emergency Officer

- Assumes accountability to the Board of Directors to ensure a suitable and robust Business Continuity Policy is in place.
- Provides strategic lead on business continuity matters.
- In conjunction with the Emergency Planning Manager (EPM) ensures this policy is checked annually and reviewed every 3 years to ensure its continued relevance and suitability remains in line with core standards produced by NHS England.
- If required, provides a post incident debrief report to the Board of Directors.

4.2 Emergency Planning Officer/Manager

- Ensures the Business Continuity Policy is checked annually and reviewed every three years to align with current nationally recognised business continuity standards.
- Liaise with staff at all levels to assist with their understanding of the requirements of the policy.
- Ensure all staff are made aware of e-learning materials on business continuity management.
- Co-ordinate the process for the annual update of business continuity plans identifying a named individual responsible for each plan.
- Provide a business continuity plan template to plan authors where required.
- Assist plan authors where possible in completing business continuity plans.
- Check all plans have been agreed and signed off by a person of suitable authority other than the plan author e.g., Team Manager, Clinical lead, Portfolio Lead, Head of Service or Corporate Director.
- Collate and store business continuity plans submitted by plan authors in electronic format on shared drive for on call managers.
- Where possible and in co-operation with our trust Communications Team, ensure that staff are made aware of any situation where business continuity plans should be reviewed or activated.
- When made aware of any incidents will perform a formal or informal debrief if required and provide suitable recommendations.
- Where plans are not produced to deadline or in adherence to quality standards the EPM will liaise with the relevant manager or Director to ensure work is undertaken to resolve the matter.
- The EPM may request the business continuity matters are raised on the appropriate trust risk register.
- The EPM will liaise with teams to agree suitable dates to ensure plans are exercised; those lessons learned are incorporated into revised plans and that a record is maintained.

4.3 Executive Directors

- Seek assurance from their service leads and Managers that plans are being completed of sufficient quality to deadline and exercises are being undertaken to test business continuity arrangements.
- Follow the directions in the appropriate plan in the event of a Business Continuity Incident.
- Provide feedback as required in the event of a post incident debrief.
- In the event our Directors experience circumstances that:
  a) exhaust all their available resources
  b) exceed the provision of business continuity plans (including assistance from pre-defined external providers) and
  c) require the authority of a more senior member of staff than their service lead, they will then take direction from our Executive Directors.

  Executive Directors may choose to declare a Critical or Major Incident or use the Major and Critical Incident Plan to respond to this situation to make strategic decisions on service priority, source mutual aid from other areas and liaise with partners. In such circumstances they will take direction from the Accountable Emergency Officer or nominated Deputy.

4.4 General managers

- Make suitable checks to ensure that plans are of sufficient quality and completed to deadline, signing them off as appropriate.
- Liaise with the Emergency Planning Manager and place business continuity issues on the appropriate risk register if required.
- Ensure managers and staff are aware of their business continuity plan and the requirement to participate in exercises.
- Follow the directions in the plan in the event of a Business Continuity Incident.
- Provide feedback as required in the event of a post incident debrief.
- Produces post exercise and incident reports and incorporates learning from incidents into Business Continuity Plans.

4.5 Plan Authors

- Ensure plans are completed in adherence to the procedures listed in section 5.
- Act as the business continuity lead for the team(s) for which they are completing the plans.
- Share the business continuity plan with team members before each review and request feedback to form new versions.
- Ensure the business continuity plan is discussed at team meetings before each review.
- After a business continuity incident ensure that lessons learned are incorporated into a new version of the plan within 4 weeks.
- Ensure business continuity plans in hard copy and electronic formats are stored in a suitable location that is always accessible to all team staff with other business continuity materials (emergency equipment, evacuation plans, paper records etc.)
- Ensure that new members of staff are made aware of the business continuity plan on their first day with the team.
- Act as first point of contact for all business continuity matters within the team including the provision of situation reports (sitreps) when plans are invoked.
- Ensure up to date contact details for suppliers and staff are accessible in the plan or clearly referenced elsewhere.
- Ensure plans are completed to deadline.
- Ensure plans are updated if teams are reorganised in a way that affects location, structure, functions, or personnel.
- Assist with the development of exercises with the Emergency Planning Manager as agreed with General Managers and Directors.
- Follow the directions in the plan in the event of a Business Continuity Incident.
- Provide feedback as required in the event of a post incident debrief.

4.6 All Staff

- Know the location of the team business continuity plan and have knowledge of its contents
- Co-operate with the plan author in updating the plan.
- Agree to take part in any exercises as required by the Emergency Planning Manager, Team Manager or General Manager.
- Inform the plan author and/or manager of any changes to the plan e.g. change in address, personnel, team procedures etc.
- Follow the directions in the plan in the event of a Business Continuity Incident.

- Provide feedback as required in the event of a post incident debrief.

5   Procedure and Implementation

All business continuity plans will be updated on an annual basis by the Plan Author. All plans must be signed off by their Manager, General Manager or Head of Service for the team concerned provided that individual is not the plan author. Any member of staff that signs off a business continuity plan must have knowledge of the Business Impact Assessment (BIA) and Business Continuity Management System (BCMS) that our trust operates to.

Should a team undergo re-organisation or change its staff, function, or procedures in a way that would significantly affect the accuracy of the business continuity plan, the Plan Author will ensure the plan is amended, signed off and submitted to the Emergency Planning Manager within one calendar month of any changes made. All business continuity plans will include the name of the team/department on the cover along with full address details with postcodes of the premises and hours of service.

5.1 Business Continuity Plan Contact Details
   Each plan should contain:

- In table format, full telephone contact details for the team manager(s) in order that a member of the team may be contacted in an incident. Should the team provide a 24/7 service, contact details are to include numbers for 'on call' staff. These should be listed in the order for contact. Personal contact details, if required, should be held securely on a separate document to the business continuity plan.
- A staff list containing details of all team members. This is to assist management in periods where staff shortages occur. Staff information need only contain contact telephone numbers (including work mobile) and a home location e.g., name of town or village. A full address is not necessary. Should this be required in an incident these are to be sought through usual channels and must not be included in the business continuity plan.
- Full contact details of all suppliers/contractors/service providers should be included with telephone, email and mobile numbers if possible. This includes providers of building services and telecoms providers if not provided by our Trust.
- Full address details with postcodes of all work premises from where the team operates.

5.2 Risk Register – Impacts and Contingencies
   The Business Continuity Plan will include the following risks:

- Severe weather – Low Temperatures and heavy snow
- Severe weather – Storms and gales
- Severe weather – localised flooding
- Pandemic virus e.g., Influenza; Coronavirus
- Infectious Disease Outbreak in the Community
- Heatwave
- Actual or threatened disruption to road fuel supply
- Technical failure of electricity networks
- Cyber-attack causing IT outage (affecting access to clinical data and network)
- Telecoms outage (landline and/or mobile)
- Mains water supply outage

- Disruption to transport network
- Loss of premises
- Industrial action
- Surge/increase in service users
- Minimum staffing levels
- Loss of supplier/contractor

The likelihood of each risk will be confirmed by the Emergency Planning Manager and is included in the business continuity plan template.

Risk likelihoods are calculated by referring to the South Yorkshire Local Risk Registers. These are protectively marked documents that may be accessed via the Emergency Planning Manager.

Plan Authors must assess the impact of each risk on their team functions for a period of up to one day, up to one week and over one week. The impact of disruption may be none, minor, moderate, major or catastrophic. Details of how to calculate impact is included in the plan template on JARVIS.

Contingencies to address the impact of each risk may be included on the risk assessment table or refer to action cards in the appendix. It is the responsibility of the Plan Author to ensure that contingencies are relevant to the team and its functions.

5.3 Exercise and Review
This section of the plan records details of exercises. The Plan Author must record any exercises undertaken. These may be exercises organised within the team or by the Emergency Planning Manager. Exercises can be planned such as a tabletop whereby several plans are tested together or unplanned, such as presenting an issue to a team on an unannounced visit to examine team knowledge, understanding and suitability. It is recommended that those teams delivering critical services undertake at least one live exercise every 3 years. Assurance is given by recording exercises undertaken and detailing them in the annual NHS England EPRR core standard assurance return.

5.4 Record of Amendments
The Plan Author should ensure that all amendments to the plan are recorded in full.

6 Training

All Plan Authors should undertake training in Business Continuity through the Emergency Planning Manager before beginning to write a plan. This training is essential to the role.

There are no other specific training needs in relation to this policy however, the following staff will need to be familiar with its contents:

- Accountable Emergency Officer
- Emergency Planning Manager
- Directors
- Heads of Service
- General Managers

Further information is available via guidance on JARVIS.

7 Development, consultation and approval

This policy has been developed by the Emergency Planning Manager in consultation

with NHS Partners to both inform of the need to have workable and consistent business continuity plans across all areas of our Trust business that can be invoked in the event of an incident and; to inform of the standards expected in order that our Trust meets the NHS England core standards for Emergency Preparedness, Resilience and Response relating to business continuity.

Consultation has taken place with all services and interdependencies including Communications, Finance, IMST, Facilities and On Call managers between 26th January 2022 and 9th February 2022.

The revisions to this policy follows feedback from NHS England's 2023 EPRR Core Standards process and have been implemented as a mid-term review.

8   Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
All Teams / Departments to have a Business Continuity Plan	Audit review tool managed by Emergency Planning Manager NHS England annual EPRR core standard submission	Trust Emergency Preparedness Group	Annual	Audit and Risk Committee	Emergency Planning Manager	Audit and Risk Committee
Business Continuity Plans Auditing	Internal and External Audits	Trust Emergency Preparedness Group	Annually internal, 3-yearly external	Audit and Risk Committee	Emergency Planning Manager	Audit and Risk Committee

This policy will be reviewed in three years from the date of issue as shown on page 1.

9   Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and Internet	Emergency Planning Manager		
Inform all Management and Directors of new policy and their responsibilities through agenda item on management committees. Inform all staff through Communications	Emergency Planning Manager		

10   Dissemination, storage and archiving (Control)

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	Approved	19/03/2019	19th to 26th March 2019
2.0	Approved	18/03/2022	
2.1			

11   Links to other policies, standards (associated documents)

Emergency Preparedness, Resilience and Response Policy
Major and Critical Incident Plan
New and Emerging Pandemic Plan
Adverse Weather and other emergency conditions Plan
Heatwave Plan
CBRNe Plan
Evacuation Plan
Communications Plan
Business Impact Assessment
Business Continuity Management System
Security Policy
Fire Safety Policy

NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2023– NHS England
NHS England Emergency Preparedness, Resilience and Response Framework 2022 – NHS England National Emergency Preparedness, Resilience and Response Unit
Civil Contingencies Act 2004
NHS Act 2006
Business Continuity standard ISO22301

12   Equality Impact Assessment
The management of SHSC are committed to providing equality of opportunity, not only in its employment practices but also in the services for this policy for which it is responsible. The Equality Impact Assessment of the plan is neutral.

SHSC value and respect the diversity of their respective employees and the communities they service. In applying this policy they will have due regard for the need to:
- Eliminate unlawful discrimination
- Promote equality of opportunity
- Provide for good relations between people of diverse groups.

13   Contact details

Title	Name	Phone	Email
Emergency Planning Manager	Terry Geraghty	0114 226 3147	Terry.geraghty@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy <u>potentially</u> impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**

I confirm that this policy does not impact on staff, patients or the public. Name/Date: Terry Geraghty 18th December 2023

YES, Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age			
Disability			
Gender Reassignment			
Pregnancy and Maternity			

Race			
Religion or Belief			
Sex			
Sexual Orientation			
Marriage or Civil Partnership			

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date Terry Geraghty 18th December 2023

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

			Tick to confirm
	Engagement		
1.	Is the Executive Lead sighted on the development/review of the policy?		Yes
2.	Is the local Policy Champion member sighted on the development/review of the policy?		Yes
	Development and Consultation		
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?		N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?		No
5.	Has the policy been discussed and agreed by the local governance groups?		Yes
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?		Yes
	Template Compliance		
7.	Has the version control/storage section been updated?		Yes
8.	Is the policy title clear and unambiguous?		Yes
9.	Is the policy in Arial font 12?		Yes
10.	Have page numbers been inserted?		Yes
11.	Has the policy been quality checked for spelling errors, links, accuracy?		Yes
	Policy Content		
12.	Is the purpose of the policy clear?		Yes
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)		Yes
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?		Yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?		Yes
16.	Does the policy include any references to other associated policies and key documents?		Yes
17.	Has the EIA Form been completed (Appendix 1)?		Yes
	Dissemination, Implementation, Review and Audit Compliance		
18.	Does the dissemination plan identify how the policy will be implemented?		Yes
19.	Does the dissemination plan include the necessary training/support to ensure compliance?		Yes
20.	Is there a plan to i. review ii. audit compliance with the document?		Yes
21.	Is the review date identified, and is it appropriate and justifiable?		Yes

Review/New Policy Checklist

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		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Yes
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	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	No
5.	Has the policy been discussed and agreed by the local governance groups?	Yes
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Yes
	Template Compliance	
7.	Has the version control/storage section been updated?	Yes
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14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Yes
16.	Does the policy include any references to other associated policies and key documents?	Yes
17.	Has the EIA Form been completed (Appendix 1)?	Yes
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Yes
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Yes
20.	Is there a plan to iii. review iv. audit compliance with the document?	Yes
21.	Is the review date identified, and is it appropriate and justifiable?	Yes