NHS Resilience and Business Continuity Management Guidance

Interim Strategic National Guidance for NHS organisations

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For Recipient's Use			

Contents

Foreword

Our patients - and the local communities that we serve - expect the NHS to be there for them when they need it, not matter what the circumstances.

During the summer of 2007, extreme weather conditions led to some dramatic flooding across parts of England over a very short period of time – and demand for health services surged. During that time, NHS staff stepped up to the mark and provided the care that people needed, when they needed it. On that occasion, it was about flooding, but there are any number of circumstances - from dealing with an outbreak of pandemic flu right through to a terrorist attack - that require the NHS to act quickly and effectively in the event of an emergency.

Our success in dealing with such events depends not only on the passion and commitment of NHS staff at every level, but, importantly, on detailed comprehensive planning - that is why emergency planning is one of just five national priorities set out in this year's Operating Framework. This new guidance, and the work of the **NHS Resilience Project**, will help to guide and inform that planning, and help the NHS to continue to ensure it can be there for patients when they need it, no matter what the circumstances.

David Nicholson
NHS Chief Executive

Preface

On 29 November 2007, the NHS Resilience Project sponsored a symposium that was held in central London of key stakeholders across the healthcare sector with an interest in Business Continuity Management (BCM). The aims of the day were to:

- to give attendees a wider understanding of the importance of BCM across the healthcare sector
- provide clarity on the direction of the NHS Resilience Project
- focus delegates attention on areas of BCM that they may need to address within their respective organisations.

The Symposium consisted of a series of presentations establishing the context, rationale and objectives of the project, complemented by a number of small workshops to analyse some of the practicalities, key objectives and issues associated with the roll out of the NHS Resilience Project.

The workshop sessions were focused on:

1. Challenges of commissioning resilience

2. Risk and resilience to the supply chain

3. BCM planning; integrating plans, Regional and Local Resilience

4. Resilience - the relationship between Department of Health (DH), Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and NHS Trusts.

5. Practical application of BCM – impact of the Civil Contingencies Act 2004 (CCA 2004) and British Standard (BS) 25999 parts 1&2

6. BCM Training – what training, delivery and workforce issues

7. Audit and Evaluation of BCM Resilience.

The key messages to emerge from the plenary and workshop sessions were: -

- **BCM is a key issue for all NHS organisations including Foundation Trusts; this needs to be made clear from DH and in NHS Operating Framework**

- **BCM requires an integrated organisational response at local, regional and national level**

- **BCM must be part of every NHS organisation's core business not an adjunct to business. The healthcare sector must be able to survive to operate.**

How can the NHS demonstrate this?

- ensuring it is clear that BCM is a Board level responsibility
- that there is a clear framework to commission, audit and performance manage
- clarity about who has responsibility within NHS organisations to ensure BCM is implemented
- develop and deliver appropriate training.

What other messages have emerged?

- champions for BCM need to be created
- the collation and dissemination of learning and good practice from business continuity events such as the areas flooded in the Summer of 2007 (Yorkshire, Gloucestershire, etc) so NHS organisations can benefit from that experience
- develop the understanding of all supply chains – utilities, consumables, pharmaceuticals etc and deconflict supply issues, single versus multiple suppliers.

The Interim Guidance that follows builds on the outputs of the symposium and the work of the NHS Resilience Board and Stakeholder Group. It is Interim Guidance and, as such, will develop and evolve. It is the intention that final guidance will be published in 2009 - 2010. I should like to thank everyone who has been involved so far in this work and in the development of this guidance.

Dr Penny Bevan
Director
Emergency Preparedness Division

Background

1. With increased risks and a changing NHS, there is a need to ensure that NHS structures and organisations are resilient enough to both embrace change and respond to new threats. BCM is an essential component. Furthermore, the CCA 2004 and national risk and capability assessments now place clear obligations on NHS organisations to cope with disruptive challenges. Consequently, there needs to be a robust system in place in all organisations to plan, test and train for response against a range of disruptive challenges. In the recent times, a number of incidents such as bombings, extensive flooding and consequent loss of power, water and telephony have drawn attention to the importance of resilience planning.

2. This consultation outlines and calls for comment on this set of general principles to guide all NHS organisation in developing Business Continuity Management processes. Expectations are already placed on NHS organisations, whether through the Civil Contingencies Act, the NHS Operating Framework or British Standard BS 25999 requirements, for example. This interim Guidance is intended to support NHS organisations in meeting those obligations.

3. Through the use of BCM methods (in accordance with the British Standards Institution (BSI) standard for BCM - BS25999 parts 1&2), the NHS Resilience Project is tasked with improving resilience throughout the NHS ensuring continuous operational delivery of healthcare services when faced with a range of disruptive challenges. In effect, the healthcare sector must be able to "*Survive to Operate"*. The project will promote the understanding, development and implementation of a BCM culture across the NHS that will integrate all aspects of resilience planning at executive and senior management level. It will enable NHS organisations to establish BCM processes that can be developed and changed to meet the needs of the organisation and its locality as well as reflecting changes in policy and guidance.

4. The NHS Chief Executive's annual report 2007 stated there were three key questions in relation to improving the NHS;

   - how will our actions benefit patients?
   - are our actions consistent with what local healthcare services are trying to achieve?
   - thirdly, how do we ensure accountability to the public?

5. The NHS Resilience project aims to ensure the sustainability of the service in all circumstances to the benefit of patients and communities.

6. The NHS Operating Framework 2008-2009 sets out a brief overview of the priorities for the NHS including the health and service priorities for the year ahead; the reform levers and enabling strategies; the financial regime; and, the business processes.

7. Emergency preparedness is identified as one of the five priority areas for NHS organisations. The Operating Framework states in sections 2.58 and 2.59:

> *It is essential that all organisations are well prepared to respond effectively to major emergency incidents, so that they can mitigate the risks to public and patients, and maintain a functioning health service.*
>
> *In particular, PCTs will want to work with NHS organisations and other contracted healthcare providers, to ensure that plans are in place locally, so that they are in a position to respond effectively to any emergency, including a pandemic flu outbreak or dangerous incident such as a chemical, biological, radiological, nuclear or terrorist attack. All NHS organisations must have robust plans in place to respond to flu pandemic by December 2008.*

8. The central role of resilience and BCM to all NHS organisations is therefore made explicit.

9. The Pitt Review – Learning Lessons from the 2007 floods also emphasises the need for a systematic approach to the risk of flooding, the need to maintain services and business in the light of such an emergency and to have in place the means for communities to be able to recover from such events. The Report also emphasises to all organisations the need to ensure effective Business Continuity Plans (BCP) are in place. This is seen as an invaluable step in making sure services are maintained for as long as possible or that, if they are lost, that they can be recovered as quickly as possible.

10. For the NHS, the approach to BCM and Resilience must take account of the need to develop a whole health economy plan that;

- builds on the principles of mutual aid
- ensures the mutual compatibility of plans within the economy and with neighbouring health economies including the identification of mutually agreed triggers and protocols for activation of BCM processes and arrangements
- ensures that in developing BCM processes and arrangements that in protecting one NHS organisation, strains and stresses are not placed inappropriately on other parts of the health economy.

Aim of the NHS Resilience Project

11. The aim of the NHS Resilience Project is to:

- improve BCM resilience within the NHS
- resilience will ensure continuous operational delivery of healthcare services when faced with a range of disruptive challenges e.g. energy shortages, water and food restrictions, staff shortages, strike action, flooding, pandemics etc.
- the project will drive NHS compliance with the CCA 2004
- following a BCM approach alongside the new BS 25999- parts 1&2 will allow a unified and cohesive approach to BCM, and develop a resilient healthcare system which can be benchmarked against other similar sized organisations.

12. Based on a project cycle of three years, the initial effort by the Emergency Preparedness Division (EPD) at the Department of Health will be to raise awareness and consolidate the understanding and acceptance of BCM across the healthcare community.

13. The Interim Guidance that follows summarises the discussions at the symposium and takes cognisance of current good practice. It is commended to Chief Executives of all NHS organisations for review and implementation. It is Interim Guidance and will be developed and refined. It reflects what those attending the Symposium told the project team the Interim Guidance being developed needs to be, that is:

- practical and include tools to support those with responsibility for BCM
- specific in its scope
- clear about how important BCM is to the NHS.

Overview

14. This is guidance for all National Health Service (NHS) organisations on BCM. It is interim guidance and will be developed, refined and revised by the NHS Resilience Project Team who will issue final BCM guidance.

15. The aim of this interim guidance is to:

- improve BCM resilience within the NHS
- ensure through the adoption of resilience principles the continuous operational delivery of healthcare services when faced with a range of disruptive challenges e.g. staff shortages, denial of access, failures in technology, loss of utility services and failure of key suppliers.
- help drive NHS compliance with the CCA 2004
- allow a unified and cohesive approach to BCM which parallels the new British Standard BS25999- parts 1&2 , and
- develop a resilient healthcare system which can be benchmarked against other similar sized organisations.

16. All NHS organisations are expected to prepare, maintain and review BCPs based on the principle that their organisation should be able to maintain critical services for a period of seven days.

17. As this document is interim guidance more detailed baseline utility resilience standards will emerge as further work is completed. Good practice suggests that organisations should plan to be without key utilities for up to three days and restart priority clinical services at seven days.

18. Further specific guidance is due later in 2008 to support the work of NHS organisations in resilience and BCM. This will include:

- DH Estates and the Institute of Healthcare Management training DVD distributed during May 2008 on the subject NHS Lessons Learnt from Summer 2007 Floods

- firmer baseline standards around utilities resilience
- evacuation
- maintenance of critical services.

19. This section must be used in conjunction with relevant policy and guidance material including the NHS Emergency Planning Guidance 2005 and the relevant underpinning sections.

20. The purpose of the NHS Resilience and BCM Guidance is to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the CCA 2004 to:

    - continue to perform their functions in the event of an emergency so far as reasonably practicable
    - be able to maintain their own emergency response capabilities and to continue to deliver critical services
    - to provide a common baseline for all NHS organisations to achieve BCM.

21. The Cabinet Office had been undertaking work in a practioners group to look at best practice in BCM. It includes at least one NHS example. The link to this work is below:

    http://www.ukresilience.gov.uk/preparedness/ccact/good_practice.aspx

22. This Guidance is built on current good practice and shared knowledge, while also acknowledging that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It is intended to provide a platform for all NHS organisations to undertake BCM and to provide information on associated activities that may also be required.

23. In the context of this Guidance, the term NHS organisation includes all NHS Foundation Trusts.

24. BCM forms part of that responsibility for Chief Executives of all NHS organisations. This responsibility includes ensuring that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances. The NHS Resilience and BCM Guidance 2008 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a BCM process in place that will address the requirements for ensuring business continuity as required by the CCA 2004.

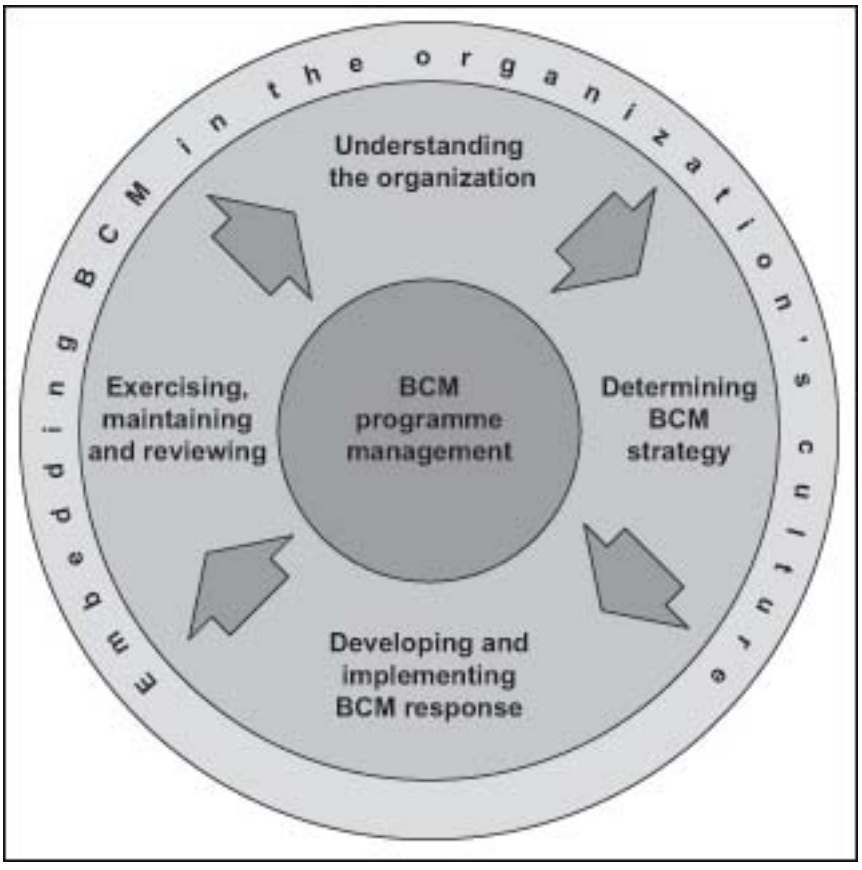
25. BS- 25999 Parts 1&2 is the common standard for all organisations in England. It is recommended that all NHS organisations aspire to comply with the requirements and must be used. This will help ensure that all organisations are working to a common standard that will aid collective resilience. The NHS Resilience website will provide links to relevant documents supporting the interim guidance.

26. This document focuses on planning, preparing and responding in the NHS in England, recognising the need for a high level of networking with services provided in Scotland, Wales, Northern Ireland and the Republic of Ireland in order to support mutual aid arrangements.

What is BCM?

27. BCM is a process that provides a framework to ensure the resilience of organisations and businesses to any eventuality, to help ensure continuity of service to key users and customers and the protection of the NHS brand and reputation. It provides a basis for planning to ensure long-term survivability following a disruptive event. NHS organisations can be faced with a range of disruptive challenges, either internal or external, which can, if not correctly managed lead to major disruptions to services

28. BCM should become part of the way NHS organisations perform their day-to-day business. It is better to plan for challenges, which may affect business, rather than having to "catch up" when an event occurs.



The BCM Lifecycle

29. BCM needs to be considered by all scales of NHS organisations including those independent sector organisations that are commissioned to provide NHS services. The key principles are the same for all NHS organisations.

30. The Business Continuity Institute (BCI) uses the following definition to describe the BCM process:

'*a holistic management process that identifies potential impacts that threaten an organisation and provides a framework for building resilience with the capability for an effective response that safeguards the interests of its key stakeholders, reputation, brand and value-creating activities'*

31. For the NHS, BCM is defined as:

The management process that enables an NHS organisation:

- *to identify those key services which, if interrupted for any reason, would have the greatest impact upon the community, the health economy and the organisation.*
- *to identify and reduce the risks and threats to the continuation of these key services.*
- *to develop plans which enable the organisation to recover and/or maintain core services in the shortest possible time.*

32. For the NHS service interruption may be defined as:

"Any disruptive challenge that threatens personnel, buildings or the operational procedures of an organisation and which requires special measures to be taken to restore normal operating functions".

33. BCM is concerned with ensuring that, at all times, the organisation can continue operating to at a pre-determined level, in the event of a major disruption.

34. Effective BCM is, therefore, not only about minimising the likelihood of an event occurring but also having the ability to recover and restart if the worst happens.

35. The consequences of not having effective BCP in place could have serious implications, including:

- failure to deliver key services
- possibility of loss of life or injury
- loss of Public Confidence
- exposure to the potential to legal action, leading to subsequent heavy financial penalties, which have the effect of reducing the funding available for managing and developing operations and staff.

Roles and responsibilities for BCM in the NHS

36. BCM forms an important part of risk management arrangements and is a requirement of the CCA 2004. The aim of BCM is to ensure that NHS organisations are able to maintain the highest level of service possible in the face of disruptive challenges. A range of challenges that might affect NHS organisations and services at any time, e.g. staff shortages, denial of access, failures in technology, loss of utility services and failure of key suppliers.

37. The aim of BCM is to enable the response to a disruptive challenge to take place in a co-ordinated manner.

38. BCM, including processes for recovery and restoration, should be considered by NHS organisations as part of its every day business processes requiring a corporate response. BCM should be embedded in the culture of the NHS as are the principles of health and safety, and there must be demonstrable commitment to the process from the Boards of NHS organisations. The skills to develop BCM processes can be seen as complementary to those involved in emergency management but the duty may best be undertaken by separate officers. It is critical though that both processes, where appropriate, are integrated and complementary to each other as a major incident may occur at the same time as a business continuity issue, or be triggered by it.

39. For NHS organisations, the key principles for maintaining BCM in contexts other than for pandemic flu are:

- to review services for which that organisation is responsible and identify the assets and that will need to be available to maintain critical services for the first hour, 24 hours, 3 days and for 7 days
- to assess progress on BCM processes against an agreed checklist.
- establish commissioning and contracting processes with providers and suppliers that require BCM processes to be explicitly described and covered by contracts. Legal advice has been sought concerning realistic planning for safeguarding and securing within the realms of possibility, supplies of goods and services to the NHS in the event of a flu pandemic. Although the advice, which is summarised below, does relate specifically to a flu pandemic, it can be applied to any circumstance that tests the resilience of NHS organisations.

Case Study

The advice is that the Secretary of State has a continuous duty to promote a comprehensive health service designed to secure improvement in physical and mental health of the people of England. An NHS Trust must exercise its functions effectively, efficiently and economically. The duty of care owed by an NHS Trust on behalf of the Secretary of State to a patient is not a contractual duty rather a statutory duty of care, the breach of which would be a tort. The obligation to fulfil these functions are absolute in the sense that if there is a failure to fulfil these functions the NHS Trust that would be liable even if a contractor to the NHS Trust caused the failure of the NHS Trust to fulfil statutory duties.

The NHS Act 2006 enables the Secretary of State, in the event of a pandemic flu epidemic, to exercise emergency powers to direct any NHS Trust that some other body perform the function of service provision to pandemic flu suffers or patients.

The NHS Trusts need to consider whether the variation clauses in their existing contracts allow for agreement with contractors to conclude assurances or separate “back-up contracts” with other suppliers in the event of a pandemic flu. If variation of contract is not possible in existing contracts then NHS Trusts need to consider renegotiation of contracts. Contractual terms can be drafted to ensure that suppliers are able to deliver just in time; time would be of essence in such contracts.

The basic aim of contractual damages is to compensate the claimant for the loss the claimant suffered as a result of the breach of contract. Force majeure essentially frees contractual parties from liability or obligation when an extraordinary event or circumstance beyond the control of the parties, prevents one or other parties fulfilling their obligation under the contract. The NHS Trusts would be under a ‘duty’ to mitigate their losses.

The Secretary of State may enable requisition or confiscation of property of supplier to the NHS whether these suppliers failed to perform their contractual duties or not.

Department of Health (DH)

40. The DH role in NHS BCM processes is led by the NHS Resilience Project.

41. The NHS Resilience Project acknowledges that several areas of the NHS already have sound, workable contingency plans covering a variety of issues. These plans have also been tested over the years by real events. However, lessons emerging from recent events suggest more attention should be focused on sustaining energy supplies, making IT and communications more resilient, exploring ways to avoid disruption to food and water supplies, managing human resources and working with external providers. The increasing level of diversity in the delivery of healthcare especially in respect of commissioning services, plus an increasing awareness of knock on effects or "mutual vulnerability" elsewhere in the healthcare sector, requires a more holistic or "joined up" approach to BCM planning.

42. Based on a project cycle of three years, the initial effort by the EPD will be to 'pump prime' the understanding and acceptance of BCM across the healthcare system. Interim Guidance will be issued through existing endorsed documents and the Project Team will coordinate the development of key objectives in partnership with recognised BCM and Emergency Planning Leads. In summary, the NHS Resilience BCM project will focus effort on improving resilience in:-

- workforce and labour
- infrastructure
- utilities
- technologies
- supplies.

43. It is particularly important for NHS organisations to ensure their ability to work as part of a multi agency response across organisational boundaries, ensuring the ability to provide and give mutual aid within the context of Local Resilience Forums (LRFs) and their sub groups. The principal mechanism for multi-agency co-operation at a local level is the Local Resilience Forum (LRF). This is based on police force areas except in London.

44. Risk assessment is seen in the CCA 2004 as the first step in the emergency planning and business continuity processes. It ensures that local responders make plans that are sound and proportionate to risks. Within each Local Resilience Forum, NHS organisations have responsibility in the context of multi-agency planning to contribute to the Community Risk Register. NHS organisations will therefore need to undertake risk assessment exercises appropriate to their facilities and services. Risk assessment is being undertaken at a regional and at a national level, with local risk assessments feeding into those.

45. Each NHS organisation will need to undertake its own internal risk assessment in order to inform its own response and to contribute an input to the multi-agency risk assessment.

46. An agreed methodology for risk assessment is available on the Cabinet Office website.

Strategic Health Authorities (SHAs)

47. SHAs are the headquarters of the NHS in their region. Within Strategic Health Authority areas, the SHA will set up appropriate co-ordination machinery to enable NHS organisations to plan and cooperate appropriately and to performance-manage those organisations for this aspect of their responsibilities. SHAs are the system managers of last resort of NHS organisations. The CCA 2004 identifies SHAs as Category 2 responders. For further information on NHS Strategic Command Arrangements, go to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081507

Primary Care Trusts (PCTs)

48. Primary Care Trusts (PCTs) provide the local management function for the NHS and operate as both providers and commissioners of services for their locality. PCTs must ensure that for all functions for which they are responsible, the highest level of service to patients is maintained regardless of what might happen to clinical/non clinical procedures or the infrastructure of facilities on a 24 hour a day, 7 day a week basis if circumstances require this. BCM is an important part of the PCTs risk management arrangements. The CCA 2004 identifies PCTs as a 'Category 1 Responder', and imposes a statutory requirement on the PCT to have robust BCM arrangements in place to manage disruptions to the delivery of services.

Case Study

In spring 2007 Halton and St Helens PCT identified as a priority the need to update and further develop its business continuity arrangements. This was sponsored by the Chief Executive and a very tight timescale was set – to have business continuity plans in place, and agreed with each director, by the end of July 2007.

Prior to this in 2005, the former Halton PCT has undertaken a considerable amount of work on business continuity through the development and completion of a series of templates, using the expertise on a consultancy basis of a member of the Business Continuity Institute with many years experience of working with the NHS. (The full case study is at Annex 1).

49. BCM is a requirement of the commissioning and associated performance management processes. PCTs, as Category 1 Responders for the CCA 2004, must ensure that all commissioned service providers are capable of providing services at an appropriate level.

Case Study

Commissioning resilience is fundamental to ensure that all organisations are able to achieve robust arrangements for dealing with incidents. In December 2007, DH produced a guidance document called 'Principles and Rules for Cooperation and Commissioning' (Gateway reference number: 9244). It is recommended that commissioners consider this document to provide clear statement of principles and rules for cooperation and competition when commissioning or providing services.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779

50. PCTs need to be assured that the BCM processes of General Practitioners (GPs) and related services including Out Of Hours (OOH) services that enable them to operate on a 24 hour, 7 day a week basis. The Royal College of General Practitioners has published 'Service Continuity Planning Framework' which provides a suggested plan template. This is due to be revised in due course. A link to the current document is given below.

http://www.rcgp.org.uk/pdf/serviceCon_RCGPServiceContinuityPlanningFrameworkWorkedExample.pdf

51. PCTs also need to be assured that the BCM processes of all providers of Primary Care enable them to operate on a 24 hour, 7 day a week basis for appropriate services.

Case Study

Eastern and Coastal Kent PCT (ECKPCT) performs a range of functions that are important to the health and welfare of the population of Kent and potentially beyond. This is particularly true during a major disruption to business or in an emergency situation, where operational demands often increase and the operating environment can become more challenging.
The three main functions of the Primary Care Trust are defined by ECKPCT as being:
1. Engaging with its local population to improve health and well being
2. Commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors and where possible in an integrated way with other agencies
3. Delivering through its arms length provider organisation high quality responsive and efficient community services.

NHS Acute and Foundation Trusts and Ambulance Trusts

52. The CCA 2004identifies all Acute Trusts as 'Category 1 Responders', and imposes a statutory requirement on the Trusts to have robust BCM arrangements in place to manage disruptions to the delivery of services.

53. In addition to their own internal performance management, Trusts are also subject to rigorous external review and monitoring of their performance against national and local targets. The *Standards for Better Health* and compliance regime for Foundation Trusts (MONITOR) require that Trusts produce and regularly review their BCM Plans. BCM is an integral part of Corporate and Clinical Governance.

Case Study

Sheffield Teaching Hospital NHS Foundation Trusts in implementing a BCM strategy has developed action cards for individual utilities (for example, bleep system failure, telephone systems failure, medical gases failure etc). These action cards are then issued to each individual ward as part of the Trust's Internal Incident Plan. (Annex 2)

Non Acute Trusts and Foundation Trusts including Specialist Trusts

54. The term non Acute Trust is used to cover both NHS non Acute Trusts and Foundation Trusts including Specialist Trusts.

55. It is acknowledged that non Acute Trusts are not formally designated responders within the definitions of the CCA 2004. However, it is considered good practice for non Acute Trusts to comply with the requirements of the Act.

56. Non Acute Trusts should also make appropriate arrangements to ensure their own business continuity including recovery and restoration.

57. NHS organisations with responsibility for provision of services to Prison Healthcare Services need to ensure that appropriate BCM processes are in place. These need to take into account the needs of the population in prison and the ability of that organisation to provide those services. Clearly close collaboration with the Prison Service will be required in developing and agreeing processes.

Guidance on BCM

58. BCM adopts the principal of building on what already exists within an organisation. Within NHS organisations there already exists informal 'workarounds' that enable key services to be delivered at the time of disruption. BCM ensures these are integrated into a formal process that enables a faster and more effective response to be deployed to maintain and/or recovery key services.

59. BS25999 parts 1&2 defines BCM as "strategic and tactical capability of the organisation to plan for and respond to incidents and business disruptions in order to continue business operations at acceptable pre-defined levels within agreed time frames".

60. BCM is a business-owned, business-driven process that establishes a fit for purpose strategic and operational framework that:

- proactively improves an organisation's resilience against disruption of its ability to achieve its key objectives
- provides a rehearsed method of restoring an organisation's ability to supply its key services to an agreed level within a agreed time after a disruption
- delivers a proven capability to manage a business disruption and protect the organisation's reputation and brand.

61. Having a planned response to a disruptive challenge will help NHS organisations ensure key services are maintained for critical patients and customers and the organisation's reputation is protected.

62. BCM arrangements can benefit an NHS organisation because they help to:

- develop a clearer understanding of how the organisation works. The process of analysing the business can yield sources of increased operational effectiveness and efficiency
- protect the community and the organisation. Ensure the impact of a disruptive challenge on service delivery is kept to a minimum
- protect the reputation of the organisation
- produce clear cost benefits. Identifying, managing and preventing disruptions in advance can reduce the costs to an organisation in terms of financial expenditure and management time
- ensure CCA 2004 compliance and good corporate governance
- enabling performance standards and key performance indicators to be maintained.

63. A successful BCM process has the potential to achieve:

- key services and critical activities are identified and protected, ensuring their continuity
- an incident management capability is provided to avoid incidents becoming a crisis

- the organisation's understanding of itself, its relationships with its partners, suppliers, other organisations and the emergency services is properly developed, documented and understood
- staff are trained to respond effectively to an incident or service interruption
- stakeholder requirements are understood and satisfied through effective delivery of their requirements.

Effective BCM is Built on the "Seven P's". (Emergency Preparedness, Civil Contingencies Secretariat, 2005).

1. **Programme** - proactively managing the process.
2. **People** - roles and responsibilities, awareness and education.
3. **Processes** - all organisational data and processes, including ICT.
4. **Premises** - buildings, facilities and equipment.
5. **Providers** - supply chain, including outsourcing and utilities.
6. **Profile** - brand, image and reputation.
7. **Performance** - benchmarking, evaluation and audit.

BCM in the Context of the Wider World

64. When NHS organisations are developing their BCM solutions it is essential that they consider the external environments in which the organisations operates. BCM strategies and plans must recognise and accommodate the influence of these external environments.

65. The following model can help identify the areas which may have influence on the organisation.

66. It is particularly important for NHS organisations to ensure their ability to work as part of a multi agency response across organisational boundaries, ensuring the ability to provide and give mutual aid within the context of Local Resilience Forums (LRFs) and their sub

groups. The principal mechanism for multi-agency co-operation at a local level is the Local Resilience Forum (LRF). This is based on police force areas except in London.

67. Risk assessment is seen in the CCA 2004 as the first step in the emergency planning and business continuity processes. It ensures that local responders make plans that are sound and proportionate to risks. Within each Local Resilience Forum, NHS organisations have responsibility in the context of multi-agency planning to contribute to the Community Risk Register. NHS organisations will therefore need to undertake risk assessment exercises appropriate to their facilities and services. Risk assessment is being undertaken at a regional and at a national level, with local risk assessments feeding into those.

68. Each NHS organisation will need to undertake its own internal risk assessment in order to inform its own response and to contribute an input to the multi-agency risk assessment.

69. An agreed methodology for risk assessment is available on the Cabinet Office website.

http://www.ukresilience.gov.uk/preparedness/risk.aspx

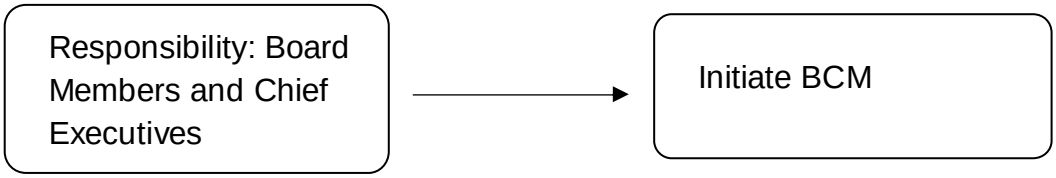
Linking BCM and Sustainable Development.

70. In addition to making the NHS more resilient to disruptive challenges, there is also a need to ensure the NHS considers its impact on the environment through reducing where possible its carbon footprint. Whilst it will not always be possible to produce resilience without totally reducing the environmental impact, through innovatively linking the resilience and sustainable development agendas, certain solutions can compliment both policy areas. For example, the use of micro power generation on site will not only provide a reduction in environmental impact, but also provide an alternative (albeit small) residual power supply source. It is recommended that BCM leads within Trusts work closely with their sustainable development leads to try maximise the links between these two policy areas.

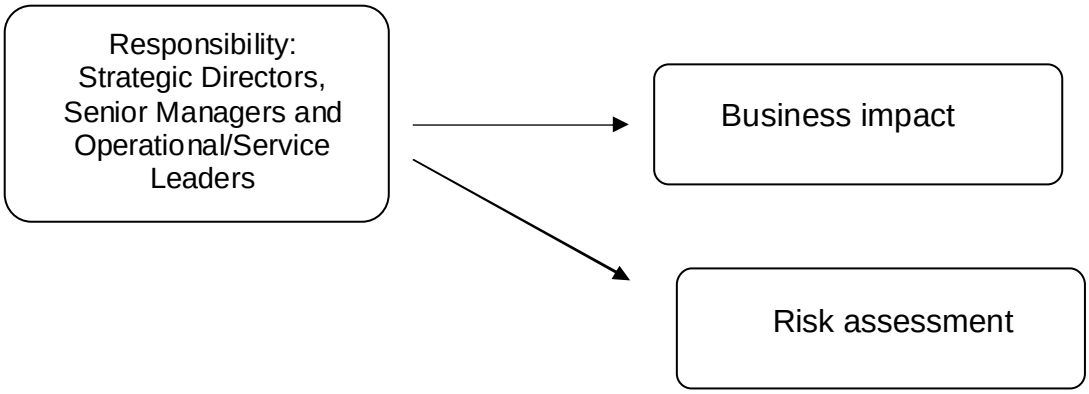
THE KEY STAGES OF BCM

71. There are 5 key stages to be followed to introduce BCM processes successfully into NHS organisations:

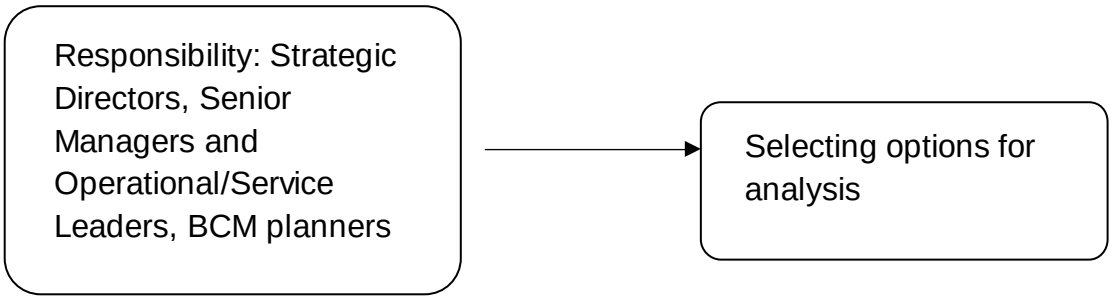
72. **Stage 1:** Programme Management: enables the business continuity capability to be both established (if necessary) and maintained in a manner appropriate to the size and complexity of the organisation.



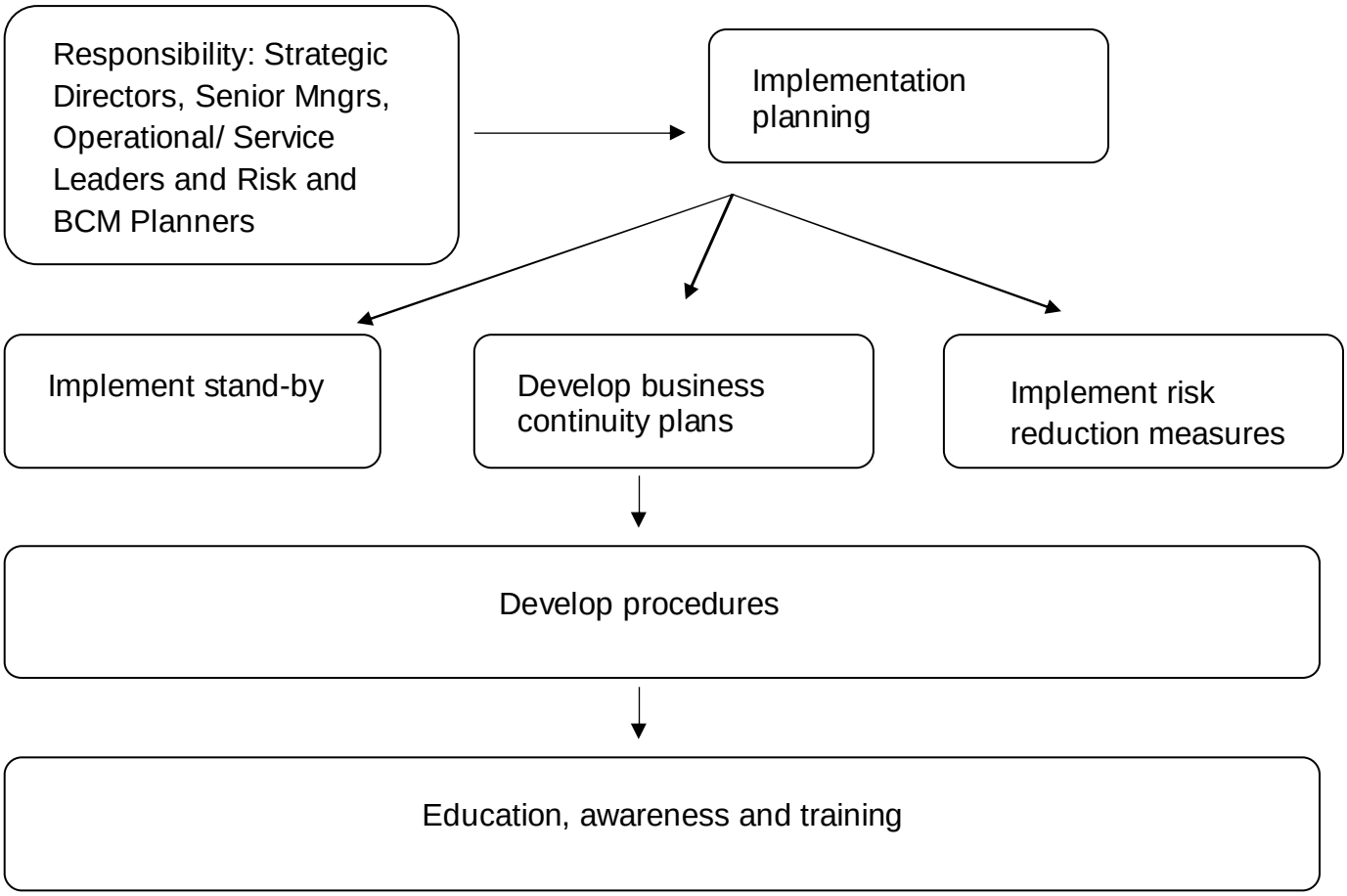
73. **Stage 2:** Understanding Your Business: Using business impact and risk assessments to identify critical deliverables, evaluate recovery priorities and assess the risks that could lead to a disruption of service.



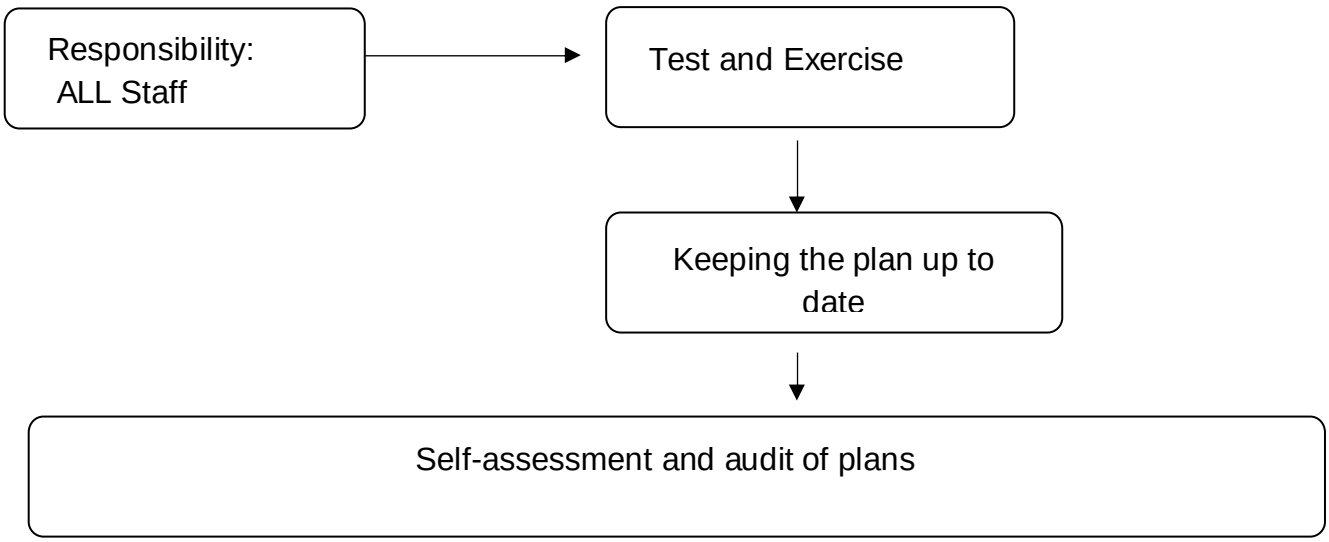
74. **Stage 3**: Determining BCM Strategies: Identifying the alternative strategies available to mitigate loss, assessing their potential effectiveness in maintaining the ability to deliver critical functions.



75. **Stage 4:** Developing and Implementing a BCM Response: Developing the response to business continuity challenges and the plans underpinning this.



76. **Stage 5:** Exercising, Maintaining and Reviewing: Ensuring plans are fit for purpose, updated and quality assured.



STAGE 1 - PROGRAMME MANAGEMENT

77. BCM must be regarded an integral part of the normal management process. The organisation's senior management must regard BCM arrangements as essential. Senior management support provides crucial:

- decisions on the scope of BCM within the organisation
- policy direction and resource provision to enable BCM to be established and maintained within the organisation
- leverage across the organisation in order for BCM arrangements to be effective
- decisions about attitudes to risk and service prioritisation that can only be taken at the top level
- responsibility for ensuring effective governance arrangements are in place.

Responsibilities

78. The organisation's management should:

- appoint or nominate a person with appropriate seniority and authority to be accountable for BCM policy and implementation
- appoint or nominate one or more individuals to implement and maintain the BCM programme.

79. Individuals tasked with implementing and maintaining the BCM programme may reside in many areas of an NHS organisation. It is essential, however, that a person with appropriate authority (e.g. board level director) has overall responsibility for BCM and is directly accountable for ensuring the continued success of this capability.

80. It is important to define the roles and responsibilities in the organisation and in partners and stakeholders

- strategic - decision makers and strategic responsibility for responding to an incident
- tactical – senior managers who are usually already likely to be involved in BCM in the organisation. These senior managers usually co-ordinate and direct resources of the organisation and ensure plans are implemented.
- communication and updating
- operational responsibilities.

81. So, within individual NHS organisations, it might be useful to state that:

- responsibility for maintaining individual services is primarily the responsibility of the relevant directorates/divisions/services/other
- ownership of BCM is required at every level of an organisation and to state the key BCM responsibilities of specific members of the organisation, for example

- Chief Executive: overall accountability for the successful implementation of BCM for the organisation
- Lead Director overall responsibility for the successful implementation of BCM for the organisation
- Directors: responsible for the successful implementation of BCM for the critical and essential services within their areas of responsibility
- Heads of Divisions/Teams/Business units/Other: oversight of the BCM implementation within their area of responsibility
- Managers and Teams: responsible for successful implementation of BCM within their area of responsibility
- Individual NHS organisation employees: each individual member of staff is responsible for ensuring they are familiar with the BCM plan and their role within it.

82. This ensures the profile of BCM issues is appropriate and decisions are made at the suitable level. BCM is an ongoing process and it is important to gain the support and endorsement of the Board at the end of each stage. It is the responsibility of the senior management to provide the assurance that BCM arrangements are robust.

Maintaining

83. The BCM Programme should be designed to ensure that business continuity is embedded within the organisation or that BCM becomes part of every service managers' normal responsibilities. The programme should also ensure that each component of an organisation's business continuity capability should be regularly reviewed, exercised and updated.

84. In addition, BCM arrangements and plans should also be reviewed and updated whenever there is a significant change in the organisation's operating environment, personnel, processes or technology, and when an exercise or incident highlights deficiencies.

Establishing BCM in the Organisation's Culture

85. The outer part of the BCM life cycle relates to an organisation's culture. To be successful, BCM has to become part of the way that an organisation is managed, regardless of size or sector. At each stage of the BCM process, opportunities exist to introduce and enhance an organisation's BCM culture.

An organisation with a positive BCM culture will gain benefits, as it will:

- develop a BCM programme more efficiently
- instill confidence in its stakeholders, especially staff, patients and customers, in its ability to handle disruptive challenges
- increase its resilience over time by ensuring BCM implications are considered in decisions at all levels for existing and new services
- minimize the likelihood and impact of disruptions.

86. To be successful BCM must be 'owned' by everyone within an organisation. Many disruptions are caused by internal failures. Within many organisations there exists a blame culture that prevents people from flagging up problems. If the culture is about only wanting to hear the 'good news' then there will be a reluctance to draw attention to failings which may subsequently lead to disruptions. Staff on the 'front line' will often be the best at identifying alternative methods working if normality is disrupted. If appropriate their ideas may be incorporated into business continuity plans.

87. All staff must be convinced that BCM is a serious issue for the organisation and that they have an important role to play in maintaining the delivery of services to their patients. It is essential that awareness programmes are established as part of the overall establishment of BCM.

Awareness

88. The BCM Programme should include processes that:

- ensures all personnel are aware of how they contribute to the achievement of the organisation's business continuity objectives
- raises, enhances and maintains awareness by establishing an ongoing BCM education and information programme for all staff
- introduces a process for evaluating the effectiveness of BCM awareness delivery.

89. Building, promoting and embedding a BCM culture within an organisation ensures that it becomes part of the organisation's core values and effective management.

Training

90. The BCM Programme should incorporate process for identifying and delivering the BCM training requirements of relevant participants, recording and evaluating the effectiveness of the training delivery.

91. BCM training is a statutory requirement placed on the NHS under the UK CCA 2004.

92. Good practice guidance on BCM training can be found at:

http://www.ukresilience.info/preparedness/ccact/good_practice/awareness_training.aspx

Documentation

93. A key element of Programme Management is the control and management of documentation. With BCM this is critical since at the time of any disruption it is essential that all players have access to and work from authorised and current incident or continuity plans and supporting documentation.

94. Much of the information contained within the BCM documentation will be of a sensitive nature and therefore must be subject to appropriate protection and confidentiality markings.

95. The management of the organisation must therefore establish and maintain a documented and controlled system of document and records management that covers identification, storage, protection, retrieval, retention time and disposal of documents and records.

STAGE 2 - UNDERSTANDING YOUR BUSINESS

96. An accurate assessment of the organisation and its business is critical, as it will provide the basis upon which all subsequent BCM strategies and plans are based. Key questions are:

- who are the key stakeholders and what are their expectations?
- what are the key services that enable the NHS organisation to meet its most important and time-sensitive objectives
- what are the critical activities? i.e. those activities which must be performed to deliver the key services
- what processes are used to deliver critical activities?
- who and what is used in these processes?
    - Internally
    - Externally
- the impact on the community and the organisation if key services and critical activities are interrupted – for whatever reason.

97. It is important to put in place a process for identifying key services – whose loss would have the greatest impact in the shortest time and which need to be recovered most rapidly - and for identifying acceptable levels of service provision. If a declared set of aims, objectives and targets exists for the organisation, this will help identify the key services the BCM process should focus upon.

98. Key services should be considered from patients and customers perspective. The services should be considered as an 'end to end' service in which many players, both internal and external, ensure delivery to patients and customers and recognise that an interruption to any element of the service may threaten the delivery of the overall service.

99. BCM is also about understanding the activities, processes and resources that the delivery of these key services depend on. Services have many dependencies both internally and externally that support them. These can include customers, suppliers, partners, agencies and other services provided internally by the organisation itself. It is important to identify these at an early stage and to take their influence into account. The involvement of representatives from these key dependencies on the BCM planning team will add significant value to the process.

Business Impact Analysis (BIA)

100. Having identified the critical processes and functions that support the key services, it is important to determine what the impact would be upon the organisation's goals and targets if these were disrupted or lost. This stage is known as Business Impact Analysis (BIA).

101. BS25999 defines BIA as “the process of analysing business functions and the effect that business disruption might have upon them”.

102. The BIA is the crucial element in implementing and underpinning the whole BCM process. BIA is a process to identify, quantify and qualify the impacts and their effects on a service of a loss, interruption or disruption of a critical activity and its’ supporting processes and resources and helps measure the impact of disruptions on the organisation. It will provide information that will underpin later decisions about business continuity strategies.

103. Experience has demonstrated there are five key elements to the BIA process: -

- defining the activity and its’ supporting processes
- mapping the distinct stages of each activity and process
- determining the impacts of a disruption
- defining the recovery time objectives
- the minimum resources needed to meet those objectives.

104. BS25999 defines Recovery Time Objective (RTO) as the target time set for the resumption of a service delivery after an incident.

The purpose of the BIA is to:

- obtain an understanding of the organisation’s key services, the priority of each and the timeframes for resumption of these following an interruption
- quantify the maximum tolerable period of disruption for each service – the timeframe during which a recovery must become effective before an outage compromises the ability of the organisation to achieve its business objectives. consider the contractual, regulatory and statutory requirements
- provide the resource information from which an appropriate recovery strategy can be determine/recommended. outline dependencies that exist both internally and externally to achieve critical objectives
- quantify the resources required over time to maintain the key services at an acceptable level and within the maximum tolerable period of disruption.

105. BS25999 defines the Maximum Tolerable Period of Disruption (MTPoD) as the duration after which an organisation’s viability will be irrevocably threatened if the service delivery cannot be resumed. The Recovery Time Objective (RTO) has to be less than the maximum tolerable period of disruption.

The BIA Process

106. **Scope**

- if the service has several teams – identify the relationship between them and their functions and various parts of the organisation
- identify the key service objectives and the success criteria of each

- confirm the incident scenarios to be investigated e.g. loss of staff, loss of premises, technology failure, including ICT0, building services failure, supplier failure, loss of utility service and possible combinations of these.

The Analysis

- identify discreet service processes across different service areas and identify the managers of these processes
- identify the service subject experts from whom information can be sought about the service processes
- identify the impacts of a disruption of critical activities on the service
- quantify the timescale within which the interruption of each service becomes unacceptable.

107. The impact of potential disruptions should be rated taking into consideration the following factors by those involved in the critical activities.

- implications for service delivery
- health, welfare and safety of stakeholders
- environmental implications
- statutory and legal obligations
- financial cost to the organisation
- impact of disruption on duties partners
- reputation.

108. The outcomes of the BIA are the identification and documentation of:

- services' aims, objectives and outputs
- key services and their dependencies including seasonal tends and or critical timing issues
- financial and non financial impacts and effects/consequences resulting from disruption of the key services over various time periods
- the BCM objectives for each key service and their dependencies.

109. A prioritised minimum acceptable resource recovery configuration, overtime, that is required to enable a predefined minimum level of continuity of key services and their dependencies. Include:

i. staff numbers and key skills
ii. vital records/data (all media)
iii. technology, including ICT
iv. consumables / pharmaceuticals
v. facilities
vi. key clients and stakeholders
vii. suppliers.

110. The output from this element of the process is used to advise internal and external functions of the resource needs of the service at the time of disruption. This provides

information to enable facilities, ICT and other key functions to develop their continuity plans to meet the key service needs.

111. Very often services are cross-department/division and agreement must be reached on the ratings. At this stage agreement from the Board on the output of the BIA should be gained because it identifies the organisation's key services and their vulnerabilities in the event of a disruptive incident and focuses the next stage of the process – Risk Assessment.

Case Study

NHS organisations, as part of the North Yorkshire Local Resilience Forum, have developed a business impact assessment template to allow members of the LRF to obtain an understanding of the organisations key services, the priority of each and the timeframes for restoring these services following disruptive challenges. This template is included at Annex 3

Risk Assessment

112. Having identified the key services and their critical activities, processes and supporting resources the next stage is to undertake a risk assessment. This is undertaken at this stage to ensure BCM is focussed on those elements that are at risk and, if the risk should materialise, would have the greatest impact on key services.

113. Traditional risk assessment techniques are used at this stage, particular efforts should be made to identify internal and external threats, single points of failure, these may be people, facilities, ICT, suppliers, etc.

114. As a result of the BIA and the risk assessment, the organisation should identify measures that:

- reduce the likelihood of a disruption
- shorten the period of disruption
- limit the impact of a disruption on the organisation’s key services.

115. These measures are known as loss mitigation and risk treatment. Loss mitigation strategies can be used in conjunction with other options, as not all risks can be prevented or reduced to an acceptable level.

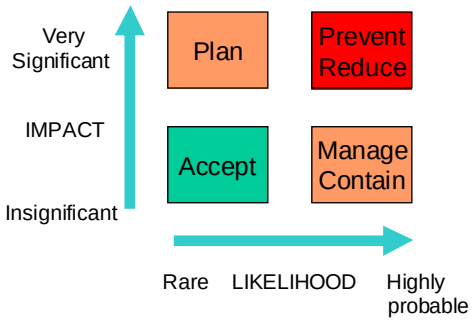
Case Study

A generic plan is a core plan which enables an organisation to respond to a wide range of possible scenarios, setting out the common elements of the response to any disruption. These elements would include invocation procedures, command and control structures, access to financial resources etc. Within the framework of the generic plan, specific plans may be required in relation to specific risks, sites or services. Specific plans provide a detailed set of arrangements designed to go beyond the generic arrangements when these are unlikely to prove sufficient. The Civil Contingencies Secretariat has developed, in partnership with stakeholders, this is an ideal document for NHS organisations to benchmark where they are with BCM. This toolkit can be found at;

http://www.preparingforemergencies.gov.uk/bcadvice/bcm_toolkit_active1.pdf

116. In assessing risks NHS organisations should take account of the Environment Agency's local flood maps, the CCA 2004, BCM Planning Assumptions and the local Community Risk Register (CCR).

117. It should now be possible to combine findings from the BIA and risk assessment to produce a ranking system identifying those areas where the initial BCM effort should be concentrated.



118. A decision has to be made as to what approach is to be taken to protect the operation once those areas most at risk have been identified. The nature of the risk - defined in terms of its likelihood and impact - will determine which BCM strategy is appropriate and what, if any, action is required. Disruptions that are low likelihood and low impact may require no specific action and may be dealt with through generic arrangements. Risks that are high impact and high probability may need the development of specific plans and risk mitigation strategies.

119. Tolerate, transfer, treat and mitigate describe strategies that could be adopted; i.e.

- do nothing
- change, transfer or end the process

- insure
- mitigate
- plan for business continuity.

120. At this stage the senior management in the organisation should agree and sign off the business impact and risk assessments. Any significant risks that have been identified, as part of this process, should be incorporated into the organisation's risk register.

STAGE 3: DETERMINING BCM STRATEGIES

121. Having identified the critical activities, processes and resources that support the key services of the organisation, completed the impact and risk assessments and agreed the recovery time objectives (RTOs), together with the minimum level of service required, it is time to consider how continuity of operation will be achieved.

122. There are four elements to this stage of the process

- develop and document an incident response structure
- determine how the organisation will recover each critical activity within the RTO and the resources required
- determine how relationships with key stakeholders will be managed at the time of disruption
- take account of those services/activities not defined as critical.

Incident Response Structure

123. An Incident Response Structure (IRS) supports all levels of activities that take place during a disruptive event. If no structure exists there is a danger that response, continuity and eventual recovery plans with be operated independent of each other. This may cause delays, conflicts, incorrect allocation of resources and failure to achieve required levels of continuity.

124. It is critical that the organisation moves at the speed of the incident in order to maintain control of the situation. In a larger organisation it is strongly recommended that separation exists between the team that manages the emergency situation, (e.g. fire and evacuation), and the team responsible for ensuring continuity of operations.

125. Procedures must be appropriate to the size and nature of the organisation and set out the basis for determining when a disruption has occurred and how plans will be invoked.

126. Members of an incident response team must have the, information, authority and knowledge to be able to assess the situation, confirm priorities and decide on the appropriate course of action which may include invoking the appropriate BCM plans.

Selecting the BCM Strategy

127. The organisation must determine how it will recover each key service and its critical activities within the RTO and the resources required to do so. In choosing the appropriate option or strategy, consideration must be given to the maximum tolerable period of disruption for each service, the costs of implementing the strategy and the consequences of inaction.

128. In setting the strategies consideration must be given to how they involve key resources, e.g. people, premises, technology, information and supplies.

129. It is recommended that five scenarios be considered when developing strategies. Do not consider what cause lies behind the scenario, rather the impact if they should occur. The five scenarios are:

- denial of access to premises
- shortage of staff
- failure of technology
- failure of key supplier or partner
- failure of utility services.

130. There are three levels at which strategies can be set:

- full availability – cannot fail
- recovery within Recovery Time Objective (RTO) at an agreed minimum level
- suspend services.

131. Where resumption of the service can be phased over a period of time then it is possible to agree levels of resumption at fixed points in time. Consideration of the impact on the organisation of the disruption over time will set the parameters for this approach. E.g. 25 per cent (minimum level agreed) to be available in 2 hours, 50 per cent in 2 days, full service in 1 week.

132. If the strategy chosen is to suspend certain services during a disruptive challenge it is essential that the stakeholders that have an interest in the services that will be suspended are advised that this is the strategy being adopted and why. If the strategy is implemented communications with the stakeholders is essential to keep them informed when service will be restored.

133. Experience has shown that strategies must also address the complete loss of ICT, standby power and other key resources for extended periods. Therefore within the NHS strategies must be developed for the highest priority services that will enable them to continue under these circumstances.

Relationships with Key Stakeholders

134. When undertaking the second stage of the BCM process the key stakeholders for the organisation will have been identified. These stakeholders normally have high expectations of the NHS. If the organisation is faced with a disruptive challenge the stakeholders' expectations will be raised.

135. They will expect to be informed of what actions will or are being taken to maintain key services and when the organisation will return to normal.

136. It is therefore essential that a communications strategy is developed to ensure all stakeholders are kept informed. If the organisation has a person or department responsible for public relations they should be involved in developing this strategy.

Taking Account of the Non Critical

137. It is important to recognise that services or activities which have not been identified as key/critical must eventually be restored. The period of disruption will have built up a backlog of work that must be 'caught up'. This is referred to as the 'backlog trap' and failure to remove the outstanding work within an acceptable period once the organisation has returned to normal may have serious impacts on objectives, targets, finance and reputation.

138. Once the strategies have been developed they should be agreed and signed off by senior management before the BCPs are developed.

STAGE 4: DEVELOPING AND IMPLEMENTING A BCM RESPONSE

139. The first action for many organisations has been to create a BCP without going through the key steps outlined in the Stages 1-3. The danger in taking this approach is that a true understanding of the organisation and how it delivers key services will not have been achieved.

140. Consideration of various strategies and their resource requirements may have been missed. As a result the plan produced may not be fit for purpose and not offer the protection and benefits that would have been possible. By completing the processes set out in Stages 1-3 the organisation can now develop realistic and appropriate business continuity plans.

141. Experience has shown that organisations can be disrupted for many reasons. Business continuity planning has traditionally been written on known threats, loss of IT, loss of a building through fire, flooding, etc. In recent times however the UK has experienced some unexpected disruptions, including a widespread outbreak of foot and mouth disease, extensive disruptions to the rail network, a national shortage of oil based fuels, the loss of water supplies for weeks. In most cases existing plans did not cover these disruptions and the impacts they had on organisations.

Developing Plans

142. When developing plans it is important that all elements of the organisation are involved. If this does not happen assumptions will be made about the ability of other parts of the organisation to respond and meet the needs of the plan.

143. BCPs should provided answers to basic questions:

- what is to be done
- when
- where are the alternative resources located
- who is involved
- how is continuity to be achieved?

144. In any organisation there may be a suite of interconnected plans covering emergency, business continuity, incident, and recovery management. The plans produced should be appropriate for the organisation. A small organisation, operating from one site may only need a single document that covers incident and continuity management, whilst larger organisations will need integrated corporate, divisional and service unit plans based on a common structure. Such plans must be synchronised to eliminate conflicts

and ensure that agreed restoration priorities are achieved. In a large organisation a central BCM team or BCM co-ordinator undertakes this role.

145. Ownership of the plan must be identified. In larger organisations there will be plans at different levels, business unit managers should own operational plans. All plans must be regularly reviewed and when significant changes occur to the organisation or the environments in which it operates. The responsible owner must undertake the review that is then signed off at a higher level.

146. The plans must also take account of any external arrangements for managing an incident. These include the actions of the emergency services, local authorities and other external agencies in the event of a major disruption or, if sharing a building, what contingency arrangements do the facilities management company or landlord have.

Plan Contents

147. The following headings provide an indication on how a BCP should be structured:

- Purpose of Scope
- Roles and Responsibilities
- Invoking the Plan
- BCM Strategy
- Alternative Locations
- Mutual Aid
- Contact Details
- Priorities
- Vital Documents and Resources
- Action Sheets and Check Lists
- Log Sheets
- Staff Issues
- Public Profile
- Salvage
- Return to Normal
- Triggers and activation protocols.

148. Effective continuity plans are written on the basis of recovering the key services and critical activities of the organisation whatever the cause of the disruption. Plans should provide a framework against which continuity can be achieved.

149. As the plans are used under challenging and stressful circumstances they should be concise, simple and easy to follow. In addition plans should ensure the organisation maintains compliance with applicable laws and regulations during the period of their implementation.

150. Plans will be subject to change and therefore version controlled and configuration management must be applied. Each copy of the plan must be numbered and controlled distribution established. Where sensitive information is contained in the plan then it must be given the appropriate level of confidentiality.

Implementing Plans

151. Having completed the plans they must be implemented. Those who hold positions that are named in the plan must be made aware of their role and have the appropriate training to enable them to fulfil their duties and responsibility. Exercising plans is one of the principal methods of ensuring that those who will be involved in managing an incident and effecting continuity are aware of the contents of the plan and their roles.

152. It is essential to determine how the plans will be distributed to staff and how can copies of the plan and accompanying documentation be accessed.

153. Arrangements must be made for the plans to be monitored and by whom.

154. Appropriate stakeholders, both internal and external need to be aware that the organisation has plans in place to deal with disruptions. They need to be conscious of what will be done, what services will be available and at what levels. Where appropriate they also need to know what the organisation will not be doing whilst it recovers.

155. External stakeholders, partners and suppliers, who have a role to play in assisting the organisation cope with disruption, need to know their duties and responsibilities to support the organisation's requirements. As these partners and suppliers may also be impacted by the same disruption it is important that they have plans to maintain their own continuity of service.

156. It is not sufficient ask a key partner or supplier if a BCP exists or even to have sight of their plan. It is essential that the partner or supplier can demonstrate the effectiveness of the BCM process and that they can meet your organisation's requirements in the event of a disruption.

157. BS25999 parts 1&2 has been developed as a certification standard. It will therefore be possible to ask key partners and suppliers to demonstrate compliance with the standard and certification would provide appropriate proof. If a supplier or partner is certified to BS25999 parts 1&2 it is important for the NHS organisation to determine the scope of their certification and satisfy itself that the partner or supplier can meet the continuity requirements of the NHS organisation.

158. BCM requirements should be built into commissioning, procurement and contract management processes.

STAGE 5: EXERCISING, MAINTAINING AND REVIEWING

Exercising

159. The exercising of plans is essential as there is not a plan created which will work first time. Exercising ensures that disconnections and omissions within the plan are fixed before it is used in reality. The Chartered Management Institute's BCM research found that 89 per cent of those that exercised their BCPs found errors. It is far better to have found the errors at rehearsal than the first time the plan is invoked. Having found the errors it is essential that timed based actions are created to rectify the errors and omissions.

160. Exercising helps to build confidence in team members by clarifying roles and responsibilities, supplying practical training and awareness and providing valuable experience of responding to an incident.

161. There are various forms of rehearsals but it important to:

- test the systems
- exercise the plans
- rehearse the people.

162. Exercises must have defined aims and objectives that may include:

- affirmation that everyone understands their role and that there is an overall appreciation of the plan
- checking that the invocation procedures and callout communications work
- ensuring that the accommodation, equipment, systems and services provided are appropriate and operational
- testing the key services can be recovered within the RTO and to the levels required.

163. Exercises should not 'risk' the organisation by causing disruptions, they must be practical and cost effective, be appropriate to the organisation and designed to build confidence in the plan.

164. The Civil Contingencies Secretariat has provided details of Exercising Good Practice which can be obtained via their website at`;

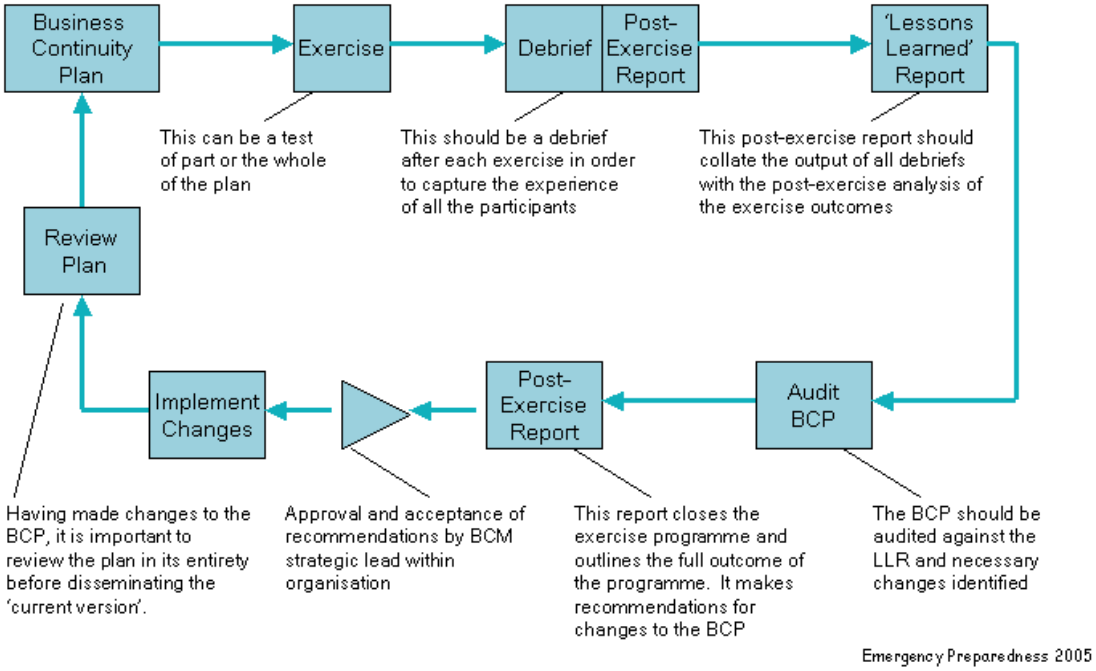
http://www.ukresilience.info/preparedness/ccact/good_practice/exercising.aspx

165. A log of all actions and outcomes must be made during an exercise and this must be reviewed as soon as possible after the event. It is a good idea that this review is carried out with the participants so they can express their own views on what went well or otherwise. To assist with this, participants should be asked to maintain their own 'diary

of events' throughout the exercise. If independent observers have been used their views should also be included.

166. A post exercise report should be completed which will include recommendations on actions to adjust the plans. A senior manager of the unit in which the exercise was conducted should sign off the report and actions to be taken. The process of exercising is set out in the figure below:

Exercising the Business Continuity Plan - The learning cycle



167. The CCA 2004 places a requirement on NHS organisations as Category 1 Responders to have regularly exercised their plans. In accordance with national emergency planning guidance for each NHS organisation, a live exercise will take place every three years to test the emergency and BCPs, with a table top exercise annually and a test of communications cascades every six months. These arrangements will also ensure that the organisation is able to respond effectively on any day and at any time.

168. To meet this requirement a regular programme of exercises should be established and documented; these should take place at a period determined by the top management or when there have been significant changes to the organisation or the environments in which it operates.

Maintaining

169. The purpose of the BCM maintenance process is to ensure that the organisation's BCM competence and capability remains effective, fit-for purpose and up-to-date.

170. The organisation changes, contact details, suppliers, partners, customer and clients are continually changing. It is important that processes exist within the organisation to ensure that these changes are recorded and the BCPs are adjusted accordingly.

171. The maintenance programme should also identify any new key services and their dependent activities that need to be included in the BCM programme.

172. Where changes to BCPs have been made then the up to date plans should be subject to version and distribution control within the organisation.

Reviewing

173. At appropriate intervals the organisation should make arrangements to ensure that the BCM process is reviewed to ensure its continuing suitability, adequacy and effectiveness. This can be done via an independent audit of BCM competence and capability to identify actual and potential shortcomings. It should establish, implement and maintain procedures for dealing with these.

174. A BCM self-assessment process plays a role in ensuring that an organisation has a robust, effective and fit-for-purpose BCM competence and capability. It provides the qualitative verification of an organisation's ability to recover from an incident. Self-assessment is regarded as good practice and should be conducted against the organisation's objectives.

Case Study

Once BCM plans are complete, it is recommended that NHS organisations complete the planning cycle by regularly completing base line audits to monitor on going compliance with the BCM strategy. A suggested BCM Audit checklist, originally produced by John Sharp, BCM Consultant Kiln House Associates, and Cabinet Office Civil Contingencies Secretariat has been included at Annex 4 for use by other NHS organisations.

Thank you to all those people who contributed to the publishing of this operational guidance, in particular the NHS Resilience Stakeholder Group

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Annex 1

Good Practice Example

Halton and St Helens PCT Business Continuity Project

In spring 2007 Halton and St Helens PCT identified as a priority the need to update and further develop its business continuity arrangements. This was sponsored by the Chief Executive and a very tight timescale was set – to have business continuity plans in place, and agreed with each director, by the end of July 2007.

In 2005 the former Halton PCT had undertaken a considerable amount of work on business continuity through the development and completion of a series of templates, using the expertise on a consultancy basis of a member of the Business Continuity Institute with many years' experience of working with the NHS.

In view of the very tight timescale it was therefore agreed to build on this work across the new PCT footprint using the same consultant. His first step was to review the existing templates and to make any necessary changes to ensure that they took into account all new legislation and guidance issued since 2005 and fully met the criteria set out in BS25999.

The resulting documentation followed a logical sequence which started with the identification of key business functions (services) and the consequence of not being able to provide them. It then detailed how the services were delivered and identified key internal and external stakeholders and dependencies. The business assets (staff, buildings, equipment and facilities needed to deliver the services) were then listed, together with the vital information held in each location. The document then went on to list the suppliers of essential services and any alternative arrangements which could be invoked during an emergency. A business impact analysis was then carried out and a business impact score and risk score were allocated. Added together, these scores enabled the service's time critical functions to be ranked in order of priority and the business continuity maintenance programme to be set.

A project plan was agreed and a steering group was established, with members who had responsibility for leading on the production of robust business continuity plans within their own directorates. The steering group's first meeting was held in early June 2007 with further weekly meetings arranged to keep the project on track and to provide support to members as they began to populate the templates. Individuals were also given one to one training as necessary.

As each set of templates was completed in draft, it was sent to the consultant who quality-assured it and provided feedback to the author, who was then tasked with incorporating any amendments.

By the deadline of the end of July 2007, the PCT had business continuity plans for many of its key services. However, due to the project's short timescale it had not been possible to engage fully with all the staff within the service provision directorate so as an interim measure it was

agreed with the director that for these services, a simplified 'action plan' style template would be acceptable, supported by the overall PCT business continuity plan (see Appendix).

A series of 4 table top business continuity exercises using different scenarios took place from September to December 2007. The events were well attended by staff from every area of the PCT and tested whether their plans contained the information and level of detail necessary to enable them to maintain services during an incident. The key learning points from each of the exercises were captured and circulated and staff were then requested to review and amend their business continuity plans if necessary and have them agreed by their directors during early 2008. It is intended that a further series of table top exercises will be arranged for autumn 2008, allowing a opportunity to further refine each of the plans before the end of the year.

The PCT has shared the experience gained from the project with other local PCTs and the package has now been purchased from the consultant to roll out across Cheshire.

Key points:

- Sponsorship of BCM at Chief Executive level is key to its success.
- Ownership of the plans by the staff who would be responsible for invoking them is vital, and they need to be fully involved in the process to develop them.
- It is important to implement an agreed process with a template compliant with the latest guidance. This ensures that all the organisation's business continuity plans follow the same logical approach and meet the national BCM criteria.
- Allow sufficient time for making sure staff understand the concept of business continuity and training them and supporting them in completing the templates.
- Testing the plans through a programme of exercises is important – each of the table top exercises which the PCT held highlighted a range of issues which had not been considered originally by the authors. For example, one issue which came out of the exercises was the need for managers to hold up to date contact details for their staff. This led to a full PCT-wide audit of staff skills and contact information by the human resources directorate.
- Plans must be current. They must be reviewed and updated regularly. This is particularly important if there are changes to structures, staff roles or premises within the organisation.
- Plans must be held within the relevant service/team, with all staff aware of what they contain, where they are held and how and when to activate them.

Structure of the overall PCT Business Continuity Plan

	Para	**THE BUSINESS CONTINUITY PLAN**
SECTION A		**INTRODUCTION**
	1	Plan Aim
	2	Plan Objectives
	3	Plan Scope - generic response, specific procedures, current risks
	4	Incident trigger definitions – 'Recovery Incident'
	5	Recovery Incidents – response objectives
	6	Recovery Incidents – control and coordination
	7	Recovery Teams – locations, staffing and facilities
	8	Recovery Teams – roles and responsibilities
	9	Plan review procedure
	10	Training objectives
SECTION B	Para	**GENERIC RESPONSE PLAN**
	11	Alerting Phase actions
	12	Activation Phase actions
	13	Response Phase actions
	14	Key contacts
SECTION C	Para	**ACTION CARDS**
	15	Recovery Team
	16	Recovery Manager
	17	Recovery Incident Manager
	18	Specialist Adviser
	19	Recovery Incident Support Team Manager
	20	Telephone Operator
	21	Log Keeper
SECTION D	Para	**CORPORATE PLANS AND PROCEDURES**
	22	Risk areas for the current programme
	23	Other relevant PCT plans and procedures
	24	Media Management Guidance Note
SECTION E	Para	**SERVICE PLANS AND PROCEDURES**
	25	Corporate Business Plans and Procedures
APPENDIX 1		Staff Skills Audit pro forma

Annex 2

Good Practice Example

Sheffield Teaching Hospitals NHS Foundation Trust

Examples of Action Cards devised at part of the BCM processes for utilities failures

- bleep system failure on wards
- telephone system failure on wards
- water system failure on wards
- electricity system failure on wards
- piped medical gases system failure on wards and departments

Internal Incident Plan

ACTION CARD

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

BLEEP SYSTEM FAILURE ON WARDS

The Hospital Bleep System is independent of the telephone system, although at each campus, the Bleep consoles and the desk top operator boxes are all in one location. While the failure of the telephone system would result in an inability to access and activate the bleep system, a fault to the bleep system could result in loss of bleep services, and yet telephone services may remain unaffected. In order to maintain communications, the nurse in charge should do, or delegate the following duties to staff:

- Check that the telephones are working. Even if the majority of telephones are not working, there will be a single telephone connected to a separate central 'Switch' which should still work. This may be situated in a non clinical area in the ward. If no telephones are working, refer to the 'Telephone System Failure on Ward Action Card.'

Action Plan:

In the event of an interruption of the bleep system supply to the wards, the fault will need reporting immediately to the Switchboard Staff.

Report:

- Report the fault to the **Switchboard staff**. Ensure that Switchboard staff is aware of the time of bleep system failure, precise location, effect, and impact.
- Try to ascertain the estimated timescales for disruption / resolution.
- Switchboard may be able to supply mobile telephones for temporary use. If not, use own personal mobile telephone - priorities will need to be identified. Relevant staff should be informed of the mobile telephone numbers being used.

Communication:

- Inform the Unit Bleep holder of the situation, identifying any immediate risks or concerns. This person will communicate the incident via the Directorate Escalation Policy as required. If no contact can be made with the Unit Bleep Holder, contact the Duty Matron via Switchboard.
- Use discretion with regard to informing patients since staff should not wish to cause undue concern.

EMERGENCY CALLS

All 2222 emergency calls i.e. Cardiac arrest, Fire Alert and Security Alert should still be made to Switchboard Staff, who will contact the relevant team via numbers isolated for emergency calls or via mobile telephone.

Safety:

- If staff are being deployed as 'runners' to relay messages, the nurse in charge must be made aware of the runner's intended destination, anticipated time of arrival and / or return back to the ward area. Personal alarms or deploying runners in pairs may prove necessary, particularly if the journey or destination is remote, or if the message is to be relayed outside of daylight hours.

continued

Security:

- There may be engineers etc. coming and going. Please ensure ID is shown.

REMAIN IN COMMUNICATION WITH THE UNIT BLEEP HOLDER / MATRON OR IF NOT AVAILABLE, THE DUTY MATRON.

YOU WILL RECEIVE ADVICE FROM THE ABOVE CONTACT REGARDING ANY ACTION TO BE TAKEN.

Internal Incident Plan

ACTION CARD

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

TELEPHONE SYSTEM FAILURE ON WARDS

In order to maintain communications, the nurse in charge should do, or delegate the following duties to staff:

- Check the other telephones. Even if the majority of telephones are not working, there will be a single telephone connected to a separate central 'Switch' which should still work. This may be situated in a non clinical area in the ward.

Action Plan:
In the event of an interruption of telephone system supply to a single ward or department, the fault will need to be reported immediately to the Switchboard Staff.

Report:
- Report the fault to the Switchboard staff. Ensure that Switchboard staff are aware of the time of telephone system supply failure, precise location, effect and impact.
- Try to ascertain an estimated time period for the disruption / resolution.
- If no telephones are working, a member of staff will need to be sent to inform Switchboard staff. Switchboard may be able to supply mobile telephones for temporary use. If not, use own personal mobile telephone - priorities will need to be identified. Relevant staff should be informed of the mobile telephone numbers being used.

Communication:
- Inform the Unit Bleep holder of the situation, by going to the nearest working telephone - this may not be in your ward or department. Identify any immediate risks or concerns. This person will communicate the incident via the Directorate Escalation Policy as required. If no contact can be made with the Unit Bleep Holder contact the Duty Matron via Switchboard.
- Instruct staff to only use the available telephone for urgent calls / bleeps.
- Inform relevant medical and all key staff e.g. pharmacy, physiotherapy, blood results reporting, of the available ward contact number (limit this cascade for urgent contacts only).
- Use discretion with regard to informing patients since staff should not wish to cause undue concern.
- Assess the need for faxing and implement an alternative system in the absence of faxing capability.

Safety:
- If staff are being deployed as 'runners' to relay messages, the nurse in charge must be made aware of the runner's intended destination, anticipated time of arrival and / or return back to the ward area. Personal alarms or deploying runners in pairs may prove necessary, particularly if the journey or destination is remote, or if the message is to be relayed outside of daylight hours.

continued

Security:

- There may be engineers etc. coming and going. Please ensure ID is shown.

REMAIN IN COMMUNICATION WITH THE UNIT BLEEP HOLDER / MATRON OR IF NOT AVAILABLE, THE DUTY MATRON.

YOU WILL RECEIVE ADVICE FROM THE ABOVE CONTACT REGARDING ANY FURTHER ACTION TO BE TAKEN

Internal Incident Plan

ACTION CARD

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

WATER SUPPLY FAILURE ON WARDS

In the event of an interruption of water supply to a single ward or department, the fault will need to be reported immediately to the Estates Department.

Action Plan:

The nurse in charge should do, or delegate the following duties to staff:

Report:

- Report the fault to the Estates Helpdesk e**xt: 68686**, this is a **24 hour** number. Ensure that the Estates Department is aware of the time of water supply failure, precise location, effect, impact and risks and any urgent requirements.
- Try to ascertain an estimated time period for the disruption / resolution.

Infection Control / Personal Hygiene:

- Provide patients with hand "wet wipes" as necessary.
- Utilise spray foam cleansers for sanitizing skin when changing soiled patients.
- Nursing staff should maintain hand hygiene using hand wipes and alcohol rub.
- Use disinfectant wipes to cleanse surfaces as necessary.

Waste Disposal:

- Inform patients that the toilets will not flush.
- Determine which waste may be discarded in the sluice hopper, and which receptacles can be cleaned manually using appropriate detergents (Chlorclean or detergent and Sodium Hypochlorite solution). This process **CAN** be used for waste from infected patients, such as those with Clostridium Difficile. Alternatively, use disposable bedpans / urinals and discard used items and products in clinical waste bags.
- Staff must be made aware of their responsibilities regarding Infection Control and Health and Safety, and must wear personal protective equipment (PPE) such as aprons, gloves and masks / goggles as necessary, and must comply with COSHH regulations when handling detergents.
- The sluice hopper will not flush, and it may be necessary to store receptacles such as bed pans containing waste in a designated area in the dirty utility / sluice room, pending the return of the water supply. Standard infection control measures must be adhered to i.e. keeping items covered, hand cleansing etc.

If in doubt, seek advice from the Infection Control Team.

Hydration and Nutrition:

- If the loss of water supply is noted on a single ward, obtain a water supply from the nearest ward or department.
- In the event of a significant or prolonged disruption to the water supply, bottled drinking water will be distributed to the wards via the Estates Department.
- A limited number of large dispensing flasks may be obtained from Catering Department to enable hot and cold water for drinks to be transported to the ward from an area unaffected by water supply failure.

continued

- Disposable cups etc may need to be used when the regular supply of crockery has been used. Risks assess patients' safety / ability to use disposable cups. Provide assistance where necessary.

Communication:

- Inform the Unit Bleep holder, who will escalate the information via the Directorate Escalation Policy as required. If no contact can be made with the Unit Bleep Holder contact the Duty Matron via Switchboard.
- Use discretion with regard to informing patients since staff should not wish to cause undue concern.

Security:

- There may be engineers etc. coming and going. Please ensure that ID is shown.

REMAIN IN COMMUNICATION WITH YOUR UNIT BLEEP HOLDER / MATRON OR IF NOT AVAILABLE, THE DUTY MATRON OUT OF HOURS.

YOU WILL RECEIVE ADVICE FROM THE ABOVE CONTACT REGARDING ANY FURTHER ACTION TO BE TAKEN

Return to Normal Working:

- On resumption of the water supply, the Estates Department will give instructions regarding any water quality checks / running of water / flushing of outlets that need to be performed before resumption of water use.
- Liaise with the Unit Bleep holder regarding any additional staffing requirements to assist with the service / activity recovery process e.g. catching up on bed baths, washes etc.

ACTION CARD

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

ELECTRICITY FAILURE ON WARDS

In the event of a major interruption to the electricity supply to wards, in most cases, the emergency generators will automatically activate, to provide power to the emergency (red) E sockets and emergency lighting.

In the event of a local power failure to a single ward or department, the emergency generator may not activate automatically and the fault will need to be reported immediately to the Estates Department.

Action Plan:
The nurse in charge should do, or delegate the following duties to staff:

Report:
- Report the fault to the Estates Helpdesk ext: 68686, this is a 24 hour number. Ensure that the Estates Department is aware of the time of electricity supply failure, precise location, effect, impact and risks and any urgent requirements.
- Try to ascertain an estimated time period for the disruption / resolution.

Lighting:
- Get out the emergency torches and lanterns.

Sockets:
- Check the Emergency / Red E Sockets have power.
- Switch off and unplug any non essential electrical items from Emergency Sockets as it is important not to overload the system.

Infusion Devices:
- Check all infusion devices in situ to ensure battery back up power is working. Risk assess which drugs must continue.
- If battery power fails take the following steps;
  1) Replace with alternative infusion device if available, if not try to locate an alternative device from another area.
  2) If no alternative immediately available, contact the Unit Bleep holder.
  3) If appropriate, prepare to use burettes to control infusion rates if no working devices are available.
  4) Ensure hourly infusion rate observations are taken and recorded.

- Note the time of the power failure to help to estimate the period of back up power available on equipment in use. Some newer devices may be able to indicate battery back up power available.

Communication:
- Inform the Unit Bleep holder, who will escalate the information via the Directorate Escalation Policy as required. If no contact can be made with the Unit Bleep Holder contact the Duty Matron via Switchboard.

continued

- Use discretion with regard to informing patients since staff should not wish to cause undue concern.

Other Equipment:

- Check the battery power status of all essential equipment / devices i.e. Dynamaps, SATS monitors etc.
- Identify spare equipment available in the event of the loss of battery reserves for essential equipment.
- Check the Emergency Equipment i.e. Defibrillator is working on battery back up power.
- Try to locate an alternative device from another area if necessary.
- Contact the Unit Bleep holder if no alternative device is immediately available.
- Identify any patients being nursed on inflatable mattresses. Risk assess the situation and plan for potential transfers to alternative beds / mattresses depending upon anticipated timescales for return of power (Do not task patients / staff with unnecessary moves if by the time the moves have been done, power is restored). In some circumstances, it may be necessary to use the beds of more ambulant patients as a short term measure.
- Locate the wards supply of manual sphygmomanometers and deploy for use in physiological monitoring.

Safety:

- Ensure that any patients, whose pressure relieving mattresses fail, receive regular pressure area care. This should be recorded.
- Outside daylight hours, patients should be asked to remain on their beds / at their bedsides, and not to mobilise without a nurse escort.
- Patients will need to be given a means of attracting a nurse's attention in the absence of buzzers. If bells are available, these should be given to patients. In the absence of bells, make-shift systems such as a spoon to be rattled against a cup could be used.
- Identify patients requiring close supervision / regular physiological monitoring and ensure they receive appropriate care. Note that security systems may not work, so close supervision of patients who have a tendency to "wander" should be maintained.

Waste Disposal:

- In the absence of a working sluice machine, bedpans and urinals may need to be emptied in the sluice hopper, and cleaned manually using appropriate detergents (Chlorclean or detergent and Sodium hypochlorite solution). This process CAN be used for waste from infected patients, such as those with Clostridium Difficile. Alternatively, use disposable bedpans / urinals and discard used items and products in clinical waste bags.
- Staff must be made aware of their responsibilities regarding Infection Control and Health and Safety, and must wear personal protective equipment (PPE) such as aprons, gloves and masks / goggles as necessary, and must comply with COSHH regulations when handling detergents.

Meals:

- In the absence of facilities for producing hot drinks, cold alternatives should be offered.
- A limited number of large dispensing flasks may be obtained from the Catering Department to enable hot water for drinks to be transported to the ward from an area unaffected by the power disruption.
- Preparations should be made in conjunction with the Catering Manager, for the provision of sandwiches and cold meals in the absence of hot meal trolleys.

continued

- Fridge temperatures should be monitored, and fridge contents disposed of as necessary. In liaison with Catering Services, once power supply has been restored, replacement foods should be obtained.

Security:

- Be vigilant regarding access and exit to the ward, especially with confused and vulnerable patients.
- There may be engineers etc. coming and going. Please ensure ID is shown.

IT:

- Manual requests for tests and investigations may need to be made. You may need to use a runner for this.
- Paper records of all patient movement i.e. transfers and discharges must be maintained, for inputting once power and computer access returns.

Ventilation:

- If the air conditioning fails (seasonal), windows should be opened where possible to maintain a comfortable temperature.

REMAIN IN COMMUNICATION WITH YOUR UNIT BLEEP HOLDER / MATRON OR IF NOT AVAILABLE, THE DUTY MATRON.

YOU WILL RECEIVE ADVICE FROM THE ABOVE CONTACT REGARDING ANY FURTHER ACTION TO BE TAKEN.

Internal Incident Plan

ACTION CARD

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

PIPED MEDICAL GASES FAILURE ON WARDS AND DEPARTMENTS

In the event of an interruption of piped medical gases supply to a single ward or department, the fault will need to be reported immediately to the Estates Department.

Action Plan:

The nurse in charge should do, or delegate the following duties to staff:

Report:

- Report the fault to Estates Helpdesk ext: 68686, this is a 24 hour number. Ensure that the Estates Department is aware of the time of piped medical gases supply failure, precise location, effect, impact and risks.
- Try to ascertain an estimated time period for the disruption / resolution.

Oxygen:

- Switch off all piped oxygen flow meters.
- Risk assess which patients must continue to receive oxygen therapy.
- Locate the ward or department's supply of portable oxygen cylinders. Ensure that there are sufficient supplies of flow meters, keys, connectors and cylinder holders when converting from piped oxygen to portable oxygen cylinder supply.
- Seek assistance with locating the required equipment and sufficient oxygen cylinder supplies from the Unit Bleep holder.

Medical Air:

- If applicable, see local Plan.

Nitrous Oxide:

- If applicable, see local Plan.

Suction:

- Switch off all suction flow meters that are delivered via wall units.
- Risk assess which patients must continue to receive suction.
- Locate the ward or department's supply of portable suction equipment (these should be checked daily).
- Seek assistance with locating the required equipment from the Unit Bleep holder.

Waste Anaesthetic Gas Scavenging:

- If applicable, see local Plan.

Communication:

- Inform the Unit bleep holder, who will escalate the information via the Directorate Escalation Policy as required. If no contact can be made with the Unit Bleep Holder contact the Duty Matron via Switchboard.

continued

- Use discretion with regard to informing patients since staff should not wish to cause undue concern.

Safety:

- Identify patients requiring close supervision / regular physiological monitoring and ensure they receive appropriate care.
- Ensure patients, relatives and staff are aware of the presence of portable cylinders and other equipment that may increase the risk of tripping / falling.
- Staff should be vigilant regarding the storage and security of medical gas cylinders. Any discrepancies in stock or any unauthorised movement of medical gas cylinders should be immediately reported to **Pharmacy Department**, and if necessary, to **Security**.

Security:

- There may be engineers etc. coming and going. Please ensure that ID is shown.

REMAIN IN CONTACT WITH YOUR UNIT BLEEP HOLDER / MATRON OR IF NOT AVAILABLE, THE DUTY MATRON.

YOU WILL RECEIVE ADVICE FROM THE ABOVE CONTACT REGARDING ANY FURTHER ACTION TO BE TAKEN

Annex 3

Good Practice Example

Business Impact Assessment
North Yorkshire Local Resilience Forum

SHEET 1 : SIMPLIFIED BUSINESS IMPACT ASSESSMENT (BIA)

1. List your organisations Key Functions in priority order.

Key Functions (Priority Order)
1.
2.
3.
4.
5.
6.

2. Using the guidance set out below undertake a Business Impact Analysis of your department, filling in your answers to the following questions on the blank BIA Pro-forma (Sheet 2) under the relevant headings :

PEOPLE	PREMISES	PROCESSES	PROVIDERS	PROFILE
Key Staff : What staff do you require to carry out your key functions?	**Buildings :** What locations do your department's key functions operate from? (Primary site, alternative premises)	**IT :** What IT is essential to carry out your key functions?	**Reciprocal Arrangements :** Do you have any reciprocal agreements with other organisations?	**Reputation :** Who are your key stakeholders?
Skills / Expertise / Training : What skills / level of expertise is required to undertake key functions?	**Facilities :** What facilities are essential to carry out your key functions?	**Documentation :** What documentation / records are essential to carry out your key functions, and how are these stored?	**Contractors / External Providers :** Do you tender key services out to another organisation, to whom and for what?	**Legal Considerations :** What are your legal, statutory and regulatory requirements?
Minimum Staffing Levels : What is the minimum staffing level with which you could provide some sort of service?	**Equipment / Resources :** What equipment / resources are required to carry out your key functions?	**Systems & Communications** What systems and means of communication are required to carry out your key functions?	**Suppliers :** Who are your priority suppliers and whom do you depend on to undertake your key functions?	**Vulnerable Groups :** Which vulnerable groups might be affected by failing to carry out key functions?

SHEET 2 : BIA PRO-FORMA FOR YOUR DEPARTMENT (Function……)

PEOPLE	PREMISES	PROCESSES	PROVIDERS	PROFILE
Key Staff :	**Buildings :**	**IT :**	**Reciprocal Arrangements :**	**Reputation :**
Skills / Expertise / Training :	**Facilities :**	**Documentation :**	**Contractors / External Providers :**	**Legal Considerations :**
Minimum Staffing Levels :	**Equipment / Resources :**	**Systems & Communications**	**Suppliers :**	**Vulnerable Groups :**

SHEET 3 : CONSIDERATIONS FOR INCREASING YOUR ORGANISATIONS RESILIENCE

PEOPLE	PREMISES	PROCESSES	PROVIDERS	PROFILE
Key Staff : Can staff be contacted out of hours? Could extra capacity be built into your staffing to assist you in coping during an incident.	**Buildings :** Could you operate from more than one premise? Could you relocate operations in the event of a premise being lost or if access to the premise was denied?	**IT :** Is data backed-up and are back-ups kept off site? Do you have any disaster recovery arrangements in place?	**Reciprocal Arrangements :** Do you have agreements with other organisations regarding staffing, use of facilities in the event of an incident?	**Reputational Damage :** How could reputational damage to your organisation be reduced? How could you provide information to staff and stakeholders in an emergency (e.g. press release)?
Skills / Expertise / Training : Could staff be trained in other roles? Could other members of staff undertake other non-specialist roles, in the event of an incident.	**Facilities :** Are any of your facilities multi-purpose? Are alternative facilities available in the event of an incident?	**Documentation :** Is essential documentation stored securely (e.g. fire proof safe, backed-up)? Do you keep copies of essential documentation elsewhere?	**Contractors / External Providers :** Do you know of alternative contractors or are you reliant on a single contractor? Do your contractors have contingency plans in place? Could contractors be contacted in the event of an incident?	**Legal Considerations :** Do you have systems to log decisions ; actions ; and costs, in the event of an incident?
Minimum Staffing Levels : What is the minimal staffing level to continue to deliver your key functions at an acceptable level ? What measures could be taken to minimise impacts of staff shortfalls?	**Equipment / Resources :** Could alternative equipment / resources be acquired in the event of an incident / disruption? Could key equipment be replicated or do manual procedures exist?	**Systems & Communications** Are your systems flexible? Do you have alternative systems in place (manual processes)? What alternative means of communication exist?	**Suppliers :** Do you know of suitable alternative suppliers ? Could key suppliers be contacted in an emergency?	**Vulnerable Groups :** How could vulnerable groups be contacted / accommodated in the event of an incident?

SHEET 4 : USING BUSINESS IMPACT ANALYSIS TO BUILD A PLAN

	BIA Identifies your requirements for continuing your key functions	Business Continuity Plan Documents how your requirements identified in the BIA can be achieved
PEOPLE	• Key Staff • Key Skills • Expertise / competence required • Minimum staffing levels required to continue / recover key functions	• Notification / invocation procedure / protocol • Management structure for dealing with an incident • Information and advice to staff (response procedures) • Key staff / contact list (including out of hours details) • Multi skill training in key areas • Reciprocal Arrangements to cover staff short falls • Home working • Staff welfare issues
PREMISES	• Key facilities • Key Equipment • Key Resources • Specialist Equipment • Security / restrictions • Alternative sites • Alternative facilities	• Loss / damage assessment • Site security • Relocation arrangements / protocol • Inventories of equipment / resources and details of how to recover these • Salvage, site clearance and cleaning arrangements
PROCESSES	• Key processes • Critical periods • Key IT systems / applications • Key documentation / data • Record keeping requirements • Key communication requirements	• Action cards for recovery of key processes • Checklists • Copies / Back-ups / safe storage (recovery procedure) • Contingency procurement arrangements • Documented manual procedures • Data recovery procedures
PROVIDERS	• Key dependencies (supply and receipt) • Key suppliers • Key contractors / service providers / suppliers • Reciprocal arrangements in place with other organisations	• Contact details for key providers / contractors / suppliers / support services • Alternative suppliers (required for key functions) • Alternative providers (required for key functions) • Alternative contractors (required for key functions) • Resilience capability of suppliers / providers / contractors to business disruption • Third party business continuity arrangements
PROFILE	• Key stakeholders • Legal / statutory / regulatory requirements • Vulnerable groups	• Communication strategy / plan / procedures • Stakeholder liaison (regulator, clients, unions) • Media liaison • Public information / advice • Notification of at risk groups / alternative care arrangements

Annex 4

A suggested BCM Audit checklist for use by NHS organisations

This was originally produced by John Sharp, BCM Consultant Kiln House Associates, and Cabinet Office Civil Contingencies Secretariat

Stages	Key Issues	Example Evidence	Rating
BCM Programme	Responsibility for BCM issues is clearly defined within the organisation at the corporate management level.	Named executive director accountable for BCM policy and implementation Reports to senior management groups	1-2-3-4-5
	BCM Manager or Co-ordinator appointed	Named individual in post responsible for implementing and maintaining the BCM programme	1-2-3-4-5
	BCM is formalized through the organisations policy and procedures	A BCM policy exists The BCM policy is published internally and externally	1-2-3-4-5
	Responsibility for business continuity issues is well embedded within individual services or management units	BCM is included in job descriptions and skill sets of service and support managers. BCM responsibilities enforced by inclusion in organisation's appraisal, reward and recognition policies.	1-2-3-4-5
	Responsibility for business continuity issues is well embedded within the organisation.	There is a programme in place raising awareness throughout the organisation and its key stakeholders. Feedback mechanisms exist whereby functional managers and staff can flag up BCM issues Evidenced through minutes of meetings and reports. Induction programmes include awareness of BCM.	
	Assurance of organisation's BCM capability	KPIs set for BCM implementation and maintenance. BCM responsibilities reviewed by the organisations audit process.	1-2-3-4-5
Understanding the Organisation	Identification of the organisation's objectives, stakeholder obligations, statutory duties and environment in which the organisation operates	Analysis of stakeholder obligations and expectations. Listing of statutory duties	1-2-3-4-5
	Key services and products delivered by and on behalf of the organisation have been identified and have been agreed by the executive board	Documented procedures for identifying and reviewing key services and products. Executive board minutes confirming key services and products.	1-2-3-4-5
	Critical functions, processes and supporting resources, within and without the organisation, that are needed to delivery the key services and products have been identified.	Documentation detailing critical functions, processes and supporting resources. Mapping of critical suppliers and partners	1-2-3-4-5
	Risk assessment has been used on the critical activities and supporting resources to focus effort on the areas of greatest need	Documented procedures to review and rank risk. Identification of 'single points of failure'	1-2-3-4-5

	Countermeasures exist to minimise risks that have been identified, including measures to combat potential loss of information.	Documented evidence of risk mitigation covering people, systems, information, premises and equipment and suppliers..	1-2-3-4-5
	Identification of the impact over time on the organisation and its stakeholders of the loss of any key service or product	A structured business impact analysis (BIA) process exists for the organisation that prioritises key services and products. A documented BIA that covers the key services and products of the organisation. Executive board minutes confirming BIA.	1-2-3-4-5
Determining BC Strategies	Development of appropriate strategies to limit, over time, the impact of the loss of key services and products on the organisation and its stakeholders	Documented strategies to support each key service and product. Strategies cover: people, premises, technology, information, supplies and stakeholders. Strategies take account of other Category 1 responder's actions, including those undertaken in an emergency situation. Executive board minutes confirming strategy selection and their required resource allocations.	1-2-3-4-5
	Development of strategies to minimise supplier disruption.	Procurement policies for key supplies that require BCM to be incorporated into supply contracts. Evidence of BCM included in supply contracts. Alternative suppliers identified.	
Developing and Implementing a BCM Response	Generic business continuity plans (BCPs) are developed which are flexible enough to maintain continuity of key services and products through a range of disruptive events	Structure and procedures for developing BCM plans. Reports. Meeting minutes Plans are clear, unambiguous and easy to use. Documented evidence of consultation with relevant staff in functional units and incorporation of feedback during plan development. BCM plans identify objectives, personnel involved, and command and control arrangements **BCPs contain references to other sources of relevant information, advice and other documentation.**	1-2-3-4-5
	A clear procedure exists for invoking the BCPs and delivering the response	Documented invocation and response procedures Key staff are identified in plans. Call out lists for BCM team members.	1-2-3-4-5
	BCPs have cleared ownership and are signed off at the appropriate level.	**It is clear who is responsible for ensuring that each section/department or site has a BCP.** All BCPs are signed off by plan owners.	1-2-3-4-5
	Appointment of a BCM team that is trained to deliver the BCPs	**Details of BCM team members.** **Training programme for BCM team members.** **Training record for BCM team members.**	1-2-3-4-5

	A clear procedure exists that ensures internal and external stakeholders are aware of what actions the organisation's will take if BCPs are activated	A communications policy document. Letters, emails, circulars, meeting minutes, internet and intranet pages which raise awareness of BCPs.	1-2-3-4-5
	Ensuring communications with stakeholders at the time of disruption to key services and products	BCPs contain arrangements for communicating with clients, customers, staff, stakeholders, partners, and the media. BCPs linked to Communication plans.	1-2-3-4-5
	Ensuring latest BCPs and supporting materials are always available.	Copies of plans and essential equipment/ documents (in electronic or hard copy) are easily available on and off- site. All plans are subject to document and version control processes.	1-2-3-4-5
	BCPs linked to other event plans within and without the organisation.	Links to emergency, recovery, major incident, communication plans, etc. are documented.	1-2-3-4-5
Exercising	Ensuring there is a balanced programme of exercise types which validates the full range of BCM capabilities	Records of regularly tested contact arrangements and exercises Planned exercises /test schedules.	1-2-3-4-5
	Exercise programmes have clear objectives	Exercise scenarios	1-2-3-4-5
	Ensuring there is a documented process for capturing and taking forward the lessons identified	Notes of exercise debriefs, 'lessons learnt' reports. Exercise review report to relevant management team. Action plans. Review of actions at plan preparation/review meetings. Evidence that the lessons learnt from exercises have been incorporated into BCPs.	1-2-3-4-5
Maintaining	Ensuring that the BCPs are kept up to date	There is an established and documented BCP review process. BCP review is built into the business planning cycle. Notes from review meetings. Issue of version controlled updates and acknowledgement systems for recipients	1-2-3-4-5
	Ensuring that when major changes to the organisation, the environment in which it operates or threat levels change the organisation's BCPs are reviewed and modified if appropriate.	There is a mechanism to identified trigger BCP review points. Notes from review meetings. Actions plans Review of actions at plan preparation/review meetings	1-2-3-4-5
Reviewing	A clear mechanism is in place for measuring the effectiveness of BCM arrangements	BCM review programme Self assessment reports Internal audit reports Benchmarking against standards (e.g. BS25999) and guidelines External reviews by peers from other services, partner authorities, etc.	1-2-3-4-5
	Ensuring that the review process drives improvement by identifying lessons, and appropriate action is taken	Review reports to relevant management team. Action plans. Review of actions at BCM review meetings. Evidence that the lessons learnt from reviews have been incorporated into the organisations BCM processes.	1-2-3-4-5

Links to useful resources

NHS Resilience

The NHS Resilience Project is tasked with improving resilience throughout the NHS in order to ensure continuous operational delivery of healthcare services when faced with a range of disruptive challenges.

http://www.dh.gov.uk/en/Managingyourorganisation/Emergencyplanning/DH_079649

British Standards Institution

The BSI leads in advocating, defining and implementing best practice across every field of human endeavour including business continuity.

http://www.bsigroup.co.uk/en/

UK Resilience

This website exists to provide a resource for civil protection practitioners, supporting the work which goes on across the United Kingdom to improve emergency preparedness.

http://www.ukresilience.gov.uk/

Good practice guidance on BCM training can be found at:

http://www.ukresilience.info/preparedness/ccact/good_practice/awareness_training.aspx

Continuity Central

Continuity Central provides a constantly updated one-stop resource of business continuity.

http://www.continuitycentral.com/

Cabinet Office

http://www.cabinetoffice.gov.uk/

The Cabinet Office had been undertaking work in a practioners group to look at best practice in BCM. It includes at least one NHS example. The link to this work is below:

http://www.ukresilience.gov.uk/preparedness/ccact/good_practice.aspx

An agreed methodology for risk assessment is available on the Cabinet Office website.

http://www.ukresilience.gov.uk/preparedness/risk.aspx

Civil Contingencies Secretariat

The Civil Contingencies Secretariat has developed, in partnership with stakeholders, this is an ideal document for NHS organisations to benchmark where they are with BCM. This toolkit can be found at:

http://www.preparingforemergencies.gov.uk/bcadvice/bcm_toolkit_active1.pdf

The Civil Contingencies Secretariat has provided details of Exercising Good Practice which can be obtained via their website at`;

http://www.ukresilience.info/preparedness/ccact/good_practice/exercising.aspx

NHS Emergency Planning Guidance

The NHS Emergency Planning Guidance gives plans and advice on preparing for specific types of disasters and attacks,

http://www.dh.gov.uk/emergencyplanning

The NHS Strategic Command Arrangements are to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081507

NHS Commissioning

Commissioning resilience is fundamental to ensure that all organisations are able to achieve robust arrangements for dealing with incidents. In December 2007, DH produced a guidance document called 'Principles and Rules for Cooperation and Commissioning' (Gateway reference number: 9244). It is recommended that commissioners consider this document to provide clear statement of principles and rules for cooperation and competition when commissioning or providing services.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779

The Royal College of General Practitioners

The Royal College of General Practitioners has published 'Service Continuity Planning Framework' which provides a suggested plan template. This is due to be revised in due course. A link to the current document is given below.

http://www.rcgp.org.uk/pdf/serviceCon_RCGPServiceContinuityPlanningFrameworkWorkedExample.pdf

Glossary and Acronyms

GLOSSARY AND ACRONYMS

Based on and adapted from the glossary to *Emergency Preparedness* (Civil Contingencies Secretariat) and other sources.

Additional information can be found in the Glossary and Acronyms supporting the NHS Emergency Planning Guidance 2005

http://www.dh.gov.uk/emergencyplanning

A

(The) Act

The *Civil Contingencies Act 2004*. This Act sets the framework for civil protection in the UK.

B

Bronze

See Operational Control

Business Continuity Management (BCM)

A management process that helps manage the risks to the smooth running of an organisation or delivery of a service, ensuring that the business can continue in the event of disruption.

Business Continuity Plan (BCP)

A plan to facilitate BCM, ensuring that an organisation can continue to perform its ordinary functions, whatever the circumstances.

Business Impact Assessment

The process of analysing business functions and the effect that business disruption might have upon them.

BS-25999 Parts 1&2

BS 25999 has been developed by the British Standards Institution, using a broad based group of world-class experts representing a cross-section of industry sectors and the government to establish the process, principles and terminology of BCM.

C

Capability

A demonstrable capacity or ability to respond to and recover from a particular threat or hazard. Originally a military term, it includes personnel, equipment, training and such matters as plans, doctrine and the concept of operations.

Capability Gap
The gap between the current ability to provide a response and the actual response assessed to be required for a given threat or hazard. Plans should be made to reduce or eliminate this gap, if the risk justifies it.

Capabilities Programme
The UK Capabilities Programme comprises 17 capabilities that are either structural (e.g. regional response), functional (e.g. decontamination) or essential services (e.g. financial services).

Category 1 Responder
A local responder organisation listed in Schedule 1 Part 1 of the *Civil Contingencies Act* likely to be involved with a central role in the response to most emergencies.

Category 2 Responder
A local responder organisation (though it may not be locally based) listed in Schedule 1 Part 3 to the *Civil Contingencies Act* and likely to be heavily involved in some emergencies or in preparedness for them.

Chemet
A scheme administered by the Meteorological Office, providing information on weather conditions as they affect an incident involving hazardous chemicals.

The Civil Contingencies Act 2004
The *Civil Contingencies Act 2004*. This Act sets the framework for civil protection in the UK.

Civil Defence
Preparedness by the civil community to deal with hostile attack.

Civil Protection
Preparedness to deal with a wide range of emergencies from localised flooding to terrorist attack.

Command and Control
Principles adopted by an agency acting with full authority to direct its own resources (both personnel and equipment).

Command
The authority for an agency to direct the actions of its own resources (both personnel and equipment).

Community Resilience
The ability of a local community to withstand an emergency successfully because of effective emergency and business continuity preparedness by public and private sector groups.

Community Risk Register (CRR)
An assessment of the risks within a local resilience area agreed by the Local Resilience Forum as a basis for supporting the preparation of emergency plans.

Consequences
The perceived or estimated potential impact resulting from the occurrence of a particular hazard, measured in terms of the numbers of lives lost, people injured, the scale of damage to property and the disruption to a community's essential services and commodities.

Control
The authority to direct strategic and tactical operations in order to complete an assigned function and includes the ability to direct the activities of other agencies engaged in the completion of that function. The control of the assigned function also carries with it a responsibility for the health and safety of those involved.

Control of Major Accident Hazards Regulations 1999 (COMAH)
Regulations applying to the chemical industry and to some storage sites where threshold quantities of dangerous substances, as identified in the Regulations, are kept or used.

Co-ordinating Group
A group comprising the senior representative at the scene of a major incident from each service or agency present. The group is normally chaired by the police and decides on actions to be taken.

Counter Terrorism Security Advisers (CTSA)
Police officers who provide advice on preventing and mitigating the effects of acts of terrorism.

D

Damage
Physical destruction, corruption of information, or loss of beneficial social phenomena (e.g. trust).

Data Protection Act
The *Data Protection Act 1998* came into force in March 2000. It requires organisations which hold data about individuals to do so securely and to use it only for specific purposes. It also gives an individual the right, with certain exemptions, to see that personal data.

E

Emergency

An event or situation which threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.

Emergency planning (EP)

Maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of an emergency.

Exercise

A simulation to validate an emergency plan or rehearse its procedures.

Exercise Programme

Planned series of exercises to validate plans and to train and develop staff competencies.

F

Freedom of Information Act

This Act allows the public access, regardless of nationality or country of residence, to information held by public authorities or anyone providing services for them.

G

Gold

See Strategic Control

H

Hazard

An accidental or naturally occurring phenomenon with the potential to cause physical (or psychological) harm to members of the community (including loss of life), damage or losses to property, and/or disruption to the environment or to structures (economic, social, political) upon which a community's way of life depends.

Hazard Assessment

A component of the risk assessment process in which identified hazards are assessed for future action.

Hazard Identification

A process by which potential hazards are identified.

Hot Zone

Area of contamination in a CBRN incident. This zone will be surrounded by the inner cordon. Access to this zone will only be permitted to personnel with the appropriate personal protective equipment (PPE). Decontamination will take place at the hot zone/warm zone boundary.

I

Impact
The scale of the consequences of a hazard or threat expressed in terms of a reduction in human welfare, damage to the environment and loss of security.

Incident Response Structure
An Incident Response Structure (IRS) supports all levels of activities that take place during a disruptive event.

Integrated Emergency Management (IEM)
The process of emergency management carried out across partner bodies so that arrangements are coherent and support each other. An approach to preventing and managing emergencies that entails five key activities - assessment, prevention, preparation, response and recovery. IEM is geared to the idea of building greater overall resilience in the face of a broad range of disruptive challenges

J

Joint Working
A single programme being delivered jointly by a number of organisations.

K

L

Local Resilience Forum (LRF)
A process for bringing together all the Category 1 and 2 responders within a local police area for the purpose of facilitating co-operation in fulfillment of their duties under the Act.

Local Responder
Organisations which respond to emergencies at the local level – including Category 1 and 2 bodies, and others without statutory obligations under the Act.

M

Major Incident
Any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the local authority.

Maximum Tolerable Period of Disruption
The timeframe during which a recovery must become effective before an outage compromises the ability of the organisation to achieve its business objectives. consider the contractual, regulatory and statutory requirements

Media Plan
A key plan for ensuring co-operation between emergency responders and the media in communicating with the public during and after an emergency.

Multi-agency Plan
A plan, usually prepared and maintained by a lead responder, on behalf of a number of organisations who need to co-ordinate and integrate their preparations for an emergency.

Multi-level Plan
A plan, usually initiated and maintained by central government or a regional office, which relies on the participation and co-operation of local responders. The plan will cover more than one level of government.

Mutual Aid
An agreement between responders, within the same sector or across sectors and across boundaries, to provide assistance with additional resource during an emergency which may go beyond the resources of an individual responder.

N

O

P
Plan Maintenance
Procedures for ensuring that plans are kept in readiness for emergencies and that planning documents are up to date.

Plan Validation
Measures to ensure that a plan meets the purpose for which it was designed, through exercises, tests, staff 'buy-in' and so on.

Planning Assumptions
Descriptions of the types and scales of consequences for which organisations should be prepared to respond. These will be produced by aggregating elements of the risk assessment.

Public awareness
A level of knowledge within the community about risk and preparedness for

emergencies, including actions the public authorities will take and actions the public should take.

Q

R

Recovery
The process of restoring and rebuilding the community, and supporting groups particularly affected, in the aftermath of an emergency.

Recovery Time Objective
The Recovery Time Objective (RTO) is the duration of time and a service level within which a business process must be restored after a disaster in order to avoid unacceptable consequences associated with a break in continuity.

Regional Civil Contingencies Committee (RCCC)
Regional body which meets during an emergency when a regional response or other action at regional level is required.

Regional Resilience Director (RRD)
Head of Regional Resilience Team.

Regional Resilience Forum (RRF)
A forum established by the government offices of the region to discuss civil protection issues from the regional perspective and to create a stronger link between local and central government on resilience issues.

Regional Resilience Team (RRT)
Small team of civil servants within a government office of the region working on civil protection issues, headed by the Regional Resilience Director.

Resilience
The ability of the community, services, area or infrastructure to withstand the consequences of an incident.

Risk
Risk is a product of the likelihood of harmful consequences arising from particular identified hazards or threats and the potential impact of these upon people, services and the overall environment. It is a measure of the potential consequences of a contingency against the likelihood of it occurring. The greater the potential consequences and likelihood, the greater the risk.

Risk Assessment
A structured and auditable process of identifying hazards and threats, assessing their likelihood and impacts, and then combining these to provide an overall assessment of risk, as a basis for further decisions and action.

Risk Management
The culture, processes and structures that are directed towards the effective management of potential risks and adverse effects.

Risk Rating Matrix
Matrix of impact and likelihood for an event, to ascertain the risk.

Risk Treatment
A systematic process of deciding which risks can be eliminated or reduced by remedial action and which must be tolerated.

S

Scientific & Technical Advice Cell (STAC)
Scientific and Technical Advice Cell (STAC) should be available at the SCG/RCCC to offer health-related scientific advice for all incidents that require strategic co-ordination. The STAC will provide advice on health, public health, health protection and other scientific advice as part of the incident management process.

Sensitive information
Information which is not available to the public and which is:
(a) information which it would be contrary to interests of national security or public safety to disclose,
(b) information which would significantly harm the legitimate business interests of the subject of the information to disclose or
(c) information which is personal data for the purposes of the *Data Protection Act*, disclosure of which would breach the data protection principles under that Act.

Silver
See Tactical Control

Strategic Level (Gold)
A strategic level of management establishes a policy and overall management framework within which tactical managers will work. It establishes strategic objectives and aims to ensure long-term resourcing/expertise A Strategic Co-ordinating Group (SCG) may be formed to control of a whole incident and can be established at another organisation, usually the Police HQ. The 'blue light' services call their strategic control 'Gold'.

T

Tactical Level (Silver)

A tactical level of management provides overall management of the response to an emergency. Tactical managers determine priorities in allocating resources, obtain further resources as required, and plan and co-ordinate when tasks will be undertaken The District Emergency Centre (DEC) would operate therefore as a tactical level control. Representatives of other organisations will be accommodated to maximise co-ordination.
The 'blue light' services call their tactical control 'Silver'.

Threat

The intent and capacity to cause loss of life or create adverse consequences to human welfare (including property and the supply of essential services and commodities), the environment or security.

Threat assessment

A component of the risk assessment process in which identified threats are assessed for future action.

U

V

Voluntary Sector

Bodies, other than public authorities or local authorities, which carry out activities otherwise than for profit.

Vulnerability

The susceptibility of a community, services or infrastructure to damage or harm by a realised hazard or threat.

Vulnerable People

People present or resident within an area known to local responders who because of dependency or disability need particular attention during emergencies.

W

Warm Zone

Area surrounding the hot zone in a CBRN incident. The outer boundary of the warm zone will be the outer cordon. Decontamination will take place at the hot zone/warm zone boundary.

Warning and Informing the Public

Establishing arrangements to warn the public when an emergency is likely to occur or has occurred and to provide them with information and advice subsequently.

X

Y

Z

ACRONYMS

Acronyms used elsewhere in Emergency Planning Publications
Based on and adapted from the glossary to *Emergency Preparedness* (Civil Contingencies Secretariat) and other sources.

A
ALARP As Low as Reliably Practicable

B
BCI Business Continuity Institute
BCM Business Continuity Management
BCP Business Continuity Planning or Business Continuity Plan
BIA Business Impact Assessment

C
C&C Command and Control
Cat1 Category 1 Responder as defined by the *Civil Contingencies Act 2004*
Cat2 Category 2 Responder as defined by the *Civil Contingencies Act 2004*
CBRN Chemical, Biological, Radiological, Nuclear
CCA *Civil Contingencies Act 2004*
CCDC Consultant in Communicable Disease Control
CCR Community Risk Register
CCS Civil Contingencies Secretariat - Cabinet Office
COBR Cabinet Office Briefing Room (also known as COBRA)
COMAH *Control of Major Accident Hazards Regulations 1999*
COSHH Control of Substances Hazardous to Health
CRR Community Risk Register
CsCDC Consultants in Communicable Disease Control

D
DH Department of Health
DPA *Data Protection Act 1998*
DPH Director Public Health
DsPH Directors of Public Health

E
EA Environment Agency
EP Emergency planning
EPO Emergency Planning Officer

F
F&RS Fire and Rescue Service

FOI *Freedom of Information Act*

G
GCG Gold Coordinating Group
GOs Government Offices
GORs Government Offices in the Regions
Gold Strategic Control
GP General Practitioner

H
HAZMAT Hazardous Materials
HPA Health Protection Agency

I
IEM Integrated Emergency Management
IPE Individual Protective Equipment
IRS Incident Response Structure

J

K

L
LA Local Authority
LRF Local Resilience Forum(s)

M
MI Major Incident
MTPoD Maximum Tolerable Period of Disruption

N
NRF National Resilience Framework

O

P
PCT Primary Care Trust

Q

R
RA Risk Assessment
RCCC Regional Civil Contingencies Committee

RDPH Regional Director of Public Health
RIA Regulatory Impact Assessment
RRD Regional Resilience Directors
RRF Regional Resilience Forum(s)
RRT Regional Resilience Team
RTO Recovery Time Objective

S
SCG Strategic-Co-coordinating Group (Gold Control)
SHA Strategic Health Authority
Silver Tactical Control
STAC Scientific and Technical Advice Cell

T

U

V
VAS Voluntary Aid Societies – WRVS, St John Ambulance, St Andrew's Ambulance and British Red Cross Society

W

X

Y

Z