Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Evacuation and Shelter Policy

This is a new procedural document: Please read in full

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Author/reviewer: (this version)	Neil Colton – Fire Safety Advisor
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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1	8 February 2021	• This is a new procedural document, please read in full	Neil Colton

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1 INTRODUCTION

The NHS Emergency Planning, Response and Recovery National Framework (2015) identifies evacuation and shelter as a key priority for NHS Trusts.

This policy provides a framework for the Trust to plan, prepare and respond for evacuating and sheltering patients, staff and others from, or within, its inpatient settings, including whole site evacuation.

While this policy concentrates on the shelter and evacuation of inpatient sites, the principles are sufficiently flexible to be adapted for use in other Trust buildings or facilities.

Evacuation planning is part of broader emergency planning and preparedness and takes account of the Trust's:

- Major Incident Plan;
- Fire Response Plans and Evacuation Strategies;
- Business Continuity Management plans;
- Lockdown Policy
- Yorkshire & Humberside and East Midlands Ambulance Divert Policy

2 PURPOSE

This policy will help the Trust to:

- Support a partial or total evacuation involving patients, visitors and staff;
- Ensure all Trust inpatient facilities have plans in place to effect an evacuation if required;
- Maintain the services being evacuated whenever possible;
- Identify and support vulnerable people being evacuated.

This Policy utilises the Fire Evacuation Strategies and associated local evacuation plans.

This policy seeks to:

- Enable a robust and effective response to an incident requiring the partial / full evacuation of an inpatient facility;
- Allow staff to act effectively in support of an evacuation;
- Provide appropriate information to the Trust's senior managers;
- Provide a risk-based process to enable the decision to evacuate and shelter.

The Trust is required to have business continuity arrangements in place to reduce the risk of evacuation in predictable circumstances.

The Trust owes a duty of care to its patients and staff. Although in a dynamic situation the emergency services would instruct that an evacuation should be commenced. This remains on the understanding that it is the Trust's sole responsibility to ensure suitable and sufficient plans are in place to evacuate one of its facilities.

The Trust has responsibilities under the:

- Health and Safety at Work Act 1974, (section 2(1) and (section 2(2);
- The Management of Health and Safety at Work Regulations 1999 (regulation 3), (regulation 4 and Schedule 1), (regulation 8(1)), (regulation 8(1)(a) and (b)) and regulation 4(4);
- Safety Signs and Signals Regulations 1996;
- Regulatory Reform (Fire Safety) Order 2005 (article 14(1) and (article 14 (2);
- Department of Health Fire code guidance (HTM 05-01) Regulated Activities Regulations Section 9 sub section (2), Section 7 sub section (1 and 2) and Section 10 sub section (2).

3 DUTIES AND RESPONSIBILITIES

During an emergency evacuation and shelter incident the **most senior person on duty**, normally the Matron, Clinical Site Manager, Ward Manager or Senior Nurse in charge will be responsible for taking the decision to activate an immediate local evacuation and shelter plan. The individual roles and responsibilities for Trust staff and supporting partner agencies are detailed below.

The **Board of Directors** is responsible for approving the Evacuation and Shelter Policy and to receive ongoing assurance reports as to the application and performance of the Policy.

The **Chief Executive Officer (CEO)** has overall responsibility for ensuring the Trust has an Evacuation and Shelter Policy and local plans in place and will lead the tactical response to any evacuation incident.

The **Chief Operating Officer (COO)** that Accountable Emergency Officer will ensure local plans are regularly tested to assure the Trust response is as effective as possible and is accountable for ensuring all evacuation incidents are reviewed to ensure lessons are learned.

The **Emergency Planning Officer (EPO)** has responsibility for the Trust's evacuation plans and processes, supporting the testing and exercising local evacuation and shelter plans at appropriate intervals and communicating Trust plans to all key parties.

Divisional Directors/Heads of Departments will ensure local plans are developed, agreed, managed and monitored.

Local Managers (**and/or their deputies**) will:

- Develop, disseminate and implement the local evacuation and shelter based on risk assessments specific to their area;
- Facilitate and validate their local plans by regularly testing through table-top or live exercises; test the local plan on an annual basis;
- Maintain records of all training and testing undertaken;
- Fulfil the function of **Evacuation Co-ordinator** for their area of responsibility;
- Appoint appropriate deputies;
- Identify themselves to the Emergency Services Response Team and act as the Trust liaison at scene;
- Ensure good housekeeping of evacuation routes is maintained at all times;
- Support debriefing sessions after and evacuation and shelter incident.

The Fire Response Team will:

- Respond and attend the central point identified in the local plan;
- Await further instruction from the Evacuation Co-ordinator;
- Assist with evacuation and shelter should it be required.

Estates & Facilities will:

- Send appropriate technical representation to the evacuation to assist the **Evacuation Co-ordinator** and the emergency services;
- Support the isolation of utilities and other services should it be required and/or authorised.

All Trust Staff will make themselves familiar with their duties and actions required in their local evacuation plan.

4 PROCEDURE

4.1 Risk Assessment

There are many types of incident which may affect the Trust and its ability to maintain patient and staff safety. There are various risks which may result in a need to shelter patients and staff in places of greater safety or to activate partial or full site evacuation.

These can include:

- power and other utilities failure;
- adverse weather;
- flooding;
- fire;
- irritant fumes or hazardous materials release;
- hostage incident;
- external event such as a terrorist incident.

The different nature and severity of these risks will determine the level of evacuation and support required.

The primary purpose of any evacuation is to ensure the safety and security of patients and staff; this will be at the forefront of every decision. The decision to shelter or evacuate must be made based on the overall risk to patients, staff involved in their care and other members of the public who may be affected by the incident.

It is essential that a risk assessment underpins the site specific planning process. Site specific evacuation and shelter plans should be informed by risks most likely to impact the site and the wider local area using relevant resources including the Local Resilience Forum (LRF), Local Health Resilience Partnership (LHRP) and Trust EPRR Risk Registers.

Within each site, the risk assessment process should include the risks associated with the location(s) of certain types of patients in relation to the ease of evacuation. This risk assessment will not only direct mitigating measures but also lead the planning process.

4.2 Planning Assumptions

Local site-specific plans must identify possible places to shelter and triage patients. Plans should identify on-site and off-site shelter locations to hold patients in the initial stages of an evacuation. Planning should identify how patient care would be delivered in the short, medium and long term, depending on the cause of the evacuation.

Local plans should consider and plan for partial and complete evacuations; this should include suitable triage and sheltering areas outside the building. Planning should also identify the staff required in these areas in order to ensure the continued care of patients.

Where appropriate patient care and safety together with sufficient staff, medication and other resources cannot be maintained, it may be preferable for some patients and personnel to remain *in situ* rather than evacuate.

In extremis it is acknowledged in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It should also be noted some patients may experience greater harm by being moved than by not being moved.

The Trust will take into account the diverse needs of all people on site including patients, staff and visitors when developing Evacuation and Shelter Plans and will undertake assessment and planning in the pre-incident stage including engagement with partner organisations.

Planning will include:

- the development of local evacuation plans which are integral to the organisation's business continuity arrangements;
- local exercising as part of the overall EPRR training programme including suitable exercises to support the requirements of the site and the likely risks faced. It is acknowledged it is difficult to conduct a live exercise of these plans and other arrangements, such as table-top exercises, will be used;
- local plans will be based on a reasonable worst case scenario, taking account the requirements of different times of the day and days of the week and the numbers of staff on duty.

4.3 Activation Triggers

The decision to evacuate may be triggered by an internal incident.

Local staff may activate immediate shelter or partial evacuation plans to ensure the safety of patients e.g. in the event of a fire in their locality.

The decision to conduct whole site evacuation is the responsibility of the Chief Executive Officer (CEO) or the On Call Executive Director.

The Trust will take into account factors such as

- Risks patients and staff are exposed to;
- Nature and diverse needs of the patients being cared for on the site;
- Level of staffing available;
- Trigger for the evacuation;
- Time of day an evacuation may be needed;
- Command control structure which will be required.

4.4 Shelter

Building specific Fire Evacuation Strategies will identify an immediate shelter location, including holding areas appropriate to local needs. In the initial stages of evacuation a number of 'shelter in place' locations should be considered to include options both on-site, as well as healthcare settings off-site and non-healthcare settings off site.

Off-site shelter points should reflect an area of safety, away from the premises, where people can wait until they are either redirected to another place, hospital or taken home.

Key element for any 'off site' evacuation will be close liaison with the relevant local authority;

- Doncaster Royal Infirmary & Mexborough Montagu Hospital – Doncaster Council;
- Bassetlaw District Hospital – Bassetlaw District Council;

Each local authority has pre-designated Community Rest Centres remote from each hospital which can give the degree of safety required to care, triage and re-direct to the appropriate location.

The choice of shelter locations will be dynamically determined at the time of the evacuation and should include such factors as;

- Wind direction;
- Incident type and its geographic spread;
- Security and safety considerations.

The decision should be made in consultation with multi-agency partners including the Police Incident Commander, Local Authority partners and health tactical/strategic partners.

The command and control process of a hospital evacuation will be based on the existing Trust Major Incident Plan Command and Control Structure (CORP/RISK 1). This process is widely recognised and understood by all category 1 and 2 Responders, and provides for clarity in communication. The Trust has the capability of siting the Incident Control Room in a different location if the incident occurs on the Doncaster Royal Infirmary site, or off site, if necessary.

Command Structure; (also see below (pages 10 – 13) for detailed definitions)

- Strategic Sets strategic direction of organisation (makes decision to evacuate a building). Coordinates and liaises between partner organisations (working with NHS England Area Team and local authorities). Prioritises scarce resources.
- Tactical Coordinates activities and resources in an area of operations (i.e. a number of wards or floors or a building). Also interprets strategic direction set by strategic

group (develops and implements tactical plan for evacuation of building following strategic instruction to evacuate)

- Operational executes tactical plans – provides command and control for single functional area (i.e. ward or floor)

Strategic (Gold) Command

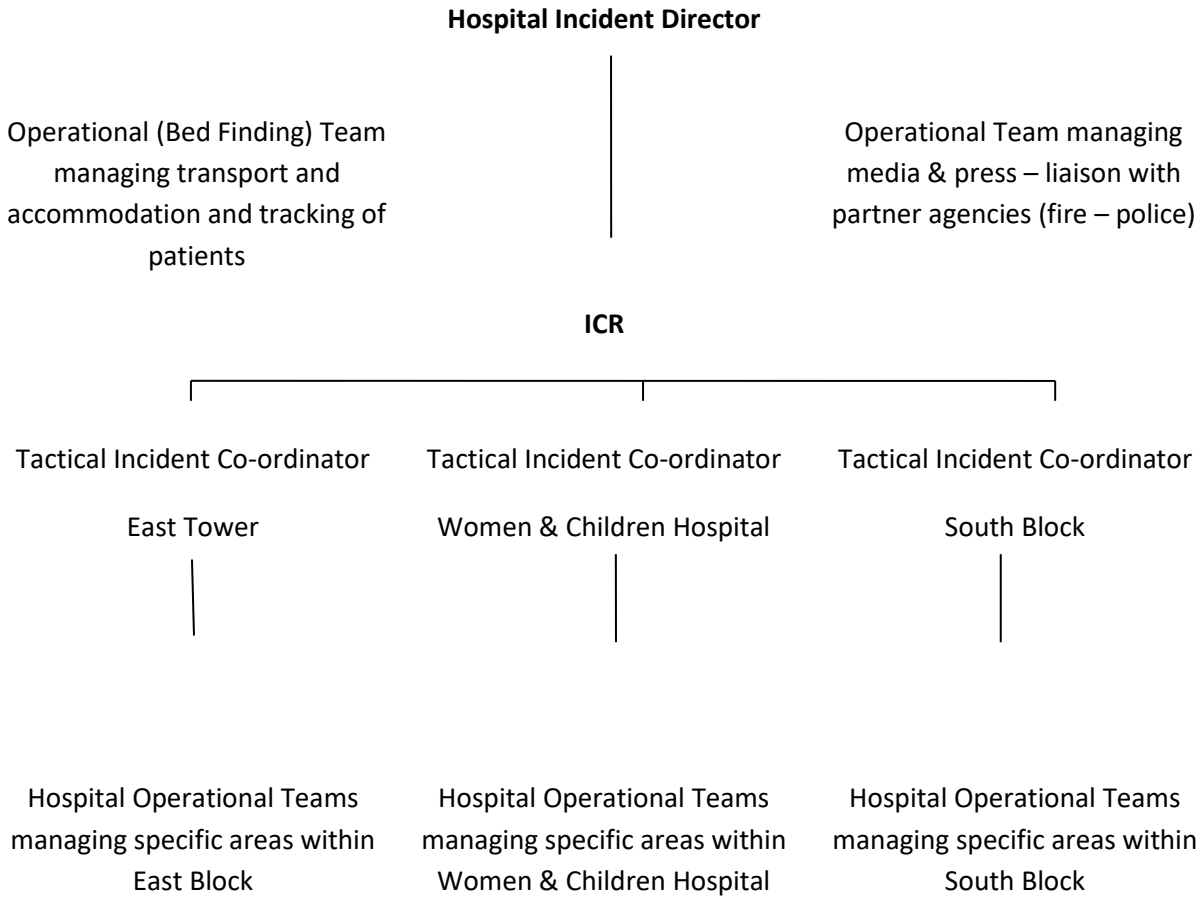
The Hospital Incident Control Team will be led by an Incident Director who will be the on-call executive/general manager. Command and Control will be established in line with the guidance set out in the Major Incident Plan.

The primary functions of the Incident Director are to:

- Formulate a strategic plan for the evacuation, and to communicate this with the Incident Co-ordinator leading the Tactical/Silver Team (s), multi-agency partners, and NHS England -North (Yorkshire and the Humber);
- Liaise with multi-agency partners to ascertain the method of transport and the onward destination of evacuated patients;
- Ensure that an identified and pre -planned recovery team are activated as part of the command and control process and that command staff are provided with easily identifiable role designated tabards;
- Dependant on the type of evacuation the Hospital Incident Control Team will need to establish a robust command and control structure. For a whole site evacuation it would be appropriate to establish separate Hospital Tactical Command Teams to manage specific areas of the site, including teams to manage specific areas such as transport, relocation of patients, or press and media (see example in diagram below).

NB: In the event that any ward or department identifies Evacuation Priority 3 and 4 patients (Table 4; page 15), (EP 3 and 4) and evacuation is Stage 1 or 2, this will be escalated immediately to the Executive Director 'on call' so that senior decision making is quickly available to manage the evacuation of this level of patient, and a Specialist Tactical Command team organised to co-ordinate the evacuation and manage the clinical demands of the patients identified. This includes, but is not exclusive to, such areas as Intensive Care Unit, Theatres, Renal Services, patients on general wards dependant on external assisted ventilation systems such as C-PAP/BiPAP.

Table 1: Example of a potential command structure for a site wide evacuation at DRI



The Incident Director and team should give specific consideration to the following:

- Early declaration of an internal major incident in order to mobilise support;
- Consider where the incident is taking place, and which patient areas are affected and early identification of potential challenges in evacuating complex, critically ill patients will enable senior support to be deployed to those areas;
- Identification of the locations of compressed gases and cylinders to inform police and fire services;
- Seek early advice and support from blue light services attending regarding the safety of evacuation versus shelter in situ;
- Advise partner organisations as soon as possible where patients are being evacuation to (Evacuation Muster Points – EMP);
- Early deployment of a communications Silver cell to ensure all key messages both within the organisation and externally, are despatched in a timely manner;
- Consider early divert of emergency ambulances, depending on where the evacuation event is taking place;
- At the point of Stand-down from the incident, ensure that sufficient time is given to staff within the hospital to reorganise work and patient care, before allowing any persons waiting to get back into the building, to re-enter. Clear communication to the public about the reasons should be articulated.

Tactical (Silver) Command

The Hospital Tactical Command Team will be led by a Tactical Incident Co-ordinator who will set up at a location as close to the safety cordon as is practical to do so and certainly within close (safe) proximity to the site/building/area being evacuated. This will be determined at the time by the Incident Control Room team.

The primary functions of the Incident Co-ordinator is to:

- Designate evacuation zones according to the reason for the evacuation. Inform Strategic Command of the zones for onward communication to multi agency partners;
- Instigate the triage and classification of all patients being evacuated;
- Maintain a list of all patients and staff being transferred to sites outside the hospital.

Operational (Bronze) Command

The Trust may need to set up one or more Hospital Operational Teams to manage specific activities, which could include the main evacuation area, and including any designated receiving areas, such as buddy areas and muster points. Information from all Hospital Operational Teams will be escalated to the Tactical Command Team.

The primary functions of the Hospital Operational Command Roles are to:

- Triage patients into priorities for evacuation;
- Evacuate the patients to the designated evacuation zones;
- Ensure accompanying patient records are with the right patient and patient evacuation sheets are completed for every evacuated patient;
- Provide assistance and expertise to ambulance services, including NHS, private or charitable ambulance services, with regard to individual patients' clinical needs.

4.5 Evacuation Levels and Stages

Table 2: Evacuation Levels

There are three levels when evacuation may be necessary or should be considered:

The levels when evacuation may be necessary and its implications Level	**Implication**
Level 1	No immediate threat to life or safety, but there is an incident on an adjoining floor or in an adjacent building (advance warning provided)
Level 2	A situation with no immediate threat, but one where the incident is likely to spread, or be prolonged so as to affect patient care in that area, from an adjoining area (advance warning provided)
Level 3	The situation where there is an immediate threat to life or safety (no advance warning provided)

The decision to shelter or evacuate should only be taken if, following a dynamic risk assessment, the risk to life of remaining *in situ* is assessed to be greater than the risk of evacuation.

Staged of Evacuation

The need for evacuation will depend on the incident. The type of incident will also influence the time available for evacuation and whether partial or full evacuation is required. Should evacuation be necessary, advance warning may allow staff and patients to prepare an efficient and effective evacuation.

Staged evacuation should be considered where different parts of premises are to be evacuated. Evacuation is undertaken in a controlled sequence with those parts of the premises expected to be at greatest risk being evacuated first.

The following stages apply:

Table 3: The Stages of an evacuation and the implications:

Stage	Implication
Stage 1	Evacuation of a single ward/department
Stage 2	Evacuation of one floor
Stage 3	Evacuation of an entire block/building
Stage 4	Evacuation of an entire site

Should evacuation become necessary in one ward/department there will be a variety of patient dependencies that need to be considered. The evacuation should be based on the concept of progressive horizontal evacuation, with only those people directly at risk from the effects of the incident being moved. This involves moving people at immediate risk to a primary holding area or place of temporary safety (Stage 1).

If the incident is not contained to one ward, a whole floor may need to be evacuated with patients moved vertically to a place of safety (Stage 2), as appropriate. The occupants may remain in the primary holding area until the incident is dealt with or await further evacuation to another area. This procedure should give sufficient time for non-ambulant and partially ambulant patients to be vertically evacuated to a place of safety.

It may become necessary to evacuate an entire block or zone (Stage 3). In addition, it may be that more than one block or zone is affected leading to the evacuation of the entire site (Stage 4).

Tracking staff during an evacuation is a challenge; however the Trust has a duty of care to know which staff are working within the building at any one time. The nurse/person in charge must be aware of staff are on duty.

Following evacuation, it is highly likely there will be a need to assess and reassess (re-triage) patients to assist with their appropriate allocation to other shelter places, for example another hospital, a nursing home or their own/relative's home.

4.6 Patient Management

Triage

Triage assists with making decisions on whom to evacuate and in what order; triage needs to be a dynamic process which helps determine, their mobility, the type of shelter and equipment required, the length of time to relocate the resources required when evacuating patients and the transport required for evacuation.

It is important in an evacuation that the most efficient and effective system is adopted to ensure the timescales taken to evacuate are kept to the very minimum while maximising patient and staff safety. To achieve this, each patient in each individual clinical area will be

prioritised in order of evacuation; it is generally the most mobile and least dependant patients who are the first to evacuate, whilst the patients with the highest dependencies remain until appropriate care and support is in place to facilitate their safe evacuation. This however depends on each differing situation and the Incident Control Team will undertake a dynamic risk assessment to determine and communicate the exact process of evacuation flow.

Patients are to be reviewed and classified for evacuation as follows:

Table 4

Evacuation Priority	Triage Assessment
First to be Evacuated	EP1 – patients requiring minimal assistance
Followed by	EP2 – Patients requiring some assistance
Followed by	EP3 – Patients requiring maximum assistance to move
Then finally	EP4 – Patients who will meet the risk-based evacuation principles as set out in the national ethical guidance.

The concept of moving patients in an evacuation situation is based on doing the 'most for the most'; by adopting a reverse triage approach set out below (table 5). The Trust will adopt this process in the event of a 'no notice' evacuation.

Once the evacuation has been undertaken and patients are in a place of relative safety the Trust will return to the nationally accepted triage regime where those patients with the highest needs are treated as the highest priority and will be moved onward to suitable locations consummate with their needs.

Table 5: Reverse Triage and Priorities for Onward Transfer

Triage Category	Reverse Triage Evacuation Priority	Transfer Priority Level	Priority for Onward Transfer
EP1	These patients require minimal assistance and can be moved **FIRST** from the ward. Patients are ambulatory and 1 x staff member can safely lead several patients who fall into this category to the holding area	**P3**	These patients will be moved **LAST** as transfers from the hospital to another healthcare/reception facility/discharge.
EP2	These patients require some assistance and should be moved **SECOND** in priority from the ward area. Patients may require wheelchairs or stretchers and 1-2 x staff members to aid transport	**P2**	These patients will be moved **SECOND** in priority as transfers from the scene of the incident to another care facility within the Trust or to another hospital

EP3	These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the ward area. These patients may at least require 2-3 x staff members to evacuate	**P1**	**FIRST:** These patients require maximum support to sustain life. These patients move once they are stable in the hospital holding area to another site or hospital
EP4	This category uses risk-based principles in accordance with Trust ethical guidance. Its invocation is only for the period of time the incident is 'live'. Patients who are in this category are **unlikely to survive evacuation** from the hospital and would require significant resources to move them. They should only be moved once all other patients have been evacuated and if sufficient resources are available.	**Risk-based**	These patients should only be transferred to another hospital if sufficient resources are available or if their remaining at the evacuated hospital endangers the lives of staff with them. Clinical care should be based on the outcome of the risk-based principles and in line with ethical guidance.

Evacuation Priority 1 - Independent or P3 Patients (Green Label)

Patients who can self-evacuate will be encouraged to do so with guidance but minimal assistance to a pre-designated Fire Assembly Point (FAP) or Emergency Muster Points as designated within Divisional Business Continuity Plans – Loss of Premises on site. Once at the FAP/EMP, these patients will be reclassified as Priority 3 patients and will be further evacuated off site if necessary, to:

- Community and local authority services i.e. reception centres;
- Other inpatient units if necessary;
- Go home with appropriate records.

Reception Centres will be supported by the evacuating Trust's staff and the Incident Control Team will delegate an appropriate member of staff as follows:

- A senior nurse with the authority to manage and support nurses and staff from other agencies (minimum Band 7);
- A senior manager to act a liaison officer for the hospital.

The Reception Centres may need additional staff and this will be coordinated by the local Multi-Agency Tactical Command.

- District nurses;
- A GP;
- GP Practice Nurses;
- Local pharmacist(s).

Evacuation Priority 2 - Dependant or P2 Patients (Yellow Label)

Patients who require some assistance to evacuate, this may involve the use of wheelchairs, beds, trolleys and ski pads etc.

These patients will need to be transferred to another facility that contains appropriate clinical equipment and with appropriate medical and nursing care. This may be off site in this or another Trust or a local facility.

Tactical Silver Command will allocate a specific FAP/EMP on site and staff it with the appropriate resources for the type of patients being transferred there until further decisions regarding onward transfer are agreed.

These locations will be detailed in each site specific evacuation plan but may be subject to change during a developing incident. This will be part of Tactical Silver Commander's decision making responsibilities in consultation with the Hospital Incident Control Room.

A list of patient's details, the care they need, any equipment and where they are re-allocated to must be maintained by the Hospital Silver Tactical Command. It is likely that most of these patients will need assisted transfers, but this will be clearly identified during consultation with the ambulance services and prior to the decision to transfer out of the FAP/EMP.

Communication with the Ambulance Service and other ambulance providers must be effective to ensure appropriate use of blue light transfers.

CLINICAL DECISION-MAKING IN EVACUATING COMPLEX HIGHLY DEPENDANT PATIENTS

NHS England EPRR: Planning for the Shelter and Evacuation of people on healthcare setting 2014

When considering whether to move a patient, there are a number of factors which need to be considered:

- Difficulty of movement, e.g. mobility, dependency and any equipment required to support the patient during evacuation;
- The time and number of people it would take to move a particular patient versus moving other patients also on the ward/clinic;
- The risk to the patient of them being moved;
- The risk to the patient of them remaining in situ.

The following evacuation priority descriptions are likely to trigger the above risk assessment on a patient by patient case.

Evacuation Priority 3 - Very Dependent or P1 Patients (Red Label)

Very dependant patients have clinical treatments and/or conditions that create a high dependency on staff and treatment. This will include those in critical care areas, operating theatres, coronary care units, patients on non-invasive ventilation systems and for those that evacuation would prove potentially life-threatening.

The Incident Control Team will designate a specialist Silver Command consisting of Clinical and managerial staff to manage the evacuation of EP3 patients to a pre-determined interim EMP ward and/or department, with the appropriate staffing skills and equipment that will ensure the clinical needs of EP3 patients are met while waiting for re-location to an appropriate permanent location. It is essential that accurate decision logs are maintained by this team in preparation for any consequent inquiry resulting from the evacuation.

Evacuation Priority 4 – Expectant or P4 Expectant Patients

The Expectant category arises when the Trust has to apply risk management principles which balance the need to evacuate large numbers of patients from an area or building and the consequential resources and time required to prepare these patients for evacuation against the ability of the hospital to respond to the clinical needs of every individual during the evacuation.

The evacuation triage category of 'Expectant' is used to determine those patients whose injuries or clinical support requirements are so extensive that they will not be able to survive evacuation and/or onward transportation balanced against the clinical care, resources and time available.

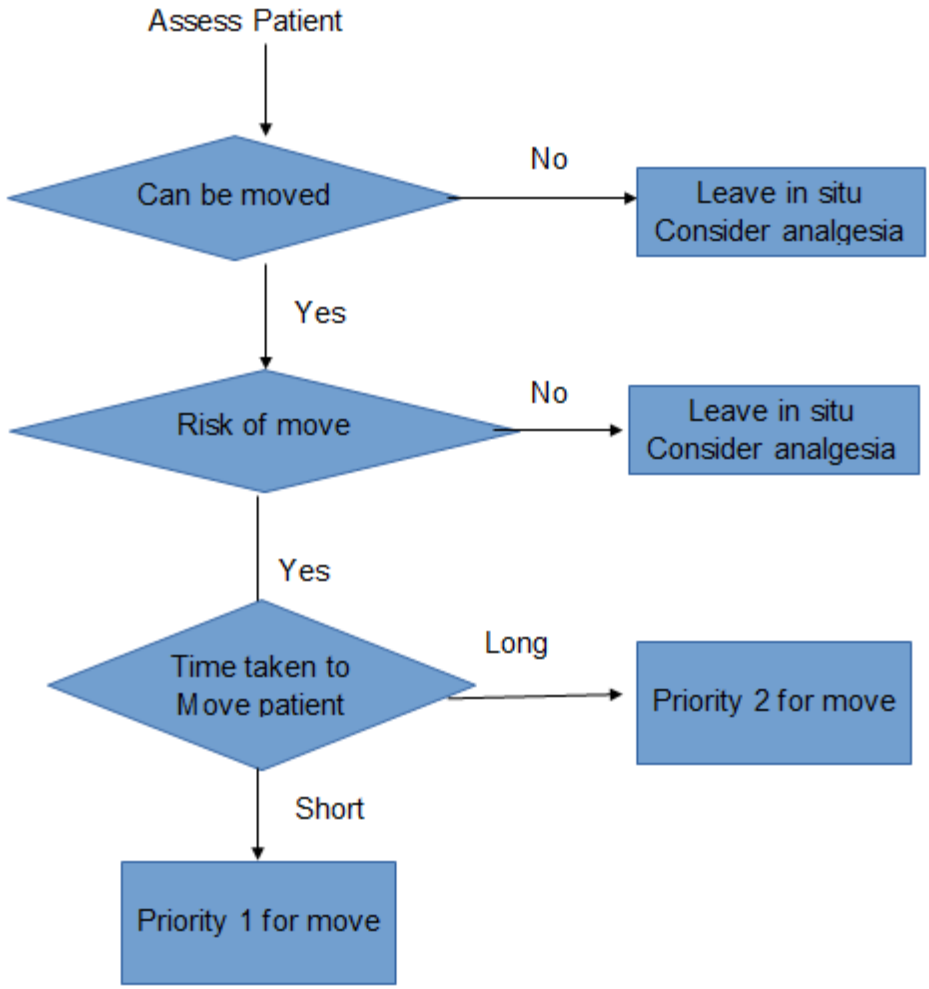
This will require the Trust to undertake a dynamic risk assessment that could lead to a decision that patients with potentially un-survivable injuries may not be currently evacuated, thus allowing the hospital, and other responding organisations, to focus resources on a great number of patients. It is important that with any decision made that the dynamic risk assessment is regularly reviewed and amended as the situation changes.

In this case, the Trust will need to prioritise which EP4 patients are evacuated and it may be necessary to invoke an 'EP4 Expectant' category, based upon current guidance on ethical decision making. It is essential that any decisions and the rationale made around this category are clearly recorded in the incident logs and therefore retrievable in any subsequent inquiry. The Expectant category is only to be used with the authority of the Hospital Incident Control Team and, following appropriate clinical diagnosis and dynamic risk assessment, as set out in national clinical guidance.

During an incident, where such patients are at risk, the principle of the 'Three Wise Persons' should be employed and this will require the Medical Director or his deputy in his absence, to identify a specialist team to assess this triage category of patient.

The NHS Guidance referred to, offers an algorithm in order to risk assess patients in triaging for evacuation. It was developed by the NHS England EPRR Clinical Reference Group, as a method of risk assessing the order of evacuation of patients in an emergency situation:

Table 6:



(Source: NHS England EPRR Clinical Reference Group)

Equipment for the Movement of Patients

Each building within the Trust's stock has been surveyed, during the process of creating a Fire Evacuation Strategy. This process has identified and detailed the evacuation equipment provisions required to ensure an effective and efficient evacuation.

Recovery and Repatriation

Recovery planning should start as soon as possible during the evacuation. Recovery and restoration of the provision of services are likely to be dictated by the circumstances at the time of the event.

The longer term response is likely to be dictated by the circumstances at the time of the event.

There are four main areas to consider, Humanitarian, Economic, Environmental and Infrastructure.

Table 7:

Humanitarian	Patient repatriation/return Ongoing patient care Updates to patients, families, and visitors Displacement of staff to other healthcare sites, both within and outside the Trust [welfare, travel costs, providing managerial support and visibility Psychological support
Economic	Insurance Incident costs Landlord / tenant agreements & responsibilities SLAs with partner agencies / Trusts Provision of supplies / equipment where Trust inpatients are in other healthcare Trusts Budget arrangements
Environmental	Site clean-up requirements [Pollution or contamination – specialist companies required] Waste
Infrastructure	Repair / rebuilding site Consideration of leased modular buildings / trailers to provide specific areas, such as treatment rooms, Operating Theatres and Imaging facilities Site security

5 TRAINING/SUPPORT

Training and exercising will be detailed within the Trust's Major Incident and Business Continuity 3-Year Training Plan, and agreed at the Business Continuity Steering Group.

6 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Awareness, knowledge and Understanding of the plan.	Emergency Planning Officer.	Annual awareness/training programme on the plan.	Trust OLM used to record attendance at awareness/training. Reported via the Business Resilience Steering Group (BRSG).

Compliance with the plan.	Emergency Planning Officer.	Annually.	Emergency Planning Officer is responsible for ensuring Divisional and Departmental managers are aware of any issues relating to their area of responsibility. Escalate to Accountable Emergency Officer (AEO) and Operational Group. Statutory requirement to undertake self-assessment and report to NHS England on compliance with National Standards for EPRR.
Building Specific Fire Evacuation Strategies.	Fire Safety Manager.	Risk Assessed.	Updated following Fire Risk Assessment – Fire Safety Committee.
Training and exercise compliance.	Emergency Planning Officer.	Annual Desk Top Exercise 3-yearly Live Exercise.	Reported via BRSG.

7 DEFINITIONS

Evacuation is the removal, from a place of actual or potential danger to a place of relative safety, of people and (where appropriate) other living creatures.

Horizontal Evacuation means moving away from the area of danger to a safer place on the same floor as the individual(s) is on. If fire is the cause of evacuation, movement should be to the next fire compartment section on that floor (i.e. through at least one set of fire doors)**.** If necessary those who have evacuated horizontally may need to consider a vertical evacuation.

Vertical Evacuation means using a stairwell, or lift (if safe and appropriate (i.e. only a designated fire lift should be used during a fire)) to move to either the floor above or below, as appropriate, to move away from the area of danger to a safer place.

Shelter is defined as “a place giving temporary protection”. It may be necessary to move patients into temporary shelters until such time as they are able to return to the affected healthcare facility, or until they are able to be transported to another healthcare facility.

Shelter in place: In certain situations the safest place to take refuge or cover is to remain in the current location. This is often referred to “shelter-in-situ”.

Vulnerable/vulnerability can generally be defined as affecting those that are less able to help themselves or who are unable to be 'self-reliant', however, it is diverse and can also be the result of one or more external factors coming together simultaneously that creates vulnerability in some people who were previously not vulnerable.

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

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

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 1)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

CORP/HSFS 1	- Health and Safety Policy
CORP/HSFS 14	- Fire Safety Policy
CORP/HSFS 15	- Security Policy incorporating Bomb Threat/Suspect Packages
CORP/RISK 9	- Business Continuity Strategy and Policy
CORP/COMM 27	- Media and Public Relations Policy
CORP/RISK 1	- Major Incident Plan
PAT/PS 8	- Safeguarding Adults Policy
PAT/PS 10	- Safeguarding Children Policy
PAT/PA 33	- Clinical Site Management Team Operational Policy
CORP/EMP 4	- Fair Treatment for All Policy
CORP/EMP 27	-Equality Analysis Policy

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016).

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

- NHS England EPRR - Planning for the Shelter and Evacuation of people in healthcare settings (2014)
- Emergency Planning Framework (2013)
- Business Continuity Management Framework (service resilience) (2013)
- Command and control arrangements (2013
- Civil Contingencies Act (2004)
- Cabinet Office 'Expectations and Indicators of Good Practice Set for Category 1 and 2 Responders (2013)
- Cabinet Office 'Emergency Response and Recovery (2013)
- Health and Safety at Work etc Act (1974)
- Regulatory Reform (Fire Safety) Order (2005)
- Evacuation and Shelter Guidance. Cabinet Office (2014)
- The MEND Guide – Comprehensive guide for Planning Mass Evacuations in Natural Disasters
- Planning Consideration: Evacuation and Shelter in Place. FEMA
- Review in to Five London Hospital Fires and their Management. NHS London (2009)
- Responding to pandemic influenza: The ethical framework for planning and policy. Dept of Health (2007)
- Hospital Emergency Evacuation Toolkit, Florida Dept of Health (2011)
- Evacuation and Shelter in Place Guidance for Healthcare Facilities, Los Angeles County Emergency Medical Services Agency (2012)

APPENDIX1- EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Evacuation and Shelter Policy – CORP/HSFS 35 v.1	Emergency Planning	Neil Colton	New	June 2020

1) Who is responsible for this policy? Emergency Planning Officer – Chief Operating Officer's Office

2) Describe the purpose of the service / function / policy / project/ strategy? Safely evacuate persons within Trust buildings.

3) Are there any associated objectives? Regulatory Reform (Fire Safety) Order 2005 – Health & Safety at Work etc Act 1974 – Civil Contingencies Act 2004

4) What factors contribute or detract from achieving intended outcomes? – Behaviour and understanding

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - NO

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] – N/A

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

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

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

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: July 2023

Checked by: Neil Colton **Date: 05/02/2021**