

Classification: Official

Publications approval reference: PRN00619\_i



# **Health Technical Memorandum 05-03: Operational provisions Part A: Training**

# Preface

## About Health Technical Memoranda

Health Technical Memoranda (HTMs) give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

The focus of Health Technical Memorandum guidance remains on healthcare-specific elements of standards, policies and up-to-date established best practice. They are applicable to new and existing sites, and are for use at various stages during the whole building lifecycle.

## Language usage in technical guidance

In HTMs and HBNs, modal verbs such as “must”, “should” and “may” are used to convey notions of obligation, recommendation or permission. The choice of modal verb will reflect the level of obligation needed to be compliant.

The following describes the implications and use of these modal verbs in HTMs/HBNs (readers should note that these meanings may differ from those of industry standards and legal documents):

- “Must” is used when indicating compliance with the law.
- “Should” is used to indicate a recommendation (not mandatory/

obligatory), i.e. among several possibilities or methods, one is recommended as being particularly suitable – without excluding other possibilities or methods.

- “May” is used for permission, i.e. to indicate a course of action permissible within the limits of the HBN or HTM.

## Typical usage examples

- “All publicly-funded organisations must ensure that all contracts established to collect and treat waste conform to the Public Contracts Regulations.”  
[obligation]
- “All low voltage (LV) distributions should be configured as TN systems.”  
[recommendation]
- “Alcohol hand gels that do not contain siloxanes may be rinsed out and the packaging recycled or placed into the municipal waste stream.”  
[permission]

“Shall”, in the obligatory sense of the word, is never used in current HTMs/HBNs.

## Project derogations from the Technical Guidance

Healthcare facilities built for the NHS are expected to support the provision of high-quality healthcare and ensure the NHS Constitution right to a clean, safe and secure environment. It is therefore critical that they

are designed and constructed to the highest and most appropriate technical standards and guidance. This applies when organisations, providers or commissioners invest in healthcare accommodation (irrespective of status, e.g. Foundation and non-Foundation trusts).

Statutory standards plus technical standards and guidance specific to NHS facilities:

- [Health Building Notes](#)
- [Health Technical Memoranda](#)
- [Complete list of NHS estates related guidance](#)

The need to demonstrate a robust process for agreeing any derogation from Technical Guidance is a core component of the business case assurance process.

The starting point for all NHS healthcare projects at Project Initiation Document (PID) and/or Strategic Outline Case (SOC) stage is one of full compliance.

Derogations to standards will potentially jeopardise business case approval and will only be considered in exceptional circumstances. A schedule of derogations will be required for any project requiring external business case approval and may be requested for those that have gone through an internal approvals process.

While it is recognised that derogation is required in some cases, this must be risk-assessed and documented in order that it may be considered within the appraisal and approval process.

Derogations must be properly authorised by the project's senior responsible owner and informed and supported by appropriate technical advice (irrespective of a project's internal or external approval processes).

This guidance is not mandatory (unless specifically stated). However, any departures/derogations from this HTM – including the measures implemented – should provide a degree of safety not less than that achieved by following the guidance set out in this HTM.

# Executive summary

Fire safety training is essential to managing the risk of fire within healthcare settings. It enables staff to:

- safeguard patients, service users, staff and visitors
- to respond to a fire, and
- to limit its effect.

Staff also need to know how to prevent fires and recognise hazards. This revised version of 'HTM 05-03: Operational provisions Part A' now solely focuses on training. It brings together the recommendations and advice that were previously contained in the HTM 05 series.

This HTM is one of a suite of documents setting out the fire safety requirements within the NHS. The complete suite is set out in [HTM 05-01: Managing healthcare fire safety](#), [HTM 05-02: fire safety in the design of healthcare premises](#) and [HTM 05-03: fire safety in the NHS, operational provision](#), and is commonly referred to as Firecode.

This HTM sets out the management responsibilities for ensuring that appropriate training is delivered to mitigate risk and deal with all stages of a fire incident, as well as more detailed information on what should be included in the training. It highlights the need for, and benefits of, integrating training and exercising for larger incidents with the requirements of the NHS emergency preparedness, resilience and response (EPRR) policy.

Fire safety training does not exist in isolation. This HTM refers to actions that will need to be taken in the case of a fire. This may

involve skills that are covered in other training programmes, such as the ability to keep very high dependency patients safe during an evacuation or how to isolate medical gases. This document sets out a process for analysing training needs to facilitate the requirements and benefits of meeting these training needs.

While much relevant training can be delivered remotely, training that involves the practical application of skills and knowledge are likely to be delivered face-to-face. This is particularly important when developing team management skills in emergency situations and for training on equipment such as evacuation equipment and fire extinguishers.

The Fire Safety Adviser (Authorised Person (Fire)) may be required to fulfil several roles and responsibilities, such as Authorised Person (Fire Training). In a smaller organisation, the same person may fulfil all of these; however, in larger organisations, it may be appropriate to have separate people fulfilling these responsibilities. In this document, the Fire Safety Adviser specifically responsible for overseeing and delivering fire safety training is referred to as the Authorised Person (Fire Training).

The roles of the Fire Safety Manager and/or the Authorised Person (Fire Training) are crucial in both identifying and establishing the necessary training requirements. These individuals also provide the technical and practical knowledge to support staff members receiving training as well as confirm that the healthcare organisation has personnel who are adequately trained in fire prevention and response procedures in the event of a fire.

They also provide advice where the health-care organisation faces situations of extreme operational pressure that may require staff fire safety awareness and training to be updated to deal with unusual situations.

It should be stressed that training alone does not make any relevant fire-safety-appointed individual fully competent. This will come from developing these skills and knowledge with experience and ongoing behaviours.

This document is intended to provide guidance on fire safety training in all healthcare settings. It is important that every organisation provides appropriate training and ensures that their staff training complements other training provided for staff such as EPRR or medical gases.

The Equality Act 2010 prohibits discrimination against people with disabilities. This covers a variety of situations including the provision of workplace training. It is important that any training is fully accessible and meets the needs of participants. This includes not only classroom or online training, but also practical training. Some disabilities are not immediately obvious such as mental health conditions and neurodivergences. Whether diagnosed or not, people with these conditions legally fall under the definition of having a disability in the UK. The design and delivery of training should take this into account.

## Major changes in HTM 05-03 Part A since the previous edition

This HTM now solely covers fire safety training whereas it previously covered “general fire safety”, including training. There is some mention of training in the extant HTM 05-01 on management, which will be omitted when that document is revised. This HTM also:

- details management responsibilities from board-level director downwards

- highlights that the Fire Safety Adviser may be required to fulfil several roles including that of fire safety training and identifies competencies for the specific role of Authorised Person (Fire Training)
- includes advice on the use of technologies such as e-learning and permits their greater implementation
- offers guidance on utilising modern communication methods such as videoconferencing
- outlines the necessary training content when providing training for different staff groups/cohorts
- details appropriate scheduling for training to be completed
- requires that the Fire Safety Manager develop processes to evaluate staff competency and ensure the effectiveness of training programmes
- provides advice on specific evacuation training and confirmation of the methodology by using evacuation drill/tabletop exercises, and alignment with EPRR
- provides further advice on training needs analysis including transferability of training
- gives specific guidance on training for theatre staff including the risk from surgical fires
- includes advice on training during periods of extreme operational pressure such as during industrial action or during a pandemic
- provides advice on specialist training including medical gases
- provides advice on moving and handling in the evacuation of patients who require assistance
- provides information on personal emergency evacuation plans (PEEPs)
- provides guidance on training for major incidents and alignment with the NHS EPRR framework.

# Acknowledgements

**Anthony Pitcher** Senior Fire Safety Advisor, NHS Wales Shared Services Partnership - Specialist Estates Services

**Bill Connelly** Fire Safety Officer, Health Facilities Scotland

**Chris Callow** Risk Based Inspection Programme Lead, National Fire Chiefs Council

**David McCabrey** Principal Engineer, Health Estates Northern Ireland

**David Russell** Main technical author, PartB Group

**Kenny Pitkethly** Fire Safety Officer, Health Facilities, Scotland

**Kevin Finch** Home Office Fire Safety Unit

**Mairead McCartan** Fire Safety Manager, Belfast Health and Social Care Trust

**Mazin Daoud** Head of Fire Safety, NHS England

**Michael Rope** Head of Technical Guidance, NHS England

**Mike Ralph** Principal Engineer, NHS England

**Pete Wise** Technical Director, PartB Group

**Peter Aldridge** Secretary, National Association of Healthcare Fire Officers (Leeds Teaching Hospitals NHS Trust)

**Peter Wilkinson** Technical Director Chartered, Engineer, IFE

**Richard Clark** Fire Engineering/Building Safety, National Fire Chiefs Council

# Contents

<b>Preface</b> .....	<b>ii</b>
About Health Technical Memoranda	ii
Project derogations from the Technical Guidance	ii
<b>Executive summary</b> .....	<b>iv</b>
Major changes in HTM 05-03 Part A since the previous edition	v
<b>Acknowledgements</b> .....	<b>vi</b>
<b>1 Introduction</b> .....	<b>1</b>
Who is this document for?	2
<b>2 Requirements to carry out training</b> .....	<b>3</b>
Legislative	3
Health Technical Memorandum 05 series (Firecode)	4
Management responsibilities	4
<b>3 The need for training</b> .....	<b>9</b>
<b>4 Fire safety training</b> .....	<b>10</b>
Ward or department training	10
Evacuation training	13
Recording and assessing training programmes	15
Fire safety training audit	16
<b>5 Fire drills and evacuation exercises</b> .....	<b>17</b>
Fire drills	17
Exercises	18
<b>6 Training needs analysis</b> .....	<b>20</b>
Developing the training needs analysis	20
Transferability of training	20
Steps to developing the TNA	21
Using the training needs analysis	23
<b>7 Training methodology</b> .....	<b>25</b>
Face-to-face training	25
e-learning	25
<b>8 Training during periods of extreme operational pressure</b> .....	<b>27</b>
The risk of imminent danger	27

Training delivery	28
<b>9 Specialist training</b> .....	<b>29</b>
Medical gases	29
Moving and handling	30
Personal emergency evacuation plans	31
Fire extinguisher training	31
Major incident training	31
<b>References</b> .....	<b>34</b>
Acts and Regulations	34
NHS England publications	34



# 1 Introduction

## Note on the Building Safety Act

Following the tragic fire at Grenfell Tower in London in 2017, the government initiated an independent review of building regulations and fire safety which was chaired by Dame Judith Hackitt and is often referred to as the “Hackitt review”. This looked primarily at safety in high-rise residential buildings. A number of recommendations were made which resulted in primary legislation in the Building Safety Act 2022 (the Act) and a large amount of secondary legislation including the Higher-Risk Buildings (Descriptions and Supplementary Provisions) Regulations 2023. The Act created “the building safety regulator”, which sits within the Health and Safety Executive, which was established to raise safety standards in all buildings and also to take over regulation of higher-risk buildings. These include any buildings at or above 18 m or seven storeys that have two or more residential units. Hospitals that meet the same height criteria are also considered to be higher-risk buildings for some parts of the Act. In the Regulations referred to above, “a hospital” is specified (under section 120D of the Building Act 1984). What this means is that a hospital building that meets the height criteria is subject to the building safety regulator when completing building works and must apply to the building safety regulator for building control approval under Part 3 of the Act where such approval is required. Hospitals are not, however, subject to the management requirements set out in Part 4 of the Act as, being a workplace, hospitals are already subject to the requirements of the Regulatory Reform (Fire Safety) Order 2005 to carry out, review and record fire risk assessments. Despite this, cognisance should be taken of the recommendations in the Hackitt review and the requirements in the Act, along with the recent changes to the Fire Safety Order, some of which have come about as a result of the Hackitt review and have been introduced by the Act.

**1.1** Although the need to respond to a growing fire is rare, adequate fire safety training is nevertheless essential for all staff to make sure that all staff and patients are protected, particularly where the safety of patients will rely on the staff being able to effectively implement the fire emergency plan. Fire safety training is also an essential element of the business continuity strategy.

**1.2** This HTM sets out guidelines for the training of staff in fire safety based on the need to safeguard both patients and staff in case of fire. It does not cover technical fire safety training such as fire risk assessments or the training required for staff involved in the

procurement, installation and maintenance of fire safety equipment such as fire detection and alarm systems.

**1.3** At an organisational level, healthcare organisations should put in place appropriate systems to support training. A suitable programme of fire safety training should be developed and implemented. This should be delivered in a systematic and structured way and be based on the risk from fire and the role that staff undertake. Fire should be viewed as part of the emergency planning process in general. A review of this system should be part of the fire safety management cycle of healthcare organisations.

**1.4** Fire safety training should not only cover the actions to be taken in case of fire, but also cover an awareness of the importance of practical fire safety measures that prevent a fire or reduce its impact. Staff should understand the importance of practical fire safety features such as fire doors and fire detection and alarm systems and the need for a high standard of fire prevention. Where staff have a technical role that requires an understanding of technical fire safety matters, staff should receive and maintain a suitable level of knowledge in fire safety to undertake their roles. A training needs analysis (TNA) will need to be completed to define exactly what training is needed for particular roles, which is

likely to be influenced by considerations such as patient dependency.

**1.5** Suitable management systems need to be put in place to test and monitor the effectiveness of training.

## Who is this document for?

**1.6** This document is intended to provide guidance for those responsible for managing fire safety within healthcare organisations, and those who need to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (FSO). It can also provide useful guidance for any healthcare setting.

# 2 Requirements to carry out training

## Legislative

**2.1** In England, the FSO makes fire safety training a legal requirement. Under Article 21, the responsible person must ensure that employees are provided with adequate safety training. This needs to happen at the time when they are first employed and updated should they be exposed to an increased risk such as:

- changing responsibilities
- the introduction of new equipment or new technology, or
- a new system of work.

**2.2** Article 21 of the FSO sets out that adequate training must be provided when staff are exposed to new or increased risks because of a change in working environment and/or equipment. Refresher training should take place at regular periods.

**2.3** Under Article 9 of the FSO, the responsible person must make a suitable and sufficient assessment of the risks to which relevant persons are exposed for the purpose of identifying the measures they need to take to comply with the requirements of the FSO. This should form the basis for all fire safety training.

**2.4** Should a member of staff be transferred or given a change of responsibilities, they must receive suitable and sufficient instruction

and training on the appropriate precautions and actions required to safeguard themselves and others.

**2.5** Article 15 of the FSO states that suitable procedures need to be put in place for serious and imminent danger from fire. This will require that an emergency plan be developed and maintained for the premises that is appropriate for the risk from fire. All staff should understand their role in an emergency plan. It is also vital that emergency plans are evaluated through fire drills and practical training that will test the effectiveness of the training given to staff.

**2.6** Article 13 of the FSO requires that appropriate measures for firefighting must be provided. Healthcare organisations should provide appropriate training for staff to support the use of firefighting equipment. Appropriate firefighting at an early stage of a fire may prevent a small fire growing out of control and spreading, potentially affecting the means of escape and posing a risk to people. The use of a fire extinguisher could negate the need to move a critically ill patient. The use of fire extinguishers should be described in the hospital protocol.

## Health Technical Memorandum 05 series (Firecode)

**2.7** The HTM 05 series sets out recommendations and guidance for the management of fire safety in healthcare buildings. This guidance recognises the nature of healthcare organisations and the need for a robust system of fire safety management. The guidance series and recommendations contained in this HTM should allow the current statutory regulations to be applied sensibly within a framework of understanding.

**2.8** Efficient application of fire safety procedures is subject to staff knowing what to do. Healthcare organisations are required, both under law and under the provisions of Firecode, to provide effective training in fire safety and how to respond to an outbreak of fire. This applies to all staff without exception.

**2.9** Senior medical and managerial staff should lead by example. This is of vital importance, and it is the duty of senior managers of all disciplines to ensure that they and their staff receive basic instruction in fire safety and further training appropriate to the specific needs of their workplace.

**2.10** Every member of staff in premises providing healthcare should:

- be aware of the findings of relevant fire risk assessments
- know the measures in place to reduce the risk, including fire detection and warning, escape routes and fire compartmentation, and understand the emergency plan
- understand their role in the emergency plan and how this integrates with other team members' roles
- know the special arrangements for serious and imminent danger to persons from fire

- understand the characteristics of fire, smoke and toxic fumes
- know the fire hazards involved in the working environment
- practice and promote fire prevention
- understand the need and practical requirements for evacuating disabled people including personal emergency evacuation plans (PEEPs)
- know how to recognise a change in their work environment that constitutes an immediate risk that needs to be addressed, and how to access appropriate professional support.

**2.11** Staff responsible for the care of patients should:

- be familiar with the evacuation procedures, equipment, and associated escape routes at their location and at their time of duty
- take part in practical training sessions, which should include evacuation techniques. This includes the ability to move patients who require dedicated life support or who have other special needs.

## Management responsibilities

**2.12** Firecode policy is for chief executives to nominate (and where necessary appoint, for example, Authorised Persons (Fire)) staff with specific roles in fire safety. The FSO requires the responsible person to appoint one or more competent persons to assist in the undertaking of preventive and protective measures. The responsible person is defined in Article 3 of the FSO as the employer.

**2.13** Under Firecode, the primary responsibility for ensuring that there is an effective policy for training all staff in fire safety procedures rests with the appointed board-level director assisted by the Fire Safety Manager, who

should receive suitable training prior to assuming their duties.

**2.14** To satisfy the legal requirements for training, staff need to understand the fire risks to which they may be exposed and know what to do in the event of a fire so that fire safety procedures can be applied effectively. This requirement applies to all staff, irrespective of their seniority or professional discipline.

### Board-level director

**2.15** The board-level director assisted by the Fire Safety Manager with responsibility for fire safety is responsible for ensuring fire safety training meets the statutory requirements and guidance in Firecode, ensuring that:

- a TNA has been completed for all staff and is to be reviewed:
- whenever there are any changes that may affect its efficacy, or
- at least every three years
- staff training is monitored and recorded with a suitable system in place to ensure that staff training is completed at the appropriate time
- the emergency plan is tested using appropriate fire drills and exercises which capture the lessons learned
- training is subject to an annual audit and is included in an annual report to the healthcare organisation's board
- there is coordination with the healthcare organisation's emergency preparedness, resilience and response (EPRR) planning process.

**2.16** The board-level director should ensure, through senior management and line management structures, that full staff participation in fire training and fire evacuation drills is maintained. All staff training should take place during the normal working hours of those being trained.

**2.17** Healthcare organisations should report to the board (see HTM 05-01) on the following:

- What arrangements are in place to provide fire safety training?
- Do these arrangements include training for volunteers and/or employees of other organisations that work within the premises?
- How is the TNA communicated to staff?
- How do those requiring training arrange to receive the appropriate fire safety training?
- What are the training arrangements for temporary, agency and/or bank staff?
- What are the arrangements for recording (i) attendances at fire safety training sessions (ii) the general content of each training session attended?
- How is the responsibility for ensuring staff members are made available for fire safety training communicated to line managers?
- What arrangements are in place to communicate the relevant information for the fire and rescue service to use at an emergency?
- How is the fire and rescue service engaged in the process to ensure that sufficient information is available in a usable format?
- How is fire safety training integrated into business continuity training, where appropriate?

### The Fire Safety Manager

**2.18** The Fire Safety Manager is responsible for ensuring that an appropriate programme of fire safety training is developed and suitable arrangements are in place for the delivery of training to all employees and other relevant staff. It is the responsibility of all staff with line management responsibility to ensure that all

their staff have attended the appropriate fire safety training as detailed in the TNA matrix.

**2.19** The Fire Safety Manager is responsible for ensuring the efficacy of fire safety training by:

- ensuring an appropriate programme of fire safety training is in place and, together with the Authorised Person (Fire Training) and training department (where appropriate), completing a TNA
- making sure that suitable arrangements are in place for the delivery of training
- ensuring the training is delivered by persons competent in fire safety in the healthcare environment: where accreditations for such a role are introduced by NHS England, staff delivering such training should meet that standard or be working towards meeting it
- together with the Authorised Person (Fire Training), ensuring that the level of fire safety knowledge is appropriate by means of workplace question-and-answer (Q&A) and evacuation exercises
- ensuring large-scale fire incident exercises are completed regularly involving Joint Emergency Service Interoperability Programme (JESIP) models and principles to test interoperability and liaison with emergency services including the fire and rescue service. The nature, extent and frequency of exercises should take into account the nature of the risk and the requirements of the emergency services, together with any business continuity requirements. Exercises can also be carried out using appropriate simulation and desktop exercise tools
- periodically reviewing the technical content of fire safety training programmes and material.

## The Authorised Person (Fire Training)

**2.20** The Authorised Person (Fire Training) is responsible for:

- ensuring an appropriate programme of fire safety training is delivered
- ensuring the effectiveness of staff training is assessed either via a workplace Q&A or completing/monitoring a small-scale drill or exercise
- advising the Fire Safety Manager as to whether legal requirements are being met
- ensuring staff are apprised of the relevant findings of the fire risk assessment.



### Note on the roles of the Fire Safety Manager and Authorised Person (Fire Training):

The Fire Safety Adviser (Authorised Person (Fire)) may be required to fulfil several roles and responsibilities, such as Authorised Person (Fire Training). In a smaller establishment, the same person may fulfil all of these; however, as the size of the establishment increases, it may be appropriate to have separate people fulfilling these, one of which is overseeing and delivering fire safety training. In this HTM the Fire Safety Adviser specifically responsible for overseeing and delivering fire safety training is referred to as the Authorised Person (Fire Training).

The roles of the Fire Safety Manager and/or the Authorised Person (Fire Training) are crucial in both identifying and establishing the necessary training requirements. These individuals also provide the technical and practical knowledge to support staff members receiving training as well as confirm that the healthcare organisation has personnel who are adequately trained in fire prevention and response procedures in the event of a fire. They also provide advice where the healthcare organisation faces situations of extreme operational pressure that may require staff fire safety awareness and training to be updated to deal with unusual situations.

## Local management

**2.21** Local management such as senior nurses and ward or department heads should make sure that:

- staff have received suitable training
- sufficient Fire Wardens are in place
- an evacuation drill/exercise or tabletop/walkthrough is completed in line with the TNA

- there are always enough appropriately trained staff available to implement the local fire emergency action plan.

**2.22** Local management should also ensure that on their first day, all new staff in the ward/department are given basic familiarisation training within their workplace. This includes:

- local fire procedures and evacuation plan means of escape
- the location of fire alarm manual call points
- the location of firefighting equipment
- any identified fire risks
- keeping a record of staff induction and attendance at fire safety training.

Staff should also know how to recognise a change in their work environment that constitutes an immediate risk that needs to be addressed immediately, and how to access appropriate professional support.

## Fire Wardens

**2.23** Fire Wardens are the focal points for local staff in relation to fire. They will be the “eyes and ears” within a local area for fire safety. They will report any issues identified to their line manager. Their training should cover the practical and organisational elements of fire safety required to carry out their role. In addition to general requirements that will come from the emergency plan, Fire Wardens will need appropriate training regarding:

- how to identify the fire safety elements in their area, their importance and how they operate (such as the location of fire-resisting compartments, the fire detection and alarm system, fire doors and fire extinguishing media)
- a basic technical understanding of how fire safety elements function and when to highlight issues

- the organisational fire safety structure to enable the reporting of fire issues to both their line managers and the Authorised Person (Fire Training)
- how to recognise a change in their work environment that constitutes an immediate risk that needs to be addressed immediately, and how to support local staff and access appropriate professional support.

## Fire Incident Manager

**2.24** The most senior person in charge of an area and present at the time that an incident occurs should assume the role of the Fire Incident Manager.

**2.25** The Fire Incident Manager is required to:

- take control of the incident
- direct the local response
- ensure that the fire detection and alarm system has been activated and that staff in the area are aware of the incident
- initiate the local fire emergency action plan
- determine whether evacuation is necessary and commence the evacuation if appropriate
- liaise with the Fire Response Team and the Fire Response Team Leader on their arrival.

## Fire Response Team Leader

**2.26** The Fire Response Team Leader needs to understand the emergency plan and how this will be carried out in the initial stages of an incident (and potentially in a growing incident). The team leader should be able to deal with

smaller incidents and bring them to a successful conclusion. As the staff that form the fire response team are likely to come from different departments, the Fire Safety Manager, in conjunction with the Authorised Person (Fire Training), should ensure that staff who form part of the fire response team have appropriate training to carry out this task. The Fire Safety Manager should make sure that appropriate training is carried out such that the team:

- can work effectively together at an incident
- understands the fire risk assessment, the fire safety measures in place to reduce risk and the emergency plan
- have sufficient knowledge of fire to manage an incident
- have the opportunity to train together to practice fire incident management.

## Trainers

**2.27** Staff delivering training should have the necessary healthcare experience to deliver technical fire safety training. This includes competencies in both fire safety and the delivery of training. Where accreditations for such a role are introduced by NHS England, staff delivering such training should meet that standard or be working towards meeting it.

**2.28** Where fire safety training relates to local situations and specific staff procedures and roles, it is likely that this training may be provided by managers to their staff on a cascade basis. This should be based on the requirements of the emergency plan and the training content should be agreed by the Authorised Person (Fire Training).



# 3 The need for training

**3.1** This chapter highlights the statutory and mandatory training requirements that should be recorded on the electronic staff record.

**3.2** Training is essential to enable staff to carry out emergency planning in case of fire. The purpose of an emergency plan is to ensure that all the staff on the premises know what to do if there is a fire and that the premises can be safely evacuated if required to do so. The roles in this HTM are indicative of the typical roles required in a healthcare environment. A specific emergency plan should describe the numbers of staff and their roles in case of fire.

**3.3** All staff, including part-time, bank and agency staff, should attend a local fire-safety training course to include the first-aid firefighting and emergency evacuation procedures appropriate to their workplace.

This training should take place on or before their first day of work.

**3.4** Where staff cannot be made available for training or miss training opportunities and so cannot meet the standard set out in the TNA, advice should be sought from the Authorised Person (Fire Training) on what ongoing training is appropriate. This should be set out as part of the fire safety management procedures in a healthcare organisation.

**3.5** Training should be based on a TNA, which may require some staff to receive more frequent training (for example, those staff involved in direct patient care).

**3.6** Training for staff on night duty is particularly important in view of the reduced level of staffing which applies at that time.

## 4 Fire safety training

**4.1** Consideration should be given to the establishment of a fire-training team, ideally with a specific venue, for the purpose of training staff in fire safety procedures. Such a facility may prove economical for a large healthcare site, where a fire-training unit would be under the care of the Authorised Person (Fire Training). The unit would supplement the standard training in fire safety and evacuation procedures by providing those parts of fire safety training that would be impracticable to undertake at a work location.

**4.2** All training should be accessible. The information and instructions given should be in a form that can be used and understood. It should take account of people with hearing or visual impairment and people living with neurodivergent and neurodegenerative conditions. It should also take into account people who do not use English as their first language. This is applicable to all forms of training, including e-learning and any training material delivered using video or electronic means.

### Ward or department training

**4.3** Training should be based on a TNA, which may require some staff to receive more frequent training. For example, those staff involved in direct patient care will normally require instruction on evacuation.

**4.4** The frequency and duration of refresher fire safety training should take account of:

- the significant findings of fire risk assessments carried out as a statutory duty under the FSO
- the emergency plan for the workplace
- the need to be familiar with fire evacuation aids
- changes in equipment or the introduction of new equipment/technology
- changes that may have taken place to the layout of the workplace
- changes that may have taken place in staffing levels and/or patient care
- changes to the use of the workplace
- the role staff are expected to perform in a fire emergency.

**4.5** Additional training should be provided to meet the special requirements of particular locations and for those staff who have special responsibilities. Examples are:

- Nursing staff and any others who may have to assist in the evacuation of patients should receive instruction and training in appropriate methods of evacuation. This includes techniques for moving and assisting patients (and others) to evacuate quickly in an emergency. The challenges of moving patients from critical care areas, or similar locations where highly dependent people are cared for, should be well-rehearsed.

- Staff working in mental health environments, particularly in acute in-patient units where the fire safety measures do not follow normally accepted practices (for example, the use of staff alarms and security measures).
- Porters, security staff, cleaners, etc., with regard to escape routes to be kept clear/managed.
- Medical staff with specific responsibilities such as managing or isolating medical gases, initiating evacuation, management of evacuation or using fire extinguishers or other firefighting media.
- Telephone switchboard operators, who should be instructed and trained in the actions they should take in the event of fire (for example, communicating with the fire and rescue service in accordance with guidance in HTM 05-03 Part B). This should include differentiating between a fire alarm activation and a confirmed fire, and the need to inform the fire authority if a fire alarm actuation becomes a confirmed fire.
- Estates staff, who need to have precise instructions for dealing with the safe control and isolation of services such as gas, water, electricity, ventilation, piped medical gases, etc., which they may need to control during a fire under the direction of medical staff. Estates staff should also be trained in the management of hot works, hot works permits and the fire prevention measures that are required.
- Kitchen staff who are responsible for fryers and fixed extinguishing systems.

**4.6** There is significant value in staff from all departments and of all grades receiving multidisciplinary training in their place of work as part of mandatory training. The successful resolution of a fire emergency depends on

staff from different departments working together.

### On or before the first day of work

**4.7** Basic fire safety training should be completed before anyone starts work; it applies to temporary, bank or agency staff, including volunteers.

**4.8** This may be by e-learning, by video or face-to-face and should include:

- the dangers posed by fire, including fire growth rate, smoke spread, the effect of fire gases on people and human behaviour during a fire
- the indications of a fire
- the importance of fire prevention
- the main causes of fire and how to mitigate them including arson, smoking, cooking and electrical hazards
- the safe use and storage of medical gases including oxygen
- good housekeeping and the importance of maintaining all escape routes so that they are free from obstructions
- how to recognise a change in the work environment that constitutes a risk that needs to be addressed immediately, and how to access appropriate professional support
- what to do on hearing the fire alarm; this may be generalised, with specific training provided on local induction
- what to do on discovering a fire, including how to raise the alarm and familiarisation of both continuous and intermittent alarm sounds and visual alarm indicators, with specific training provided on local induction
- the process of progressive horizontal evacuation
- the safe use of fire extinguishers

- the need to report to the assembly point and to carry out a roll-call as soon as possible at the designated assembly point
- the importance of fire protection measures provided in the building such as fire doors, fire extinguishers, etc., and what practical matters to be aware of (for example, not wedging fire doors open and how to report faults such as fire doors not closing or being damaged)
- the PEEPs process, including what they need to do if they become disabled themselves, and fire procedures for both individual disabled people and standard plans for disabled people. This is distinct from the evacuation of patients who require evacuation assistance (for example, very high dependency patients)
- the effects of false alarms and unwanted fire signals.
- evacuation processes for patients, visitors and members of the public: this should also include the management of evacuation, the roles and responsibilities on the ward or department, an understanding of progressive horizontal evacuation (where necessary) and how to carry out vertical evacuation using stairs and lifts
- escape route familiarisation, fire alarm call points and fire extinguisher locations/types in the department and immediate work area, including assembly points
- information regarding PEEPs in their workplace
- the interaction between security measures and the need to provide appropriate evacuation procedures, particularly in areas where specialist procedures may be required such as mental health wards

## On starting in a ward or department for the first time

**4.9** Training may be face-to-face (by the Fire Warden, Authorised Person (Fire Training)/trainer or local manager/senior staff), by e-learning, by video or any combination of the above. For staff working in patient treatment or care areas, this should include a face-to-face element, with a checklist to be followed and the trainee to sign that they have received and understood the training. This should include:

- the emergency plan, including raising the alarm and action to take on hearing the alarm or discovering a fire
- staff responsibilities during an incident that happens in the built environment locally when the fire alarm activates (magnetic locks releasing, door hold-open devices deactivating, lifts grounding, etc.)
- fire risk assessment significant findings and requirements

- the role of the fire response team
- fire prevention measures for hazardous processes, substances, equipment and medical gas cylinders in the area.

**4.10** The training should give staff the required level of knowledge to enable them to identify the need to raise the alarm in case of fire and how to respond. They should be able to assist in the evacuation of their workplace and assist others where necessary. They should also be aware of any hazards that are specific to their workplace.

**4.11** As soon as practicable when starting on a ward/department (and at least annually thereafter), staff responsible for dependent patients should carry out an evacuation drill/exercise on their own (or similar) ward/department. This may be a walk/talk-through and include:

- action to take on discovering a fire: sounding the fire alarm, calling the

switchboard and evacuation (typically one or two beds)

- action to take on hearing the fire alarm
- first-aid firefighting
- evacuation methods specific to the patients' requirements and/or those noted in a PEEP.

**4.12** Refresher training should be conducted in accordance with the requirements identified in the TNA.

## Fire Wardens

**4.13** Training should be provided regularly for Fire Wardens, preferably face-to-face. This should include:

- daily/weekly/monthly checks
- minimising the risk of a fire occurring
- minimising the risk should a fire occur
- evacuation aids (where applicable)
- first-aid firefighting.

## Evacuation training

**Fire Incident Managers (local management such as senior nurses and ward or department heads who are responsible for the initial management of an incident)**

**4.14** The fire incident manager is required to take control of the incident and direct the local response, ensuring that the fire alarm system has been activated and that staff in the area are aware of the incident, initiating the local fire emergency action plan.

**4.15** Those staff with the initial responsibility for managing an incident should receive appropriate training to undertake that role. This should include:

- understanding the emergency plan for their area of responsibility and how this relates to the general hospital emergency plan, should an evacuation that involves more than the immediate area become necessary
- being able to make appropriate decisions in the initial stages of an incident (for example, prioritising patient evacuation, information gathering and delegating appropriate tasks to team members to assist in evacuation) and being able to monitor and assess the situation
- determining whether evacuation is necessary and when to commence the evacuation where appropriate
- being able to implement an evacuation and to identify, inform and liaise with the adjacent areas, prioritise evacuation sequences and delegate teams for patient evacuation (for example, those in imminent danger and those whose evacuation time will be extended due to their medical condition)
- liaising with the fire response team so that an appropriate level of incident management can be established in a growing incident. Where an incident is stood down, liaising with the fire response team should include returning the situation to normal such as reinstating fire detection and alarm systems. If possible, an immediate hot debrief should be carried out to learn any lessons from the incident. These can then be captured for use in informing future training and procedural reviews.

## Fire Response Team Leader and fire response team

**4.16** Training should be completed before appointment and refreshed at least annually thereafter.



**4.17** The Fire Response Team Leader should receive appropriate training to manage the fire response team and to be able to liaise with the fire incident manager to ensure the initial control of an incident, as well as with the fire and rescue service.

**4.18** A fire response team will have several components such as (but not limited to) clinical site manager, estates department, porters, security, Authorised Person (Fire) and Authorised Person (Fire Safety Maintenance). The training should incorporate the following:

- communications both within the fire response team and with the wider site team dealing with an emergency
- first-aid firefighting
- incident management to enable the emergency plan to be implemented appropriately regarding the potential for a growing incident that may require significant evacuation: this should include training in how the emergency plan is intended to operate and the necessary incident management skills to carry it out
- liaising with the fire and rescue service and other first responders
- operating the fire alarm system, including information on the panel, silencing and resetting
- how to safely complete a fire alarm “seek and search” protocol (see HTM 05-03 Part B)
- how to read and interpret fire alarm zone charts
- when to stand down the alarm in the case of a false fire alarm activation
- actions required if a fire alarm will not reset
- the investigating of a false alarm.

## Higher risk wards/departments

**4.19** The risks to patients, business continuity or the environment are more complex; therefore, specialist training will be required to account for certain situations such as:

- the dependency of the patient receiving life support including the safe evacuation of patients dependent on life support
- the work process being carried out
- the critical nature of equipment, wards or departments
- an increased likelihood of fire occurring (for example, mental health wards/ departments).

In this situation, training requirements are to be based on a specific TNA, which must be completed.

**4.20** Where the risk is critical to business continuity, the TNA should be completed by a group of people including:

- the fire adviser
- ward/department heads
- EPRR lead
- the local fire and rescue service (where available)
- specific subject matter experts.

## Senior management

**4.21** Senior management are likely to need to respond to a fire that is not initially controlled and requires an evacuation of an area greater than that immediately affected. Senior management’s role and training is likely to reflect the healthcare organisation’s major incident policies and procedures. There is also likely to be an overlap with training that is required in the NHS EPRR framework.

## Estates department

**4.22** Many estates and facilities staff work throughout the premises. They may also be responsible for contractors working on the site. A specific TNA should be completed and include:

- control of contractors through a permit to work system which includes fire safety training
- isolation of services
- the importance of fire compartmentation and how to identify relevant fire-resisting walls/floors/ceilings and monitor its effectiveness.

## Non-clinical areas (including concessions)

**4.23** This should include an annual e-learning process as a minimum and an annual fire drill. Healthcare organisations should ensure that any concessions or staff employed on their premises have appropriate training and that this is integrated with the healthcare organisation's own training programme.

## Facilities that do not accommodate dependent or very high dependency patients

**4.24** Depending on the risk, e-learning and trained Fire Warden training together with an annual fire evacuation drill is likely to be sufficient. However, those responsible for fire safety at any location must make sure that the training is suitable for staff to act upon the findings of the fire risk assessment and the emergency plan.

**4.25** Training should cover the danger from fire and basic safety measures to prevent fires. It should also provide a basic understanding of how the fire safety features of a building protect people within it, the use of fire extinguishers, and evacuation facilities for disabled people and people especially at risk.

Note:

“People especially at risk” is defined in HTM 05-03 Part K.

## Periodic fire safety training

**4.26** All staff should receive regular updated fire safety training and instruction. The duration and frequency of the training should be determined by a TNA. This should take into account the guidance in this HTM, the fire risks present in the premises, the number and dependencies of people at risk and the responsibilities of staff in a fire emergency. The outcomes of the fire risk assessment and the resulting determination of training requirements should be formally recorded and periodically reviewed. It is expected that staff involved in the direct care of patients, who may need to help evacuate others, should receive instruction more frequently than those who may only be required to evacuate themselves from the building on the sounding of the fire alarm.

**4.27** The TNA should consider each member of staff's general duties, their role in preventing fire and their potential role in executing the fire emergency action plan. An example approach to developing a TNA is given in Chapter 6.

**4.28** The frequencies for training are intended to be indicative and to illustrate a flexible approach. The format, content, frequency and duration of training sessions indicated in this HTM should be treated as guidance only and adapted to the situation based on the risk assessment.

## Recording and assessing training programmes

**4.29** The training programme should include practical sessions and fire drills to supplement classroom instruction and e-learning. Training sessions should be well-publicised and arrangements made in good time for the

release of staff. In order to identify individual staff members' training needs and to verify that training has been completed, records should be kept of:

- staff attending training
- the dates and duration of the training sessions
- the nature of training given
- the details of those instructing.

**4.30** Training records should be made available to each staff member's manager to facilitate them discharging their duty to confirm that all their staff attend fire safety training.

**4.31** It is likely that the practical performance of staff at training will offer the best indication of the effectiveness of a programme and the degree to which staff have assimilated instruction.

**4.32** Assessing the effectiveness of training schemes is important, but often difficult to carry out with certainty. The Fire Safety Manager in conjunction with the Authorised Person (Fire Training) should, on a regular basis (but normally no less than every two years), devise methods of assessing the effectiveness of staff training, the results of which should be used to inform the TNA.

**4.33** The recording system should enable the Fire Safety Manager to oversee training programmes effectively and check that training goals have been met, including those for part-time, bank, agency and night-duty staff.

**4.34** Line managers are responsible for recording staff attendance at training sessions and should alert the Fire Safety Manager where it has not been possible for staff to attend the required training session. It is

recognised that the operational difficulties of releasing staff for training, and instances where it may be necessary to utilise temporary nursing and other staff whose fire safety training may have lapsed, may result in staff without current training being on duty. The local manager should ensure that a sufficient number of trained staff are available to carry out the emergency plan in case of fire.

**4.35** The local manager should make sure that staff members on duty at any time who are not up to date with regard to fire safety training are kept to an absolute minimum and are programmed to receive the training as a matter of priority.

**4.36** Any training delivered by e-learning should be completed within one month of the session commencing. Any session not completed within the month should result in the e-learning programme being recommenced. If an e-learning system consists of various modules, each new module should be completed within a defined timescale, and each module should be successfully completed before progressing to the next.

## Fire safety training audit

**4.37** It is necessary to make certain that the programme of fire safety training is delivering the desired outcomes and ensuring that staff are aware of their fire safety responsibilities and their role in fire prevention and implementing the fire emergency plan.

**4.38** The efficacy of the fire safety training programme should be included in the annual fire safety audit.



# 5 Fire drills and evacuation exercises

## Fire drills

**5.1** Fire drill and exercises offer the opportunity to evaluate procedures based on the emergency plan and for participants to practice the roles that they may have to undertake. This should provide the participants with the necessary experience in a practical scenario to put their skills and knowledge of emergency procedures in place. It should also develop the teamwork and organisational skill required when a fire occurs.

**5.2** The effectiveness of emergency plans for dealing with a fire, and of various aspects of fire safety training, should be tested by means of practical fire drills, preferably both day and night.

**5.3** The frequency and organisation of such exercises is a matter for local management. It is recommended that they take place at least once a year or as determined by the fire risk assessment. For example, if there is a high staff turnover, there may be a need to carry them out more often.

**5.4** A fire drill should confirm the understanding of the training and provide information to improve future training. The Authorised Person (Fire Training) should determine the objectives of the drill, which may include:

- identifying any weaknesses in the evacuation strategy

- testing the procedure following any recent alteration or changes to working practices
- familiarising new members of staff with procedures
- familiarising staff with patient evacuation procedures
- testing the arrangements for the general evacuation of disabled people or specific PEEPs.

Fire drills should simulate conditions in which at least one of the escape routes is deemed to be obstructed by fire or smoke.

**5.5** Should an evacuation become necessary, it will require staff from different teams to work together. Although training will be based on specific workplaces, teams comprised of members from various departments should be given the opportunity to practice together, where required by the emergency plan.

**5.6** Drills should not endanger those taking part. During drills, the member of staff who is told of the fire should operate the fire alarm, and thereafter the fire routine should be rehearsed as fully as circumstances allow.

**5.7** Practical walkthrough training and simulated evacuations can also be a valuable aid in training, particularly where the nature of the patient care will mean that an evacuation drill presents an unacceptable risk. Where it is

unreasonable to carry out fire drills due to the nature of patient care, the use of simulated evacuation is acceptable and should be carried out. This may also be the case for disabled members of staff where the level of risk required for a disabled person may not be acceptable for a fire drill. The procedures put in place should take account of this and allow for simulation in the case of fire drills or other emergency evacuation practices. For a specific PEEP, any simulation should be informed by discussion with the disabled person. Simulation can also be used to practice features of general PEEPs that have been put in place for visitors.

**5.8** Fire evacuation drills may not be necessary within mental health in-patient facilities owing to operational considerations in relation to patient care. An assessment for the need of an evacuation drill should be completed with clinical staff. Alternative ways of ensuring that an effective evacuation can be carried out (such as desktop exercises and walkthroughs) should be considered.

**5.9** Observers should be appointed and positioned to oversee and monitor the fire drills. Records giving details of the drills and their outcome should be kept. It is important to identify lessons learnt, and to capture as much detail about the incident and the experiences of those involved as soon as is reasonably practicable. The purpose of a debrief is to identify issues that need to be addressed. A hot debrief should be carried out after a fire drill. The post fire drill or exercise reports should be supported by action plans with timescales and accountable owners. They should also include recommendations to update any relevant plans or procedures as well as identify any required training or organisational improvements that need to be put in place.

**5.10** Training should cover the need for staff to make an assessment of whether an evacuation is necessary, taking into account the immediate risk. This is vital as it is likely to happen before any formal fire management

structure has been put in place at the early stage of an incident.

## Exercises

**5.11** Exercises are larger in scale than a fire drill. An exercise is a simulation of an emergency situation which has three main purposes:

- to validate plans (validation)
- to develop staff competencies and give them practice in conducting their roles in the plans (training)
- to evaluate well-established procedures (testing).

**5.12** To be considered effective, planning for emergencies cannot be considered reliable until it is exercised and has proved to be workable. Misplaced confidence may occur if an emergency plan only exists in writing.

**5.13** An exercise should be used to validate emergency plans and the effectiveness of training. The participants in exercises should have received appropriate training in these aspects before any exercise. An important aim of an exercise should be to make people feel more comfortable in their roles, and to build teams and morale.

**5.14** Exercises fall into three categories: discussion-based, table-top and live exercises. Discussion-based exercises are based on a completed emergency plan and are used to develop awareness about the plan through discussion. This can be a valuable way of introducing staff to how an emergency plan is intended to operate at a larger scale. They offer the opportunity to confirm knowledge and understanding, especially where staff are expected to manage a growing or larger incident.

**5.15** Table-top exercises are another useful tool to practice evacuation exercises. These can be discussion-based and classroom-based exercises in which a team can act out

their roles and responsibilities in an emergency. They can provide a cost-effective opportunity to practice roles, responsibilities and procedures in a safe environment without causing disruption in a clinical setting. Table-top exercises can be timed exercises where team members practice responding to a variety of scenarios that reflects the emergency plan. For larger scale scenarios, they can bring together participants from other organisations such as the fire and rescue service. It is important that any table-top exercise is planned and facilitated by appropriately qualified staff

**5.16** Live exercises are a live rehearsal for implementing a plan. Such exercises are particularly useful for testing emergency plans and specifically logistics, communications and physical capabilities. They also offer the opportunity to practice multi-agency interoperability. To be effective, these require extensive preparation. Depending on the scale and nature of the exercise, the participation of

other bodies such as the fire and rescue service should be considered.

**5.17** All forms of exercises also provide experiential learning, helping participants develop confidence in their skills and providing experience of what it would be like to use the plan's procedures in a real scenario. They can be used to identify gaps in emergency plans and training, and test the strengths and potential outcomes of plans.

**5.18** As part of the NHS EPRR framework, healthcare organisations should conduct exercises to meet the requirements of preparation for the common consequences of incidents and emergencies. The opportunity should be taken to include a fire in a hospital as this is likely to require multi-agency attendance to resolve the incident. Where emergency planning exercises do not involve fire, they can be used to take the opportunity to train staff in the management of large-scale incidents.

# 6 Training needs analysis

## Developing the training needs analysis

**6.1** The TNA should be developed by the Fire Safety Manager in conjunction with the Fire Safety Adviser/Authorised Person (Fire Training) and should determine the appropriate training, in terms of content and frequency, for each group of staff whose activities, responsibilities and actions in the event of a fire are similar.

**6.2** In some cases, the TNA is likely to identify staff groups whose fire safety training requirements are minimal. For example, administration staff that work in offices remote from patient care areas, and whose duties do not bring them into patient or public areas, are likely to need to respond to a fire alarm activation by leaving the building and assembling at a predetermined assembly point. For these staff, annual fire safety training may comprise participation in a successful unannounced fire drill. This would be supplemented by a safety training session every three years.

**6.3** In other cases, some groups may require more frequent training with considerable instruction. For example, staff that work in operating theatres are likely to require some training in the characteristics of ignition and fire growth, especially in such an oxygen-enriched atmosphere (for example, the risk of fire to patients undergoing surgery). This will reduce the risk to patients and equip staff with the information necessary to prevent an incident occurring or, should one occur, with

the appropriate action to take. This training will also assist staff who must decide whether to continue with a procedure or seek to evacuate, as well as the evacuation techniques necessary to evacuate a very high dependency patient.

**6.4** The TNA example shown in Table 1 on page 33 is not exhaustive and is intended to highlight the process of, and the arrangements for, recording the analysis outcomes in a format that permits staff and their line managers to identify their training needs. The TNA will be informed by the roles required to carry out the emergency plan efficiently and effectively in case of fire.

## Transferability of training

**6.5** Any TNA for a member of staff should consider previous learning. This can be in the form of training from a different sector such as staff having received fire extinguisher training, staff having experience of managing fire evacuations or staff in senior emergency management situations. The TNA should provide the flexibility for this to be accepted as part of any training programme where it can be shown that it is comparable to the proposed training.

**6.6** Likewise, where staff move to different departments or from site to site, it is likely that their training needs will be an update on any existing training that they have received, based on this new situation. Where a member of staff changes role and has new

responsibilities, it should not be presumed that previous training is sufficient.

## Steps to developing the TNA

### 1. Determine staff members' fire safety responsibilities

**6.7** Consider the fire safety responsibilities of each staff member in terms of their role in preventing fires, managing fire safety and their response as part of the emergency action plan. The following examples are used to illustrate the process:

- An administrator that works in an office and does not enter patient or public access areas as part of their role: Has a general role for fire safety with no specific fire hazards and their fire emergency action plan is to evacuate themselves and attend the assembly point.
- An administrator that is ward-based or often enters ward areas: Has a general role for fire safety with no specific fire hazards and their fire emergency action plan may require them to assist in the evacuation of visitors and/or ambulant patients.
- A member of ward housekeeping staff: Has a general role for fire safety but may have to manage specific fire hazards associated with cleaning fluids, storage of waste and other combustibles. Their fire emergency action plan may require them to clear escape routes of service and cleaning equipment, and to assist in the evacuation of visitors and/or independent patients.
- A member of the food delivery catering staff: Has a general role for fire safety but may have to manage specific fire hazards associated with catering equipment. Their fire emergency action plan may require them to clear escape routes of equipment, to ensure the safe storage of potentially hot equipment and

to assist in the evacuation of visitors and/or ambulant patients.

- A member of the nursing staff on a general ward: Has a general role for fire safety but may have to manage specific fire hazards associated with medical gases. Their fire emergency action plan may require them to evacuate dependent patients, both horizontally and vertically, using evacuation equipment.
- A member of nursing staff on a critical care unit: Has a general role for fire safety but may have to manage specific fire hazards associated with medical gases. Their fire emergency action plan may require them to avoid patient evacuation where possible and to evacuate very high dependency patients, both horizontally and vertically, using evacuation equipment if necessary.
- Where members of staff are not directly employed by a healthcare organisation (for example, catering, cleaning or estates staff), it should be ensured that their training is included in the TNA.

### 2. Group staff with similar fire safety responsibilities

**6.8** Using the staff responsibilities identified in step 1, group together those members of staff that have similar fire safety responsibilities even though their usual functions may not be similar. For example:

- A dietician that regularly visits the ward areas may have similar fire safety responsibilities to an administrator that is ward-based or often enters ward areas.
- A physiotherapist, doctor or consultant that is ward-based or regularly visits the ward areas may have similar fire safety responsibilities to ward staff and may be able to assist in implementing the emergency action plan.



- A consultant surgeon or member of the operating theatre staff may have similar fire safety responsibilities to a member of nursing staff on a critical care unit.

### **3. Determine the training requirement for each fire safety responsibility**

**6.9** For staff to meet their fire safety responsibilities, they must receive adequate training. From the examples given in step 1, there are some discrete training requirements applicable to each group of staff represented. This would require the development of specific training packages such as:

- general fire safety and fire prevention
- general fire safety and fire prevention and the safe storage and use of equipment, combustibles and flammable solvents
- general fire safety and fire prevention and the safe storage and use of potentially hot equipment
- general fire safety and fire prevention and the safe storage and use of medical gases including cylinders
- the evacuation process: people who can self-evacuate
- the evacuation process: assisting independent patients and visitors
- the evacuation process: evacuating dependent patients
- the evacuation process: evacuating very high dependency patients.

**6.10** In some cases, it may be appropriate to combine training packages to provide training sessions with a broader relevance where there are sufficient common elements. For example, it may be appropriate to combine the training packages aimed at domestic staff with those aimed at catering staff where much of the training is common to both groups.

### **4. Determine the nature, duration and number of training sessions required to deliver the appropriate level of training for the fire safety responsibilities**

**6.11** For some groups the training syllabus will be relatively small, whereas others may require significant training input. Some fire safety training elements may be adequately delivered using alternative methods to face-to-face training. For example, general fire safety awareness and basic fire prevention may be adequately delivered to some groups using e-learning or printed media.

**6.12** The duration of any fire safety training session should be determined mainly by the content of the training syllabus that needs to be delivered. For some groups, the fire safety training syllabus is modest and will not require an extensive training session to deliver its content.

**6.13** However, for other groups it may not be practical to deliver the entire training syllabus to a training group in a single session. Therefore, several shorter duration training sessions, each presenting a different part of the training syllabus, may be preferable.

### **5. Determine the frequency at which each training element should be repeated**

**6.14** The frequency and/or duration of fire safety training should reflect the complexity of the information that needs to be imparted. The following example illustrates a flexible approach determined by the training needs of each group. For some groups, such as those whose fire emergency action plan consists of self-evacuation, the frequency of face-to-face fire safety training may be extended to as little as once every three years, provided that:

- in each intervening year, basic fire safety awareness is delivered through

e-learning, an interactive website or printed media, and

- an unannounced fire drill takes place, providing that the fire drill is considered successful.

### Training for staff working in operating theatres and other high-risk environments

**6.15** In operating theatres, there is a potential risk to patients of surgical fires due to the presence of the three main components of the fire triangle: a fuel source (such as surgical fabrics, swabs and alcohol preparation solutions), an oxidiser (such as oxygen or nitrous oxide) and an ignition source (such as electrical surgical equipment, lasers and fibre-optic lights). For staff working in operating theatres and other similar high-risk environments, the fire safety training syllabus is therefore likely to be extensive, requiring training in a broad range of fire safety topics including:

- fire prevention
- characteristics of fire and smoke
- reducing fire spread
- use of fire extinguishers
- deciding when to evacuate
- evacuating very high dependency patients.

See also the Surgical Fires Expert Working Group's (2020) report ['A case for the prevention and management of surgical fires in the UK'](#).

**6.16** Effective fire safety training for such groups is likely to require practical sessions in the use of fire extinguishers and the evacuation of very high dependency patients. Facilitating these practical exercises will not be easily achieved if combined with other fire safety training elements in a single session. It may be more appropriate to provide training in

the form of several shorter sessions, each concentrating on a particular aspect of the fire safety training syllabus. For example:

- Session 1: familiarisation session on the use of fire extinguishers.
- Session 2: classroom session on fire prevention, fire and smoke spread, etc.
- Session 3: department-based session on the theory of evacuating very high dependency patients, including a walkthrough of the fire emergency action plan.
- Session 4: practical session on evacuating very high dependency patients.

**6.17** A rolling training programme may comprise, for example, the delivery of each training session in turn with an interval between each training session.

**6.18** The information developed in the TNA can be readily displayed in a matrix format which identifies each staff group, each fire safety training package and the frequency with which each group should receive each training package that is appropriate for their fire safety and fire emergency action plan roles.

## Using the training needs analysis

**6.19** Table 1 on page 33 provides a typical TNA that can be used as a foundation for a healthcare organisation's TNA and as a baseline for a reasonable level of staff training. It is not intended that the format, content, frequency and duration of training sessions are fixed by this, but that they are modified and adapted to suit local circumstances and specific training needs for individuals and groups.

**6.20** The specific nature, duration and frequency of fire safety training should be determined by the Fire Safety Manager, reviewed periodically, and adjusted as

necessary to deliver the desired training outcomes.

**6.21** The provision of training should be determined based on the need to facilitate staff undertaking their roles in fire safety and implementing the fire emergency action plan. Limitations in the availability of training resources or the ability of staff to be released from their duties to attend training are not considered an appropriate basis on which to develop a programme of training.

**6.22** Using the approach described in Table 1, each staff group will receive refresher fire safety training at least once in every 12-month period, even though the nature of such training may vary from an unannounced fire drill (for those whose actions during a fire incident require self-evacuation only) to practical training in techniques for evacuating very high

dependency patients (for those in critical care environments).

**6.23** The TNA should be reviewed periodically and in response to:

- relevant changes including staffing, the number and dependency of patients, the nature of evacuation equipment provided and changes to the premises
- the fire safety training audit having identified that the level of understanding and awareness among staff of their fire safety responsibilities and their role in fire prevention and implementing the fire emergency action plan, is unsatisfactory
- a report by the enforcing fire authority highlighting training needs.



# 7 Training methodology

**7.1** Training can be delivered in various ways, face to face, through e-learning (including video), by practical skill acquisition such as fire extinguisher training or through exercises where staff work as a team to implement an emergency plan and bring a simulated fire incident to a successful conclusion. The TNA should identify which is the appropriate methodology for delivering training. There may be drawbacks to each form of training. For example, face-to-face training delivered to large numbers of people in a large theatre may not be effective as training in small groups.

## Face-to-face training

**7.2** In certain situations (for example, training in a practical skill such as using an evacuation sheet or fire extinguisher), face-to-face training is likely to be the only appropriate method. Showing a member of staff an escape route from a department is likely to be more effective when walked through practically than just by providing someone with a plan. Modern training delivery methods such as live virtual training via videoconferencing tools are a development of face-to-face training and can be particularly useful in small groups.

**7.3** This type of training also provides the instructor with the ability to evaluate their students in real time. Instructors can see how attentive a student is, how engaged they are with the studying materials and how well they understand it. This can also be used to evaluate the effectiveness of the training. Instructors can easily adjust the session to help their students learn more effectively.

**7.4** Face-to-face training can strengthen interpersonal relationships between staff. Dealing with a fire incident involves staff working as a team. Face-to-face team learning provides an engaging environment for staff to exercise their roles and responsibilities as well as see how they work together as part of a team. It also provides the facility for discussion and debate among staff which promotes the effective acquisition of new skills and knowledge.

## e-learning

**7.5** The use of e-learning is a rapidly developing area and may offer a number of benefits to an organisation such as ease of delivery. Care should be taken if adopting e-learning as the primary means of providing fire safety training to ensure it is best for the healthcare organisation based on the TNA.

**7.6** In extreme circumstances where a member of staff cannot be made available for training delivered by the Authorised Person (Fire Training) (for example, due to long-term sickness), the use of e-learning may be considered as a temporary alternative. However, no member of medical staff who has contact with patients should go without training conducted by the Authorised Person (Fire Training) for longer than two years. Therefore, medical staff who have contact with patients should not receive refresher training via e-learning more than once in a two-year period. (Note: staff who are working permanent night-duty do not constitute extreme circumstances.)

**7.7** In all but the smallest healthcare organisations (such as small GP practices with a single-stage evacuation plan), e-learning is not acceptable as the sole means of training staff. E-learning can only be used to support training delivered by a person competent in fire safety in the healthcare environment.

**7.8** E-learning is unlikely to be acceptable as the sole means of training for the following reasons:

- it may not take account of significant findings from fire risk assessments
- it may not take account of changes in working practice
- it cannot adequately train staff in skills that are inherently practical in nature, such as evacuation techniques, particularly those involving patient evacuation or the initial training in the use of fire extinguishers
- it is unlikely to provide job-specific training
- there is little opportunity for direct feedback to trainees' questions.

**7.9** Where e-learning is used, the learner should be provided with a process for contacting an appropriately trained member of staff who can clarify any points that remain unclear for the learner. The test results should

be recorded as part of the training management systems. All e-learning packages should be kept under review to consider any updates that may be required.

**7.10** With improving technology, it is likely that new opportunities for the delivery of training will become available. For example, the use of online platforms would allow group training sessions where trainers can interact with staff. These can be used to deliver knowledge-based learning and give opportunities for teams to carry out discussion-based scenario exercises. Computer-based learning platforms now offer the opportunity to explore the built environment, which could be used to familiarise staff with a building such as videos of specific wards/departments.

**7.11** Blended learning (a mixture of more than one type of learning) is likely to provide the best possible training approach offering a collaborative and comprehensive approach to learning. The delivery methodology of any training should be an important consideration when developing a training package. Any fire safety training package should be approved by the Fire Safety Manager in conjunction with the healthcare organisation's training department.

**7.12** It is incumbent on the Authorised Person (Fire Training) to assess the best way of delivering training based on the TNA and the outcomes of the fire risk assessment.

# 8 Training during periods of extreme operational pressure

## The risk of imminent danger

**8.1** Under the FSO, there is a duty to provide appropriate procedures to be followed in the event of serious and imminent danger from fire. There must be a sufficient number of competent persons nominated to implement these procedures to ensure the safety of all relevant persons. The procedures must be supported by appropriate training and instruction including safety drills. Under normal conditions this is provided by the emergency plan supported by appropriate training.

**8.2** While emergency plans should contain a degree of flexibility, it is inevitable that situations will occur where elements of the plan may become compromised (for example, owing to a flood, fire exit routes and fire assembly points may become unsafe or inaccessible in a short timeframe). Fire safety training should cover the importance of dealing with such incidents and highlight where appropriate support can be provided, led by the Authorised Person (Fire Training).

**8.3** There will be some situations where the normal running of the hospital will be disrupted by events such as:

- staff shortages
- industrial action
- health issues such as a pandemic or additional levels of patient care during the busy winter period that requires a

rapid alteration to clinical practice that can impact on fire safety (such as the use of temporary structures or buildings not designed as medical facilities, or the increased use of oxygen cylinders as seen during the COVID-19 pandemic).

**8.4** In these situations, there is the potential for fire safety training to be compromised:

- if the physical environment changes quickly, appropriate site-level training should be developed
- clinical processes may change; these may require a new assessment of the risk from fire.

**8.5** Where fire exits are rendered unavailable (due to a flood, for example), local management should recognise the need to use alternative escape routes and call upon the advice of the Authorised Person (Fire).

**8.6** Where an emergency causes significant disruption that affects either the viability of the emergency plan or requires alterations to clinical or management practices, the emergency plan should be updated. An assessment should be made of what areas of training will need to be updated and the criticality of their delivery. This should be carried out in conjunction with an assessment of the emergency plan. This is likely to be led by the board-level director with responsibility for fire safety supported by the Fire Safety

Manager and Authorised Person (Fire Training). The assessment should include:

- where, due to changes in the emergency plan, updated training needs to be provided to support the operational delivery of the plan
- any training that is required to support new clinical or general operational guidance that affects fire safety: this may be initiated by updates from NHS England or from processes such as the National Patient Safety Alert system. The need for new or updated training should be assessed by the Authorised Person (Fire Training).

## Training delivery

**8.7** Any event that disrupts the normal operation of a health facility is likely to disrupt the normal delivery of staff training. This can be for various reasons such as altered working practices due to clinical reasons (for example, working from home during a pandemic), staff shortages or the redeployment of staff to deal with an immediate risk.

**8.8** Depending on the likely time and extent of the disruption, the Fire Safety Manager

should assess the impact on training. This assessment should include.

- the ability to deliver scheduled fire safety training with adjustments to accommodate the priorities of response during abnormal operating situations
- the need to prioritise any training required by new clinical procedures. These may have a direct impact such as the use of non-medical buildings to provide care or the indirect consequences of greater use of oxygen cylinders during periods of extreme pressure
- the need to use alternative training delivery methods. It is likely that the use of e-learning delivery methods and computer communications would be preferred to face-to-face delivery methods
- the need to convey urgent fire safety updates, where the use of electronic media should be considered. It should be made clear that professional support is available from the Authorised Person (Fire Training) to both provide appropriate updates and clarify understanding.

# 9 Specialist training

## Medical gases

**9.1** Medical gases are either used from stored cylinders or via piped gas systems in hospitals. All staff responsible for medical gases should receive training in general safety considerations necessary in using gas, including fire safety. This should include:

- identifying medical gases in use and their application
- what procedures are necessary for the safe use of medical gases
- understanding the hazard warning signs and safety information including labelling on oxygen canopies and tents
- understanding how to safely move and store medical gas cylinders
- understanding how many medical gas cylinders should be stored in any local location
- managing potential ignition sources, including those introduced by patients and service users
- training for staff who will need to be able to operate shut-off valves for use in an emergency
- post-fire oxygen cylinder management
- an awareness of the need to consider medical gas safety during periods of extreme pressure, often exacerbated by a surge in respiratory conditions where this may present an increased risk from fire. This will include the need to seek

specialist fire safety advice from the Authorised Person (Fire).

**9.2** Training should also cover aspects of fire prevention such as the following:

- The risk from flammable materials placed in cylinder stores, manifold rooms or liquid oxygen compounds.
- The risk from flammable materials that may be found near patients including some nail-varnish removers, oil-based lubricants, skin lotions and emollients, cosmetic tissues, clothing, bed linen, rubber and plastic articles, alcohols, acetone, certain disinfectants and skin-preparation solutions. Staff should be aware of the fire risks posed by these materials.
- The numerous potential ignition sources such as open flames, burning tobacco and cigarettes, sparks and electrical sparks (including those that may be produced by some children's toys), high frequency, short-wave and laser equipment, arcing and excessive temperatures in electrical equipment such as hairdryers, cardiac defibrillator discharge and static electricity.
- The increased use of electrical points within the hospital to charge electrical items such as the following: mobile phones, mobile computers and e-readers, iPads, e-cigarette chargers (there have been several nationally reported incidents of charging devices overheating and catching fire).

- The increased risk of an oxygen-enriched atmosphere may be present when medical oxygen or nitrous oxide/oxygen mixtures are used. It should be noted that nitrous oxide also supports combustion.
- The risk presented from gases other than oxygen. A mixture of breathing gases will support combustion. In an oxygen- or nitrous-oxide-enriched atmosphere, materials not normally considered to be flammable may become flammable (flammable materials ignite and burn more vigorously).
- The risk associated with clothing may become saturated with oxygen or nitrous oxide and become an increased fire risk (when returned to normal ambient air, clothing takes about five minutes to be free of the gas enrichment). Blankets and similar articles should be turned over several times in normal ambient air following suspected oxygen enrichment.
- The fire risk associated with hyperbaric oxygen chambers which may be pressurised with oxygen up to three atmospheres. Pressurisation increases the fire risk still further and, in an emergency, it will take an appreciable time to remove an occupant. Therefore, the most stringent fire precautions to avoid ignition are necessary in and around hyperbaric oxygen chambers, including the design of electrical services. Training should also include the fire precautions necessary for the release of hyperbaric oxygen from a chamber.

**9.3** During periods of extreme pressure, often exacerbated by a surge in respiratory conditions, demand on supplies of oxygen cylinders, especially the smaller sizes, increases due to the need to provide essential oxygen treatment in areas without access to medical gas pipeline systems. This surge in demand increases the known risks associated

with the use of oxygen gas cylinders, and introduces new risks across two main areas:

- appropriate ventilation (both in physical environments and in ambulances)
- the safe storage of cylinders.

**9.4** Advice on these matters can be obtained from the Medical Gases Safety Group and the Authorising Engineer (Medical Gases).

## Moving and handling

**9.5** Training should be provided in the evacuation of patients who will require assistance. This should consider the patient-handling methods that would be appropriate in an evacuation, bearing in mind building constraints on the escape route and the types of patients.

**9.6** The training should include the minimum number of staff required at specific locations to achieve the safe and speedy evacuations of all patients. It should also include the appropriate evacuation routes and alternative routes if required from a location, and include the use of lifts, if appropriate, and of disabled refuge points.

**9.7** Specific training should also cover the various methods of assisting dependent patients provided such as:

- the evacuation of patients on their beds
- evacuation sheets which can be fitted on to hospital beds and allow patients to be slid safely along corridors and/or downstairs
- evacuation chairs (stair chairs) which can be used for the evacuation of mobility-impaired patients
- the specific needs of evacuating patients of size and highly infectious and radioactive patients
- the use of evacuation lifts



- evacuation mats which resemble thin mattresses.

## Personal emergency evacuation plans

**9.8** PEEPs are specific plans developed to facilitate the safe evacuation of people with disabilities or other needs requiring assistance during evacuations. PEEPs outline specific procedures and support to be provided to individuals who may need adaptations to standard evacuation procedures. This may be in the form of a specific adjustment, such as a vibrating pager for a deaf person or specific adaptation for someone with a mobility impairment. Healthcare organisations should engage with staff who need a PEEP to provide appropriate adjustments.

**9.9** The emergency plan should also include standard plans for occasional visitors. Standard evacuation plans are written procedures that can be used as options for disabled people to choose from. There will be situations where visitors to hospitals who are not patients do not make a disability known to staff. It is important that emergency plans take this into account.

**9.10** A vital ingredient of any PEEP is staff training. All staff should receive appropriate training to assist disabled people. This is distinct from specific training required when dependent patients require specific evacuation planning. (Further guidance can be found in the Home Office's (2007) 'Fire safety risk assessment: means of escape for disabled people' (updated in 2023).)

## Fire extinguisher training

**9.11** The early use of fire extinguishers can control a fire and prevent an incident growing to a stage where it threatens people not in the immediate area. Extinguishers should primarily be used to protect life and facilitate safe escape. They should otherwise only be used if

they can be used safely and without risk of trapping the user.

**9.12** People with no fire extinguisher training should not be expected to attempt to extinguish a fire with fire extinguishers available. However, all staff should be familiar with the location and basic operating procedures for the equipment provided in case they need to use it. If the emergency plan means that certain people (for example, Fire Wardens) will be expected to take a more active role, they should be provided with more comprehensive training.

**9.13** The TNA should identify staff groups who should receive practical training in how to use fire extinguishers. This may be due to the nature of their work, such as staff working in operating theatres, or because of the need to have a minimum number of staff trained in first-aid firefighting.

**9.14** Where the emergency plan and fire risk assessment has identified that only certain staff groups are expected to use fire extinguishers, other staff should be trained to recognise that the fire extinguishers provided are accessible and in good condition. Fire Wardens should be able to understand whether the appropriate fire extinguishers are provided in the area under their remit and whether they are being maintained at the required intervals.

## Major incident training

**9.15** All staff should receive training to equip them for a major incident. For staff with responsibilities in a defined area at an operational level (for example, in a ward or department), standard fire training should be sufficient. This should include an understanding of how the emergency plan will evolve if a fire incident grows and of their role within that plan. This should be supported by fire drills.

**9.16** Staff who have a managerial role (for example, the incident response team who will

initially have a tactical role in managing an incident) should receive appropriate training supported by regular exercises. Senior staff who are likely to have a strategic role in a major incident should receive appropriate training for their role, backed up by exercise training.

**9.17** The NHS has produced [minimum national occupational standards \(NOS\) for EPRR](#).

These set out the minimum national occupational standards that health commanders, managers, staff responding to incidents as part of an incident management team and other staff involved in EPRR should achieve to be competent and effectively undertake their roles. It is also useful to consider more general training on the JESIP process and links with local resilience forums.

**9.18** It is probable that in a significant fire the roles outlined in the NHS EPRR framework overlap with those that are required for incident command. The EPRR framework seeks to have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios. In assessing the skills that are required to manage a growing and potentially large-scale fire, the NOS could form a basis for training in fire incident management. The EPRR requires that a TNA is carried out as part of the process of putting in place the structure for dealing with emergencies. This should be utilised when assessing the skill sets and roles for dealing with fire incident management.



Table 1 Training needs analysis

	Initial fire safety induction	General fire safety (e-learning)	General fire safety (classroom learning)	Fire safety induction (local-workplace specific)	Medical gases (including pipeline systems and cylinders)	Fire evacuation drill	Assisting independent patients & visitors	Evacuating dependent patients (theory and practical)	Evacuating very high dependency patients (theory and practical)	Role and responsibilities of the fire response team
A non-medical member of staff with no patient or public-facing responsibilities	A	12	36	B		12				
A non-medical member of staff that is ward-based or often enters ward areas	A	12	24	B		12	12			
Porters	A		12	B	12	12	12			
A member of the nursing staff on a general ward	A		12	B	12	12		12		
A member of nursing staff on a critical care unit	A		12	B	12	12			12	
A member of healthcare staff working in an operating theatre	A		12	B	12	12			12	
Member of the fire response team	A			B		12				12

Notes:

A = on starting work for the organisation. B = On starting work in a specific area.

Where staff complete general fire safety classroom training in a 12-month period, there is no requirement to also complete e-learning in that period.

Staff will work varying shift patterns and undertake hybrid working or work part-time hours. This needs to be taken into account. It should not be used as a reason to reduce the level of training. Staff based in community settings should have their training adapted for their specific scenario. Where staff are working outside of healthcare premises or at home, fire safety training should be included in general health & safety training and any training that links specifically to patients in their home. This should include basic training on how to identify specific fire hazards in the home, the use of medical gases and what arrangements are available to put appropriate safeguards in place.

# References

## Note:

The publication dates provided in the references list below correspond to when this edition of HTM 05-03 Part A was drafted. The dates give context on the currency of referenced sources at the time of writing.

Standards and other specification documents are continually being updated, and readers should ensure they consult the latest editions of such documents, including any amendments issued after publication, to ensure they remain up to date with and can react to changing requirements.

## Acts and Regulations

### Building Safety Act 2022.

<https://www.legislation.gov.uk/ukpga/2022/30/contents/enacted>

### Equality Act 2010.

<https://www.legislation.gov.uk/ukpga/2010/15/contents>

### Higher-Risk Buildings (Descriptions and Supplementary Provisions) Regulations 2023.

<https://www.legislation.gov.uk/ukdsi/2023/9780348242812/contents>

### Regulatory Reform (Fire Safety) Order 2005. SI 2005 No. 1541.

<https://www.legislation.gov.uk/uksi/2005/1541/contents/made>

## NHS England publications

### Health Technical Memorandum 05-01. Managing healthcare fire safety. 2013.

<https://www.england.nhs.uk/publication/managing-healthcare-fire-safety-htm-05-01/>

### Health Technical Memorandum 05-03 Part B. Fire detection and alarm systems including the reduction of false alarm and unwanted fire signals.

<https://www.england.nhs.uk/publication/fire-safety-in-the-nhs-health-technical-memorandum-05-03/>

### Health Technical Memorandum 05-03 Part K. Guidance on fire risk assessments in complex healthcare premises.

<https://www.england.nhs.uk/publication/fire-safety-in-the-nhs-health-technical-memorandum-05-03/>

## Miscellaneous references

Home Office (2007). **Fire safety risk assessment: means of escape for disabled people** (updated in 2023).

<https://www.gov.uk/government/publications/fire-safety-risk-assessment-means-of-escape-for-disabled-people#full-publication-update-history>

Surgical Fires Expert Working Group report (2020). **A case for the prevention and management of surgical fires in the UK.**

<https://www.pslhub.org/learn/patient-safety-in-health-and-care/high-risk-areas/surgery/preventing-surgical-burns/a-case-for-the-prevention-and-management-of-surgical-fires-in-the-uk-expert-working-group-recommendations-september-2020-r3572/>

NHS England  
Wellington House  
133–155 Waterloo Road  
London  
SE1 8UG

This publication can be made available in a number of alternative formats on request.

© NHS England 2024

Publications approval reference: PRN00619\_i

---