

**NHS England
Emergency Preparedness,
Resilience and Response
(EPRR)**

**Planning for the Shelter and
Evacuation of people in
healthcare settings**



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Planning for the shelter and evacuation of people in healthcare settings

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This material should be read in conjunction with the NHS England Emergency Preparedness Framework. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at <http://www.england.nhs.uk/ourwork/epr/>

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Forward

1. This guidance updates and supersedes the 2009 Department of Health guidance '*Planning for the evacuation and sheltering of people in health sector settings: Interim strategic national guidance*'.
2. This guidance was developed by a Task and Finish Group convened by NHS England comprising of representatives from a variety of healthcare service providers across the country.

Purpose of Guidance

3. The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Under the Civil Contingencies Act (2004), NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients (for detail see Section 5). This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).
4. This guidance is intended to provide a framework for all Health and Social Care providers in the planning, preparation and response to sheltering and evacuating of patients, staff and others from, or within, health care settings, including whole site evacuation.

Context and Scope

5. While this guidance concentrates on the shelter and evacuation of hospital sites, the principles are sufficiently flexible to be adapted for use in respect of other buildings or facilities on healthcare provider sites or to wider primary, social and community care and independent sector facilities.
6. Shelter and evacuation planning is part of broader emergency planning and preparedness, it should take account of existing:
 - Major Incident plans;
 - Fire Response plans;
 - Business Continuity Plans;
 - Lockdown / Controlled Access plans;

Definitions

7. For the purposes of this guidance:

Command is defined as; “The exercise of vested authority that is associated with a role or rank within an organisation, to give direction in order to achieve defined objectives)”¹.

Control is defined as “The application of authority, combined with the capability to manage resources, in order to achieve defined objectives.”¹

Co-ordination is defined as “The integration of multi-agency efforts and available capabilities, which may be interdependent, in order to achieve defined objectives.”¹

Evacuation is defined as “Removal, from a place of actual or potential danger to a place of relative safety, of people and (where appropriate) other living creatures.”¹

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

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

Shelter is defined as “a place giving temporary protection”². It may be necessary to move patients into temporary shelters until such time as they are able to return to the affected healthcare facility, or until they are able to be transported to another healthcare facility.

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

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

¹ Cabinet Office (2013) Lexicon of Multi-Agency Emergency Management Terms
Version 2.1.1 <https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon>

² Oxford Dictionaries

Other commonly used resilience terms are available in the Cabinet Office's Civil Contingencies Secretariat Lexicon available online¹.

Risk Assessment

8. There are many types of emergency that may affect an organisation and its ability to maintain patient safety. There are various risks that may result in a healthcare facility requiring to shelter its patients and staff in places of greater safety or to activate partial or full site evacuation. These can include:
 - Power and other utility failure
 - Explosion or suspect package
 - Adverse Weather
 - Flooding
 - Fire
 - Irritant fumes or hazardous materials release
 - Terrorist event
9. The different nature and severity of these risks will determine the level of evacuation and support that the organisation requires.
10. The primary purpose of any sheltering or evacuation is to ensure the safety and security of patients; this will be at the forefront of every decision. Therefore, the decision to shelter or evacuate must be made based on the overall risk to patients and personnel involved in their care, and other members of the public who may be in the vicinity of the event.
11. As part of planning, it is imperative that a risk assessment starts the process. Site specific shelter and evacuation plans should be informed by risks most likely to impact the site and the wider local area using relevant resources including the Community Risk Register. Within the site, the risk assessment process should include the risks associated with the location(s) of certain types of patients in relation to the ease of evacuation. This risk assessment will not only direct mitigating measures but also lead the planning regime.

Planning Assumptions

12. Health and social care organisations need to develop site specific plans that identify possible places to shelter and triage patients. Plans should identify on-site and off-site shelter locations to hold patients in the initial stages of an evacuation. Planning should identify how patient care would be delivered in the short, medium and long term, depending on the cause of the requirement for the shelter and/or evacuation in the first instance.
13. Hospitals should consider and plan for partial and complete evacuations; this should include suitable triage and sheltering areas outside the hospital building. Planning should also identify the staff required in these areas in order to ensure continued medical care for sheltered patients.

¹ Cabinet Office (2013) Lexicon of Multi-Agency Emergency Management Terms
Version 2.1.1 <https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon>

14. Where appropriate patient care and safety together with sufficient staff, medications and other resources can be maintained throughout the incident, it may be preferable for some patients and personnel to remain in-situ rather than to evacuate.
15. In extremis it is acknowledged that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. As is the case with healthcare in general, in the event of demand for services exceeding or overwhelming supply, the underlying principle is to achieve best health outcomes for patients based on the ability to achieve health benefits. It should also be noted, that some patients may experience greater harm by being moved than by not being moved and this will require clinical and managerial dynamic decision-making.

Roles and Responsibilities

Responsibilities of the healthcare providers

16. NHS Trusts should already have procedures for evacuating areas of a facility in the event of major disruptions. These should be aligned with the organisation's incident response plans. The total evacuation of a hospital or mental health facility would, however, be considered only under extreme circumstances. In such circumstances the decision to evacuate would be made locally taking into account:
 - the overall risk to patients;
 - appropriate safe transport and patient-tracking mechanisms; and
 - a suitably resourced destination.
17. Key elements which need to be considered by the NHS are:
 - Maintaining primary care services to the population being evacuated, including health resources to any evacuation or humanitarian aid centres, for example community nurses, GPs, and pharmacies, to offer support during the period of evacuation.
 - Close working with social services and voluntary organisations, identifying and supporting those deemed vulnerable by the incident who are being evacuated.
 - All hospitals and in-patient care facilities should have plans in place to effect a whole-site evacuation, if required. However, such plans should ensure that any evacuation of a hospital is seen as a last resort.
18. NHS England and the NHS in England must plan for the provision of healthcare services for a significant population influx that may have been evacuated from a wider geographical area. This should include providing healthcare to those made ill, or more seriously so, by the process of evacuation.
19. All NHS Trusts are expected to have business continuity arrangements in place to reduce the risk of evacuation in predictable circumstances.
20. NHS organisations owe a duty of care to both their patients and their staff and therefore healthcare providers should be aware and understand that it is not the responsibility of the emergency services to decide to evacuate an NHS facility; this responsibility rests with the organisation under whose care the patient(s) are under. NHS organisations have responsibilities under:
 - Health and Safety at Work Act 1974, (section 2(1) and (section 2(2)
 - The Management of Health and Safety at Work Regulations 1999 (regulation 3), (regulation 4 and Schedule 1), (regulation 8(1)), (regulation 8(1)(a) and (b)) and regulation 4(4)
 - Safety Signs and Signals Regulations 1996
 - Regulatory Reform (Fire Safety) Order 2005 (article 14(1) and (article 14 (2)
 - Department of Health Fire code guidance (HTM 05-01)
 - Regulated Activities Regulations Section 9 sub section (2), Section 7 sub section (1 and 2) and Section 10 sub section (2)

Role and Responsibilities of key partners

21. The roles and responsibilities of key resilience partners are set out in documents published by the UK Government. They are:

Cabinet Office Emergency preparedness:

<https://www.gov.uk/government/publications/emergency-preparedness>

Cabinet Office Emergency response and recovery

<https://www.gov.uk/government/publications/emergency-response-and-recovery>

Cabinet Office Evacuation and Shelter Guidance

<https://www.gov.uk/government/publications/evacuation-and-shelter-guidance>

22. The roles and responsibilities of the health sector are to provide primary care for the evacuated population and working with other partners such as Local Authorities, utility companies and the Voluntary Sector to identify and support the vulnerable. NHS Trusts remain responsible for patients evacuated from their facilities, for their continuing care and treatment albeit in other locations, whether those are healthcare premises or not, until those patients are formally discharged from their care.
23. Local Resilience Forums have an important role to play with ensuring that partners are engaged in relation to the planning for evacuation at healthcare facilities in their respective area. Due to the complex nature of these types of incidents Local Resilience Forums are asked to ensure that sites are identified in their areas, appropriately risk assessed through the Community Risk Register and specific plans are in place for the “high” or “complex” sites.
24. Links to Local Resilience Forum plans will need to be investigated including the availability and suitability of Local Authority facilities and the liaison channels that ensure emergency support centres (eg Rest Centre, Survivor Reception Centre, Humanitarian Assistance Centres) are set up and staffed appropriately to meet patient care needs.

Plans and Planning

25. Health organisations will need to develop a site specific plan for sheltering and evacuation. These plans will need to be based on the principles set out in the Cabinet Office Evacuation and Shelter Guidance 2014¹, especially Appendix B, ‘Suggested Roles and Responsibilities’
26. The need to plan and prepare for sheltering and evacuation is emphasised for NHS organisations. In doing so, all health sector organisations will wish to take into account of the diverse needs of all people on site including patients, staff, visitors and contractors when developing shelter and evacuation plans. It is suggested NHS organisations should undertake:
- assessment and planning in the pre-incident phase including engagement with partner organisations,

¹ <https://www.gov.uk/government/publications/evacuation-and-shelter-guidance>

- formulation of organisational plans,
 - discussion and dissemination of plans in a suitable for approval and/or adoption.
27. It is suggested that this planning phase should include:
- The development of a site specific shelter and evacuation plan that is an integral part of the organisation's suite of resilience plans (i.e. business continuity arrangements and/or major incident or incident response plan). It should be available in whatever format suits the organisation best and be widely available.
 - Training and exercising, as this should be a formal part of staff training and education for the organisation and be part of an overall programme including suitable exercises to support the requirements of the site and the likely risks faced.
 - Developing plans for how a response will be mounted in a reasonable worst case scenario, taking account of the requirements of different times of the day and days of the week and the different circumstances that may apply, for example, the numbers of staff on duty.
 - Making contact with the Local Resilience Forum (LRF) evacuation lead (usually the local authority) and any other organisation named in the plan.

The basis for planning and responding

28. The following key points have been identified, that health sector organisations should note:
- The starting point for planning should be the identification of local risks.
 - Planning must be flexible to allow the response to be tailored to the event, with dynamic risk assessment.
 - There is a need to be joined up at and make use of existing local planning arrangements e.g. Local Resilience Forums.
 - Resources should be sought from a wide range of agencies and partners – locally, regionally, nationally and internationally, as appropriate for the organisation.
 - Plans should include the probable/possible loss on site of the Incident Control Centre (ICC) room facility during the evacuation.
 - Call-off contracts should be considered.
 - Having the right up to date contacts is critical.
 - Identifying the vulnerable(including those with special communication needs) is a key issue and registration of evacuees and consideration of a logistics database being quickly established.
 - Police may not always be able to secure all evacuated areas and premises given the likely demands on their resources.
 - Examples of best practice would be useful.
 - It is acknowledged that it is difficult to fully exercise a shelter and evacuation plan and therefore need to develop other ways of testing the arrangements.
 - Plans are needed on arrangements for warning and informing, particularly delivering urgent alerting.
 - Mapping of shelter and evacuation zones should form part of the planning

- Transport arrangements with safe routes should be identified both in and out of the site.
- Take account of all on-site people e.g. patients, staff, visitors and contractors.

Activation Triggers

29. The risks which may result in a healthcare evacuation are set out in paragraph 8 above. The decision to evacuate may therefore be triggered by an internal emergency e.g. a fire, or an external emergency e.g. flooding.
30. Hospital staff may activate immediate shelter or partial evacuation plans to ensure the safety of patients e.g. in the event of a fire in their locality.
31. The decision to conduct whole site evacuation is the responsibility of the organisation's chief officer or those with delegated authority e.g. Director on-call.
32. It is the responsibility of the health care organisation to make the arrangements for that shelter and/or evacuation (or invacuation) in a manner appropriate to that organisation. Organisations need to take into account factors such as the risks they are exposed to, the nature and diverse needs of the patients being cared for on the site, the level of staffing available, the trigger for the evacuation and the time of day an evacuation may be needed. and the command control structure which will be required.

Shelter

33. Health organisations will need to develop site specific plans that identify possible places to shelter including holding areas that are appropriate to local needs. Organisational links to other healthcare partners (including independent providers) and the Local Resilience Forum(s) will be an important part of this work.
34. In the initial stages of evacuation a number of 'shelter in place' locations should be considered to include options both on-site, as well as healthcare settings off-site and non-healthcare settings off site. On-site shelter points should take into account local fire compartment planning. Off-site shelter points should reflect an area of safety, away from the health care organisation, where people can wait until they are either re-directed to another health setting, hospital or taken home. Common choices for off-site shelter points are:
 - Churches
 - Town Halls
 - Community Centres
 - Local Authority rest centres (if in the locality)
35. The choice of shelter locations should be pre-determined with assistance from the organisation's Emergency Preparedness, Resilience and Response (EPRR) Officer and where appropriate the Local Authority and other healthcare partners. Shelters can mirror the concept of an ambulance major incident casualty clearing station where patients are being held in a relatively safe environment, awaiting transport.
36. Where short-term shelter is considered to be a necessity, health organisations should have plans in place reflecting the Cabinet Office Evacuation and shelter guidance¹.

¹ <https://www.gov.uk/government/publications/evacuation-and-shelter-guidance>

Evacuation Levels and Phases

Evacuation Levels

37. For health and social care providers there are three primary levels when evacuation may be necessary or should be considered:

Table 1: The levels when evacuation may be necessary and the implications

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

38. The decision to shelter or evacuate should only be taken if following a dynamic risk assessment, the risk to life of remaining in situ is assessed to be greater than the risk evacuation. In certain circumstances, it will be safer to remain in situ or invacuate rather than evacuate.

Phases of Evacuation

39. The need for shelter or evacuation will depend on the circumstances of the incident. The type of incident will also influence the time available for evacuation and whether partial or full evacuation is required. Should evacuation be necessary, advance warning can allow staff and patients to prepare and facilitate an efficient and effective evacuation.
40. Phased evacuation should be considered where different parts of premises are to be evacuated. Evacuation is undertaken in a controlled sequence with those parts of the premises expected to be at greatest risk being evacuated first.
41. The following stages apply:

Table 2: The Stages/Phases of an evacuation and the implications

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

42. Should evacuation become necessary in one in-patient ward/department there will be a variety of patient dependencies to consider. The evacuation should be based on the concept of progressive horizontal evacuation, with only those people directly at risk from the effects of the incident being moved. This involves moving people at immediate risk to a primary holding area or place of temporary safety (Phase 1). If the incident is not contained to one ward a whole floor may need to be vertically evacuated with patients moved to a lower or upper floor (Phase 2), as appropriate.
43. The occupants may remain in the primary holding area until the incident is dealt with or await further evacuation to another similar adjoining area or down the nearest stairway. This procedure should give sufficient time for non-ambulant and partially ambulant patients to be vertically evacuated down or up stairways as appropriate, to a place of safety. It may become necessary to evacuate an entire block or zone of the hospital (Phase 3). In addition, it may be that more than one block or zone of the hospital is affected leading to the evacuation of the entire site (Phase 4).
44. It is acknowledged that tracking staff during an evacuation is a challenge, however each organisation has a duty of care to know which staff are working within the building at any one time, including contractors. The nurse/person in charge of a patient area should be aware of which staff are on duty due to the staff duty rota. The rota can be used to support the nurse/person in charge's local knowledge of staff on duty and should be available at short notice wherever possible¹.
45. Following any evacuation, it is highly likely that there will be a need to assess and reassess (re-triage) the dependency of patients to assist with the appropriate allocation of patients to onward places of safety, including medium and long-term shelter, for example, another hospital, to a nursing home or to their own home.
46. Healthcare organisations should have plans in place to repatriate patients that have been evacuated and plans to provide continuing clinical support to these patients as appropriate.

¹ NHS London, (2009)

Patient Management

Triage

47. It is the responsibility of all healthcare staff to do the most for the most during an incident involving the evacuation of patients. In-patient consultant-led speciality teams and nursing staff will have a key role prioritising their in-patients for inter-hospital transfer if required. Triage assists with making decisions on whom to evacuate and in what order and needs to be a dynamic process.
48. Triage also helps determine the resources required to shelter and/or evacuate patients, the mobility of patients, the type of shelter and equipment required, the length of time it will take to facilitate the relocation and the type of transport required for off-site evacuation.
49. The national ambulance service major incident triage card system (TSG Associates Smart cards) can be adapted to assist with evacuating patients. The system is predominately used for multiple casualty incidents though the cards, colours used and tracking system can be modified for evacuation use in a hospital situation (see Table 3 overleaf).
50. The evacuation triage algorithm uses mobility and dependency to determine the evacuation triage priority, categorising patients into the groups Very Dependent, Dependent, and Independent.
51. In order to aid planned and emergency evacuation health organisations should consider recording patient's evacuation triage priority, the equipment required to be evacuated with the patient, the staff resources needed to evacuate the patient and the specialist drugs required for evacuation in an easily accessible location.

Clinical Decision Making

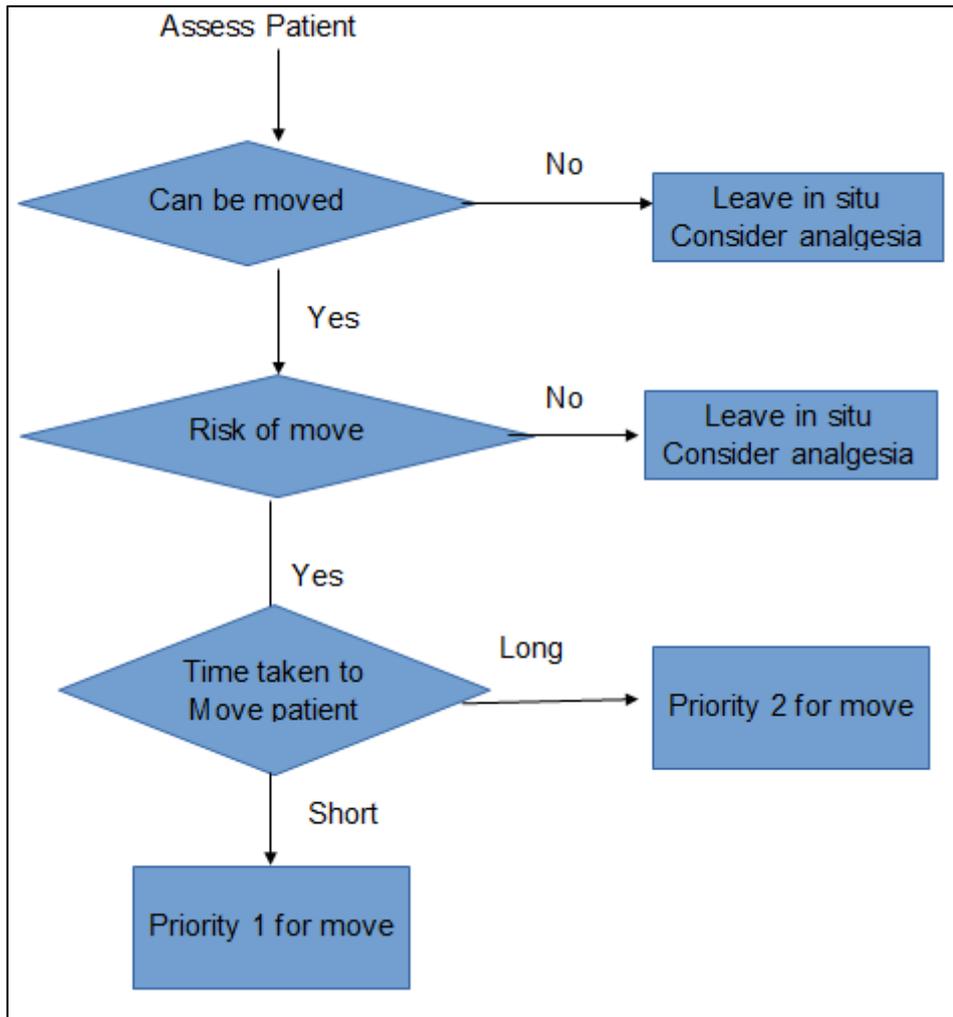
52. When considering whether to move a patient, there are a number of factors which should be considered including:
 - Difficulty of movement (ie mobility of patient, what equipment is needed to be taken to ensure patient care)

Table 3: Healthcare Evacuation Triage Priorities:

Evacuation Priority	Category	Triage Card Colour (if used)	Definition
Evacuation Priority 1	Very dependent	Red	<ul style="list-style-type: none"> a. patient is on assisted ventilation b. patient is of such a weight as to require the assistance of 3 or more staff to effect evacuation c. patient cannot be disconnected from 1 or more pieces of apparatus for more than 60 seconds d. patient is connected to life support machinery e. patient is unconscious and in life threatened state f. patient requires more than 7 minutes to be disconnected from 1 piece of equipment g. patient is undergoing surgery h. patient has undergone major surgery under general anaesthetic i. patient requires 2 staff to effect evacuation j. patient can only be moved on his/ her bed k. patient is in critical condition/attached to more than 1 piece of apparatus l. patient is unconscious m. patient is under section mental health act n. patient is blind or deaf or has other extra-ordinary communication needs
Evacuation Priority 2	Dependent	Yellow	<ul style="list-style-type: none"> a. patient can only move on his/her bed b. patient is connected to 1 piece of apparatus (e.g. drainage bag) c. patient must be moved in a wheelchair by another person d. patient requires more than minimal assistance or is unwilling to be dressed in adequate clothing requiring therefore 1 or more persons to assist e. patient has dementia to the extent that they cannot be left without supervision f. patient can walk unaided for less than 5 metres g. patient has severe sight impairment or severe hearing impairment
Evacuation Priority 3	Independent	Green	<ul style="list-style-type: none"> a. patient can mobilize by him/herself in a wheelchair b. patient can walk unaided at less than normal pace c. patient has significant sight or hearing impediment d. patient can walk at same speed and for same distance as a member of staff e. patient can get out of bed and dress in adequate clothing with none or minimal assistance

- The time that would be taken in moving a particular patient vs moving other patients also on the ward/in the clinic.
 - The risk to the patient of them being moved
 - The risk to the patient of them remaining in situ.
53. This has been set into a simple algorithm (see Figure 1 overleaf). To illustrate the principles being used, some examples of how this may be implemented are below:
54. **Example 1:** A complex patient on multiple inotropes, who is unstable upon turning. Using the algorithm the decision would be that this patient is very high risk for evacuation and may die if moved. If the trigger for evacuation were a fire in a distant portion of building which whilst operating the fire alarms in the patient's vicinity, but is currently at low risk of spread to the Intensive Care Unit, then the patient should remain in situ.
55. **Example 2:** A complex patient on multiple inotropes, who is unstable upon turning. Using the algorithm the decision would be that this patient is very high risk for evacuation and may die if moved. If the trigger for evacuation were a fire in the ward below, which whilst operating the fire alarms in the patient's vicinity, is considered very likely to involve the unit, then the dynamic risk assessment including the risks posed to staff caring for the patient should result in the patient being moved, even if to a place of temporary shelter for re-triage.
56. **Example 3:** A complex patient is connected to an extracorporeal device (ECMO). If the trigger for evacuation were a fire in the ward below, which whilst operating the fire alarms in the patient's vicinity, it is acknowledged that due to the connection to the extracorporeal device (ECMO) it would take staff at least thirty minutes to prepare for evacuation. The dynamic risk assessment including risks to posed to staff caring for the patients should result in the patient being left in situ with consideration given to adequate and appropriate sedation.
57. **Example 4:** A complex patient is connected to an extracorporeal device (ECMO). If the trigger for evacuation were a fire in another ward in same block, which whilst operating the fire alarms in the patient's vicinity, it is acknowledged that due to the connection to the extracorporeal device (ECMO) it would take staff at least thirty minutes to prepare for evacuation. The dynamic risk assessment including risks to posed to staff caring for the patient should result in this patient being a low priority for evacuation. However staff should begin preparations as long as this does not endanger other patients, and should ensure that continuous dynamic risk assessments are carried out for all patients under their care.

Figure 1: Evacuation and Shelter Aide Memoire v1.0



(Source: NHS England EPRR Clinical Reference Group)

Tracking and identification of patients evacuated

58. Tracking is necessary to track the movement of all patients and staff from their originating department or ward to a place of safety (even if interim), other health location or outside of the area.
59. Health organisations should ensure that a robust mechanism of evacuating patient notes with patients, including electronic notes where appropriate exists. Patient notes should be where possible gathered up and kept with the patient; this is a responsibility of the clinician caring for that patient. Triage labels can also be used to document important information relating to those patients, if appropriate.
60. Health organisations should ensure a mechanism for tracking patient movements by implementing a dedicated command role with action card and tabard. Any member of staff (clinical or non-clinical) can perform the role of a 'Tracking Officer'. It is critically important that all departments keep a log of all

of their own patients and staff in order to communicate this information to the Tracking Officer as soon as they have evacuated¹.

61. Any major incident triage card system in use at a hospital could be utilised for evacuation purposes using the principles set out in the Healthcare Evacuation Triage Priorities (Table 3). Where the national 'ambulance' triage card system is in use a tear off transport tag to track a patients departure from a particular area could be used for immediate tracking purposes.
62. A patient and staff tracking proforma should also be used to note persons accounted and unaccounted for.

Moving vulnerable patients

63. What makes a person vulnerable, or become vulnerable in an emergency will vary from person to person and from one type of emergency to another. This highlights the point that it is not necessarily only those who would normally be described as vulnerable that are affected such as hospital patients, sensory impairment and the patients with a disability for example, but it also recognises that some people may become vulnerable because of their inability to cope with changing circumstances or the need for support with communications when explaining the evacuation process.
64. Health organisations should determine the potential scale of requirements of sheltering and evacuating patients and other vulnerable people on their premises, which should be estimated in advance without divulging information about individuals. This information can be fed into planning of resources and equipment. In the context of evacuation within a healthcare setting, the main groups of clinically vulnerable patients are likely to be being cared for in locations such as:
 - critical care (adult, children, neo-natal and others)
 - infectious disease and isolation units
 - operating theatres and their associated recovery areas
 - mental health, including high secure units, and intellectual and developmental disabilities units
 - children's wards and units
 - cancer treatment wards, outpatient units
 - renal dialysis units, renal wards, outpatient units and associated areas
 - cardiac treatment wards, outpatient units and associated areas
 - bariatric wards and units
65. Please note that this list is for purposes of illustration only and is not intended to be exhaustive. Planning by health organisation should include managing mental health patients if the organisation cares for them at any time, especially those requiring specific security and pharmaceutical measures. Consideration should be given to the sheltering of immuno-suppressed patients not in the same location as other known infectious patients.

¹ NHS London, 2009

66. Plans should include how medications can be obtained from alternative organisations when planning for on or off-site shelters in non-clinical facilities.
67. Where a health organisation cares for patients in critical care, detailed planning around the shelter and evacuation should take place. Organisations should ensure that a system is in place to evacuate patient equipment and that the patient shelter location has sufficient resources to maintain vital critical care equipment.
68. A Personal Emergency Evacuation Plan (PEEP), a pre-determined plan to work from/make reference to in the event of evacuation, should be completed for any patient who may need assistance to evacuate. For patients being cared for in Mental Health and Intellectual and Developmental Disabilities settings, consideration should be given to including specific needs such as the communication needs of the patient, the number of staff required to escort the patient and the potential destination following evacuation.

Transport

69. Health organisations will need to consider how transport to support the process of shelter and evacuation and any subsequent re-shelter will be effected. This may need to form part of any mutual aid agreements it may be appropriate for the organisation to have.
70. As well as the varying needs of patients depending on their assessed vulnerability, particular attention and consideration will need to be given to:
 - transport of patients on site between buildings
 - transport of patients to places of shelter on site e.g. to a holding area
 - transport of patients from one healthcare site to another hospital or healthcare site
 - transport of patients to places of shelter off site
71. Health organisations need to link with local partners and the Local Resilience Forum(s) to ensure that several organisations are not dependent on the same transport providers.
72. Health organisations should identify possible sources of transport including:
 - Statutory ambulance service
 - Patient transport services
 - Commercial
 - NHS
 - Buses e.g. accessed via local authority and commercial
 - Voluntary Aid Societies
 - Others
73. Relevant requirements and command arrangements should be written into private ambulance transport contracts for use in an emergency.
74. Transport decisions should be linked to the triage evacuation priorities process.

Command, control and co-ordination

75. Experiences of NHS organisations in real and exercised evacuations demonstrates clearly the need for there to be well established and practised arrangements for command, control and coordination to be in place, to ensure as successful an outcome as possible to the incident.
76. The strategic national guidance on command and control that can be found in the NHS England Command and Control Framework¹.
77. Command, control and coordination arrangements for shelter and evacuation need to be site specific and an integral part of existing organisational command, control and coordination processes for major incidents and business continuity events already in use.
78. Healthcare organisations should ensure that their command structure is compatible with the emergency services² and is recognised and understood by local partners. Roles and responsibilities for key actions should be defined and individuals in designated roles should be easily identifiable (for example by wearing a tabard of a particular colour and/or with the role of the wearer marked upon it), making it clear to staff and other agency commanders who they should approach.
79. Additionally, in the context of sheltering and evacuation healthcare organisations need to give emphasis to ensuring their command, control and coordination processes take account of features that may be particular to shelter and evacuation scenarios such as:
 - the warning that may or may not be given for an evacuation
 - the possibility that crucial parts of the infrastructure may be lost at some point in the process e.g. command suite, power; communications systems
 - the role of external agencies
 - the need to track patients and staff
 - the need to fall back to a remote location to maintain the command centre
 - the need to be able to provide command, control and coordination support out of hours as well as when the site is fully staffed
 - the ability to embrace the need to provide an internal focus to support the internal response with the need to have an outward facing focus to support multi agency and stakeholder liaison.
 - the need to ensure that senior commanders are able to focus entirely on command and control and not be required to be available for media interviews. A dedicated person should be identified for the purposes of media liaison who is not involved in incident command and control
 - the need to maintain links with other NHS organisations

¹ <http://www.england.nhs.uk/ourwork/eprr/gf/>

² <http://www.jesip.org.uk/>

Communications

80. Category 1 responders have a duty under the Civil Contingencies Act 2004 to communicate with the public, and specifically to ensure that the public is made aware of the risks of emergencies that the public is provided with information and advice.
81. Responders are required to:
- **In planning terms** – to warn and inform the public of any imminent or actual dangers that health organisations are preparing to address and the types of responses planned.
 - **In responding** – communication arrangements should be appropriate to the message(s) and the needs of the audience
82. Communications should come from a single source that is regarded as authoritative and that represents the response. A consistent message is important and will reduce the risk of miscommunication and/or conflicting messages. Reference should be made to the Cabinet Office 'Evacuation and Shelter Guidance'¹ (Page 48, (2014 edition)) for characteristics of messages and considerations to be taken when communicating with internal and external stakeholders during an incident.
83. While planning for communications during an emergency, responders are to consider that disruptions to infrastructure may compromise this vital requirement. Effective and robust business continuity procedures to ensure systems are in place to communicate both internally and externally regardless of the emergency that is being faced should be in place. The use of communications equipment already in place in the building will assist an incident response due to familiarisation with the equipment, but consideration should be given to patients communication needs, back up resources such as radios and use of runners in passing messages, as appropriate.
84. Special consideration should be given to the use of social media in this situation. Whilst it offers a useful way of getting information direct to people, it should form part of a communications plan and if a wide area incident, due consideration should be given to involving multi agency partners to ensure only official information is broadcast and stakeholders are getting consistent messages.

¹ <https://www.gov.uk/government/publications/evacuation-and-shelter-guidance>

Equipment to support the movement of patients

85. Where progressive horizontal evacuation is being adopted, non-ambulant patients should, where possible, be evacuated by bed or by wheelchair with any equipment required for their welfare and their medical notes.
86. When/if the need for vertical evacuation is identified, alternative equipment may be necessary if evacuation lifts are not provided¹. Examples of such equipment include evacuation sheets, ski pads, evacuation chairs, stretchers etc.
87. Health care organisations should ensure that all very dependent in-patient beds (see Triage section) have ski sheets under the mattresses, or equivalent drag mattresses, or rapid casualty evacuation sheets should be available to aid the swift evacuation of patients.
88. On wards with dependent patients where ski sheets (or equivalent) are not used under each mattress, there should be an adequate supply of drag mattress or rapid casualty evacuation sheets available for emergency use.
89. Health care organisations should, if caring for them, make adequate provision of bariatric evacuation equipment that can be deployed as needed.
90. Health organisations should ensure that all evacuation equipment is tested on a regular basis.

¹ Beds and wheelchairs may continue to be used where the facility is equipped with evacuation lifts provided in accordance with Health Technical Memorandum (HTM) 05-03: Part E.

Site Management

91. The security of a building is of principle concern while it is being evacuated. Use of the lockdown process for controlling the movement and access – both entry and exit – of people around building or area is an effective way of achieving this. It should be noted that healthcare organisations cannot physically prevent people from leaving their premises (even if the hazard or threat is outside the building which is locked down).
92. By operating a lockdown process, the healthcare facility can help to prevent further safety issues from occurring. Lockdown is achieved through a combination of physical security measures and the appropriate deployment of security personnel. The speed at which the assessment of need and the decision to activate a lockdown is taken is critical. This will determine the success of the lockdown in preventing the situation from worsening.
93. A lockdown/ controlled access activation can lead to an evacuation. For example, if a lockdown continues to the point at which the healthcare facility can no longer adequately function, a partial or full evacuation of a site or building may be necessary. Therefore, a lockdown/access activation plan and an evacuation plan are mutually supportive.
94. Local advice for NHS premises is available from your Local Security Management Specialist (LSMS). Further lockdown advice is available from NHS Protect.¹

¹ <http://www.nhsbsa.nhs.uk/Protect.aspx>

Recovery and Repatriation

95. National Recovery Guidance can be found at:
<https://www.gov.uk/government/publications/emergency-response-and-recovery>
96. It is important to recognise that the three disciplines of Incident Response, Business Continuity and Recovery will be activated during an evacuation. Both Business Continuity and Recovery planning should start as soon as possible, ideally during the evacuation itself, although it will be dictated by the circumstances at the time. Early consideration of recovery and patient repatriation options including the strategic opportunity to plan for a new normality will ensure a smooth transition through each phase of the incident.
97. The Recovery Team should be led by a senior Director, independent of the Incident Response Team, but liaising closely with them and answering to the Trust Strategic Command level.
98. There are four main areas to consider, Humanitarian, Economic, Environmental and Infrastructure.

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

(source: adapted from Emergency Response and Recovery, Cabinet Office 2013)

99. The recovery plan should include
- Recovery plan activation triggers
 - Triggers for moving from Incident Response phase to Recovery phase and from Recovery to normality, i.e. repatriation of patients.
 - Multi-agency involvement and agreements related to the evacuation plan.

Training and Exercising

100. Training and exercising to enable an organisation to respond appropriately to a shelter and/or evacuation scenario should be a formal part of staff training and education for the organisation and be part of an overall programme including suitable exercises to support the requirements of the site and the likely risks faced.
101. Organisations should ensure that staff are familiar with all evacuation routes which should be tested on a regular basis.
102. Where evacuation equipment is provided, staff should be adequately and regularly trained in the operation and use, and there should be sufficient numbers of adequately trained staff on duty at all times.

Equality and diversity

103. Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

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