NHS Emergency Planning Guidance 2009

Planning for the evacuation and sheltering of people in health sector settings: Interim strategic national guidance

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First published: April 2009

Prepared by Emergency Preparedness Division

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Contents

This material should be read in conjunction with the NHS Emergency Planning Guidance 2005. 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 www.dh.gov.uk/emergencyplanning

Foreword

The Department of Health's Emergency Preparedness Division identified as a key priority for 2008/2009 the development of NHS Emergency Planning Guidance on the subject of evacuation of healthcare premises. Recent events, including fires at the Royal Marsden, Chase Farm and Northwick Park Hospital sites have reaffirmed that the need to evacuate healthcare premises presents a very real risk to the sector.

In parallel, the Department of Health is participating in the World Health Organisation's (WHO) World Disaster Reduction Campaign on Hospitals Safe from Disasters. This campaign aims to raise awareness and effect change that will:

Protect the lives of patients and health workers by ensuring the structural resilience of health facilities;

Make sure health facilities and health services are able to function in the aftermath of emergencies and disasters, when they are most needed; and

Improve the risk reduction capacity of health workers and institutions, including emergency management.

The **aim** of this work being led by my Division is to deliver interim guidance for consultation on evacuation of health care premises on April 2009 and final guidance including material to support its implementation in the NHS, by Autumn 2009.

The **objectives** of the work is to:

Enable the Department of Health to publish subject specific guidance on evacuation of healthcare premises that reflects the current understanding of the range and type of incidents that may occur and require a response from the NHS in England

Ensure the guidance reflects the current organisation of health services and the relevant partner organisations

Enables the Department of Health and its partner organisations to provide effective support for and coordination of its roles and responsibilities at national level

Ensure the involvement and engagement of all relevant organisations in the development of the revised guidance

Ensure the guidance will reference and complement other DH documents/ firecode regulations and wider publications from the built environment to shelter within the community

In Autumn 2008, an Expert Steering Group was established by the Division through which it can address the aims and objectives for the development and production of the guidance. In particular it is considering:

- Confirm the target audience and parameters
- The content of the guidance
- The structure of the guidance
- The presentation of the guidance
- Identification of key legislation, guidance, best practice, shared knowledge and other material that must be incorporated into the guidance or be used in conjunction with the guidance
- Reflecting the interface between all other relevant organisations and delivery partners
- Identification of the relevant roles and responsibilities of organisations and delivery partners

Ensuring the needs of vulnerable people are reflected in the guidance
Considering the wider health implications

The work of the Expert Steering Group in developing the Guidance was informed by the contributions made at a workshop held on 4 February 2009 in Solihull. Following this workshop, workstreams and products were identified to support the development of the Guidance. The full list of these are shown at Annex 1.

Although these underpinning materials will not be available until later in 2009, it is suggested that NHS organisations undertake the following in order to improve their readiness to plan and respond to an evacuation and shelter incident:

- develop means for categorising patients according to their dependency using a tool made available in this document
- review evacuation routes in all buildings and ensure that staff are aware of them
- review command, control and coordination arrangements for each site to ensure that they are capable of being adapted to the needs of evacuation and shelter
- working with multiagency colleagues, review arrangements for the establishment of cordons for each site including access/egress for emergency vehicles
- review staff training and ensure that the principles of vertical evacuation are understood
- review staff training in the use of evacuation equipment e.g. evacuation sheets
- map out of hours staff coverage and consider the implications for how evacuation and sheltering might be undertaken under those circumstances
- have sight of the relevant Local Resilience Forum's Generic Evacuation Plan (or any other wider area evacuation plan)
- ask the Local Resilience Forum (or equivalent) to discuss at its next meeting the topic of evacuation and sheltering of NHS sites in its area.

I should like to thank everyone who has been involved so far in this work and in the development of this guidance.

Dr Penny Bevan
Director
Emergency Preparedness Division

Scope and purpose of the guidance

1. This document provides best practice guidance for National Health Service (NHS) organisations in England in planning, preparing and managing for evacuation and sheltering of people from health care settings in response to all types of emergencies that arise from any accident, infectious epidemic, natural disaster, failure of utilities or systems or hostile act resulting in an abnormal casualty situation or posing any threat to the health of the community or in providing services for the community. The Guidance is intended to address the needs of children and vulnerable people. It is interim strategic national guidance.

2. The purpose of the document is to provide a framework for people who manage health services to design and plan a coordinated response and to provide preparatory training for the staff of services required in the event of major incidents and to link with wider area evacuation planning, response and recovery procedures.

Background

3. The Evacuation and Shelter Guidance: Non-statutory guidance to complement Emergency Preparedness and Emergency Response & Recovery published by The Cabinet Office in 2006 (referred to after this as the Evacuation and Shelter Guidance) summarises the evacuation and shelter responsibilities for health:

> *NHS Trusts should already have procedures for evacuating areas of a facility in the event of major disruptions. These should be aligned with the hospital's major incident 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 pre-planned and suitably equipped destination.*
>
> *Whilst separate specific guidance will be issued on evacuation planning by the DH, the key elements which need to be considered by the NHS are:*
> *•Maintaining primary care services to the population being evacuated, including special measures to offer support during the period of evacuation.*
>
> *•Through close working with social services and voluntary organisations, identifying and supporting vulnerable people who are being evacuated.*

•All hospitals trusts and in-patient care facilities should have plans in place to effect an evacuation if required. However, such plans should ensure that any evacuation of a hospital is seen as a last resort.

All Strategic Health Authorities (SHAs) must have a plan to provide 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.

All NHS Trusts are expected to have business continuity arrangements in place to reduce the risk of evacuation in predictable circumstances.

What the guidance is built on

4. This Guidance has been prepared under the auspices of the Department of Health's Emergency Preparedness Division and provides best practice guidance for NHS organisations about planning and managing evacuation and sheltering in response to an emergency.

5. As part of this process, expert input has been provided by a range of relevant organisations including Acute and Foundation Trusts, Primary Care Trusts, Mental Health Trusts, Ambulance Service Trusts and Strategic Health Authorities, General Practitioners, the Institute of Healthcare Engineering and Estates Management, the National Association of Healthcare Fire Officers, DH Estates, NHS Counter Fraud and Security Management Services, Centre for Protection of the National Infrastructure, the Local Government Association, the British Red Cross, St John Ambulance, the Women's Royal Voluntary Service, the United Kingdom Homecare Association, the Police, Fire and Rescue Services.

6. This Guidance is built on best practice and shared knowledge and the material on which this guidance is based is evidence based where this is possible. It is also acknowledged that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. The Guidance is intended to provide a platform for all NHS organisations to undertake planning for preparation and response to evacuation and sheltering in health sector settings and to provide information on associated activities that may also be required. In the context of this Guidance, the terms NHS organisation and NHS Acute Trust includes NHS Foundation Trusts.

Responsibility for implementation of this Guidance

7. The NHS Emergency Planning Guidance 2005 gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisation's arrangements for ensuring business continuity as required by the CCA. Planning for the evacuation and sheltering of people in heath care settings affected by emergencies forms part of that responsibility for Chief

Executives of all NHS organisations. SHAs and Primary Care Organisations will need to ensure that arrangements made within their boundaries and with neighbours are adequate and appropriate to local circumstances.

8. The measure of success anticipated, should be the result of implementing the proposals made in this document (supported by the subsequent development of technical guidance and the final guidance). In the context of the CCA, health sector organisations should be able to demonstrate the improvement in their capacity and capability to undertake evacuation and sheltering by having:

Prepare

- a better understanding of the potential risks that might give rise to the need to evacuate
- the necessary relationships in place within the organisation and with external partner organisations to enable appropriate planning, response and recovery

Plan

- in place an effective, workable, deliverable plan for evacuation and shelter that is well exercised and is subject to regular review

Respond

- the ability to respond to an event that results in an evacuation and/or need to evacuate in such a manner that organisations can respond more confidently

Recover

- the ability to recover in a more ordered and efficient manner and having a shortened recovery time

World Health Organisation: Hospitals Safe From Disasters Programme

9. In the development of this Guidance, the Department of Health is participating in the World Health Organisation's programme for 2008 – 2009 Hospitals Safe From Disasters. Further information about the programme and its resources can be found at;

http://safehospitals.info/index.php?option=com_frontpage&Itemid=103

The legislative and statutory context

The legal and statutory context: health and safety including fire safety orders and Firecode

10. NHS organisations owe a duty of care to both their patients and their staff. This common law duty of care requires them to take reasonable care and skill in treating and providing other services to patients, and in a providing a system of work for their employees. The duty of care extends to arrangements for the evacuation of a hospital and continues to apply to patients once evacuated from hospital.

11. In addition to common law, there are a number of relevant obligations set out in legislation, as set out below.

12. The Health and Safety at Work Act 1974 (HSW) establishes a general duty on employers to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees (section 2(1) of the HSW). This general duty on employers is particularised in relation to maintaining systems of work which are safe and without risk to health (section 2(2)). In particular, employers must provide information, instruction, training and supervision that is necessary to ensure, so far as is reasonably practicable, the health and safety at work of employees and ensure that access to and egress from a workplace are safe and without risks to health and safety; and to ensure that the working environment is safe and adequate as regards facilities. Employers (and self-employed persons) have general health and safety duties to conduct their undertaking in such a way to ensure that persons not employed are not exposed to health and safety risks. People under control of non-domestic premises also have a general health and safety duty (section 4) to towards persons who are not their employees.

13. The Management of Health and Safety at Work Regulations 1999 (the MHSW Regulations) set out some key further duties which will apply to evacuations. The MHSW Regulations require that an employer undertakes a risk assessment of the risk to health and safety of employees and persons not employed, where that risk arises from or in connection with the business (regulation 3). This may apply to the risk of fire in premises. After identifying any preventative and protective measure those measures must be made in accordance with the general principals of prevention (regulation 4 and Schedule 1 to the MHSW Regulations) which includes evaluating risks that cannot be avoided, developing a coherent overall prevention policy, and giving appropriate instructions to employees. An employer must establish, and where necessary give effect to, appropriate procedures to be followed in the event of serious and imminent danger to persons at work (regulation 8(1)) and the employer must nominate a sufficient number of competent persons to implement those procedures in so far as they relate to the evacuation from premises (regulation 8(1)(a) and (b)). Regulation 4(4) of the Health and Safety

(Safety Signs and Signals) Regulations 1996 establishes the requirements for evacuation signage.

14. The Regulatory Reform (Fire Safety) Order 2005 (referred to in this guidance as “The Fire Safety Order”) sets out legislative requirements for fire safety in the workplace. The legislation requires the Responsible Person (usually the employer or building owner) to take general fire precautions in order to protect anyone who may be using the premises, or who may be affected by a fire within the premises. The term ‘general fire precautions’ includes measures to ensure means of escape from the premises can safely and effectively be used at all times. A suitable and sufficient risk assessment should be undertaken to consider the risk from fire to all relevant persons. Amongst other factors, the fire risk assessment should consider how occupants will be evacuated from the premises in the event of a fire (or other significant incident resulting in evacuation), including the availability of suitably trained staff to assist with the evacuation. Responsible persons have a duty to ensure that routes to emergency exits are kept clear at all times (article 14(1) of the Fire Safety Order), and the duty to ensure that the premises meets prescribed requirements (article 14(2 of the Fire Safety Order).

15. Department of Health Firecode guidance (HTM 05-01) sets out management arrangements to ensure duties under the Fire Safety Order can be effectively implemented.

16. The principles applied under the Fire Safety Order for evacuation, can be applied equally to any foreseeable event where evacuation would be considered a reasonable response under the wider umbrella of the Health & Safety at Work Act 1974.

17. In making arrangements for evacuation, NHS bodies may also need to consider their general statutory duties relating to human rights and equality.

The legislative and statutory context: the NHS

18. This guidance must be used in conjunction with the NHS Emergency Planning Guidance 2005 including the associated relevant underpinning sections of the Guidance;

- Strategic Health Authorities (SHAs);
- Immediate medical care at the scene;
- Primary care organisations;
- Ambulance services;
- Acute and Foundation Trusts; and
- Non acute and Specialist Trusts.

19. The NHS Emergency Planning Guidance 2005 and its underpinning documents provide general guidance, information and context for NHS organisations. This includes an overview of important related legislation including the Civil Contingencies Act 2004 (the CAC) and its categorisation of organisations as Category 1 or Category 2 responders. In brief the responsibilities of each category of responder and the designation of NHS organisations is shown below.

Category 1: those organisations at the core of the response to most emergencies and subject to the full set of civil protection duties.

For the NHS these include NHS Acute and Foundation Trusts, Ambulance Trusts and Primary Care Trusts. The Health Protection Agency (HPA) is also a Category 1 responder.

Category 2: co-operating bodies less likely to be involved in the heart of planning work but will be heavily involved in incidents that affects their sector.

For the NHS, Strategic Health Authorities are Category 2 responders.

20. The purpose of the NHS Emergency Planning Guidance 2005 is therefore to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the CCA to:

- respond to a major incident or incidents or emergency; and
- manage recovery whether the incident or incidents or emergency has effects locally, regionally, or nationally.

21. Throughout this Guidance the term emergency is used as in the CCA, i.e. to describe an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders.

22. The responses outlined in this guidance should only be considered appropriate in the event of emergencies that comply with the definition above. Under no circumstances should any NHS organisation seek to initiate or adapt these in order to respond to a problem arising from staff shortages, waiting list pressures, management failures or other local institutional deficiency.

23. NHS bodies are subject to the provisions of the National Health Service Act 2006, although this contains no specific provisions relating to evacuation and shelter. It should however be noted that NHS bodies have a duty to co-operate with each other in exercising their functions (section 72), which may extend to co-operating on matters relating to emergency planning and evacuation.

Definitions and terminology

24. Clear definitions are needed that provide a common vocabulary for all who might be involved in evacuation and sheltering in the context of health sector settings. This is particularly needed to enable outside agencies and especially the Fire and Rescue Services to understand how to assess what help they might be able to provide with evacuation based on information given on arrival at the healthcare site.

Evacuation

25. Evacuation is defined generally as;
To move people, and where appropriate other living creatures, away from an actual or potential place of danger to a safer place

In the context of a community based evacuation (of which a healthcare facility may be a part), the following describes the definition of scale:

***Small scale/local evacuation**: up to 1000*

***Medium scale evacuation:** 1000 – 25000*

***Large scale evacuation**: 25000 – 100000*

***Mass evacuation**: used in some contexts and plans*

***Wide area evacuation:** preferred for upper end of the spectrum of potential numbers*

In the context of a healthcare facility evacuation the following describes the definition of scales:

Minor	up to 50 inpatients
Moderate	50-100 inpatients
Significant	100-500 inpatients
Major	500+ inpatients

Shelter

26. The key terms used in shelter are (please note that these terms are descriptive and are not intended to indicate escalation of any kind. They can be used individually regardless of the scale of an incident):

    Shelter: *taking refuge or cover from an actual or perceived danger*

    Shelter in-situ*: situation where the safest place to take refuge or cover. is the person's current location.*

    Dispersal*: a form of evacuation where people are simply directed to move away from a particular location without the need for temporary accommodation*

Describing patients' dependency

27. Following any evacuation, it is highly likely that there will be a need to assess and reassess the dependency of patients to assist with the appropriate allocation of patients to places of safety and shelter, for example, another hospital; to a nursing home; to home.

28. In order to support communication with other agencies, and particularly Fire & Rescue services, involved in evacuation and sheltering of health sector sites, there is a need to agree a terminology that links to any triage and patient identification system that will identify the dependence of patients. It is proposed that terminology used by Fire & Rescue services be adopted. An outline of this model is shown below. Further work is to be done in this area.

29. Consensus terminology suggested is based on that used by Fire & Rescue Services and is likely to most universally be understood by non-clinical staff at scene:

    Independent

    Dependent

    Very dependent

Planned and emergency evacuation in health sector settings

30. In the context of health sector settings when evacuation has become necessary, it is generally undertaken in stages where patients are involved. Progressive horizontal evacuation is a tried and tested process adopted throughout hospitals and other similar healthcare buildings in England. This involves moving people at immediate risk to a place of temporary safety beyond the nearest fire compartment wall. From here further evacuation can take place should it become necessary.

31. There are four main stages of evacuation – *please note that these stages are not necessarily progressive and/or sequential*:

    Stage 1 – horizontal evacuation from the sub compartment where the incident originates to an adjoining sub compartment or compartment;

    Stage 2 – horizontal evacuation from the entire compartment where the incident originates to an adjoining compartment on the same floor;

    Stage 3 – vertical evacuation to a lower floor substantially remote from the floor of origin of the incident (at least two floors below), or to the outside.

    Stage 4 – whole site evacuation

32. And for all stages of evacuation consideration needs to given to the needs of patients receiving specialist care, for example, those patients who are critically ill.

Activation of site-specific evacuation procedures and triggers

33. This section refers primarily to site-specific evacuation procedures and triggers. Risk based planning is at the heart of the government's approach to civil contingencies. It is essential that evacuation and shelter planning and capabilities are both tailored and proportionate to the risks faced by the community and the organisation. Many risks that may cause the need for an evacuation can be identified and planned for through the use of information held by the Local Resilience forum (LRF) including the Community Risk Register.

34. An evacuation involving health may be triggered by a variety of causes. These may include:

    - infrastructure failure
    - fire
    - power or other utilities failure
    - coastal flooding
    - fluvial flooding
    - gas leak
    - internal contamination
    - hostage taken
    - conventional and/or non conventional terrorist attack or credible threat
    - other

35. The decision to evacuate may therefore come from an internal emergency e.g. a fire or an external emergency e.g. a fluvial flood.

36. The order to evacuate therefore can be given internally or may be made by an external agency usually the Police. Wherever the order to evacuate comes from, it is the responsibility of the health sector organisation to make the arrangements for it in a manner appropriate to that organisation taking into account factors such as the nature of the patients being cared for on the site, the level of staffing available and the trigger for the evacuation.

37. Whatever the trigger and wherever the order for evacuation has come from, the decision to evacuate should only be taken if, following a risk assessment, the risk to life of remaining in situ is assessed to be greater than the risk of evacuation.

38. Sometimes this decision will be easily reached as the risk will be obvious. On other occasions, this will not be the case. In certain circumstances, it will be safer to stay put rather than evacuate.

39. There are three primary conditions when evacuation would be necessary or should be considered:

Extreme emergency – where there is an immediate threat to life or safety;

Emergency – no immediate threat, but an incident is likely to spread from an adjoining area;

Precautionary – no immediate threat to life or safety, but there is an incident on an adjoining floor or in an adjacent building.

40. In extreme emergency situations, the sequence of evacuation should be considered for patients who are usually categorised as follows:

a. those in immediate danger;

b. ambulant patients;

c. the remaining patients who are not ambulant.

41. Following any evacuation, it is highly likely that there will be a need to assess and reassess the dependency of patients to assist with the appropriate allocation of patients to places of safety and shelter, for example, another hospital; to a nursing home; to home.

42. The consensus terminology suggested for describing this dependency is:

Independent

Dependent

Very dependent

43. All staff in the organisation should be able to order an evacuation to allow for the circumstances where an immediate response is needed to ensure the health, safety and welfare of people. The decision to evacuate must be made as near to the scene of the potential evacuation as possible, that is, by a member of staff on site, for example, the person in charge of the ward or department at the time. These staff need to have freedom to make such a decision.

44. All decisions should be logged if possible and reported appropriately and immediately. Appropriate command, control and coordination arrangements should be established as soon as is practicable.

The Planning Process

45. Health organisations will need to develop a site specific plan for evacuation and sheltering. These plans will need to be based on the principles set out in the Evacuation and Shelter Guidance 2006 and the content of this Guidance and its underpinning materials as prepared. Work is in progress to develop a specific template for plans for health organisations as part of the work to produce this Guidance. This will be available by 30 November 2009.

46. As part of planning, it is imperative that a risk assessment starts the process. Site specific evacuation and shelter plans should be informed by risks most likely to impact the site and the wider local area using relevant resources including the Community Risk Register. Within the site, this should include the risks associated with the location 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. Annex 3 shows an abstract from the National Risk Register showing the relative likelihood and relative impact of a range of potential incidents.

47. The need to plan and prepare for evacuation and sheltering is emphasised for NHS organisations. In doing so, all health sector organisations will wish to take into account the needs of all people on site including patients, staff, visitors, contractors and others when developing evacuation and shelter plans. It is suggested NHS organisations should undertake:

    - assessment and planning in the pre incident phase including engagement with partner organisations,
    - formulation of organisational plans,
    - discussion and dissemination of plans in a suitable form for approval and/or adoption.

48. It is suggested that this planning phase should include:

    - The development of a site specific evacuation and shelter plan that is an integral part of the organisation's major incident plan. It should be available in whatever format suits the organisation best and be widely available.
    - Training and exercising 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 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

49. In preparing the Cabinet Office Guidance on Evacuation in Shelter in 2006, the following key points were identified that might be useful for health sector organisations to 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 more 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 private sector partners – locally, nationally and internationally.
- Call-off contracts should be considered.
- Having the right up to date contacts is critical.
- Identifying the vulnerable is a key issue.
- 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 an evacuation plan and therefore need to develop other ways of testing the arrangements.
- Guidance is needed on arrangements for warning and informing, particularly delivering urgent alerting.

Site specific planning – a suggested generic format

50. In the interim is suggested that to develop site specific plans health organisations use the following headings for their plans. This is adapted from the generic evacuation plan shown in Evacuation and Shelter.

Suggested headings for a generic evacuation and sheltering plan for health organisations

Usual control version, ratified, review dates etc

OVERVIEW
Purpose of the plan
Scope of the plan
Key principles of the plan

DETAILED PLAN
Command and control
- Of incident
- Of decision to return
- Of recovery

Evacuation process in detail, who does what, when, on whose instruction linked to existing major incident and fire plans
Schematic plan of the process

ROLES AND RESPONSIBILITIES
Actions cards for key roles

Key contacts (both internal and external), distribution lists and contact numbers
– it is suggested that these are kept in control rooms and that they are updated separately and distributed as necessary. This approach will mean that it will not be necessary to update the entire plan when contacts and/or numbers change.

Given below is a prompt list of external contacts for inclusion in the list held

Prompt List of External Contacts

Ambulance Control – Direct Line

PCT On Call Director

Out of Hours GP Services

Fire & Rescue Service

Police

Local Authority (District/Borough Council)

Tenants e.g. shop owners including pharmacy

External contractors including car park management companies

Voluntary Groups e.g. St John Ambulance; Red Cross; WRVS.

The ethical issues

51. The circumstances under which the decision to evacuate is taken may vary as may the circumstances of the evacuation and subsequent sheltering. The purpose of this section to outline Guidance that is available to:

    - advise on ethical issues that might arise;
    - advise staff on support that is available in terms of insurance and indemnity; and,
    - advise on issues regarding responsibility for patients during the course of evacuation and shelter.

52. The NHS Emergency Planning Guidance advises that in the event of demand for healthcare exceeding or overwhelming supply, the underlying principle is to achieve the best health outcomes based on the ability to achieve health benefits. Regard must be given to appropriate professional guidance including the General Medical Council's "Good Medical Practice".

53. The UK Committee on the Ethical Aspects of Pandemic Influenza (CEAPI) has been set up to advise on the ethical issues arising from an influenza pandemic.

54. The establishment of the Committee follows the Chief Medical Officer's recommendation in chapter 6 of his Annual Report 2005, that a national group be set up to explore such ethical issues. The CMO highlighted the difficult issues that may arise in healthcare during a pandemic (e.g. prioritisation of limited resources, conflicts between personal and professional obligations of staff) and the need for both the public and professionals to address such issues in advance of a pandemic.

55. The guidance is available at:

    http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/DH_065163

56. Following the work of CEAPI, any evacuation plan should be underpinned by the following principles.

57. Services for people who require them should be based on equal concern and respect for everybody who is involved. This means that:

    - everyone matters;
    - everyone matters equally - this does not mean that everyone is treated the same but according to their needs;
    - the interests of each person are the concern of all of us, and of society;
    - the harm that might be suffered by each person matters, and so minimising the harm that disasters and major incidents cause is of central concern.

58. The other core values in CEAPI's ethical framework that should guide the design of services are:

- respect;
- minimising the harm that major incidents or adversity can cause;
- fairness;
- working together;
- reciprocity;
- keeping plans and responses in proportion to threat and need;
- flexibility;
- good decision-making:
    a. openness and transparency;
    b. inclusiveness;
    c. accountability;
    d. reasonableness.

59. Work is in progress to develop specific guidance if appropriate for the insurance and indemnity of staff operating during evacuation and shelter of NHS sites. This will be available in the final version of the Guidance.

Roles and responsibilities of key partners

60. The roles and responsibilities of key resilience partners are set out in documents published by the Civil Contingencies Secretariat. The two key documents are:

    Emergency Preparedness

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

    Emergency Response and Recovery*

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

    *Please note that this document is being revised and is subject to consultation:

    http://www.ukresilience.gov.uk/news/err_consultation.aspx

61. This section should be used in conjunction with the NHS Emergency Planning Guidance and its sections setting out the roles of responsibilities of NHS organisations and key partners in planning and response.

    http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121072

62. The roles and responsibilities of the health sector as shown in Evacuation and Shelter Guidance 2006 has already been shown in the introduction at paragraph 3. In summary those responsibilities are: providing primary care for the evacuated population. Working with local authorities to identify and support the vulnerable. NHS Trusts plan for the evacuation of hospitals and Strategic Health Authorities plan for provision of healthcare to refugees.

Local authorities

63. The role of local authorities in evacuation and sheltering is set out below for ease of reference. There are two types of local authority structure in England: single-tier and two-tier.

64. In the two-tier system, a county council and several district and borough councils divide responsibilities for local authority services. County councils are responsible for running children's services which includes children's social services and education, adult social care, Other functions include, strategic planning, regeneration, transport and roads, libraries, refuse disposal and trading standards. District and borough councils are responsible for leisure, environmental health, housing, planning control and refuse collection.

65. In the single-tier system, one authority is responsible for all local authority functions. This applies to unitary, metropolitan authorities and London boroughs including all councils in Wales and Scotland. This currently appears in the Cabinet

Office's consultation version of the revised Emergency Response and Recovery guidance. Local authorities are responsible for co-ordinating welfare support to their communities in the event of an emergency and play an important leadership role, which includes:

- providing temporary shelter (rest centres) including any transport arrangements needed to help people get to and from these; (District/Borough/Unitary)
- providing information from the electoral roll to police casualty bureaux to assist in accounting for evacuees; (District/Borough/Unitary)
- ensuring suitable arrangements are in place to meet welfare needs; (County/Unitary)
- feeding and providing refreshment for those in temporary shelter; (District/Borough/Unitary)
- establishing arrangements for local GPs to issue emergency prescriptions at rest centres; (District/Borough/Unitary)
- meeting needs for temporary accommodation where evacuation is extended; (District/Borough/Unitary)
- the production and exercising of evacuation and shelter plans, including mutual aid arrangements with other authorities for cross-border and very large-scale incidents; (County/Unitary)
- leadership during the recovery phase of an evacuation; (County/Unitary)
- leading the rehabilitation of the community and restoring the environment, with assistance from the Government Decontamination Service if necessary; (District/Borough/Unitary) and
- co-ordinating work to meet the long-term social and welfare needs of survivors, their families and friends. (County/Unitary).

Other potential key partners

66. In addition to local authorities, other key partners and organisations that may be involved in a multi agency response for evacuation and shelter that health sector organisations will wish to involve in their planning include:

Police
Fire and Rescue Service
Ambulance Service
Voluntary and community sector
Environment Agency
Highways Agency
Transport companies
Maritime and Coastguard Agency
Prison Service and Immigration Service
Employers

Command, control and coordination

67. This intention of this section is to emphasise the need for explicit, site specific and integrated command, control and coordination arrangements to be developed to support an evacuation in a health sector setting. Although this should not differ from existing systems, it is imperative that these are established early and maintained throughout. It does not seek to duplicate the strategic national guidance on command and control given in Strategic command arrangements for the NHS during a major incident that can be found at:

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

68. In this guidance, command is defined as;

    "the authority for an agency to direct the actions of its own resources (both personnel and equipment)" *Cabinet Office (2007) Lexicon of Multi-Agency Emergency Management Terms Version 1.0*

69. And control is defined as:

    "the authority to direct Strategic and Tactical operations in order to complete an assigned function, including the ability to direct the activities of other agencies engaged in the completion of that function." *Cabinet Office (2007) Lexicon of Multi-Agency Emergency Management Terms Version 1.0*

70. Experience by 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 event.

71. Command, control and coordination arrangements for evacuation and sheltering needs to be site specific and an integral part of existing command and control and coordination processes for major incidents already used by NHS organisations using the same terminology, on call mechanisms, command suites, communication methods, and other faculties and mechanisms. However, there needs to be a clear review of processes that take account of features that may be particular to evacuation ns sheltering 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 liaison.
- the need to ensure that senior commanders are able to focus entirely on command and control and not be required to 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 including the PCTs and the SHAs

72. Health organisations therefore need to give emphasis to reviewing command, control and coordination processes in the context of evacuation and sheltering. Links to the existing NHS Emergency Planning Guidance on this topic need to be made.

73. Tools and templates specific to evacuation and sheltering to support health organisations are being developing on this topic as part of the work on this Guidance. The areas that will be covered will include descriptions of:

- What command, control and coordination might look like in this context
- Where it might be located
  - on site
  - secondary on site
  - off site/fallback
- Where is the focal point?
- How to link up with others? This area needs to be linked to consideration of mutual aid including what role the SHAs may have in this process.
- Training and practice in this area is emphasised.

Mutual Aid

74. The NHS Emergency Planning Guidance gives general guidance about mutual aid. This is:

The SHA must be able to assume strategic control of incidents as required. Each SHA needs to ensure that it has an overview of all incidents within its boundary and that appropriate arrangements are made to allow for a well co-ordinated response, taking into account the requirements of the Civil Contingencies Act. SHAs must take a proactive lead in guaranteeing the availability of practical mutual aid and support both within their area, and across SHA boundaries.

In developing arrangements for mutual aid, NHS organisations will need to be clear what aid might be required, what they themselves can offer and who their partners are. Administrative boundaries, including national boundaries within the UK, should not be a reason for not working with organisations over those boundaries in developing mutual aid arrangements.

If the scale of an incident escalates beyond the local SHA's capacity or area, or if its duration or nature is such that wider NHS resources are required, the SHA will enact mutual aid protocols with neighbouring SHA(s) and, where appropriate, the devolved administrations of Scotland, Wales and Northern Ireland. For events that require mutual aid on a large scale, the Department of Health, via the Department of Health (DH) Major Incident Coordination Centre, can implement national co-ordinating arrangements. These arrangements are intended to support the SHAs, ensure wider NHS resources are made available and wider government assistance is accessed, as required. Usually it will be the role of SHAs to contact the DH Major Incident Coordination Centre..

75. The importance of having good mutual aid arrangements has been acknowledged by the publication of a short guide produced jointly by the Cabinet Office, the Local Government Association (LGA) and the Society of Local Authority Chief Executives (SOLACE) aimed at local authorities. This guide seeks to state the case for the benefits of mutual aid and to encourage action by offering advice on a range of practical considerations.

76. It is available at:

http://www.ukresilience.gov.uk/news/mutual_aid.aspx

77. NHS bodies should also note that they have a statutory duty to co-operate with each other in exercising there functions (section 72 of the NHS Act 2006).

78. Work is in progress to develop specific guidance for the NHS on mutual aid in the content of evacuation and sheltering. This will be based on examining by location:

What is mutual aid and how can it be made to happen rather than merely being a good idea on paper?

Are there examples of existing formal mutual aid agreements including Memorandums of Understanding (MOUs) that can be drawn on?

How are resources that might be used on the day identified and allocated?

What is the role of the SHAs in this area?

Where might additional help/resource come from?

- Neighbouring hospitals
- Hazardous Area Response Team (HART)
- Medical Emergency Response Incident Team (MERIT)
- Medical Incident Commanders
- Voluntary Aid Societies (VAS)
- Other third sector groups
- Local Authorities
- Independent healthcare sector
- Others

Evacuation processes and pathways

Evacuation

79. In healthcare buildings, particularly in patient access areas, the immediate and total evacuation of the building in the event of an incident may not be possible or desirable. Patients with restricted mobility, patients who use wheelchairs, and patients confined to bed cannot negotiate escape routes, particularly stairways, unaided. Patients under medication may require staff assistance, and patients who are dependent on electrical/mechanical equipment for their survival cannot always be disconnected and moved rapidly without serious consequences.

80. Earlier in this document it has been noted that there is an assumption by Fire & Rescue Services nationally that there will be a sufficient number of adequately-trained staff on duty in the building to provide assistance with any necessary evacuation in the event of an incident. However, while the total evacuation of buildings accommodating fully mobile occupants might be practical, the evacuation of an entire hospital in the event of an incident would be an enormous exercise in which patients might be placed at risk due to trauma or their medical condition.

81. Should evacuation become necessary, other than for those premises with fully independent mobile occupants, it 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. Adopting this approach ensures that the concept of "inclusive design" has been applied.

82. Healthcare premises accommodating dependent[1] and very high dependency[2] patients are divided into a series of compartments providing one hour of fire resistance. These compartments are further divided into sub compartments. Compartments and sub compartments should be constructed to provide 60 and 30 minutes' fire containment respectively, without adjacent areas becoming affected. This helps in the provision of refuge facilities.

83. Where the evacuation involves very high dependency patients, additional consideration should be given to the distance of travel that might be necessary to reach a place of safety where essential treatment and care could be recommenced.

84. The basic strategy for the evacuation of dependent or very high dependency patients should be to move them on their bed or in a wheelchair, to a safer area on the same floor.

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[1] **Dependent:** all patients except those classified as "independent" or "very high dependency"

[2] **Very high dependency:** those whose clinical treatment and/or condition creates a high dependency on staff. This will include those in critical care areas, operating theatres, coronary care etc and those for whom evacuation would prove potentially life-threatening.

85. When evacuation has become necessary, it is generally undertaken in stages where patients are involved. Progressive horizontal evacuation is a tried and tested process adopted throughout hospitals and other similar healthcare buildings in England. This involves moving people at immediate risk to a place of temporary safety beyond the nearest fire compartment wall. From here further evacuation can take place should it become necessary.

86. There are four main stages of evacuation that have been described earlier in the document in paragraph 27.

87. The principle of progressive horizontal evacuation is that of moving occupants from an affected area through a fire-resisting barrier to an adjoining area on the same level, designed to protect the occupants from the immediate danger (a refuge). The occupants may remain there 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 evacuated down stairways to a place of safety, should it become necessary to evacuate an entire storey.

88. Patient-access areas should be designed to allow for progressive horizontal evacuation other than in premises where patients fall into the independent[3] category.

89. Areas to which patients have access should ideally not be located on storeys where evacuation in an emergency would necessitate travelling up a stairway to a final exit.

90. The need for evacuation will depend on the circumstances of the incident.

91. The potential need for evacuation is a foreseeable event and should therefore be planned in advance. Whilst it may not be possible to devise a plan for a precise location to evacuate to, consideration will need to be given to any requirements for continuing treatment or care e.g. evacuation mid-way through a surgical operation, intensive care patients, or mental health patients under section. All will have particular needs, which should be pre-planned.

92. Tools and templates specific to evacuation and sheltering to support health organisations are being developing on this topic as part of the work on this Guidance. This will include:

    Succinct guidance about how to identify evacuation pathways, how they might be signed, and how to review the location of wards and departments to ensure that in the event of an evacuation being needed, that the process is not unnecessarily

[3] **Independent:** patients will be defined as being independent:
(i) if their mobility is not impaired in any way and they are able to physically leave the premises without staff assistance; or
(ii) if they experience some mobility impairment and rely on another person to offer minimal assistance. This would include being sufficiently able to negotiate stairs unaided or with minimal assistance, as well as being able to comprehend the emergency wayfinding signage around the facility.

cumbersome. For example, where might critical care units and other services where patients require specialist equipment for treatment and monitoring be located? Are there any members of staff who might be considered vulnerable people, for example, through disability that might need to be identified and supported appropriately?

What are the links to existing guidance on estates and fire processes including Fire Code?

How does vacating premises link to requirements to ensure the safety and security or premises and personnel

93. Further information can be found in:

HTM 05-02 – Guidance in support of functional provisions for healthcare premises
HTM 05-03: Part E – Escape lifts in healthcare premises
HBN 00-04 – Common activity spaces

Security and site management

94. In planning for an evacuation, health sector organisations will need to consider the following issues in the context of security of the site. Where security officers are in place in an NHS organisation they may be able to assist in the following functions during the course of an evacuation:

The discovery of the incident – how is this communicated? This may include, for example, escalating information to senior management about the nature of the incident, monitoring of Closed Circuit Televisions, maintaining the control room and liaising with the emergency services as appropriate.

During the course of the incident - helping to evacuate patients, maintaining cordon controls, and helping to provide critical information to emergency services and responders. This may also include providing information about site layout.

Post incident - maintaining the integrity of the incident by preventing access to buildings/site.

95. The design of healthcare buildings should ensure that escape routes are of adequate dimensions to cope with the preferred options for evacuation. HTM 00-04 Common Activity Spaces, provides suitable guidance on the widths of circulation routes, stairways and landing widths and depths.

96. All final exit doors intended for evacuation should be designed to open in the direction of escape and be of an adequate width to accommodate the numbers of people likely to use them. Revolving doors should be avoided, but where they are used, they must easily convert to outward-opening doors; or there should be outward-opening doors adjacent to the revolving door, capable of allowing safe egress for the numbers of persons likely to use them. Turnstiles and shutters are not acceptable on escape routes and should not be used.

97. Sliding doors are acceptable on escape routes provided they convert to outward-opening doors when subjected to reasonable pressure from any direction. In the case of powered sliding doors, they should in addition be provided with a monitoring system to ensure that they fail-safe to the fully open position in the event of a power failure.

98. All escape routes should be adequately indicated by signs and, where necessary, by other wayfinding systems.

99. Escape routes should not obstructed by the storage of combustible or other materials likely to cause a hazard or reduce the availability or suitability of the escape route.

Lockdown

100. A lockdown is the process of controlling the movement and access – both entry and exit – of people (NHS staff, patients and visitors) around a trust site or other specific trust building/area in response to an identified risk, threat or hazard that might impact upon the security of patients, staff and assets or, indeed, the capacity of that facility to continue to operate. In this way, a trust can either contain or exclude staff, patients or visitors. Supporting the overarching objective of excluding or containing staff, patients or visitors, a lockdown may be characterised as a partial (static or portable), progressive or full lockdown.

101. Experience has shown that during a wide range of incidents, health services are vulnerable. Contamination, infection or even the sheer pressure of the ensuing numbers of people seeking care can threaten services to the point of collapse. Therefore locking down an NHS site or NHS building may be a proportionate response from a variety of threats and hazards to safeguard patients, staff, visitors, and protect NHS assets.

102. A lockdown can lead to an evacuation. For example, if a lockdown continues to the point at which the trust can no longer adequately function, a partial or full evacuation of a site or building may be necessary. Therefore a lockdown plan and an evacuation plan are mutually supportive.

103. A partial lockdown can be defined in a number of ways. In most instances, a partial lockdown is the locking down of a specific part of a trust site or a specific building or part of a building. A partial lockdown which may originally have been ‘static’ in nature may evolve into a ‘portable lockdown’. A portable lockdown is when an ongoing lockdown is moved from one location on a trust site to another. A progressive lockdown, which can also be called an incremental lockdown, can be a step-by-step lockdown of a trust site or building in response to an escalating scenario. Finally, a full lockdown is the process of preventing freedom of entry to and exit from either an entire NHS trust site or from a specific NHS building. Regardless of the nature of the lockdown, a lockdown is achieved through a combination of physical security measures and the deployment of security personnel.

104. In line with its responsibility to ensure a safe and secure environment, the NHS Security Management Service in association with the Department of Health’s Emergency Preparedness Division, has developed practical guidance on the lockdown of NHS healthcare sites for Local Security Management Specialists. This lockdown guidance document is published in the *NHS Security Management Manual* and is available from the trusts LSMSs. A summary version of this guidance will also be available soon on 'nhsnet' at the NHS Safe and Secure Facilities Website which can be found at https://nww.cfsms.nhs.uk/sfh

105. Other work on security and lockdown of health sector settings is being undertaken as part of work streams to develop technical supplements for the final version of this Guidance. Comments on the particular topics of security and lockdown are welcomed as part of this consultation.

Equipment to support moving patients during an evacuation

106. Where progressive horizontal evacuation is being adopted, non-ambulant patients should, where possible, be evacuated by bed or by wheelchair. Once the need for evacuation becomes vertical, alternative equipment will be necessary. 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.

107. Where escape lifts are not provided, other equipment to transport semi or non-ambulant occupants vertically through the building will be necessary. Examples of such equipment include Evacuation Sheets, Ski Pads, Evacuation Chairs, stretchers etc. Where this type of equipment is provided, staff should be adequately and regularly trained in the operation and use, and there must be sufficient numbers of adequately trained staff on duty at all times.

108. Tools and templates specific to evacuation and sheltering to support health organisations are being developed on this topic as part of the work on this Guidance. This will include: equipment to support moving patients during an evacuation including clear information available about the range of equipment that might be used to support evacuation and sheltering, for example, ski pads, evacuation chairs, the contents of grab bags, etc.

109. The groups working on this will also consider whether there is a need to identify equipment, for example, drag stretchers, mattresses with handles, and other resources to support evacuation that might need to be included in PODs or stockpiles held either locally, regionally or nationally.

Triage

110. Tools and templates specific to evacuation and sheltering to support health organisations are being developing on this topic as part of the work on this Guidance. This will include:

    - Examining the ambulance service triage and identification system to support evacuation and shelter
    - Triaging for movement out of wards/healthcare facilities
    - Triaging for access to transport
    - How will patients be identified as a result of the triage and how does this link to the earlier suggestion that there is clarity about how patients are defined and described for the purposes of evacuation so that all agencies involved have a common vocabulary?
    - Linkage to patient tracking and identification

111. In-patient consultant led speciality teams will have a key role prioritising their in-patients for inter-hospital transfer if required.

112. Patients injured during evacuation will be prioritised for emergency treatment and transport (at on or off site patient holding areas) to an appropriate Emergency Department if required using existing ambulance protocols, ability to walk, physiological derangement and anatomical patterns of injury.

113. In-patients requiring continuing in-patient care will be prioritised for treatment and transport by their degree of dependency and by in-patient medical speciality, to an appropriate receiving hospital.

114. Patients that may not require acute hospital admission may be discharged by relevant medical speciality consultants and teams to home or community beds with arrangements for further follow up.

115. Other work on prioritising and triaging patients is being undertaken as part of existing work streams in EPD and the Pandemic Influenza team. Consideration of the needs of patients who are being evacuated and possibly sheltered might be either built in to this work or developed from this work.

116. Whatever triage method is used will also need to take account of the potential likelihood that injuries may be sustained and/or the condition of evacuees may deteriorate during the course of the evacuation and sheltering process.

Patient tracking and identification

117. Tools and templates specific to evacuation and sheltering to support health organisations are being developed on this topic as part of the work on this Guidance. This will include:

- How will patients be tracked?
    - within the hospital
    - outside the hospital
- What form will the ID on the patient take? It is preferable for this to be integrated in whatever method is used to identify the triage/prioritisation category of patients.
- The possible links to existing mechanisms including the ambulance service processes for identifying patients and to the Police Casualty Bureau will be investigated.
- What goes with the patient? Notes? Drugs? Anything else? Are there any regulatory or legal issues that need to be taken into account, for example, the Data Protection Act that will need to be identified clearly in the final Guidance?.

Moving vulnerable patients

118. Clear guidance is being developed about how to handle and deal with vulnerable patients. Links to the Civil Contingencies document published in 2008 "Identifying People who are Vulnerable in a Crisis – Guidance for Emergency Planners and Responders" will be made and used. This document can be found at:

    http://www.cabinetoffice.gov.uk/ukresilience/news/vulnerable.aspx

119. This more recent document will be used in addition to the definition of vulnerable people given in the CCA. In the context of evacuation within a health setting the main groups of vulnerable patients are likely to be being cared for in locations such as:

    - critical care (adult, children, PICU, NICU and others)
    - infectious disease and isolation units
    - operating theatres and their associated recovery areas
    - mental health units including high secure 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
    - others

    Please note that this list is for purposes of illustration only and is not intended to be an exhaustive lists of all locations where vulnerable patients may be being treated.

Transport

120. Health organisations will need to consider how transport to support the process of evacuation and shelter will be made. This will need to form part of the process in developing Mutual Aid agreements. Particular attention will need to be given to consideration of:

    - transport of patients on site between buildings
    - transport of patients from one healthcare site to another hospital or healthcare site
    - transport of patients to paces of shelter on site e.g. to a holding area
    - transport of patients to places of shelter off site

    and of the varying needs of patients depending on their assessed vulnerability.

121. Tools and templates specific to evacuation and sheltering to support health organisations are being developed on this topic as part of the work on this Guidance. This will include:

    - How can transport be sourced? What might be available?.
    - What are the possible sources of transport if it is needed? Will this be uniform across the country or will it vary according to location? Suggestions included:
        - ambulance
        - patient transport services
        - commercial
        - NHS
        - buses e.g. accessed via local authority including school buses
        - Voluntary Aid Societies (VAS)
        - Others
    - The need to link with the Local Resilience Forum to ensure that transport resources to help ensure that several organisations are not depending on the same transport providers.
    - The need to incorporate these arrangements within Mutual Aid agreements

Communications

122. The NHS Emergency Planning Guidance gives general guidance on handling communications as follows:

Responders duties to communicate with the public under the CCA are based on the belief that a well-informed public is better able to respond to an emergency, and to minimise the impact of the emergency on the community and on NHS services.

The CCA gives two distinct legal duties to responders:

***in planning terms**, warning and informing the public of the likely risks and threats that NHS organisations are preparing to address and examples of the types of responses planned.*

***in responding**, communications arrangements should be appropriate to the message and the kind of audience.*

Based on these principles, the response of NHS organisations will be the right people, receiving the right message(s) at the right time.

Media liaison and handling will be an integral part of planning a response to any major incident. Media Protocols and Media Liaison Panels should be in place to ensure consistency of messages provided to the media. Integrated emergency plans, including business continuity plans, should generally provide for the identification of those officers with responsibility for media liaison, as well as identifying the media liaison roles of those with specific duties during an incident (including Chief Executives, On-Call Directors and Managers, as well as Communications Managers). Communication lines, with appropriate control rooms and centres, including the DH Media Centre, should be identified in plans.

123. In reviewing methods for communicating within NHS buildings, the use of existing systems, for example, tannoy systems, is encouraged rather than providing additional systems specific to evacuation and sheltering. NHS organisations are reminded not to rely on the use of mobile telephones as a primary means of communication. NHS organisations may wish to consider ways of improving their resilience in the use of mobile phones by, for example, having contracts with more than one network provider; double chipping mobile hones of key personnel.

124. During the course of an evacuation and shelter event, NHS organisations will need to take into account the need to maintain internal communications to support the process and the need to deal with external communications, for examples, with police, fire and rescue, local authorities, relatives, media. Arrangements made need to reflect these distinct roles. The focus needs to be on internal communications to keep those involved in the incident apprised of what is going on and what action is needed.

125. All local responders have duties under the CCA to:

•raise public awareness prior to an event;
•warn the public at the time of an event or when one is likely; and
•inform and advise the public in the immediate and long term post-event

126. The duties apply both to planning for and carrying out evacuation and shelter Health organisations will wish to enhance their communications response in line with the recommendations made in Evacuation and Shelter 2006. This highlights that aall local responders have a duty under the CCA to make arrangements to warn, inform and alert the public and media in an emergency. This duty applies to evacuation.

127. The document particularly highlights that evacuation scenarios present particular communication challenges for planners, and communication breakdown is likely to be the single biggest cause of failure during a short-notice evacuation. Detailed suggestions on how the communication requirements of the Act may be carried out, the generic forms of communication that may be used and a list of Category 1 responders from whom to identify a lead responder to maintain arrangements can be found in the Emergency Preparedness guidance.

128. Key points made in the document are that communications on evacuation should be:
    - persuasive;
    - aim to reduce anxiety;
    - take into account the different risks faced by an area;
    - take into account different vulnerable and language groups;
    - maintain contact with evacuees whilst they are away from home; and
    - be exercised

    and should
    - Involve LRF partners and business in evacuation and shelter communications plans
    - Use the media in an evacuation scenario.
    - Incorporate resilience and security issues for evacuation communications.
    - Make use of tools and templates specific to evacuation and sheltering to support health organisations are being developed on this topic as part of the work on this Guidance.

Shelter

129. Health organisations will need to develop site specific plans that identify possible places to shelter including holding areas that are appropriate to local needs. Links to the Local Resilience Forum(s) will be an important part of this work.

130. Tools and templates specific to evacuation and sheltering to support health organisations are being developing on this topic as part of the work on this Guidance. This will include:

    A guide to identification of places to shelter is needed that possibly includes case studies/scenarios of examples to cover the likely range of solutions including:

    - NHS on site
    - NHS off site
    - Clinical facilities off site
    - Non clinical off site accommodation including rest centres

    Clarification about where responsibility for patient management lies according to site and over time while sheltering.

Training and exercising

131. The NHS Emergency Planning Guidance gives the Chief Executive of each NHS organisation responsibility to ensure that arrangements are in place to enable adequate training, exercising and testing of emergency planning arrangements and that the Board receives regular reports, at least one annually, regarding this

    - As a minimum requirement, NHS organisations are required to undertake a minimum of:
    - A ‘live’ exercise every three years
    - A ‘table top’ exercise every year
    - A test of communications cascades every six months

132. Each individual NHS organisation must evaluate its own exercise requirements, which may be in excess of the minimum specification outlined above. Similarly, decisions to direct exercises at specific staff groups and departments should be made after reviewing local emergency planning needs.

133. NHS organisations should consider holding joint exercises with partners in the NHS and with other multi-agency partners where practicable. Extra consideration should be given to this approach when planning a ‘live’ exercise.

134. In the context of evacuation and sheltering in the health sector, health organisations should consider inclusion of appropriate practical training and exercises as part of their programme.

135. Tools and templates specific to evacuation and sheltering to support health organisations are being developing on this topic as part of the work on this Guidance.

Business continuity

136. Business Continuity Management forms an important part of risk management arrangements and is a requirement of the Civil Contingencies Act 2004. The aim of business continuity management is to ensure that NHS organisations are able to maintain the highest level of service possible whatever might happen to the infrastructure. There is a range of problems that might affect NHS organisations and services at any time, for example, loss of water or power, flooding, or criminal action.

137. The aim of business continuity planning is to enable planning and reaction in a co-ordinated manner. Whilst business continuity and major incident planning are usually separate processes within an organisation, a major incident may occur at the same time as a business continuity issue, or be triggered by it.

138. Business continuity management, including processes for recovery and restoration, should be considered by NHS organisations as part of its every day business processes requiring a corporate response. Business continuity should be seen as embedded in the culture of the NHS as principles of health and safety, and there must be demonstrable commitment to the process from the Boards of NHS organisations. The skills to develop business continuity plans are complementary to those involved in emergency planning and may therefore need to be undertaken by separate officers. It is critical though that both plans are integrated and complementary to each other.

139. Site specific plans for evacuation and sheltering should link to local arrangements for business continuity and resilience.

140. Access to the NHS Resilience website is at:

    http://www.dh.gov.uk/en/Managingyourorganisation/Emergencyplanning/NHSresilience/index.htm

Annex 1

Products identified to support the development of the Guidance

The following range of products were identified that would either help support the development of the Guidance or would form tools, templates, checklists and other products to support implementation of the Guidance.

Case studies fire flooding terrorist event power and other utility failure adverse weather fluvial flooding coastal flooding industrial action incidents involving critically ill and dependent patients other
Plan template and checklist To identify the topics that might be covered, who might be involved in the process, to provide checklists for issues to be considered, etc
Risk assessment tool that encompasses pre event risk assessment and dynamic risk assessment during the course of an incident
Off the shelf training and exercising material Vertical evacuation Horizontal evacuation Command and control Establishing shelter on site Moving patients to off site shelter(s) Managing evacuation in hours Managing evacuation out of hours
Triage – an appropriate triage system for evacuation and how this might link to patient identification and tracking
Patient ID and tracking Practical guidance and advice about what to use
A guide to equipment to support evacuation and sheltering Items to use for moving patients e.g. ski sheets, evacuation chairs, etc Contents of grab bags Equipment to support on site shelter PPE and ID for staff Other

How to identify the equipment, consumables and other items to go with each patient the contents of grab bags ID Records Drugs Other
The decisions needed at each stage of the evacuation and sheltering triggers when to evacuate how quickly to evacuate other
A guide to mutual aid Building on the Guide to Mutual Aid for Local Authorities and examples of work done in the NHS to develop a guide to mutual aid that will include: - how to develop relationships - who to work with - a template for an MOU for mutual aid
Shelter areas how to identify shelter in facilities on site off site how to stock shelter areas how to access shelter areas
Specific guidance for different people/parts of the NHS estates communications ward managers on call managers and directors others

Communications Developing a comms guide that will include: Preparing staff for the event Develop material in advance that will be helpful during and event Internal communication during an event External communication during an event with media with other agencies Communicating with relatives Liaison with Police Casualty Bureau if established Liaison with Local Authority Information Centres/Humanitarian Assistance Centres/ other centres if established
Reporting evacuations creating a database how to debrief what to report other
Management and security of the estate risk assessment tool for pre planning phase dynamic risk assessment tool for support during and event evacuation routes fire training fire boxes security of site creating cordons site control lockdown other

The workstreams

The following workstreams have been identified to help take forward the development of the NHS evacuation and sheltering Guidance. Contributors to workstreams have been sought and meetings will commence during March and April 2009. All work will be complete by 30 November 2009 or shortly thereafter.

Development of case studies

Command and control and incident management

Decisions and leadership including clarification of roles and responsibilities

Equipment and resources

Exercise and training

Guidance for specific areas and people

Medico legal and ethical including insurance and indemnity for staff

Management and security of the estate including evacuation routes, fire training, route finding, way marking, security and lockdown

Patient identification and tracking

Developing templates and checklist for plans

Reporting evacuations and developing a database of information

Identification of shelter on site and off site

Items for stockpiling

Mutual Aid

Triage

Annex 2

Glossary and acronyms – Extracted from Expectation and Indicators of Good Practice Set - Annex A: Glossary of terms and acronyms.

ACPO
Association of Chief Police Officers

BCI
Business continuity Institute

Business Continuity Management (BCM)
A management process that helps manage the risks to the smooth running of an organisation or delivery of service, ensuring that it can operate to the extent required in the event of a disruption.

Business Continuity Plan (BCP)
A documented set of procedures and information intended to deliver continuity of critical activities in the event of an emergency.

Business Impact Analysis
A method of assessing the impacts that might result from an incident and the levels of resources and time required for recovery.

Capabilities Programme
The UK Capabilities programme comprises a range of capabilities that underpin the UK's resilience to disruptive challenges. These capabilities are either structural, functional or essential services.

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

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

Capability status
Assessment of the level of capability in place.

Capability Target
The level of capability that the planning assumptions and the plan require.

Category 1 responder
A person or body listed in Part 1 of Schedule 1 to the Civil Contingencies Act. These bodies are likely to be at the core of the response to most emergencies.

Category 2 responder
A person or body listed in Part 3 of Schedule 1 to the Civil Contingencies Act. These are cooperating responders who are less likely to be involved in the heart of multi-agency planning work but will be heavily involved in planning for emergencies that affect their sector.

CBRN
Chemical, Biological, Radiological, Nuclear

CCA
Civil Contingencies Act (2004)

CCS
Civil Contingencies Secretariat

CFOA
Chief Fire Officer Association

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

Community resilience
The ability of a local community to respond and recover from emergencies.

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

Critical function
A service or operation the continuity of which a category 1 responder needs to ensure in order to meet business objectives.

Dispersal
A form of evacuation in which people are simply directed to move away from a particular location without the need for temporary accommodation.

Emergency
An event or situation which threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK or war or terrorism which threatens the security of the UK. To constitute an emergency the event or situation must require the implementation of special arrangements by one or more category 1 responder.

Emergency planning
Development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of an emergency.

Emergency planning cycle
A continuous process of assessing risk and preparing for emergencies supported by procedures to keep staff in readiness and validate plans. Plans should be reviewed and if necessary, revised when they have been activated in response to an emergency.

Evacuation
Removal of people, and where appropriate other living creatures, away from an actual or potential place of danger to a safer place.

Event or situation with threatens to damage Human Welfare
An event should only be considered to threaten damage to human welfare if it involves causes or may cause loss of human life, human illness or injury, homelessness, damage to property, disruption of supply of money, food, water, energy or fuel, disruption of a system of communication, disruption of facilities for transport, or disruption of services relating to health.

Event or situation with threatens to damage to the environment
An event or situation should only be considered to threaten damage to the environment if it

involves causes or may cause contamination of land, water or air with biological, chemical or radioactive manner or disruption of destruction of plant life or animal life.

Exercise
A simulation to validate an emergency or business continuity plan, rehearse key staff or test systems or procedures.

Generic Plan
A single plan designed to cope with a wide range of emergency.

GNN
Government News Network

GO
Government Office

Hazard
An accident or naturally occurring event or situation with potential to cause damage to human welfare in a place in the UK or to the environment of a place in the UK.

HMIC
Her Majesty's Inspectorate of Constabulary.

LA
Local Authority

Lead Government Department (LGD)
The Government department which, in the event of an emergency coordinates central government activity. The department which will take the lead varies depending on the nature of the emergency. The government regularly publishes a full list of LGDs.

Lead responder
A category 1 responder charged with carrying out a duty under the act on behalf of a number of responder organisations, so as to coordinate its delivery and avoid unnecessary duplication.

LGA
Local Government Association

Local authorities
Local authorities are responsible for co-ordinating welfare support to their communities in the event of an emergency and play an important leadership role, which includes:
· providing temporary shelter (rest centres) including any transport arrangements needed to help people get to and from these; (District/Borough/Unitary)
· providing information from the electoral roll to police casualty bureaux to assist in accounting for evacuees; (District/Borough/Unitary)
· ensuring suitable arrangements are in place to meet welfare needs; (County/Unitary)
· feeding and providing refreshment for those in temporary shelter; (District/Borough/Unitary)
· establishing arrangements for local GPs to issue emergency prescriptions at rest centres; (District/Borough/Unitary)
· meeting needs for temporary accommodation where evacuation is extended; (District/Borough/Unitary)
· the production and exercising of evacuation and shelter plans, including mutual aid arrangements with other authorities for cross-border and very large-scale incidents; (County/Unitary)
· leadership during the recovery phase of an evacuation; (County/Unitary)
· leading the rehabilitation of the community and restoring the environment, with assistance

from the Government Decontamination Service if necessary; (District/Borough/Unitary) and
· co-ordinating work to meet the long-term social and welfare needs of survivors, their families and friends. (County/Unitary)

Local Resilience Area (LRA)
The Civil Contingencies Act requires Category 1 and 2 responders to cooperate with other category 1 and 2 responders in their local resilience area. Each local resilience area (with the exception of London) is based on a police area.

Local Resilience Forum (LRF)
A process for bringing together all Category 1 and 2 responders within a Local Resilience Area for the purpose of facilitating cooperation in fulfilment of their duties under the Act.

Local responder
Organisation which responds to emergencies at the local level, these may include Category 1 and 2 responders or organisations not covered by the Act.

Local Risk Assessment Guidance (LRAG)
A document provided by central government with information on generic hazards and threats that should assist Category 1 responders in performing their local risk assessment duty of the Civil Contingency Act.

Mass evacuation
Evacuation of hundreds of thousands of people. There are very few scenarios in which this would be required. In evacuation planning the focus should be on flexible generic evacuation planning that can either operate on a smaller scale or be scaled up to this level from lower-level evacuation plans.

Media plan
A key plan for ensuring cooperation between Category 1 and 2 responders and the media in communicating during and after an emergency.

Minister (of the Crown)
Government Minister with the power to act under the Civil Contingencies Act, usually relating to the issuing of guidance, regulation and monitoring.

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

Mutual Aid
An agreement between Category 1 and 2 responders and other organisations not covered by the Act, within the same sector or across sectors and across boundaries, to provide assistance with additional resources during an emergency which may go beyond the resources of an individual organisation.

National Media Emergency Forum (MEF)
See Regional Media Emergency Forum (RMEF) for details.

NRR
National Risk Register

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

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

Planning assumptions
Descriptions of the types of scales of consequences for which organisations should be prepared to respond.

RAWG
Risk Assessment Working Group

Recovery
The process of rebuilding, restoring and rehabilitating the community following an emergency.

Regional Media Emergency Forum (RMEF)
Group of representatives from the media (editors, journalists), government, emergency services and other organisations involved in dealing with an emergency, meeting to plan and discuss communications challenges and common interests in planning and responding to emergencies.

Regional Resilience Director (RED)
Head of a Regional Resilience team (see below)

Regional Resilience Team (RRT)
Small teams of civil servants within a Government Office region working on civil protection issues.

Regulations
Contingency Planning Regulations (2005)

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

Risk
Risk measures the significant of a potential event in terms of likelihood and impact. In the context of the Civil Contingencies Act, the events in question are emergencies.

Risk appetite
Willingness of an organisation to accept a defined level of risk.

Risk assessment
A structured and auditable process of identifying potentially significant events, assessing their likelihood and impacts and combining these to provide an overall assessment of risk, as a basis for further decisions and actions.

Risk management
The culture, process and structures that are directed towards the effective management of risk.

Risk priority
The relative importance of the treatment(s) required for the management of risk, based on the risk rating and capabilities required to manage the risk.

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

Risk treatment
A systematic approach of deciding which risks can be eliminated or reduced by remedial action

and which must be tolerated.

SAC
Strategic Coordination Centre

SCG
Strategic Coordination Group

SIO
Senior Investigating Officer

Sensitive information
Information that is not reasonably accessible to the public because its disclosure to the public would, or would be likely to a) adversely affect national assessment, b) adversely affect public safety, c) prejudice the commercial interest of any person, or information that is personal data, within the meaning of section 1(1) of the Data Protection Act 1998,
disclosure of which would breach that Act.

Shelter
Taking refuge or cover from an actual or perceived danger.

Sims
Senior Identification Managers

SOLACE
Society of Local Authority Chief Executives

Specific Plan
A plan designed to cope with a specific type of emergency, where the generic plan is likely to be insufficient.

Surge capacity
A health care systems ability to expand quickly beyond normal services to meet an increased demand for medical care in the event of bioterrorism or other large-scale public health emergencies.

Threat
The intent and capacity to create loss of life or create adverse consequences to human welfare, the environment or security.

Threats Statement
A component of the Local Risk Assessment Guidance.

Utilities
Companies providing essential services e.g. water, energy, and telecommunications.

Voluntary Sector
Bodies, other than public authorities of local authorities, which carry out activities otherwise than for profit.

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

Vulnerable people
People less able to help themselves in the event of an emergency.

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

Annex 3

Risk vs. Impact