

RCHT Evacuation Plan

V4.1

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Table of Contents

1.	Introduction	5
2.	Purpose of this Policy/Procedure	5
3.	Scope	5
4.	Definitions/Glossary	5
5.	Ownership and Responsibilities	6
5.1.	Role of the Chief Operating Officer	6
5.2.	Role of the Emergency Preparedness, Resilience and Response (EPRR) Committee	6
5.3.	Role of Managers	6
5.4.	Role of Individual Staff	7
5.5.	Incident Coordination Centre (ICC) Team Responsibilities.....	7
6.	Standards and Practice	8
6.1.	Types of Scenario Requiring Partial or Full Evacuation.....	8
6.2.	How the Hospital Evacuation Plan Works and Integrates with the Major Incident Plan	8
6.3.	Command and Control Arrangements between Sites.....	8
6.4.	Location of the Incident Coordination Centre Team	8
6.5.	Decision to Evacuate	9
6.6.	Decision to Invacuate and Lockdown	9
6.7.	Speed of Evacuation	10
6.8.	Phases of an Evacuation	11
6.9.	Initial Incident and Preparation	11
6.10.	Evacuation	11
6.11.	Transportation	11
6.12.	Removal and Business Continuity	12
6.13.	Recovery	12
6.14.	Normality and learning	13
6.15.	Elective Surgery	13
6.16.	Moving and Handling	13
6.17.	Cascading the Alert.....	13
6.18.	Coordination of Transport.....	14
6.19.	Communication	14
6.20.	Clinical Site Manager Responsibilities	15
6.21.	Immediate Actions for the Clinical Site Manager	15
6.22.	Destinations for Evacuation	15
6.23.	Transfer of Patients to other Wards/Spaces within the Hospital/Trust	16

6.24. Transfer of Patients to Other Local Trusts	16
6.25. Discharge of Patients into the Community	16
6.26. Transfer of Patients into Community Hospitals	17
6.27. Transfer of Patients to Private Sector Hospitals	17
6.28. Evacuate Patients to Temporary Holding Areas (Off Site) Nominated by the Local Authority	17
6.29. Evacuate Patients to Temporary Holding Areas (Off Site) NOT Nominated by the Local Authority but arranged through the Trust.....	17
6.30. Carrying Out Patient Evacuation	18
6.31. Staff	22
6.32. Security	29
6.33. Post Evacuation	31
6.34. Supporting Other Evacuations (see Appendix 12).....	32
7. Dissemination and Implementation	32
8. Monitoring Compliance and Effectiveness	33
9. Updating and Review	33
10. Equality and Diversity.....	33
Appendix 1. Governance Information	34
Appendix 2. Quality and Equality Impact Assessment (QEIA) Form	37
Appendix 3. Suggested Patient Holding Areas for Each Hospital Site	38
Appendix 4. Rest Centres	39
Appendix 5. Action Cards	40
Appendix 6. Patient Tracking Forms (one to be completed per ward or department evacuated)....	59
Appendix 7. Inpatient Bed Data to Aid Decision Making.....	60
Appendix 8. Evacuation Triage Categories	65
Appendix 9. CHA4835 - Safety Huddle Report	66
Appendix 10. Site Maps.....	68
Appendix 11. Debrief Proforma	71
Appendix 12. Assisting External Evacuation Checklist	72

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

1. Introduction

1.1. The aim of this plan is to provide an operational approach to the management of a large-scale hospital evacuation that can be applied to any Trust site. This plan describes the actions that need to be taken to reduce the risk of harm to patients caused by an evacuation at a hospital site.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of this plan is to allow any RCHT site to effectively:

- Evacuate part of, or the whole of, any hospital site.
- Know when to implement invacuation as a more appropriate response.
- Secure evacuated parts of the site unprotected by a police cordon.
- Assist in the onward management of patients to other care facilities following evacuation of the site, or part thereof.
- Assist the Trust in managing the receipt of patients from an evacuated hospital site elsewhere.

3. Scope

- 3.1. This plan deals with the responses required by the Trust to enable the partial, full, or systematic evacuation or invacuation of the hospital site or other sites operated by the Trust in uncertain circumstances. This plan builds on the existing fire evacuation and lockdown procedures in place for all areas of the hospital and acts as a guide for the incident coordination team in coordinating evacuation and response of the Trust. This plan should be used in conjunction with the Trust Business Continuity Plans and the Major Incident Plan.
- 3.2. The total or partial evacuation of the hospital is not a decision that can be taken lightly. Traditionally, hospital evacuation procedures tend to rely on horizontal evacuation i.e., patients, staff and visitors are evacuated to a place of safety on the same floor, continuing as necessary to put as much distance as possible between those being evacuated and the incident. Vertical evacuation may then be considered and, if necessary, continued to the outside of the building.
- 3.3. While horizontal evacuation may be appropriate in response to a fire, other potential scenarios may require the evacuation of the whole building or even the entire hospital site.

4. Definitions/Glossary

- 4.1. Evacuation of the site refers to the removal of staff, patients, and visitors to an area of the site, or the whole site, or at any of the centres managed and operated by the Trust away from the main hospital site.

- 4.2. Invacuation of the site refers to the holding of staff, patients, and visitors in the hospital to ensure their safety in the event of a cordon being established but evacuation not advised. Invacuation may involve the moving of patients within the hospital away from potentially exposed areas, the closure of all windows on the affected site, lockdown of external doors opening directly into a clinical space that could compromise the safety of the hospital. The hospital has no powers to hold persons (staff, patients, or visitors) within the site against their will in an event requiring the invacuation of the site (air-borne chemical release or similar). The hospital can only strongly advise against exiting the site.

Category	Information
Patient Holding Area A	For patients that can be discharged or can be safely cared for (on a temporary basis) in such an area.
Patient Holding Area B	For patients that will need referral to another health care provider or internal Trust transfer. The transfer of the patients from these areas will be undertaken by ambulance.
ICC	Incident Coordination Centre
FCP	Forward Control Point - if emergency services are on site for the purposes of the evacuation, this is where they will coordinate the response from. This may or maybe not be in the ICC.
CF and RS	Cornwall Fire and Rescue Service

5. Ownership and Responsibilities

5.1. Role of the Chief Operating Officer

As Accountable Emergency Officer (AEO) for the Trust they should ensure that an Evacuation Plan is in place and also a mechanism for the exercising, review and revision of this plan.

5.2. Role of the Emergency Preparedness, Resilience and Response (EPRR) Committee

The Committee will sign off the Evacuation Plan and follow up any necessary actions following live use of the plan or exercising.

5.3. Role of Managers

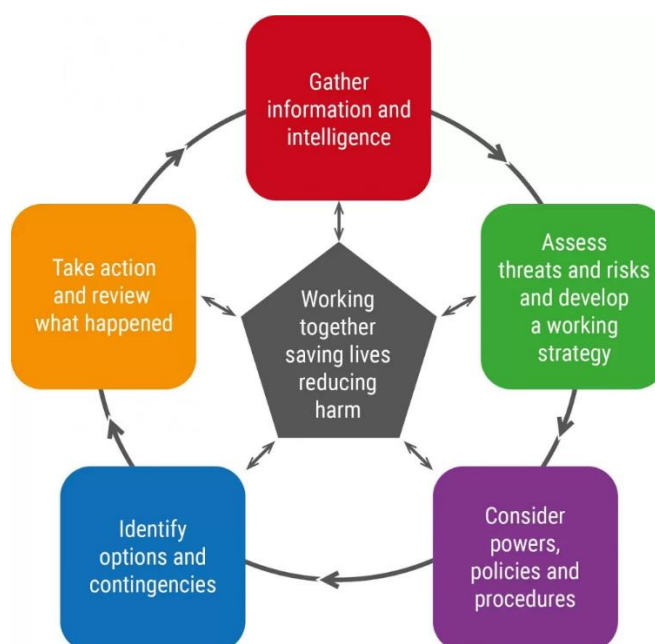
- Ensure that staff under their jurisdiction have an understanding of their working areas with regards to risks and the environment.
- Assist and lead where necessary the effective and coordinated evacuation response to an incident.
- Ensure wards/departments have printed copies of this plan in their area.

5.4. Role of Individual Staff

- Ensure they have an understanding of their working area with regards to risks and the environment.
- Contribute to the effective and coordinated evacuation response effort.
- Account for patients/visitors/staff within their working area.
- Deliver essential patient treatment during an evacuation.
- Ensure, where possible, that patient notes accompany any evacuated patient.
- Be aware of likely assembly points following evacuation.

5.5. Incident Coordination Centre (ICC) Team Responsibilities

In order for the Trust to respond to the need to evacuate as quickly as possible, the Director On Call may declare a Critical Incident or a Major Incident for the Trust. However, serious consideration should be given to at least issuing a Major Incident Standby alert. This will be cascaded within the Trust via the cascade system and internal communications and will allow the forming of the team who will agree the initial actions of the Trust prior to issuing a full Major Incident alert. Until the team forms, the Clinical Site Manager will have responsibility for leading the incident. The Clinical Site Manager will then liaise directly with the team. Where the SWAST/Devon and Cornwall Police/Cornwall Fire and Rescue Service are on-site they should provide a liaison officer in the Incident Coordination Centre (ICC). If they are unable or unwilling to do this, then the Tactical Commander may need to attend their Forward Control Point (FCP) location instead of using the Hospital ICC. Any evacuation incident involving either SWAST, Devon and Cornwall Police and Cornwall Fire and Rescue Service will likely invoke the use of Joint Emergency Services Interoperability Programme (JESIP) Joint Decision Making (JDM) model:



6. Standards and Practice

6.1. Types of Scenario Requiring Partial or Full Evacuation

- 6.1.1. A fire, flooding, breakdown of utilities, release of asbestos or other toxic substance, major equipment failure, suspicious device, or violent crime may paralyse the provision of services and jeopardise safety arrangements. In addition to these, hospitals need to be prepared to evacuate patients due to terrorist incidents and industrial accidents.
- 6.1.2. The evacuation of a hospital will only be considered in very exceptional circumstances and as a last resort. All the hospitals' elevators can and should be used unless it is a fire where the use of stairwells is advised.
- 6.1.3. In a situation where the hospital may be exposed to an external hazardous substance the appropriate course of action might be to invacuate. There is evidence to suggest that there would be more injuries or fatalities as a direct consequence of evacuation rather than the effects of the substance. This obviously does not apply in a scenario where the hazardous substance has inadvertently been released within the hospital building.

6.2. How the Hospital Evacuation Plan Works and Integrates with the Major Incident Plan

- 6.2.1. The Hospital Evacuation Plan does not replace the Major Incident Plan rather it acts as an event specific plan which has specific associated actions extending above and beyond those noted within the Major Incident Plan. This plan accepts that, because of the repercussions, Hospital Evacuation is seen as the last available option and where possible partial, as opposed to full evacuation, should always be considered. That being noted, this document is created to assist in the worst-case scenario of a full site evacuation.
- 6.2.2. For smaller scale events existing local evacuations still apply. This document acts to support these local scale evacuation plans by providing an overarching approach to a wider scale incident.

6.3. Command and Control Arrangements between Sites

The coordination between sites will be carried out by the Clinical Site Manager at RCHT. They will liaise between sites and where necessary escalate the need to evacuate up the management on call chain.

6.4. Location of the Incident Coordination Centre Team

The team needs to decide its best location, where possible this should be in the primary or secondary Incident Coordination Centre within that hospital.

6.5. Decision to Evacuate

- 6.5.1. Whilst the Clinical Site Manager or Ward Manager has the authority to evacuate in a small-scale event, a site wide evacuation should only be authorised by the Director On Call.
- 6.5.2. The decision to evacuate must be based upon the incident risk or potential risk to the Trust staff and patients. This must be balanced against the risk of not evacuating, in both immediate and long term, for staff, existing patients and future patients.
- 6.5.3. It should be noted that for some patient groups the risk of evacuation may be higher than the risk of them remaining on site. Additionally, the risk to staff in attempting to remove some patients from site may be too great.
- 6.5.4. Decisions need to be taken on the estimated speed of evacuation and the time available for this to be conducted. This will vary greatly depending, for example, on the time of day/night, the weather, and other operational pressures.

6.6. Decision to Invacuate and Lockdown

- 6.6.1. Invacuation and lockdown of the hospital may be more suitable in the event of an external incident where there is a risk to health from external factors, but evacuation would place staff, patients, and visitors at considerable risk of injury or exposure to the incident.
- 6.6.2. Invacuation will most likely involve the lockdown of the hospital. This will require access points to be secured and security to patrol any points where access is to be retained in a controlled fashion. Lockdown could present challenges to the hospital especially during an incident where patients are being admitted to the hospital. The hospital cannot hold patients or staff against their will in the facilities but can advise them to remain on site for their own protection. It may not be possible to always do this, and security will have to be prepared to re-secure any access points that are forced open. Signs should be in place to ensure patients know where they can access support from other health care facilities or in the event of partial lockdown which parts of the hospital are accessible. Ambulance service should be advised of any changes to patient drop off required as a result of the lockdown.
- 6.6.3. Following any evacuation, it may be necessary to lockdown the site to prevent further access to equipment and facilities, especially where critical infrastructure is stored or maintained. Where this is necessary security may have to continue to liaise with the Police and the Fire Services regarding on-going access. All staff will need to have identification cards with them in the event of a lockdown or will not be able to access the hospital. In any lockdown, relatives of family might be held away from treatment areas to allow appropriate clinical management and ensure the safety and security of the hospital.

6.6.4. Upon activation of invacuation the ICC will ensure that all Senior Managers are informed. Staff should make patients safe and ensure that they follow the actions necessary to protect life and services:

- Close windows and blinds/curtains.
- Where possible move away from windows.
- Ensure patients are ready to be moved if necessary.
- Explain to patients and staff what is occurring.
- Close doors.
- Carry your ID badge with you at all times.
- Assist security with checks, and report anything suspicious.

Please note: Whilst experts from outside of the Trust can advise the Trust of the need to evacuate, ultimately the decision to evacuate will reside only with the Director On Call in discussion with the operational team. The only exception to this is if the Terrorism Act 2000 or Public Health Act 1984 is used to enforce a mandatory cordon and evacuation. Depending on the nature of the incident, Police and the Fire and Rescue Service might be on site but cannot be relied upon to fully resource enough personnel to evacuate the site.

6.7. Speed of Evacuation

Depending upon the circumstances requiring the hospital to be evacuated the speed within which evacuation should be completed will differ.

6.7.1. Fast Time

This is where an incident has occurred that requires an immediate evacuation. In this instance, the evacuation will be led by the Clinical Site Manager with decisions over which areas are evacuated first being on the basis of doing the greatest good for the greatest number. This will have the greatest effect on clinical areas with patients that are not ambulant. Patients would be evacuated on a sliding scale from those that are most able to be evacuated first, to those least able to, and then those that require the most time and assistance last.

6.7.2. Slow Time

This is where the need to evacuate is known and there is time for this to happen in an ordered manner. This pre-warning will allow more time for an organised shutdown of the hospital and allow greater opportunity for movement of at-risk patient groups.

It should be noted that as an incident develops it may be necessary to move from slow to fast time evacuation and vice versa. This will depend upon the information being received by the ICC team. As such it will be vital for this to be appropriately communicated to staff during a period of expected confusion.

6.8. Phases of an Evacuation

The phases of an evacuation can roughly be broken down into 6 separate stages.

- Initial Incident and Preparation.
- Evacuation.
- Transportation.
- Removal and Business Continuity.
- Recovery.
- Normality and learning.

6.9. Initial Incident and Preparation

This is where the initial information will be received by the Trust. It is important that the Clinical Site Manager is at all times made aware of the developing incident even if the incident isn't immediately within their areas of responsibility.

The Clinical Site Manager is also importantly the most senior person available 24 hours a day and managing the operational running of the hospital. They have the responsibility to escalate an internal incident to the On Call Manager and through them to the Director On Call.

6.10. Evacuation

Working with external agencies/emergency services the scale of the evacuation will be agreed with a designated evacuation perimeter/cordon being established. Evacuation will then occur within this perimeter with staff, patients and the public being removed from this area. All patients and staff will be evacuated to designated holding points prior to suitable alternative locations being established. Clinical assessment of these patients should be made at the time of evacuation and clinical staff should be available at the holding points.

6.11. Transportation

Once patients have been removed from Trust buildings as part of the evacuation it will be necessary to coordinate a large number of external organisations in the transfer of patients either to other healthcare facilities or out into the community. This will be logistically complicated and will take a considerable period of time and a large number of resources. There will be a heavy dependence on SWAST and private ambulance providers.

6.12. Removal and Business Continuity

The Hospital should ensure that all possible patients are removed from within the evacuation perimeter. Additionally, other transportable items of medical equipment for continued hospital operational running should also be removed if it is deemed safe to do so. Business Continuity will need to occur during the evacuation as some Trust functions will be required to continue even during the most dire of events.

6.13. Recovery

The Trust will quickly attempt to return to normality. In some instances, such as where fire has occurred or contamination has spread, this recovery phase may take some time. A Trust recovery team will be formed to undertake this function. The priority will be early restoration of critical services. The table below presents the main areas for the Trust recovery team to consider:

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

6.14. Normality and learning

As with all Major Incidents (and it is likely that a site or large-scale evacuation will be a Major Incident for the Trust) there is a need to learn from the event and incorporate this into future plans, training and exercising. This learning will also occur outside of the Trust with other health care organisations benefiting from the lessons learnt.

6.15. Elective Surgery

It can be expected that the demand for level 3 Critical Care beds caused by the need to evacuate will immediately exceed any of the minimal surplus that occasionally occurs within the Trust. Consideration must therefore be given to the cancelling of elective surgery and the creation of additional level 3 Critical Care beds within theatre space at every remaining site within the Trust. However, some theatres will have to remain free in order to cope with patients whose condition rapidly deteriorates as a direct result of the evacuation. The Trust may also need to maintain the 'critical' functions of emergency surgery and caesareans.

6.16. Moving and Handling

All Trust staff are trained as part of their induction and refresher training in moving and handling procedures. Due to the nature of the evacuation, it may not be possible to give a brief on these procedures or stop those who have not been trained in assisting with the evacuation. Therefore, there is a risk to all staff when evacuating that injuries could potentially be sustained as a result of the evacuation, especially where patients are evacuated vertically, without the assistance of lifting and handling equipment. The vast majority of staff who work in clinical areas where there is emergency fire evacuation equipment i.e. Evac/Flotech Chairs, vacuum mattresses, paediatric pods, and Res Q Mats should have undertaken the training to safely evacuate patients in an emergency situation.

6.17. Cascading the Alert

The following is a list of the people and the organisations that you may need to contact, those in **bold** must be informed:

Order of organisations/people to contact (in order of importance):

Person or Organisation
Director On-Call
South Western Ambulance Service FT (SWAST)
NHS England
ICB

Cornwall Council
HTG-UK
Cornwall Partnership NHS Foundation Trust On Call Director
Duchy Hospital

6.18. Coordination of Transport

Prior to and during an evacuation, the liaison between outside transportation organisations and the Trust will quickly become one of the largest responsibilities of the ICC team. This will be undertaken by the Transport Coordinator within the team.

6.19. Communication

It can be expected that an evacuation will, by its nature, cause some unusual communications problems for the Trust. Not least will be the difficulty in communicating with people that are relocated to holding areas and maintaining communication with those being evacuated. There will be a requirement to communicate with the following main groups:

- Patients and staff being evacuated.
- Patients and staff relocated to holding areas.
- Patients expected for elective/outpatient appointments both on the day of evacuation and in the immediate future.
- Staff not being affected by the evacuation.
- External organisations assisting in the evacuation (this group will be managed directly by the ICC team).
- Media.
- Other Trusts (across the South West).

The ICC Team will oversee all of these communications however some will be carried out directly by the Duty Press Officer e.g. liaison with the media. Additionally, out of hours, the Duty Press Officer will also have responsibility for Trust wide staff communications e.g. all user emails, intranet updates, website information and SnapComms. The Duty Press Officer will utilise the health system Incident Response Communications Plan.

6.20. Clinical Site Manager Responsibilities

The operational decision making of a fast time evacuation should be coordinated through the Clinical Site Manager. Whilst every incident requiring large scale evacuation will be different with different inherent risks the desired result remains the same – the fast, efficient, and safe evacuation of staff, patients and the public from Trust buildings. To accomplish this in a fast time approach, compromises will have to be made.

6.21. Immediate Actions for the Clinical Site Manager

- Identify/quantify the exact threat that is prompting the need to evacuate.
- Identify all buildings requiring evacuation / lockdown.
- Identify location where patients will be evacuating to (see [Appendix 3](#)).
- Liaise with senior staff present within affected area to communicate need and management of evacuation.
- Liaise with senior clinicians to coordinate the movement of patients to appropriate holding areas.
- Oversee marshalling and guiding of patients to the evacuation point.
- Note the exact location of and the numbers of patients not removed from buildings e.g. disabled / vulnerable / critically ill and communicate this to the Incident Coordination Centre.

Whilst a number of criteria can be used for assessing the order of evacuation, the two simplest practical methods (where there is an immediate threat to life) is to first evacuate both those closest to the source of the incident first and those that require the least ambulatory assistance.

6.22. Destinations for Evacuation

6.22.1. For an evacuation to take place patients will need to be relocated initially within the hospital site and then potentially outside of the hospital site. Some patients can be evacuated with limited need for immediate medical treatment e.g., inpatients awaiting routine surgery. Others will require very detailed ongoing medical care and monitoring, such as those patients in Level 3 beds within critical care. Depending upon the patient, there are a number of different locations the patient could be evacuated to:

- Transfer of patients to other wards/spaces within the hospital.
- Transfer of patients to other wards/spaces within the Trust.
- Transfer of patients to other local Trusts.
- Transfer of patients into community hospitals.

- Discharge as many patients as possible into the community.
- Transfer of patients to private sector hospitals.
- Evacuate patients to temporary holding areas prior to transfer to other NHS bodies e.g. schools/community centres/town halls.

6.22.2. Any holding area that is within a Trust site should be aware that they may need to triage any self-presenters to the hospital who were seeking to access the Emergency Department or maternity care.

6.23. Transfer of Patients to other Wards/Spaces within the Hospital/Trust

Whilst the Trust does operate to almost 100% capacity at most times some bed spaces can be created through rapid discharge of patients or the cancelling of elective surgery, both of which would be expected following the decision to evacuate any of the main sites of the hospital. This must be conducted following Specialist Registrar assessment of patients in all ward space within the Trust (not just the affected site). [Appendix 3](#) identifies temporary patient holding areas that exist within each hospital site. These areas are particularly important for utilisation when adverse weather puts the patients at risk if in an unsheltered area. If these areas on-site are not sufficient to manage the situation, then consideration should be given to holding areas at other RCHT sites or off-site holding areas. SWAST may be able to deploy their temporary CCS (Casualty Clearing Station) that would normally be sent to the scene of a Major Incident for casualty triage and treatment. They may also be able to deploy a Mass Casualties Vehicle which has an extensive oxygen delivery system. A request for this vehicle should be made through NHS England. The nearest vehicles are at Exeter and Bristol.

6.24. Transfer of Patients to Other Local Trusts

Some patients will require specific conditions and treatment facilities. Level 3 beds within the Trust are at a premium and whilst some can be created for a short period of time using unused theatre space (resulting from the cancellation of elective surgery) this cannot be expected to be enough to match requirements. As such, it can be expected that there will be a very great need to transfer some critically ill patients direct to other Trusts. This transfer will be organised through NHS England and SWAST. There is escalation space identified for use during a 'Critical Incident' that could be utilised during an evacuation. These escalation spaces are at both RCHT and CFT locations. These range in readiness to open, some requiring just beds, some being completely un-stocked and having no permanent oxygen or suction capability. Most are only suitable for patients without reason to reside.

6.25. Discharge of Patients into the Community

As with externally generated Major Incidents, it is likely that there will be some patients who can be safely discharged into the community. These, for example, will be patients who have come into the hospital awaiting elective surgery or those who are fit for discharge following minor surgery. These patients will require some follow up from other health care professionals

however this can occur after evacuation. Consideration should be given to Hospital at Home. The decision to discharge patients early will be made by the ward or department Specialist Registrar.

6.26. Transfer of Patients into Community Hospitals

In consultation with partner agencies some patients may be able to be transferred into community hospitals.

6.27. Transfer of Patients to Private Sector Hospitals

At times of emergency, private sector hospitals can assist the Trust in their overall response. RCHT has existing arrangements with the Duchy Hospital. This should be coordinated through the ICC. It should be noted that there may be some monetary cost to this course of action, however, the needs of the patients come first.

6.28. Evacuate Patients to Temporary Holding Areas (Off Site) Nominated by the Local Authority

6.28.1. Some patient groups could be suitable for temporary evacuation to a non-medical facility (temporary holding area) prior to their relocation to another hospital or suitable health organisation. From these locations Trust staff would need to care for their patients' wellbeing prior to their relocation by ambulance or other transport.

These locations can be arranged through the Local Authority and are referred to by the Local Authority as "Rest Centres." They are predominantly intended for use by the public when evacuated from their home but can be used by patients evacuated from a hospital site. A list of suitable Rest Centres can be found at [Appendix 4](#).

6.29. Evacuate Patients to Temporary Holding Areas (Off Site) NOT Nominated by the Local Authority but arranged through the Trust

These areas are not nominated or arranged through the Local Authority but through direct liaison between the site and the Trust.

For RCH these could be:

- Truro and Penwith College.
- Truro Prep School (outside of school hours this would obviously be more viable).
- Treliske Retail Park (vacant unit only suitable).

For SMH these could be:

- St Piran's School (outside of school hours this would obviously be more viable).
- St Julia's Hospice.

For WCH these could be:

- Penwith College.
- Penzance Leisure Centre (this is a PFI location and there may be difficulty in using it for these purposes).

6.30. Carrying Out Patient Evacuation

6.30.1. Dependency Triage Category

6.30.1.1. It is the responsibility of all healthcare staff to do the most for the most during an incident involving the evacuation of patients. Triage assists with making decisions on whom to evacuate and in what order. The triage process also helps determine the resources required to shelter and/or evacuate patients, the mobility of patients, the type of shelter and equipment required, the length of time it will take to facilitate the relocation and the type of transport required for off-site evacuation. The triage cards brought to the area by the Clinical Site Manager are attached to patients to highlight what dependency category they fall into. [Appendix 8](#) shows the criteria for each category. Patients are categorised into 'High Dependency', 'Medium Dependency' and 'Low Dependency'. This aids staff coming to the ward/area who may not know the patients to know which just need direction on what to do i.e. those that are 'Low Dependency' and those that will require lots of time and staff to enable them to be evacuated. There is a potential caveat for the High Dependency category and that is patients who are DNACPR or where withdrawal of treatment was being considered. The dependency triage categories into which each inpatient falls should be recorded on the Safety Huddle Report (CHA4835), highlighting those that are specifically High (red) or Amber (medium). [Appendix 9](#) shows the current CHA4835 Safety Huddle Report).

6.30.1.2. In an emergency, the sequence of evacuation below should be implemented:

- Those in immediate danger (any dependency).
- Low Dependency.
- Medium Dependency (whilst preparing High Dependency patients for evacuation).
- High Dependency.

NB If patients are injured as a result of the incident that has preceded the evacuation, then MI triage cards take primacy over patient evacuation triage cards. **(Available from ED Major Incident cupboard).**

6.30.2. Specific Roles Required for Evacuation of Patients

6.30.2.1. Fire Wardens

Fire Wardens are a fire safety requirement. They must be sufficient in numbers to provide assistance at all times in the safe evacuation of a premises in the event of an alarm of fire.

They will be responsible for:

- Ensuring that locally agreed fire evacuation plans and procedures are carried out.
- Ensuring that occupants attend the designated fire assembly point.
- Reporting missing persons to the Fire and Rescue Service as well as the Clinical Site Manager.

At RCHT we would use Fire Wardens for the safe evacuation of patients in any given scenario and not exclusively for fire.

6.30.2.2. Evacuation Marshals

Evacuation Marshals will be necessary to move cohorted patient groups from one location to another. These marshals will either be located strategically along the evacuation or will lead patients in groups from start point to destination.

6.30.2.3. Patient Tracking Loggists

Patient Tracking Loggists will be necessary to track the movement of all patients from their originating department or ward to a patient holding area, other Trust location or outside of the Trust. This Loggist can be any member of staff but would ideally come from an administrative background. A patient tracking proforma is included within the appendices of this plan.

Full Action Cards are necessary for these three roles and are located within [Appendix 5](#) of this plan.

6.30.3. Organisations Directly Assisting in Patient Movement

In order to fully evacuate any of the hospital sites a number of organisations will need to be involved:

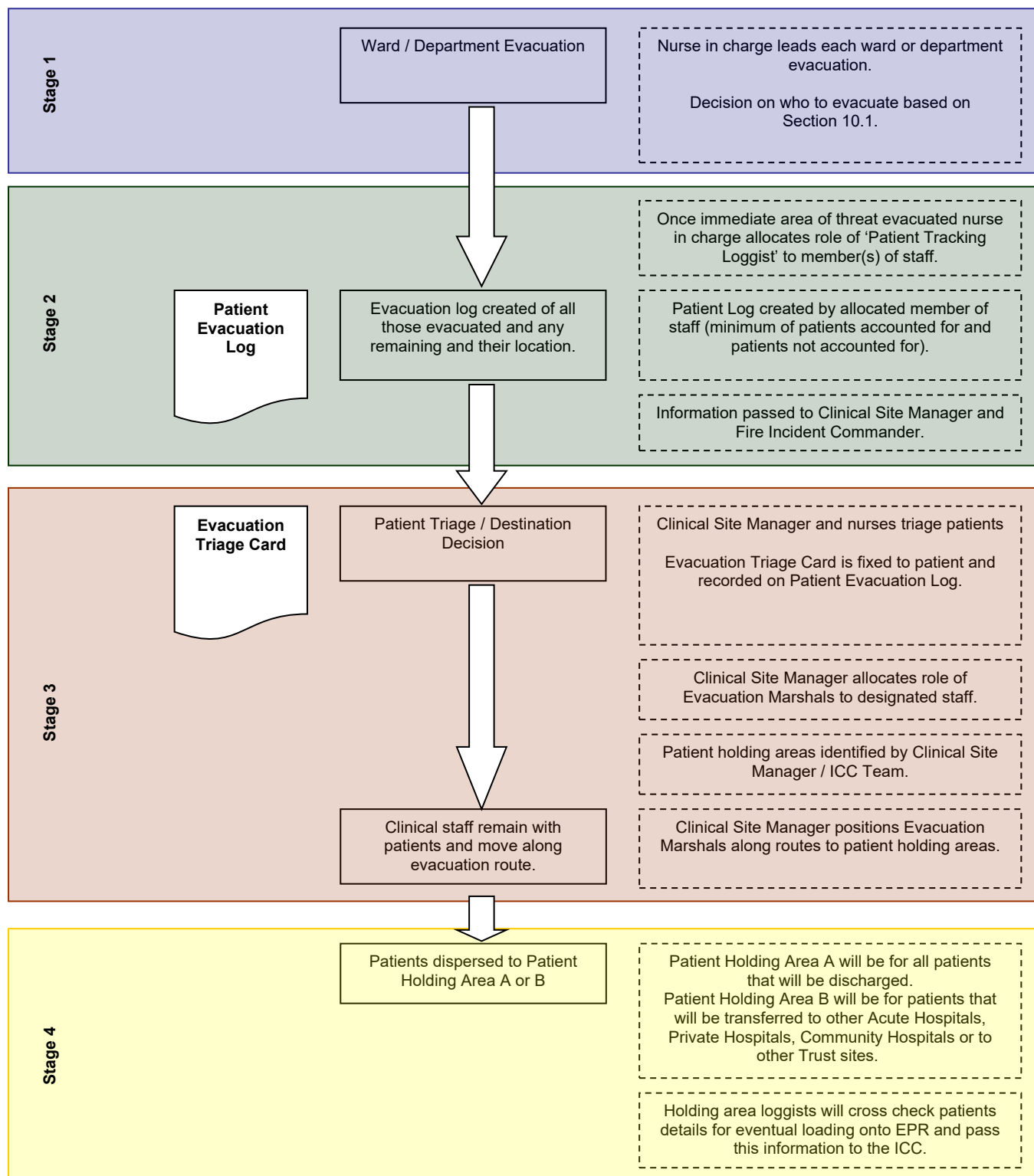
- SWAST/Cornwall Air Ambulance/Retrieve – transfer of Level 3 type patients.
- Hospital Transport (HTG-UK) – transfer of ward patients.
- Local Authority – provide rest centres (if required) and additional transport (if available).

- Community Transport – provide transport for low dependency patients.
- Private Ambulance Services – provide additional support to HTG-UK.
- Public Transport Providers – additional transport for low dependency patients.

6.30.4. Patient Holding Areas

- 6.30.4.1. The ICC Team is responsible for organising transportation of patients to their relevant location. In order to evacuate patients to the most appropriate location a clinical decision must be made for every patient on the most appropriate destination. This will be made by the senior doctor present within that area. The patient must then be evacuated to a holding area appropriate for that particular patient. For example, patients that are able to be discharged into the community should be assigned to a different holding area from patients requiring ambulance transfer to another acute hospital.
- 6.30.4.2. As such, two main holding areas must be assigned:
 - The first will be for all those patients that will be discharged or can be safely cared for (on a temporary basis) at that holding area (designated A).
 - The second (designated B) will be for referral to another health care provider or an internal Trust transfer. The transfer of patients will be undertaken by ambulances.
- 6.30.4.3. It will be necessary to coordinate with the local authority and police to ensure that appropriate traffic management occurs.
- 6.30.4.4. During a slow time, evacuation, it may be possible to evacuate some patients without the need to transfer them to a temporary holding area. This will be particularly important for critically ill patients whose movement presents a significant risk.
- 6.30.4.5. Suggested holding areas for each hospital are listed in [Appendix 3](#).

6.30.5. Patient Evacuation Process



6.31. Staff

No evacuation of the hospital can happen without the full support of all the various staff groups within the hospital. The communication procedures with staff, before, during and after an evacuation is crucial, these are outlined within the communications section of this plan. Staff will be divided into various staffing groups, these groups will have different responsibilities before, during and after an evacuation. There may be staff who have a Personal Emergency Evacuation Plan (PEEP), if they work in an area with patients who have had evacuation triage cards applied then it might be appropriate to apply a card to the staff member to show their dependency and also include them in the patient tracking form. If the staff member is not in a patient area, then the PEEP should just be followed.

6.31.1. Before Evacuation

During a 'slow time' evacuation there may be a period of time where staff are aware that an evacuation needs to take place and can prepare to evacuate. This may not be possible during a 'fast time' evacuation, with staff having to respond immediately. However, all staff have a responsibility to make themselves aware of evacuation routes and procedures. They must undertake mandatory training every year for both clinical and non-clinical staff as well as on induction for both groups and more frequently for specialist areas, e.g. Critical Care, Pathology and Pharmacy, etc.

6.31.2. During Evacuation

In both a 'slow' or 'fast time' evacuation, the ICC Team will have overall strategic responsibility for the evacuation. During a 'fast time' evacuation, there will be a need to make crucial decisions about those patients who are able to be evacuated and those that are not. Whilst it will always be the desire of the Trust to care for all patients, the Trust also has a responsibility for the ultimate safety of its staff. When there is an imminent threat to staff safety there will be a conflict between the safety and health of patients and the safety of staff. As such it is recognised that during a 'fast time' evacuation some patients may need to remain within the buildings being evacuated. This will need to be managed by the ICC with appropriate liaison between other organisations to assist.

6.31.3. After Evacuation

The post evacuation or recovery phase may last many months. Different staffing groups will recover at different paces. Additionally, the repercussions of an evacuation may extend for many years with rebuilding works or legal proceedings taking place. These repercussions could impact upon the health care of the local area e.g. for a contamination event, as well as to the Trust. It is very important to note that evidence will need to be gathered by all areas of the hospital and all staff groups involved so that a full report can be generated for the Local Health Resilience Partnership and other interested parties.

6.31.4. Staff Directly Involved in the Incident

An incident could occur whereby staff are required to remain in-situ as a result of an external incident or internal contamination e.g. a white powder incident. In these cases, other staff will need to be evacuated from the surrounding areas and specialist teams or individuals brought in to deal with these contaminated staff and return the area to normal use. This will be difficult as affected staff may be extremely worried and will naturally wish to remove themselves from the affected/contaminated areas. It is likely that the emergency services will cordon off the contaminated areas to prevent personnel self-evacuating from the area.

6.31.5. Actions for Staff, Before, During and After a 'Slow Time' Evacuation

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
Slow Time	Staff within hospital site requiring evacuation	• Divisions to lead slow time evacuation. • Contact all staff not within the hospital to appraise them of the situation. • Call in additional staff to support evacuation. • Prepare local medical supplies and equipment for possible move. • Act to reduce risk to patients and staff.	• Ensure the safety of yourself. • Prepare holding areas with appropriate equipment and medication for patient groups. • Assist in the discharge of patients where possible. • Move patients to holding areas. • Co-ordinate with ICC on patients remaining within location. • Request volunteers from staff to care for remaining patients. • Instigate local Business Continuity plans (loss or denial of access to premises).	• Ensure that all equipment and medication is returned to Trust sites and is accounted for. • Ensure that any notes kept as part of the response are passed to the ICC team. • Participate in debrief procedures. • Ensure that managers are made aware of any concerns of staff following the evacuation. Consider Occupational Health input for any staff affected physically or psychologically.
	Staff located at another hospital site not requiring evacuation	• Resident Doctors to assess patient status within all hospital space not affected by the	• Accept evacuated patients from affected site.	• Rearrange all cancelled elective surgery on clinical priority basis

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
		expected evacuation. • Arrange for patients where healthcare status is suitable for their discharge out of the Trust. • Prepare to accept evacuated patients. • Prepare for the cancellation of all elective surgery across the whole Trust.	• Arrange for the treatment of patients whose clinical condition has worsened as a result of the transfer from one site to another.	
	Staff at home	• Co-ordinate with line managers on location and time to report to work. • Make arrangements wherever possible with friends and relatives for a protracted period at work.	• If not immediately required co-ordinate with line management on location and time to report to work.	• Ensure that where staff initially participated in evacuation but then returned home that comments and issues from them are captured by the ICC.
	On call staff	• Continue to provide on call service.	• It is likely that a Major Incident could be declared for the Trust. On call staff should follow existing procedures for a MI. • Follow directions of ICC upon how to respond to the MI.	• Ensure that on call rotas are still appropriate given extended hours of work for some staff. • Ensure that any notes kept as part of the MI are passed to the ICC team.
	Nonclinical staff	• Prepare to continue to provide same service but at a different location using local	• Staff prepared to assist in the evacuation should make themselves known to their line managers (some	• Ensure that any notes kept as part of the MI are passed to the ICC team.

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
		Business Continuity Plan (loss or denial of access to premises).	non-clinical staff will be necessary). • Additional support may be needed as patient tracking loggists, runners, additional security and (where trained) to assist in the movement of patients. • Instigate local Business Continuity Plan (loss or denial of access to premises).	
	Volunteers / Students	• Volunteers to be sought to assist in evacuation. All volunteers to have had suitable training.	• Volunteers to be used to assist evacuation of patients, act as runners, and assist security.	• Ensure that any notes kept as part of the MI are passed to the ICC team.
	Security	• Obtain additional security personnel from external providers. • Liaise with volunteer's co-ordinator to obtain additional marshals to assist security. • Lockdown the site prior to evacuation	• Ensure that staff have evacuated each building. • Secure each building once vacated. • Instigate extended lockdown of all buildings. • Liaise with Police over cordon access arrangements at local level.	• Co-ordinate with ICC to ensure that threats to staff and patients have been managed or mitigated. • Reopen all buildings in a sequential manner allowing staff to return to work without compromising assets or allowing unauthorised personnel entrance to site.

6.31.6. Actions for Staff Before, During and After a Fast Time Evacuation

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
Fast Time	Staff within hospital	NO RESPONSE EXPECTED BEFORE EVACUATION IS CALLED	• Instigate local Business Continuity Plans (loss or denial of access to premises). • Ensure for the safety of yourself. • Where circumstances allow bring with you contact list of all team members. • Upon direction evacuate mobile patients. • Prepare holding areas with appropriate equipment and medication for patient groups. • Move patients to holding areas. • Co-ordinate with ICC on patients remaining within location. • Request volunteers from staff to care for remaining patients.	• Ensure that all equipment and medication is returned to Trust sites and is accounted for. • Ensure that any notes kept as part of the MI response are passed to the ICC team. • Participate in debrief procedures. • Ensure that managers are made aware of any concerns of staff following the evacuation. Consider Occupational Health input for any staff affected physically or psychologically.
	Staff located at another hospital site not requiring evacuation	NO RESPONSE EXPECTED BEFORE EVACUATION IS CALLED	• Resident Doctors to assess patient status within all hospital space not affected by the expected evacuation. • Arrange for patients where healthcare status is suitable for their discharge out of	• Rearrange all cancelled elective surgery on clinical priority basis

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
			the Trust. • Accept evacuated patients from affected site. • Prepare for the cancellation of all elective surgery across the whole Trust. • Arrange for the treatment of patients whose clinical condition has worsened as a result of the transfer from one site to another.	
	Staff at home	NO RESPONSE EXPECTED BEFORE EVACUATION IS CALLED	• Co-ordinate with line management on location and time to report to work. • Make arrangements wherever possible with friends and relatives for a protracted period of work.	• Ensure that where staff initially participated in evacuation but then returned home that comments and issues from them are captured by the ICC.
	On call staff	• Respond to Major Incident if declared	• Follow directions of ICC upon how to respond to the MI (if declared).	• Ensure that on call rotas are still appropriate given extended hours of work for some staff. • Ensure that any notes kept as part of any MI are passed to the ICC team.
	Non clinical staff	NO RESPONSE EXPECTED BEFORE EVACUATION IS CALLED	• Staff prepared to assist in the evacuation should make themselves known to their line manager (Some non-clinical	• Ensure that any notes kept as part of any MI are passed to the ICC team.

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
			staff will be necessary). Additional support needed as patient tracking loggist, runners, additional security and (where trained) to assist in the movement of patients.	
	Students / Volunteers	NO RESPONSE EXPECTED BEFORE EVACUATION IS CALLED	- Where circumstances allow volunteers to be sought to assist in evacuation. All volunteers to have had suitable training. - Where circumstances allow volunteers to be used to assist evacuation of patients, act as runners and assist security.	Ensure that any notes kept as part of any MI are passed to the ICC team.
	Security	- Security to assist Clinical Site Manager in operational response to a fast time evacuation enabling the largest number of people to be evacuated from the site in the shortest period of time. - Obtain additional security personnel from other providers. - Liaise with volunteers co-ordinator to obtain additional	- Rapidly evacuate all staff and as many patients as possible from identified buildings. - Report progress to the ICC. - Ensure that staff have evacuated each building. - Secure each building once vacated. - Instigate extended lockdown of all buildings. - Liaise with Police over cordon access arrangements at local	- Co-ordinate with ICC to ensure that threats to staff and patients have been removed or mitigated. - Reopen all buildings in a sequential manner allowing staff to return to work without compromising assets or allowing unauthorised personnel entrance to site.

Speed	Staff Group	Before Evacuation	During Evacuation	After Evacuation
		marshals to assist security. • Lockdown the site prior to evacuation.	level.	

6.32. Security

6.32.1. Current Security Levels

RCHT currently has the following provision across the Trust:

- RCH - minimum of 2 staff on duty 24/7 with normally 3.
- WCH and SMH - no dedicated security staff.

Further resources are also available via the Trust portering staff or through volunteers used as marshals (it is likely that in the event of a 'fast time' evacuation this resource will be used immediately).

Further support is available via the Trust Security Manager.

6.32.2. Use of Security Marshals

- 6.32.2.1. Security requirements during a hospital evacuation will not solely be met through the police. Internal security may be required to respond to the cause of the evacuation (such as a fire) as well as the security evacuation needs. Buildings, once evacuated, will need to be secured to prevent re-entry. The securing of these buildings may be both for a short, temporary period of time or for a longer term.
- 6.32.2.2. This will be the responsibility of the internal security personnel. They will liaise through the facilities coordinator to ensure that evacuated buildings are appropriately shut down and that the integrity of any cordon is maintained. For buildings where a 24-hour presence is usual this may be more complicated.
- 6.32.2.3. To adequately secure both an expanding number of evacuated buildings, as well as the site of an incident (for Major Incidents on-site only) it is likely that there will be a need for additional personnel. The use of marshals is ideal for these circumstances. These should wear clearly identifiable tabards and be organised by the ICC to respond to the needs of the evacuation.

6.32.3. Full Lockdown of Buildings

- 6.32.3.1. Some buildings, such as those where an operational presence exists 24 hours a day 7 days a week, there will be additional complications. Some areas of the Trust contain either pathogens and toxins or controlled drugs and full lockdown of the buildings is necessary once a controlled evacuation has taken place.
- 6.32.3.2. Where a building or area of the Trust is evacuated where any of the following are located the most senior person evacuating the site should liaise with the Security Manager and alert them to the need for additional long-term precautions:
- Hazardous substances or toxins.
 - Large stores of controlled substances such as drugs.
 - Large stores of oxygen and medical gas supplies.
 - Patient Health Records.

This will require additional personnel and resources. Liaison with the police will be necessary to inform them of the contents of some Trust buildings.

6.32.4. Site Security over an Extended Period

- 6.32.4.1. The Incident Coordination Centre Team needs to be aware of the security implications for an extended period of time. Locations which remain empty over a period of time may be subject to break in, vandalism, and theft and are more likely to be used by the homeless. Where a building is not returned to Trust use within a short period of time of the initial incident consideration should be given to increased security and if necessary, removal of items from the building.
- 6.32.4.2. Security should liaise with the Facilities Coordinator Action Card holder to prevent access to hospital buildings and entrances / thoroughfares through boarding up or hoarding / fencing areas of the Trust property that will be affected for an extended period.
- 6.32.4.3. Additional security resources can be requested by RCHT through:

Coast 2 Coast Security: Tel: 01726 71389
Bojea Industrial Estate,
Trethowel,
Bodmin Road,
St Austell,
Cornwall.
PL25 5RJ.

Kestrel Guards Security: Tel: 01209 313125

Seton Business Centre,
Scorrier,
Redruth,
Cornwall.
TR16 5AW.

Alpha Protect: Tel: 01872 719737

info@AlphaProtect.co.uk

Truro, Cornwall, TR4 9DR

6.32.5. Cordon Arrangements

During an evacuation it is likely that the emergency services will restrict access to the location requiring evacuation. Typically, this is in the form of a staffed cordon zone. Both access and egress will still be required during the evacuation for staff and other groups whilst retaining secure access to the area and maintaining some critical clinical services.

6.33. Post Evacuation

6.33.1. Staff

Following an evacuation or any other form of Trust Major Incident it is possible that staff will take some time to recover from the unusual events that they experienced. As noted in the Trust Major Incident Plan, counselling and support will be made available to all staff for as long as is required. This can be arranged direct or through POD. Occupational Health support should be offered to any staff physically or psychologically affected by the incident. It may also be necessary for staff to be based at other locations or other Trusts whilst recovery from the incident occurs.

6.33.2. Patients

Following an evacuation, patients may require long term psychological support. This can be provided through referral to their GP and should be offered to all affected patients. Additionally, it should be noted that, following an evacuation, patients may choose for a period of time to transfer their clinical care to another Trust. Whilst unfortunate this may be the best course of action for the clinical care of some patients whilst a period of recovery from the incident occurs.

6.33.3. Trust Buildings

Post incident it will be necessary to recover/restore Trust buildings or sites. This will not be an easy process and may take some months or even years. During this time a flexible approach to patient care should be adopted as well as flexibility to staff management in order to ensure that the Trust is able to restore services as quickly as possible. An event that causes a full site evacuation may also lead to future opportunities and should be looked at as a time to review the way in which care is provided and determine if a better approach is possible.

6.34. Supporting Other Evacuations (see Appendix 12)

6.34.1. Summary

In the event of an evacuation occurring at another hospital in Devon, Cornwall or the Isles of Scilly, RCHT might be asked to admit some of the evacuated patients. These may come via SWAST or be self-presenting in the event of a cordon and advice (this is only likely to occur if WCH UTC, a CFT MIU or Derriford Hospital is evacuated).

6.34.2. Expansion of Services

RCHT will have to expand its own services to increase capacity and still enable the hospital to function as normal. This expansion will be temporary in the first instance to deal with the sudden surge of patients into the healthcare system. If the hospital that has been evacuated is a neighbouring Trust, there will likely be a considerable expansion of services required in the near term until the evacuated Trust re-establishes minimal services and later restores all services. Impact will be felt across all services, but immediately in Maternity Services and the Emergency Department, where support in the community is limited and services are specialised.

6.34.3. Coordination

6.34.3.1. The evacuating Trust, SWAST and NHS England will coordinate the response of other Trusts in the event of an evacuation. Depending on the volume of patients and the location of the evacuating Trust/hospital the Director On Call may declare a Critical Incident and establish the Incident Coordination Centre Team to deal with the incident response and coordinate with these services.

6.34.3.2. If the Incident Coordination Centre Team is not established the Director On Call will coordinate the appropriate response from the hospital with assistance from the Clinical Site Manager, Chief Operating Officer and On Call Manager. The hospital will be responsible for tracking patients that have been admitted and confirming this to the evacuated hospital. Coordination will be important in accounting for patients and ensuring patient safety is maintained at all times.

7. Dissemination and Implementation

- 7.1 Once ratified by the EPRR Committee the plan will be published in the Documents Library under 'Chief Operating Officer – Emergency Planning'. Paper versions will be kept in the Incident Coordination Centre (ICC) and wards/departments in case of an IT failure.
- 7.2 The plan will also be kept alongside any patient evacuation equipment within RCHT.

8. Monitoring Compliance and Effectiveness

Information category	Detail of process and methodology for monitoring compliance
Element to be monitored	All of the plan.
Lead	Head of Emergency Preparedness, Resilience and Response (EPRR) with oversight from EPRR Committee.
Tool	Debrief from exercises/live deployment of the plan. Feedback from non-RCHT evacuation exercises/live deployments. Comparison with updated national guidance.
Frequency	Every 3 years or sooner following change in national guidance, live deployment of plan, or exercising.
Reporting arrangements	Potential SIRC if live deployment of plan for hospital evacuation and/or EPRR Committee.
Acting on recommendations and Lead(s)	Head of EPRR with action plans monitored by the EPRR Committee.
Change in practice and lessons to be shared	This will be identified following debrief from exercises/live deployment of the plan. Feedback from non-RCHT evacuation exercises/live deployments. Comparison with updated national guidance.

9. Updating and Review

- 9.1. This plan will be updated every 3 years or earlier following exercising/live deployment of the plan. Similarly, feedback from non-RCHT evacuation exercises/live deployments and updated national guidance will trigger a response.
- 9.2. The NHS England EPRR Framework requires EPRR related documents to be retained for 30 years.

10. Equality and Diversity

- 10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity and Inclusion Policy](#) or the [Equality and Diversity website](#).

10.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in [Appendix 2](#).

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	RCHT Evacuation Plan V4.1
This document replaces (exact title of previous version):	RCHT Evacuation Plan V4.0
Date Issued / Approved:	September 2026
Date Valid From:	September 2026
Date Valid To:	March 2029
Author / Owner:	Matthew Overton, Head of EPRR
Contact details:	01872 256356
Brief summary of contents:	The plan provides a framework for the major evacuation of any RCHT site.
Suggested Keywords:	Evacuation, fire, major incident, bomb threat.
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Operating Officer
Approval route for consultation and ratification:	Emergency Preparedness, Resilience and Response (EPRR) Committee
Manager confirming approval processes:	Chief Operating Officer
Name of Governance Lead confirming consultation and ratification:	Matthew Overton, Head of EPRR
Links to key external standards:	Civil Contingencies Act 2004. NHS EPRR Assurance Framework Core Standards. Health and Safety at Work Act 1974 (section 2 (1) (2) and 4). CQC Regulated Activity Regulations (section 9(2) and 10(2)).
Related Documents:	NHS EPRR Core Standards.

Information Category	Detailed Information
	2014 NHS EPRR “Planning for the shelter and evacuation of people in healthcare settings”. NHS London. Review of 5 London Fires and their Management.
Training Need Identified:	Yes – Incident Commanders
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Chief Operating Officer / Emergency Planning

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
20 April 2016	V1.0	Initial issue.	Matt Overton, Emergency Planning Lead
5 September 2018	V1.1	Name change of patient transport provider from NSL to Ezec. Provider name change from PCH to CPFT. Ward name changes.	Matt Overton, Emergency Planning Lead
1 November 2019	V2.0	Learning from Exercise Blacktower 2 and 3 and evacuation on 1 August 2019 due to toxic fume release. Transport Coordinator Action Card added.	Matt Overton, Emergency Planning Lead
3 May 2023	V3.0	Full update. Job titles updated. CCG changed to ICB. Ward names updated.	Matt Overton, Emergency Planning Lead
22 November 2023	V3.1	Incorporation of Personal Emergency Evacuation Plans for staff, using the JESIP JDM model for multi-agency evacuation incidents, evacuation triage priority of patients on Safety Huddle Report and use of System Incident Response Comms Plan.	Matt Overton, Emergency Planning Lead
26 March 2025	V3.2	National Mass Casualty Incident Equipment Vehicle now Mass Casualties Vehicle (6.23) Removed reference to ‘Truro Leisure Centre’ (6.29). Added ‘vacant unit only suitable’ to Treliske Retail Park (6.29).	Matt Overton, Head of EPRR

Date	Version Number	Summary of Changes	Changes Made by
		Added "Retrieve" (6.30.3). Amended definition in Appendix 8, under High Dependency, from "patient requires 2 staff to effect evacuation" to "patient requires a minimum of 2, ideally 4, (8 for bariatric), staff to effect evacuation. Updated job title from Emergency Planning Lead to Head of Emergency Preparedness, Resilience and Response. Updated transport provider from Ezeq to HTG-UK and updated telephone number to 01302 787499. Changed 'Sexual Health Hub' to 'Lamorna House'.	
April 2026	V4.0	Full review – minor amendments with Care Groups now Divisions and Appendix 4 Rest Centres updated following feedback from Cornwall Council.	Matt Overton, Head of EPRR
September 2026	V4.1	Appendix 12 added following learning from Exercise Vulcan. ICC location reference removed.	Matt Overton, Head of EPRR

All or part of this document can be released under the Freedom of Information Act 2000

The NHS England Framework requires EPRR related documents to be retained for 30 years. RCHT requires all Policies, Strategies and Operating Procedures, including Business Plans, to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#).

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: richt.inclusion@nhs.net.

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

Appendix 3. Suggested Patient Holding Areas for Each Hospital Site

In the event of imminent risk to patients/visitors then horizontal evacuation should be completed to any adjacent area that is safer than the location the patient/visitor has come from. Type A holding areas are for those that will be discharged and type B for those requiring transfer to another hospital either within RCHT or another Trust. If evacuating at night or at weekends then consideration should be given to outpatients, clinics and day units that will be vacant. Also, consider education facilities and training centres on each hospital site.

Royal Cornwall Hospital

Location	Description	Best suited to type A/B
Knowledge Spa	Atrium and Meeting Rooms and Lecture Theatre	Type A
Knowledge Spa	Classrooms and Clinical Areas	Type B
Post Graduate Centre	Large lecture theatre	Type A
Ingredients Restaurant	Large space with tables and chairs	Type A

West Cornwall Hospital

Location	Description	Best suited to type A/B
Cafe	Tables and Chairs	Type A
Seminar Room	First Floor	Type A
Outpatients	Ground Floor and First Floor	Type A
Penlee Unit	Ground Floor, exam rooms and recovery beds for Endoscopy	Type B

Appendix 4. Rest Centres

The following rest centres are relatively close to RCH or WCH (given the demand on patient transport to transfer the patients) and as a minimum have:

- Wheelchair accessibility (including bathrooms).
- Kitchen.
- Potential area for sleeping.
- Mobile phone signal.

Name	Address	Comments
Chacewater Village Hall	Church Hill Chacewater TR4 8PZ	60 parking spaces in village car park, 3 rooms, 4M, 4F, 2 accessible toilets, broadband, wifi, landline phone, cooker, 2 kettles, fridge, below average mobile phone signal.
St John's Hall	Alverton Street Penzance TR18 2QR	Car park nearby, 3 rooms, sleeping area main hall, 8M, 8F, 1 accessible toilet, bath/shower facilities, kitchen has hot water tap and microwave, broadband, wifi, good mobile phone signal.

Appendix 5. Action Cards

If the evacuation is deemed to be a Major Incident, then the Major Incident Action Cards should be cross compared to the Action Cards below. They will augment the actions that should be considered during an evacuation.

Incident Role	Tactical Commander (Silver) (slow time)	Action Card 1
Personnel	On Call Manager	
Location	Incident Coordination Centre (ICC)	
Role Description	Ensure the tactical command and control of the evacuation.	

Before		
Action		Date/Time/Initials
1	Incident Coordination Centre Team to meet formally and agree need for evacuation.	
2	Inform Director On Call so they can become Strategic Commander.	
3	Undertake a rough and quick risk assessment taking into account environmental conditions (day/night/weather, etc).	
4	If necessary, declare a Critical Incident or Major Incident (after discussion with the Director On Call) and communicate this using the cascade system.	
5	If known in advance, communicate timing of evacuation to all staff.	
6	Request assistance from SWAST, HTG-UK, Devon and Cornwall Police, CF and RS and other NHS bodies.	
7	Confirm location of ICC.	
8	Prepare ICC.	
9	Ensure appropriate communication with patients as well as elective patients.	
10	Agree rota for ICC Team over a protracted period of time.	
11	Consider the cancellation of all elective activity at all sites within the Trust, even if this could continue as unaffected by the evacuation.	

	This will free up staff to assist with the evacuation and ensure minimal unnecessary visitors to site.	
12	Prepare for the possible needs of staff remaining with patients for extended periods e.g. accommodation, sleeping, feeding and toilet facilities.	
13	Identify a Loggist.	
14	Consider need to put ED on divert (needs to be agreed with NHS England via the ICB).	
15	If you are a non-clinical on-call manager, then consider appointing a nurse on-call manager 'buddy' who can assist you. If a major incident is declared, they should use the 'Senior Nurse' action card from the Major Incident Plan.	

During		
Action		Date/Time/Initials
16	Coordinate the departments' local responses.	
17	Note where patients are not evacuated and their care arrangements.	
18	Continually re-evaluate threat and Trust response to ensure that both are appropriate, and speed of evacuation is suitable.	
19	Ensure a Log is completed.	
20	Only attend the area being evacuated if you feel it would assist you with commanding the incident. DO NOT BECOME DIRECTLY INVOLVED IN EVACUATION.	

After		
Action		Date/Time/Initials
21	Produce Major Incident report for the Local Health Resilience Partnership in association with the Head of EPRR.	
22	Co-ordinate the return of patients to the site.	

23	When suitable, stand down from the Major Incident (in discussion with the Strategic Commander), communicate stand down to all staff and organisations.	
24	Review and sign off Log.	

Incident Role	Strategic Commander (Gold)	Action Card 2
Personnel	Director On Call	
Location	Bedruthan House	
Role Description	Strategically lead the RCHT response to the evacuation including liaison with the media and external organisations not assisting directly with the operational response.	

Before		
Action		Date/Time/Initials
1	If slow time, set the strategic objectives with regards to the evacuation and communicate to the Tactical Commander for tactical implementation.	
2	In conjunction with the Tactical Commander, discuss the need to declare a Critical Incident, Major Incident Declared or Major Incident Standby.	
3	Identify a Loggist.	
4	Inform ICB and NHS England.	

During		
Action		Date/Time/Initials
5	If fast time, set the strategic objectives with regards to the evacuation and communicate to the Tactical Commander for tactical implementation.	
6	Respond to media enquiries in conjunction with the Duty Press Officer. Nominate a 'public face' to do media interviews.	
7	Coordinate ongoing Trust-wide staff updates, particularly for those in unaffected areas. Seek advice from Tactical Commander on content of message.	
8	Ensure a Log is completed.	
9	Agree additional financial commitment as needed.	
10	Consider the welfare of Trust staff including the deployment of occupational health if appropriate.	

After		
Action		Date/Time/ Initials
11	Ensure debriefs are conducted for those involved.	
12	Ensure that the cost of the evacuation is known.	
13	Prepare for any public or legal enquiry following deaths or injuries caused by the evacuation.	
14	Commence the Serious Incident process.	
15	After a Critical/Major Incident stand down (if declared), nominate a recovery group to take over outstanding actions from the ICC/Tactical Commander.	
16	Review and sign off the Log.	

Incident Role	Tactical Commander (Silver) (fast time)	Action Card 3
Personnel	On Call Manager	
Location	Incident Coordination Centre (ICC)	
Role Description	Ensure the tactical command and control of the evacuation.	

Before		
Action		Date/Time/Initials
1	If an imminent threat, consider declaring a Critical Incident or Major Incident for the Trust and communicate using the cascade system.	
2	Inform the Director On Call so they can become Strategic Commander.	
3	Alert all staff of the need to evacuate and the timescale involved.	
4	Meet to ensure the ICC Team know the risk to the Trust and the type and location of the threat.	
5	Identify a Loggist.	
6	If you are a non-clinical on-call manager, then consider appointing a nurse on-call manager 'buddy' who can assist you. If a major incident is declared, they should use the 'Senior Nurse' action card from the Major Incident Plan.	

During		
Action		Date/Time/Initials
7	Confirm the location of the ICC.	
8	Consider ED closure/divert if necessary (needs to be agreed with NHS England via the ICB).	
9	Request assistance from SWAST, HTG-UK, Devon and Cornwall Police, CF and RS and other NHS bodies.	
10	Prepare the ICC.	
11	Ensure appropriate communication with patients as well as elective patients.	

12	Coordinate with all other NHS and non-NHS organisations to assist where appropriate.	
13	Continually re-evaluate the threat and Trust response to ensure that it is appropriate, and the speed of the evacuation is suitable.	
14	Note where patients are not evacuated and their care arrangements.	
15	Ensure that staff accommodation, sleeping, feeding and toilet facilities are provided. This may be at locations other than the regular Trust sites.	
16	Ensure a Log is completed.	
17	Only attend the area being evacuated if you feel it would assist you with commanding the incident. DO NOT BECOME DIRECTLY INVOLVED IN EVACUATION.	

After		
Action		Date/Time/ Initials
18	Handover outstanding actions to recovery team.	
19	Produce Major Incident report for the Local Health Resilience Partnership in conjunction with the Head of EPRR.	
20	Coordinate the return of patients to the site.	
21	When suitable, stand down from the Critical or Major Incident (in discussion with the Strategic Commander) and communicate the stand down to all staff and organisations.	
22	Review and sign off the Log.	

Incident Role	Clinical Site Manager	Action Card 4
Personnel	Clinical Site Manager or Duty Bleep Holder (SMH/WCH)	
Location	Incident Coordination Centre (ICC)/Area being evacuated	
Role Description	Support the clinical operational area being evacuated and act as initial 'Tactical Commander' until relieved.	

Before		
Action		Date/Time/Initials
1	If out of hours, contact the On Call Manager and request they attend site to take on Tactical Commander role.	
2	Act as Tactical Commander until they relieve you and ensure a handover when they do.	
3	Attend area being/considered for evacuation and take "evac pack".	
4	Appraise the current bed state and location and number of particularly vulnerable patients.	
5	Create a list of prioritised vulnerable patients and resources required for their safe evacuation.	
6	Working with the Tactical Commander and Department/Ward Managers identify holding areas to evacuate patients to.	
7	Ensure that volunteer staff are identified and are located in a place of safety but where their resource can be called upon swiftly. (Postgraduate Centre or Audiology dept, as per the Major Incident Plan, could be utilised).	

During		
Action		Date/Time/Initials
8	Oversee the progressive, timely evacuation of patients ensuring those patients most at risk are evacuated first.	
9	Ensure that additional oxygen cylinders are urgently requested.	

10	Ensure that all areas utilise the patient tracking pro forma contained within this plan.	
11	Ensure that patients whose location is not known are communicated to the Tactical Commander and CF and RS (if on site) immediately.	
12	Ensure that all non-essential staff are evacuated from the site as soon as possible unless assisting in the evacuation of patients.	
13	Ensure staff have been tasked to track patients throughout the incident.	
14	Ensure that the Fire Warden role is being carried out, that they have appointed a Patient Tracking Loggist and Evacuation Marshals.	
15	Ensure staff are deployed to the patient holding area/evacuation point to care for patients. (These can be supplemented by the Fire Warden, Evacuation Marshal and Patient Tracking Loggist once the process is complete).	

After		
Action		Date/Time/Initials
16	Ensure that all areas of the Trust carry out a Hot debrief immediately following stand down and that the immediate learning points are fed back during the cold debrief.	

Incident Role	Fire Warden/Matron/Nurse in Charge	Action Card 5
Personnel	Any member of staff/nurse on duty who is leading the evacuation	
Location	Affected area	
Role Description	Fire Wardens are a fire safety requirement. They must be sufficient in numbers to provide assistance at all times in the safe evacuation of a premises in the event of an alarm of fire. They will be responsible for: - Ensuring that locally agreed fire evacuation plans and procedures are carried out. - Ensuring that occupants attend the designated fire assembly point. - Reporting missing persons to the fire and rescue service as well as the Clinical Site Manager. - Taking the lead in a non-fire related evacuation.	

Before		
Action		Date/Time/Initials
1	Ensure the Patient Tracking Loggist has an up-to-date list of patients.	
2	Inform the Clinical Site Manager of evacuation or need to evacuate.	
3	Ensure each patient has an evacuation triage card applied to them (available from Clinical Site Manager “evac pack”).	

During		
Action		Date/Time/Initials
4	Ensure Evacuation Marshals are positioned along the evacuation route if necessary (ensure they have an Action Card).	
5	Nominate a Patient Tracking Loggist (ensure they have an Action Card).	
6	Encourage all visitors to leave the building as quickly as possible, but parents of infant or paediatric patients should remain to accompany their child to ease distress and minimise safeguarding risks.	
7	Ensure that all patients within the ward space are accounted for in conjunction with the Patient Tracking Loggist.	

8	Identify location of any patients unaccounted for in conjunction with the Patient Tracking Loggist.	
9	Evacuate patients according to local evacuation procedures (this is usually into adjoining clinical space before contemplating vertical evacuation).	
10	Ensure that patient records are taken with patients.	
11	Check that any person with a mobility impairment is assisted and always accompanied by a member of staff.	
12	Carry out a thorough and methodical check to ensure that staff and visitors have left the area, including toilets and storerooms but only whilst taking the nearest and safest route out of the building. Mark the door with an 'X' to confirm an area that has been fully evacuated.	
13	Ensure that the fire doors are closed on the escape route.	
14	Conduct a roll call at the appointed assembly point to ensure that all staff within their area of responsibility have reported to the assembly point and patients are accounted for and provide feedback to the Patient Tracking Loggist.	
15	If staff or patients are unaccounted for then inform the Clinical Site Manager and CF and RS Incident Commander (if on site)	
16	If a 'fast time' emergency evacuation, move patients in the following sequence: - Those in immediate danger (any dependency). - Low Dependency. - Medium Dependency (whilst preparing High Dependency patients for evacuation). - High Dependency.	
17	Evacuate any critical equipment.	
18	Shut off medical gases if likely to cause further danger/hazard.	

After		
Action		Date/Time/ Initials
19	Once your area has been evacuated, move to a temporary holding area to assist in this area. Provide support to any staff already in this area and care for patients.	

Incident Role	Facilities Coordinator	Action Card 6
Personnel	Any senior member of staff with experience of liaising with external contractors	
Location	Incident Coordination Centre	
Role Description	On behalf of the Tactical Commander manage estates and facilities related issues such as portering, security and additional equipment.	

Before		
Action		Date/Time/Initials
1	Identify resources and access for holding areas being used prior to evacuation. These locations are pre-designated in this plan but will need to be evaluated dependent upon the incident requiring evacuation.	

During		
Action		Date/Time/Initials
2	Ensure security lockdown of evacuated areas. Work with Facilities Manager to coordinate the securing of evacuated locations. Ensure that space evacuated is not reoccupied until agreed by the ICC Team and that equipment or resources are secured.	
3	Ensure that arrangements are instigated early for a continued prolonged incident and subsequent lockdown.	
4	Work with other Trusts (CFT/UHP) to identify equipment and resources that can be utilised. Where necessary this can be directed through mutual aid requests or instigated by NHS England/ICB.	
5	Draft additional portering and security staff from the site to the affected incident location. There may be the need to call in additional staff.	
6	If catering is affected, ensure that catering at non-affected sites provides assistance to the affected site. Ensure refreshments and basic catering are provided to the holding areas.	

After		
Action		Date/Time/ Initials
7	Ensure that equipment utilised in the evacuation is returned to the Trust.	
8	Ensure that resources from outside of the Trust are returned or that appropriate financial compensation agreements are followed.	
9	Working with others ensure that the Trust buildings are returned to previous standards in order to facilitate the return of patients.	

Incident Role	Patient Tracking Loggist	Action Card 7
Personnel	Any member of staff but ideally from an admin background	
Location	Area being evacuated and then the patient holding area	
Role Description	Patient Tracking Loggists will be necessary to track the movement of all patients from their originating department or ward to a patient holding area, other Trust location or outside of the Trust. This Loggist can be any member of staff but would ideally come from an administrative background. A patient tracking pro forma is included within the appendices of this plan.	

Before		
Action		Date/Time/Initials
1	Don a 'high visibility' tabard if available.	
2	Familiarise yourself with the actions on this card and the patient tracking pro forma in the appendices of this plan.	
3	Ensure you know which specific area/patients you are responsible for logging.	
4	If a 'slow time' evacuation or the decision to evacuate is still being considered, then obtain an up-to-date list of the patients in the ward/department and populate the pro forma in advance.	

During		
Action		Date/Time/Initials
5	Review 'before' actions and complete as quickly as possible if a 'fast time' evacuation.	
6	If you have been appointed after the evacuation has started, then identify patients already evacuated from the area.	
7	Make yourself known to all staff as they evacuate in order to obtain the relevant information from them.	
8	Complete the pro forma as patients are being evacuated.	
9	Liaise with Fire Warden with any concerns regarding missing	

	patients/staff/visitors.	
10	Once patients are accounted for or reported as missing, attempt to account for all staff in the area or who were assisting with the evacuation. ID card swipe/proximity records from the Security Department might assist with this.	

After		
Action		Date/Time/ Initials
11	Submit your patient tracking pro forma to the Fire Warden.	
12	Attend any debriefing and/or complete a debrief pro forma.	

Incident Role	Evacuation Marshal	Action Card 8
Personnel	Any member of staff	
Location	Area being evacuated and then patient holding area	
Role Description	Evacuation Marshals will be necessary to move cohorted patient groups from one location to another. These Marshals will either be located strategically along the evacuation route or will lead patients in groups from start point to destination.	

Before		
Action		Date/Time/Initials
1	Don a 'high visibility' tabard if available.	
2	Clarify where the patients need to be marshalled to.	
3	Collect some evacuation triage cards from the Clinical Site Manager/Fire Warden should you need to re-triage any patient along the evacuation route.	

During		
Action		Date/Time/Initials
4	Assist and reassure patients along the evacuation route.	
5	Ideally ensure that the next Evacuation Marshall along the route is within sight of the patients.	

After		
Action		Date/Time/Initials
6	Once it has been confirmed to you that no further patients will be evacuated along your route, redeploy to the patient holding area at the end of your route.	
7	Once there, report to the Fire Warden. If not present, assist with caring for patients.	

Incident Role	Transport Coordinator	Action Card 9
Personnel	Any senior member of staff with experience of liaising with transport providers	
Location	Incident Coordination Centre	
Role Description	On behalf of the Tactical Commander manage the transport demands and resources.	

Before		
Action		Date/Time/Initials
1	Find out the patient transport resources potentially available from HTG-UK Control on 01302 787499.	
2	Ask the patient transport provider (HTG-UK) to start moving resources from other parts of the contract like Derriford.	
3	Establish the availability of other ambulance providers in the wider South West.	
4	Call in extra patient transport office staff.	
5	Ensure that the Tactical Commander (Silver) has informed SWAST, particularly if there may be the requirement to move acutely ill patients off-site.	
6	Enquire with the local authority if they have any transport available.	
7	Enquire with community/public transport providers (including taxi companies) for low dependency transfers.	

During		
Action		Date/Time/Initials
8	Call in extra resources if required as identified from the above process.	
9	If there are patients awaiting repatriation back to Hospitals elsewhere in the country appoint a patient transport provider from the receiving hospital area to come and collect the patient. Do not worry about ICB funding issues and underwrite the cost from Trust finances.	

10	Ensure the helipad are ready for use as they may be required to transfer L3 patients to other hospitals.	
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After		
Action		Date/Time/ Initials
11	Contribute to the debrief process.	

Appendix 6. Patient Tracking Forms

(one to be completed per ward or department evacuated)

Patients Accounted For					
	Originating Ward	Patient Name	Patient Number	Patient Currently Located At:	Dependency Colour
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					

Patients NOT Accounted For					
	Originating Ward	Patient Name	Patient Number	Location Patient Last Seen	Dependency Colour (If In Place)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Appendix 7. Inpatient Bed Data to Aid Decision Making

This data is variable based on bed occupancy, holding, boarding and funding and serves only as a guide. Areas with a large variation in bed occupancy such as ED, SDMA and WCH Surgical Ward are not listed.

Royal Cornwall Hospital

Ward	Speciality	Considerations for evacuation	Beds
AMU 1	Medical Admissions	4 patients are likely to require relocating to a side room. If not enough available as side rooms on base wards, consider using SDMA side rooms and procedure rooms (4 in total).	30
WHEAL FORTUNE	Maternity	It cannot be presumed that all women will have a baby as some may be admitted to NNU. When evacuating consider if partners are present or not. These will not be counted on Swift board.	25 beds and 25 cots (partners may stay overnight)
WHEAL ROSE	Maternity	Most will need single rooms.	12 beds. 6 outpatient couches.
BIRTH CENTRE	Maternity	All will need single rooms.	4 rooms
DELIVERY SUITE	Maternity	All will need single rooms and consideration for theatre provision and recovery areas. Potential area to evacuate to is Tower Theatres.	9 rooms. 2 theatres and recovery area.
AMU 2	Medical Admissions	3 patients are likely to require relocating to a side room. If not enough available as side rooms on base wards, consider using SDMA side rooms and procedure rooms (4 in total).	26
CIU	Cardiac Investigation Unit	2 patients may require relocation to side rooms. Many patients are likely to be mobile and could be evacuated to an outpatient type area. If patients are on telemetry this would not work if patients were transferred away from the CCU/CIU area	21

Ward	Speciality	Considerations for evacuation	Beds
		and may require separate monitoring.	
GASTRO and LIVER UNIT	Gastroenterology	5 patients may need relocating to a side room. One of these may be radioactive therefore would need priority over all others.	29
GRENVILLE	Renal / Endocrine	5 patients may need relocating to a side room.	24
KERENSA	Elderly Care	Patients will have varying levels of cognitive impairments such as dementia/delirium requiring line of sight observation, consideration for evacuating to an area with locked doors may be required.	25
LOWEN	Haematology / Oncology	Maximum of 7 patients will require side rooms - preferably hepa filtered rooms to decant to if patients are neutropenic.	18
PHOENIX	Stroke	None specific.	21
ROSKEAR	Cardiac	4 patients may require relocation to side rooms.	28
TINTAGEL	Elderly Care / Neurology	Patients will have varying levels of cognitive impairments such as dementia/delirium requiring line of sight observation.	29
WHEAL PROSPER	Isolation	Patients are all likely to require relocating to a side room. If not enough available as side rooms on base wards, consider using Endoscopy.	10
CORONARY CARE UNIT	Coronary Care	Patients can be safely evacuated with cardiac monitoring equipment and defibrillator if required.	10
CRITICAL CARE	Critical Care	Patients would need relocating to a recovery type setting or Wheal Coates which has medical gases/plugs/UPS to meet L3 type care setting.	17

Ward	Speciality	Considerations for evacuation	Beds
TRAUMA UNIT 1	Trauma Surgery	6 patients in D bay likely to have severe cognitive and mobility difficulties. Many patients likely to be mobile and could be evacuated to an outpatient type area.	28
TRAUMA UNIT 2	Trauma Surgery	6 patients in E bay likely to have severe cognitive and mobility difficulties. Many patients likely to be mobile and could be evacuated to an outpatient type area.	28
WHEAL COATES	ENT / Vascular / Max Fax / Oral Surgery	ENT patients may require airway support. Vascular patients may have limited mobility secondary to lower limb amputation.	21
EDEN	Gynaecology and Urology	Some patients would be mobile and easier to evacuate. 4 patients would possibly require side rooms. Some patients would be complex post op, and some may have cognitive impairment and mobility issues.	28
PENDENNIS	Acute Surgery	3 patients may need side rooms. Varying mobility for patients and different levels of acuity and equipment/pumps needing to be moved with patients.	23
ST MAWES	Surgical Admissions Ward	4 patients may need side rooms. Varying mobility for patients and different levels of acuity and equipment/pumps needing to be moved with patients.	24
EMERGENCY SURGERY UNIT (ESU)	Emergency Surgery	2 patients may require side rooms.	20
WELLINGTON	Respiratory	3 patients may require relocation to side rooms. Most equipment has a battery back-up – however, there would only be one transport monitor available. Wellington would also need access to supplemental o2	26

Ward	Speciality	Considerations for evacuation	Beds
		cylinders as not enough kept on the ward to support all patients should we need to evacuate.	
ZENNOR	Medicine	3 patients may need side rooms.	28
CLIC UNIT	Cancer and Leukaemia in Children	Some patients may need relocating to a side room. Consider using Polkerris / PAU.	4
FISTRAL	Paediatric ages 11+	Some patients may need relocating to a side room. Consider using Polkerris/ PAU.	10
POLKERRIS	Paediatric ages 0-11	Some patients may need relocating to a side room. Consider using Fistral / CLIC.	12
NEONATAL UNIT	Neonates	Some patients may need side rooms.	20 (cot spaces)

St Michael's Hospital

Ward	Speciality	Considerations for evacuation	Beds
ST JOSEPHS	Elective Breast / Orthopaedic Surgery	Patients could move to St Michaels Ward or Recovery.	28
MARIE THERESE HOUSE	Neuro-Rehabilitation	Unlikely but some patients may need side rooms for IPAC reasons. May require enhanced care level 3.	12
ST MICHAELS	Elective Breast / Orthopaedic Surgery	Patients could move to St Josephs Ward or Recovery	14

West Cornwall Hospital

Ward	Speciality	Considerations for evacuation	Beds
MEDICAL UNIT 1	Medicine	Some patients may need side rooms for IPAC reasons. Patients will have varying levels of cognitive impairments such as dementia/delirium requiring line of sight observation, consideration for evacuating to an area with locked doors may be required.	25/26

Ward	Speciality	Considerations for evacuation	Beds
MEDICAL UNIT 2	Medicine	Some patients may need side rooms for IPAC reasons. Patients will have varying levels of cognitive impairments such as dementia/delirium requiring line of sight observation, consideration for evacuating to an area with locked doors may be required.	28

Appendix 8. Evacuation Triage Categories

Evacuation Dependency	Category	Definition
RED	High Dependency	a. Patient is on assisted ventilation. b. Patient cannot be disconnected from 1 or more pieces of apparatus for more than 60 seconds. c. Patient is unconscious or in a critical condition. d. Patient requires more than 7 minutes to be disconnected from 1 piece of equipment. e. Patient is undergoing surgery. f. Patient has undergone major surgery under general anaesthetic. g. Patient requires a minimum of 2, ideally 4, (8 for bariatric), staff to effect evacuation
AMBER	Medium Dependency	a. Patient can only move on his/her bed. b. Patient is connected to 1 piece of apparatus (e.g. drainage bag) c. Patient must be moved in a wheelchair by another person. d. Patient requires more than minimal assistance. e. Patient has dementia to the extent that they cannot be left without supervision. f. Patient cannot walk unaided for more than 5 metres. g. Patient has sight impairment or hearing impairment. h. Patient is sectioned under the Mental Health Act i. DoLS
GREEN	Low Dependency	a. Patient can mobilise by him/herself in a wheelchair. b. Patient can walk unaided. c. Patient can get out of bed and dress in adequate clothing with none or minimal assistance

Appendix 9. CHA4835 - Safety Huddle Report

[CHA4835 Safety Huddle Report](#)



Royal Cornwall Hospitals
NHS Trust

Safety Huddle Report	Date:	Time: am pm	Team lead:
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Patient safety risks – please use in conjunction with the patient status at a glance board (PSAAG)/Document below the bedspace where a patient safety risk is applicable
Supporting information regarding patient care and safety will be at the detailed handover via NerveCentre and/or patients notes

Bay / side room State bedspace in the text box where a safety risk is applicable to the patient.	__ Bay	__ Bay	__ Bay	__ Bay	__ Bay	__ Bay	Side Rooms
Patients with DNACPR							
Level 3 /4 Enhanced Care - patient must have supporting assessment and care plan - there must be 2 hourly staff rotation							
Imminent risk of falling a fall within last 72 hrs or 2 of the below - cognitive impairment, unable/unwilling to use call bell/ admitted with fall/positive postural hypotension							
Behavioural concern - wandering/ aggression/ sundowning/ low mood/ risk of absconding							
Safeguarding/Security/Risk of Violence							
Additional enteral/parental support							
Therapeutic Swallowing Advice							
Very high risk of pressure ulcer as per Pressure Ulcer Risk Assessment on Nervecentre							
Planned Procedure - state what +/- NBM							
IPAC – State what							
high risk VTE concern - Omitted/declined dose of VTE prophylaxis							
Red / Amber evacuation dependency – State which							
Ward specific –							
Ward specific –							

Example Draft Only

Place patient sticker **within** this box

Safety Huddle Report

TEAM

Any anticipated team demands or challenges for the coming shift. The receiving NIC and exiting NIC confirm here that patients placed in escalation spaces, are done so in accordance with the SOP.

LOOK AHEAD

Any anticipated safety or quality issues for the coming shift

Is there anything anyone is worried about?

LOOK BACK AND LEARN

Team lead to feedback on incidents from the last 24 hours and/or recent investigations.

To facilitate a 'butterfly huddle' which is to reflect on any recent deaths, highlighting what went well, and what could have been done differently/improved on?



Example Draft Only

Print:

Signature:

Designation:

CHA4835 V3

Royal Cornwall Hospital



St Michael's Hospital

Main Entrance

2 | Chapel
St Michael's Ward

1 | St Joseph's Ward

G | St Piran's Day Case Unit
Audiology
Main Reception
Outpatients Department
Pre-Assessment Clinic
X-Ray

Trelissick Entrance

G | Hand Clinic and Physiotherapy

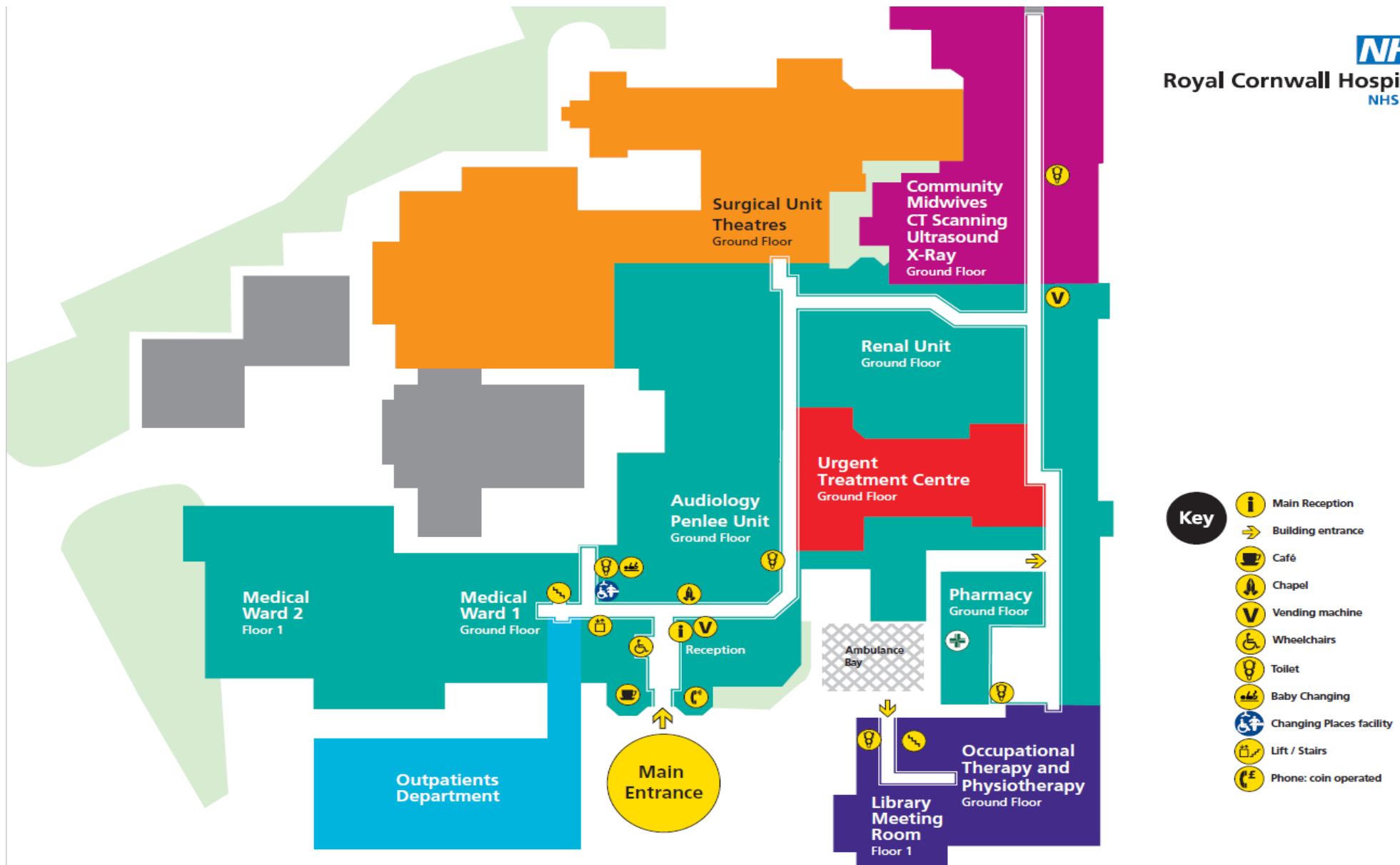
Marie Thérèse House

G | Rehabilitation Unit

St Julia's Hospice

- | | | |
|--------------------|--------------------|--|
| Pick up / Drop off | Tea Bar | Routes
External routes to all departments |
| Parking | Toilets & Changing | |
| Disabled Parking | Baby Change | |
| Motorcycle Parking | Entrances | |
| Bus Stop | Main Entrance | |
| Cycle Parking | Public Telephone | |
| Bench | Information | |
| Lift & Stairs | No Entry | |





Appendix 11. Debrief Proforma

DEBRIEF FEEDBACK FORM

Incident name:	
Date completed:	
Completed by:	
Role in this operation/incident:	
Organisation:	

After any incident or event, it is accepted there will be some areas of improvement identified, but it is also important to note good practice to assist and guide others who may face a similar set of circumstances in the future. **Your views and experience count.**

The boxes below will expand to allow you to continue to give feedback in any particular area.

Please detail the things that went well:

Please detail the things that did not go well:

What is the most valuable thing you have learned as a result of this incident?

Please provide any tips for people who may perform a similar role in the future:

Please return form to:

or email: matthewoverton@nhs.net

Matt Overton

Head of EPRR

Royal Cornwall Hospitals Trust

TRURO TR1 3LJ

RCHT Debrief Feedback Form

Appendix 12. Assisting External Evacuation Checklist

- Prepare to join escalation calls - have information on Trust current status around OPEL, Ambulance Holds, Staffing, Escalation Areas already open, etc.
- As part of Strategy for the Incident set what risks and expenditure is appropriate for the Trust in the context of support to a system wide issue. Constantly consider are we taking actions proportionate with other Trust's that are assisting the affected Trust/hospital?
- Do we need to declare an incident for our Trust?
- Expect a strict no ambulance holds directive due to SWAST potentially assisting with L2/3 transfers and ambulances moving towards the affected Trust/hospital to back fill resources going to the affected Trust/hospital.
- If there is a requirement to decant ED to alleviate ambulance holds, could you use the same tactics/mechanisms that you would to clear ED/ambulance holds for a Major Incident?
- Can we reduce NEPTS usage so our provider can offer mutual aid to the NEPTS provider at the affected Trust/Hospital?
- Determine early if we will be receiving evacuated patients directly from the affected Trust/hospital and/or repatriations from a Trust/hospital closer to the affected Trust/hospital to alleviate bed pressures for them to receive the evacuated patients. Even if our preference isn't the mixed model of transferred patients it may be inappropriate to cause issues by asking for a change of plan from organisations/command teams already under pressure.
- It is likely the affected Trust/hospital will keep their Discharge Pathway 1-2's on-site (if able) as they should be easier to discharge. This means we may receive Pathway 3's and/or those with NC2R.
- For any transfers of either type consider handover method and whether this is done centrally for all patients or Medic to Medic by specialty as would be the normal repatriation process. Do you need additional Medics for this? Transfers from other Hospitals are highly unlikely to come with any escorting staff unless absolutely necessary. Decide if we would want to directly admit to AMU, base wards, an escalation area or through ED.
- SWAST may initiate a hard divert if the affected Trust/hospital has closed their ED. Triage Minors away from ED to MIU's and consider the need to increase staffing in ED. We may need to offer mutual aid to MIU's closest to the closed ED to reduce demand on our ED. In the case of a hard divert SWAST may need to return Ambulances to a further geographical point to answer emergency calls and so THP15 will be more important than ever.
- Do we need to stand down electives? Is this proportionate? Does it help with releasing NEPTS capacity?
- Review all PDDs to facilitate discharges.

- What ask do we want to make of Community Providers to assist? This could include the transfer of patients with NC2R
- Do we need to do an all staff comms? If yes - what should it say? Consider using Facebook, WhatsApp, Kernowflex emails if we want additional staff to come in and help - staff who can assist with admissions or discharges are key.
- Refer to the Trust 'Use of Mutual Aid during a Critical or Major Incident Policy' if mutual aid is being offered or sought.
- Arrange for any patients sent directly from the evacuated hospital to be medically reviewed on arrival due to the trauma of evacuation and a potentially long transfer time. Expect these transfers to be less well "packaged" and may have missing documentation due to the evacuation.
- Specifically track admitted evacuated patients and try to ensure that they do not get transferred to a peripheral site even further from their home if possible?
- Record any expenditure related to this response.