Public – To be published on the Trust external website

Title: Fire Safety Protocol

Ref: HS-0008-001-v1.2

Status: Approved
Document type: Protocol
Overarching policy: Fire Safety Policy

Contents

1 Introduction

This document provides a framework of core safety measures across all of the Trust's property and premises. For staff to know what they need to do, to prevent fires and in the event of a fire.

This document is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

This document supports the Trust to co-create a great experience for our colleagues by ensuring that the workplace is safe and suitable and has adequate fire safety features and arrangements, which comply with the Regulatory Reform (Fire Safety) Order 2005 and ensures standard practice of protocols throughout all of its properties.

2 Purpose

It is the policy of Tees, Esk and Wear Valleys NHS Foundation Trust (the Trust or TEWV) to protect all persons on Trust premises from the hazards of fire. This document forms part of the Trust's overall Health & Safety Strategy.

3 Who this protocol document applies to

This document applies to all directly and indirectly employed staff within the Trust and other persons working within the organisation in line with the Trust's Equal Opportunities Document.

This document encompasses the management of fire safety in all the Trust's occupied premises.

This document gives commitment to be aware of fire precautions and fire safety arrangements which is a basic duty of all staff and an essential obligation for everyone with management responsibility.

4 Related documents

This document describes what you need to do to implement the fire precautions and fire safety arrangements of the Fire Safety Policy.

The Fire Safety Policy defines persons roles, responsibilities and fire management structure which you must read, understand before carrying out the protocols, described in this document.

This document also refers to: -

- Health and Safety Policy Ref: HS-0001.

5 Protocols

5.1 Fire Safety Protocol: 1. Fire Prevention / Safety

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

1	**Fire Prevention / Safety.**	See also
1.1	**Introduction:** Good management of fire safety is essential to ensure that fires are unlikely to occur or that if they do occur, they are likely to be controlled or contained quickly, effectively, and safely.	
1.2	The Regulatory Reform (Fire Safety) Order 2005 (Article 10) lists the principles of prevention as: • Avoiding risks. • Evaluating the risks which cannot be avoided. • Combating the risks at source. • Adapting to technical progress. • Replacing the dangerous by the non-dangerous or less dangerous. • Developing a coherent overall prevention policy which covers technology, organisation of work and the influence of factors relating to the working environment. • Giving collective protective measures priority over individual protective measures. • Giving appropriate instructions to employees. • The Trust discharges this duty via fire risk assessments, audits, fire training and Trust policies, protocols and procedures.	Fire Safety Protocol 2: Fire Risk Assessments.
1.3	**Personal Responsibility:** Every employee has a duty to take reasonable care of themselves and others who may be affected by their acts and omissions. Employees must not do anything that puts people at risk e.g., wedging open a fire door and they must co-operate with the policies and procedures that the Trust has put in place. Everyone has a responsibility to report anything to their Line Manager or Health and Safety Representative that may be an immediate and serious danger to safety or may be a shortcoming in the Trust's protection arrangements for safety.	

1.4	**Policies and Procedures:** There are various policies and procedures and protocols that the Trust has in place that help prevent fires e.g.: • Fire safety policy. • Nicotine management policy. • Electricity and electrical equipment procedure. • Procurement procedures. • Procedure for the searching of service user's visitors and their property. • Lone worker policy. • Health and Safety policies. All staff have a personal responsibility to comply with those procedures.	Relevant Policies and Procedures as listed.
1.5	**Fire Wardens:** In identified areas, the Trust has identified persons who are given extra training, which includes hazard spotting and fire extinguisher use i.e., fire wardens.	Fire safety protocol 5: Fire Safety Training.
1.6	**Training:** All staff receives local induction fire training and periodic fire training this includes basic fire prevention and actions to be carried out in a fire or alarm situation.	Fire Safety Protocol 5: Fire Safety Training.
1.7	**Fire Safety Management:** The Trust has a Fire Safety Group. The Fire Safety Group meets quarterly and reports to the Health, Safety, Security and Fire Group and via the Executive Risk Group to the Board of Directors. Fire safety issues including fire audit actions are standing agenda items.	
1.8	**Fire Investigation:** All fires will be investigated, and appropriate reports completed. Lessons learned will be used to reduce the occurrence of fire.	
1.9	**Fire Audits:** Each building / area where Trust staff are employed will be subject to an initial fire safety audit by a Trust Fire Safety Advisor before occupation.	

	All Trust owned / occupied premises are subject to regular audits by the Trust Fire Safety Advisors. The audits will be forwarded to the Clinical Team Manager/Head of Department / Appropriate Estates Department. Actions are monitored to ensure they are completed. Actions not completed by the due date (overdue actions) are reported to the fire safety group meeting for consideration / escalation. In the case of minor occupancies, e.g., a small number of rooms within leased premises, outside the Trust's normal operating area, an initial audit will be carried out and recorded by TEWV Fire Safety Advisors. Where there is a change to the layout of the building or its occupancy, the Fire Safety Advisors must be informed to re-evaluate the premises.	
1.10	**Medical gases:** The only medical gas the Trust uses, is Oxygen via cylinder. The Trust have no Medical Gas Pipeline Systems (MGPS) at any service lovations. Whilst Oxygen is not flammable, it will contribute to the ferocity of any fire. Departmental / Ward Managers are responsible for ensuring that full or empty gas cylinders are stored securely in an upright position in their areas of responsibility, with signage on the room door.	Fire Safety Protocol 14: Flammable and Medical gases.
1.11	**Compartmentation:** Buildings are split into fire compartments to limit fire spread, All buildings have smoke / heat detection.	Fire Safety Protocol 6: Construction and Refurbishments.
1.12	**Cooking including the use of microwaves, toasters and cookers:** Cooking Is only to be carried out in an approved area i.e., kitchen / tearoom / dining room / staff rest room where there is 30-minute fire resistance, self-closing door, appropriate fire detection and extinguishing media are fitted.	
1.13	**Smoking:** Smoking is not permitted in any part of the premises or grounds managed, leased or owned by the Trust at any time, by any person regardless of their status or business within the organisation.	Nicotine Management Policy.

5.2 Fire Safety Protocol: 2. Fire Risk Assessments

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

2	**Fire risk assessments.**	See also
2.1	As an employer, the Trust has a duty to ensure Fire Risk Assessments (FRA'S) are in place for the safety of employees. The Regulatory Reform (Fire Safety) Order 2005 applies. FRA means the original FRA and any subsequent review or audit document.	
2.2	Where the Trust owns the building or is the major occupier, FRA's will be carried out by Trust Fire Safety Advisors. The Trust use PAS 79 as the fire risk assessment template.	
2.3	Where the Trust leases / rents space in a building for Trust employed staff to work, the Trust will ensure a FRA is in place covering the area before Trust occupation (carried out by a Trust Fire Safety Advisor) or will check if leasing arrangements puts the responsibility with the Trust. A copy of the FRA should be supplied to the Trust prior to occupation. If no FRA is in place or the Trust's area is not covered, the Trust will ensure that a FRA is carried out by a Trust Fire Safety Advisor via the Landlord or TEWV before occupation. Service Leads must ensure no Trust staff occupy any premises prior to the Trust being informed.	
2.4	FRA's should be reviewed in accordance with the frequency in the Fire safety database or when notified that the risk has altered. It is the responsibility of Clinical Team Manager / Head of Department to inform the Fire Safety Advisor if any change takes place that may impact on the fire safety arrangements. The following persons need to be considered as part of the assessment within the premises: - • Employees.	

	• Employees, visitors, and other persons whose mobility, hearing or eyesight is impaired. • Other persons in the premises if the premises are multi-occupied. • Varied working practices (i.e., areas of your premises occupied when others are not). • Areas where employees/others are isolated, • Visitors. • Persons who may be asleep in the premises. • Young persons.	
2.5	All FRAs will be held electronically by Estates and Facilities Management (EFM), and a copy will be sent to the Manager responsible for the area.	
2.6	The FRA will be reviewed as above. Any areas of non-compliance will be identified and documented in the action plan. The review form and action plan are sent to the Clinical Team Manager / Head of Department / appropriate Estates Department, who will monitor and be responsible for ensuring any actions are completed within an allotted time scale.	Fire Safety Protocol 1: Fire Safety and Prevention.
2.7	A log of annual fire audit and FRA review dates is held by the estates fire safety team. Contact Fire Safety Advisor for details.	

5.3 Fire Safety Protocol: 3. Fire Strategies for new and refurbished buildings

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

3	**Fire Strategies.**	See also
3.1	**Introduction**: When a Trust building is refurbished, extended, undergone a change of use (e.g., from offices to patient use), or newly built, fire safety should be considered, in conjunction with all other building and clinical issues to ensure the building is safe, useable and conforms as closely as possible to recognised standards and building regulations. In existing buildings, conforming to standards will not always be possible, but with careful planning, equivalent standards should be	

	achievable. Any deviation from standards should be written, agreed and justified. If equivalent, safe standards are not achievable, having exhausted all possible solutions, following consultation with facilities and appropriate associate director, any remaining risks should be entered on the Trust risk register.	
3.2	**Guidance and Standards:** Design and estates staff must use the appropriate guidance, this will depend on the use of the building. If the building has no patient access, e.g., office or estates/works, Building Regulations 2010, Approved Document B could be appropriate. If the building is a patient access area, the recommendations in HTM 05 -02 should be followed. If an existing building has separate uses divided by a definite fire line, then the relative recommendations could be used for the different uses. Architects / Designers may wish to incorporate fire-engineered solutions into building design, for which there are several fire engineering guides available. Each design would have to be considered on its own merit and assessed as suitable by the Trust Fire Manager and Trust Fire Safety Advisor.	Health Technical Memorandum 05-02. Guidance in support of functional provisions for Healthcare Premises. Building regulations 2010. Approved Document B – volume 2. BS 9999:2017 Building Design
3.3	**Sprinkler or water mist systems:** Estates must discuss the fitting of sprinkler or water mist systems at design stage of any builds, with a Fire Safety Advisor giving advice to the builds requirements.	HTM05-02. Section 5.68.
3.4	**Fire alarm systems:** All buildings must be fitted with a fire alarm system, which is suitable for the occupation of the building. If there is doubt as to the future use of the building and to “future proof” it, it may be preferable to “over specify” the fire precautions. As an example, offices would not require an L1 fire alarm system, which means detection in all rooms and voids. If this were specified however, it would mean that if the building or area were to change use to a patient area, the detection system would not require upgrading. Analogue addressable fire alarms should be installed in all new systems. Depending on the building type fire alarms should be zoned so there are continuous and intermittent sounder areas to	Fire Safety Protocol 7: Fire Alarm and Detection systems.

	help with patient evacuation. Sounder zoning need not apply in non-patient areas as the evacuation strategy would be simultaneous. Detection should be installed in patient and public access bathrooms and toilets.	
3.5	**Fire doors:** Fire Safety Advisors should advise on the fitting of self-closing devices on fire doors. The use of self-closures should also be assessed by Area Managers carrying out a risk and anti-ligature / environmental assessment. These will be discussed/approved by the Environmental Risk Group.	HTM 05-02. Paragraph 5.40 and table 6.

5.4 Fire Safety Protocol: 4. Fire Evacuation Plans

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

4	**Fire Evacuation.**	See also
4.1	**Clinical Team Manager / Clinical Lead or equivalent:** Are responsible for ensuring that robust fire safety arrangements are in place for their area of responsibility.	
4.2	**Fire Evacuation Plans:** Large / complex sites will have a site evacuation plan – this will give the overview of fire safety arrangements. Each team / ward / department must also have a local fire evacuation plan that is specific to his or her area and consistent with the site plan.	
4.3	**Staff awareness of evacuation plans:** Trust staff are made aware of the fire evacuation plans in several ways: • Local induction (with Line Manager). • Fire safety lecture (compulsory). • Fire Warden training. • Participating in a fire drill (annual requirement). • Being involved in a fire incident (including false alarms). • Local fire action notices.	
4.4	**Review of Fire Evacuation Plan** The fire evacuation plan may be reviewed after: • Fire Risk Assessment / Review.	

	• Any building works, temporary or otherwise, that affects the fire arrangements (in that area or an adjacent area). • Any change in staff / client group / use of area. • A fire incident (actual or false alarm). • When any person raises a concern.	
4.5	If the fire alarm or other fire safety system (or part thereof) does not work through fault or maintenance Clinical Team Manager / Clinical Lead / equivalent must consider whether additional measures are to be set in place to mitigate the increased risk, e.g. If a fire exit door is unavailable, clarify the alternative escape routes; if the sounders are offline, ensure all staff are extra vigilant. If the disruption to the alarm system lasts, or is likely to last, for more than a few hours, consider revising the evacuation plan.	
4.6	Trust staff are always responsible for ensuring all people (service users, visitors, and colleagues) in their area of work are supported during a fire alarm activation / evacuation. The Trust should ensure that contractors have appropriate procedures in place.	
4.7	**Disabled occupants.** Patients are to be assessed by staff on entry to the ward or area that they have responsibility for. Fire Safety Advisors are to be contacted as required. Managers are to ensure that there are sufficient procedures in place to evacuate persons to a place of safety. In the case of disability, employers and service providers are under a duty to make reasonable adjustments to their workplaces to overcome barriers experienced by disabled people. Where necessary, measures will be put in place to ensure evacuation procedures include persons with disabilities. Managers are to inform Fire Safety Advisors if anyone (staff, service user or visitor) needs extra help to follow the evacuation plan, a Personal Emergency Evacuation Plan (PEEP) should be completed. (PEEPs are required for all staff, requiring assistance.)	The Equality Act 2010

5.5 Fire Safety Protocol: 5. Fire Safety Training

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

5	**Fire Safety Training.**	See also
5.1	**Introduction:** The provision of fire safety training is a legal requirement. In order to satisfy the legal requirements for training, staff need to have an understanding of the fire risks to which they may be exposed and know what to do in the event of a fire so that fire safety procedures can be applied effectively. This requirement applies to all staff irrespective of their seniority or professional discipline. Advice as to the frequency and content of training is provided in H.M Government fire safety guides and chapter 11 of Health Technical Memorandum (HTM) 05-01 Managing healthcare fire safety.	
5.2	**Responsibilities:** The Trust Fire Safety Manager is responsible for ensuring that an appropriate programme of fire safety training is developed, and suitable arrangements are in place for the delivery of that training. It is the responsibility of Matrons, Heads of Service and Departmental Managers or equivalent to ensure that all of their staff have attended the appropriate fire safety training. All staff have a personal responsibility to attend training sessions.	
5.3	**Frequency of training:** The duration and frequency of fire safety training is determined by a training needs analysis (TNA). **Fire training within the Trust Comprises:** • Local fire safety induction. • A face-to-face / Microsoft Teams (MST) fire lecture every 2 years alternating with e-learning. • Fire drills. (Annually per ward / building arranged and supervised by Fire Safety Advisor) • Fire Warden training as necessary to ensure fire wardens are on duty at all material times in non-clinical areas, with a refresher course every 4 years. Attendance at Fire Warden training counts as face-to-face fire training (fire lecture).	

5.4	**Fire extinguisher training:** The Trust provides fire extinguisher training for all staff as part of both e-learning and face to face training sessions. The Trust can provide practical fire extinguisher training. The practical element is delivered in the open air. Staff will demonstrate safe use of extinguishers on 'live' fires.	Fire Safety Protocol 9: Fire Extinguishers
5.5.	**Booking onto Training sessions**: Fire training sessions are publicised in advance on In Touch and are allocated on a first come first served basis, with 30 places for face-to-face / Teams fire lecture and 10 for Fire Warden training. Training sessions can be booked through the training event calendar on the staff intranet. Where staff booked onto a training session fail to attend without explanation, they will be marked as 'did not attend' and their Line Manager informed. If having booked on to a training session a person cannot attend for any reason, they should inform their Line Manager and the Education & Training. Sessions start promptly and may be 'locked', staff arriving late may be refused access and advised to book another session.	
5.6	**Fire safety training content.** **Mandatory annual** fire safety training: • Basic fire safety. • Fire safety responsibilities and reporting. • Fire safety in the workplace. • Good housekeeping. • Preventing unwanted fire signals. • Staff responsibilities during a fire incident. • Evacuation procedures. • Fire extinguishers (theory). **Fire Warden**-in addition to the above includes: • Role of the fire warden. • Hazard spotting. • Fire extinguisher practical use on live fires where possible. Note: The practical fire extinguisher training is carried out outside, all trainees will demonstrate safe use of fire extinguishers.	

5.6 Fire Safety Protocol: 6. Construction and Refurbishments

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

6	**Construction and refurbishments.**	See also
6.1	**Introduction:** Whenever any building works, hot works etc. are carried out, it is crucial that they do not adversely affect the safety of occupants in the building. Before any works are planned, it is vital that they are carried out safely and to the relevant standards.	
6.2	**Responsibility:** The responsibility of ensuring that works are carried out correctly and safely rests with the relevant Estates department or Capital team. These are: • For TEWV owned premises – TEWV Estates / Capital team. • For Private Finance Initiative (PFI) owned buildings – PFI Estates or FM provider. • For NHS Property Services owned buildings – NHS Property Services. • Any other buildings where TEWV staff work – The building owner / FM Contact.	
6.3	**Consultation:** If any building works could be thought to affect the fire integrity or fire safety of the building, the TEWV Fire Manager and / or Fire Safety Advisors should be consulted by the relevant Estates Department / Architect / Project Manager before work starts. It is difficult to say what specific works could require consultation, but examples are: • Any alterations or penetrations to walls. • Doors being replaced. • Fire alarm systems being worked on. Once notified, the Fire Safety Advisor will determine whether the FRA for the building / department will require amending, prior to the works, following the works, or both. Building / department occupants will be informed of any changes to fire procedures by the Fire Safety Advisor.	

6.4	Permits to work: Permit-to-work systems should be considered by the relevant estates departments (see above), whenever it is intended to carry out work which may adversely affect the safety of personnel or the environment. Examples of where permits to work could be required are; • Works that could penetrate fire resisting walls / floors. • Anything that could affect/obstruct means of escape routes. • Anything that could affect access to buildings for the emergency services. • Hot works. The relevant estates department is responsible for carrying out a risk assessment to determine the impact of the works on the building / area and occupants. This list is not exhaustive and if in doubt, the relevant estates department should contact the Fire Safety Manager / Advisor.	Fire Safety Protocol 14: Flammable and Medical gases para: 14.5 Acetylene.
6.5	**Fire Stopping** If any work penetrates a fire resisting structure, the structure should be fire stopped to the relevant standard (30, 60 minutes etc.) by a third-party accredited fire stopping company. It is the responsibility of the company / department carrying out the penetration work to ensure the fire stopping is carried out. The completed work should be inspected and signed off by the fire stopping company. A record of the fire stopping (with pictures of the work and / or labels if possible) should be completed and given to the relevant estates department and Fire Safety Advisor for their records.	

5.7 Fire Safety Protocol: 7. Fire Alarm and Detection Systems

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

7	**Fire alarm and detection systems.**	See also
7.1	Trust occupied buildings are fitted with the appropriate standard of fire alarm and detection system to comply with the statutory requirements of the Regulatory Reform (Fire Safety) Order 2005, building regulations and also Fire Code Guidance. Any deficiencies are recorded in the FRA.	
7.2	All Trust premises are expected to have a minimum of a manual / electric system i.e., manual call points (MCP) and electrical supply with a battery back-up so that if the power to the building fails, the fire alarm will still function.	
7.3	The remainder of the system design involves whether the building has smoke / heat detection and what level of coverage is included in the building. This is dependent on the level of fire risk within the building. The levels as set in the British Standard applicable (BS5839 Part 1) are: - L1, the highest standard; detection in all areas to L5 being limited detection for a specific risk e.g., to protect the route from an inner room or to operate other fire safety systems e.g., fire door hold open devices. Fire Code 05.03 Operational provisions Part B: Fire detection and alarm systems, specifies for: • Hospital Premises L1. • Other Healthcare L2 or 3 depending on risk. • For common places of work, such as offices, shops, factories, warehouses and restaurants B.S. 5839 Part 1 suggests a category M (manual) system normally satisfies the requirements of legislation. Detection being fitted in high-risk areas, areas where a fire might develop un-noticed, and to compensate for a lack in another aspect of fire safety.	
7.4	The Trust will endeavour to follow Fire Code Guidance wherever possible for hospital / healthcare buildings and where the fire alarm system or detection system is deficient; this will be documented on the FRA.	

7.5	Where any building works are carried out or changes of use to buildings or areas are proposed, consideration must be made as to whether this necessitates alteration to the fire alarm system.	
7.6	Where any fire alarm system is or appears to be faulty e.g., fault light on panel / audible alarm this should be reported immediately to: • For TEWV owned premises – TEWV Estates / Capital team. • For PFI owned buildings – PFI estates or FM provider. • For NHS Property Services owned buildings – NHS Property Services. • Any other buildings where TEWV staff work – The building owner / FM Contact.	
7.7	Fire alarm systems will be subject to servicing, maintenance and testing as per B.S. 5839 part 1. All fire safety items linked to / operated by the fire alarm e.g., magnetic locks / hold open systems will be subject to testing as per the appropriate British Standard. Any deficiencies should be reported on the FRA. For details of what happens when the fire alarm activates see evacuation strategy	
7.8	Detection should be fitted in public / patient access toilets and bathrooms in new buildings and refurbishments.	

5.8 Fire Safety Protocol: 8. False Alarms and Unwanted Fire Signals

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

8	**False alarms and unwanted fire signals**	See also
8.1	**Introduction.** A false fire alarm is detrimental to the operation of any healthcare facility. Such instances lead to disruption of service and impact upon patient care, increased costs, and unnecessary risk to those required to respond to the alarm raised. All staff have a personal responsibility to help prevent unwanted fire signals (UWFS) / fire alarm activations.	HTM 05-03 Part H. Reducing false alarms in healthcare.

8.2	TEWV buildings are fitted with fire alarm systems which incorporate manual call points (MCPs) and smoke / heat detectors. **False alarm, UWFS definitions:** False alarm – activation of the fire alarm system resulting from a cause other than fire. A false alarm becomes an UWFS at the point the Fire and Rescue Service is requested to attend.	
8.3	**Contacting Fire and Rescue Service attending a site** Fire and Rescue Service will attend by: • (9)999 call. • An automatic signal from a monitored fire alarm via an alarm receiving centre.	
8.4	**Staff procedure during fire alarm activation.** When a fire alarm system activates, the person responsible should: • Investigate the cause of the activation (if not obvious). • Following the investigation, the person responsible for the area will authorise the appropriate action, which is: • On confirmation or suspecting a fire a call (9)999 is to be made to the Fire and Rescue Service. The Fire and Rescue Service will mobilise the appropriate attendance. • Initiate the evacuation procedure (where appropriate). • If there is no fire, the person responsible may then authorise the silencing and re-setting of the fire alarm and allow the re-occupation of the area. • In all instances should the fire alarm re-sound in the same area further investigation should be undertaken.	Site evacuation plan. Local evacuation plan.
8.5	• Where the call is received from a monitored fire alarm with no (9)999 confirmation, the Fire and Rescue Service may mobilise a reduced attendance. E.g., Only one vehicle, or no vehicles. • If there are frequent unwanted fire signals, where a responding fire crew arrives at the building, there may be a charge. • Wherever possible, agreement should be reached with the Fire Service Officer attending the incident as to the probable cause.	
8.6	**Actions following the activation: -** It is generally accepted that up to 80% of the details surrounding an incident are lost within 48 hours of it happening. It is therefore	

	important that details following all false alarms and real incidents are accurately recorded following the incident. The Fire Incident Manager i.e., Ward / Site Manager, or equivalent should submit a Trust Incident report including the following information: • Building. • Location of the activation (room number, corridor, etc.). • Detector or call point if known (may be identified on the panel.) • Date. • Time. • Did the Fire and Rescue Service attend. • Cause – Including any agreement / discussion with the Fire and Rescue Service if on site. • Contact details. • Take photographs after the event and before the area is disturbed. These may give vital information to the Fire Safety Advisors.	
8.7	The Trust Fire Safety Advisors will review Trust incident reports of fire alarm activations.	
8.8	In PFI premises the PFI partner will be responsible for ensuring that the fire alarm is correctly installed, serviced, and maintained. The PFI partner will liaise with the fire alarm servicing company to try and reduce the number of false alarms. Any investigations / charges from the Fire and Rescue Service regarding false alarms / unwanted fire signals within PFI premises will result in the reports being forwarded to the PFI nominated person responsible, in the first instance.	
8.9	The Fire Safety Manager has responsibility for all aspects of fire safety, including the monitoring and mitigation of false alarms. A record of all fire alarm activations and unwanted fire signals will be kept and reported to the Board via the Fire Safety Group and Health, Safety, Security and Fire Group. The Board will set in place the policies necessary to minimise false alarms.	
8.10	• All false alarms (including unwanted fire signals) should be reported annually as part of estates return information collection (ERIC) returns.	

5.9 Fire Safety Protocol: 9. Fire Extinguishers

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

9	**Fire Extinguishers**	See Also
9.1	**Introduction:** • Fire extinguishers are provided throughout Trust premises for use in a fire emergency and are designed to deal with small fires.	
9.2	**Types of extinguishers:** We have five types of extinguishers in the Trust: a) Water for class A fires (paper, wood, textiles etc.). b) Foam for class A and B fires (paper, wood, textiles and flammable liquids). c) Carbon Dioxide (CO_2) for class B (flammable liquids and fires involving electricity) – but safe to use on all fires. d) Dry Powder for all classes of fires. These are **not** recommended for patient or office areas due to the mess they make and the potential damage they cause to electrical equipment. e) Wet Chemical for class F fires (cooking oils). **Location:** The Trust will endeavour to standardise extinguisher provision to Foam and CO_2 throughout the Trust, located together in "fire points" adjacent to fire alarm call points). Where there are issues due to service users damaging extinguishers, alternative mountings (anti-tamper boxes) or locations (store cupboards etc.) should be discussed with the Fire Safety Advisor.	

9.3	**Training:** All staff receive theoretical training on fire extinguisher use during fire lectures. The training includes the classification of fires and which extinguishers to use on the various types of fires. Staff may also receive enhanced training in the use of extinguishers, which may include a practical element where this is deemed appropriate.	
9.4	**How should they be used:** In the event of fire, the safety of life will override all other considerations, such as saving property and extinguishing the fire. Fires should be extinguished as quickly as possible, but 'first-aid' firefighting should only ever be attempted on small (approximately waste bin size) fires if it is safe to do so and the operator feels confident in extinguisher use. The extinguisher should be tested outside the fire area to ensure it is operating correctly before attempting to extinguish the fire. Only one extinguisher should be used on a fire. If this does not extinguish the fire, the door to the room should be shut and the fire left for the Fire Service to deal with. The operator should ensure their escape route is available at all times. **After Use:** Following the use / discharge of extinguishers, they should be taken out of service and reported to the appropriate estates department / PFI Partner.	
9.5	**Maintenance and Servicing:** All extinguishers should receive regular inspection and maintenance. Extinguishers should be serviced annually by a third party accredited fire extinguisher servicing company.	

5.10 Fire Safety Protocol: 10. Security and Arson

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

10	**Security and arson**	See also
10.1	**Security arrangements:** Most in-patient facilities have one point of entry which is observed by reception during 'opening' hours. All visitors to the building and wards with signing in books are required to 'sign in and out' – this is a personal responsibility. Security arrangements make a very positive contribution to the prevention and control of arson by: - • Ensuring unauthorised persons do not enter the building. • Keeping unauthorised persons out of vulnerable areas, i.e., ensuring that all doors are kept locked when the rooms or areas are not in use. • Quickly detecting intruders who may gain access to these areas: • Training staff in the need to challenge unauthorised visitors in all areas, but particularly in isolated, infrequently visited or vulnerable areas. • Ensuring that any person acting suspiciously is challenged (if safe to do so) and reported to the senior person and / or police immediately.	
10.2	**Responsibilities:** All staff have a responsibility to be vigilant and to ensure that good housekeeping is practiced in all areas - • When stores are delivered, they are quickly put away and not left out on the corridor or in the ward / department entrance. • Doors to linen rooms, stores, store cupboards, plant rooms etc., are kept locked shut, especially out of normal working hours. • Flammable liquids are kept under lock and key. • That they do nothing that will negate any fire or arson prevention and control measures within their workplace. • Tidy, unnecessary papers removed (archived / destroyed / kept in metal filing cabinet.	
10.3	**Arson:** • Arson accounts for approximately 29% of fires in healthcare premises. • Healthcare premises are particularly vulnerable to arson attacks especially isolated or disused premises. Within	HTM 05-03 operational provisions. Part F Arson prevention in

	healthcare premises internal or external storage areas, areas not in use or infrequently visited by staff may be also vulnerable. • Arson attacks are not confined to these areas and a determined arsonist will strike at anytime, anywhere, where a suitable opportunity is presented. An arsonist may seem to have good reason for being on the premises. For example, they may be a service user, a member of staff or a visitor.	NHS premises.
10.4	**Combustible Waste:** • Waste should be disposed of in accordance with the Trust`s environmental protocols. Combustible waste should not be allowed to accumulate in any areas and should be removed to a secure designated area as quickly as possible. Combustible waste should never be stored in ward entrances, staircase enclosures, on corridors, in plant rooms, service duct or tunnels or in fire escape routes. All waste containers should be kept locked when unattended.	
10.5	**Exterior of the building.** No combustible storage should be allowed to accumulate adjacent to buildings. External waste containers should be kept at least 3 metres away from buildings and where possible be in a locked compound to limit the potential for a bin fire spreading to the building. Were this is not possible waste containers should be positioned were they are observed and should be locked. Skips should normally be a minimum of 6 metres away from any building.	

5.11 Fire Safety Protocol: 11. Fire Drills

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

11	**Fire drills**	See also
11.1	**Introduction:** All fire emergency action plans need to be regularly rehearsed either through fire drills, or through other appropriate means,	HTM 05-01. Section 5.56

	walkthroughs, table-top exercises. Fire drills are necessary to evaluate the effectiveness of the evacuation procedure and should be carried out at least once in every calendar year.	
11.2	**Responsibilities:** All staff no matter how senior are expected to participate in fire drills. Senior staff should set the example. The drill may involve the whole or part of the building area being evacuated or through other appropriate means as determined by the Trust's Fire Safety Advisors overseeing the exercise.	
11.3	**Fire Drill Schedule**: The fire drill schedule is available on the estates shared drive by contacting the Fire Safety Advisors. It shows which month each building / ward / area is due its fire drill. Wards / departments will be notified when their drill is due. The fire drill schedule on the S drive will be amended on completion of any drills. Any Managers who wish to organise a fire drill should consult a Fire Safety Advisor.	
11.4	**During the drill:** The fire alarm is activated via a MCP or smoke detector. Were key operated call points are fitted a staff member should be appointed to use their key, testing the key operates the call point correctly. Staff should conduct themselves as if a fire had occurred. Observers need to note: • when the alarm is started. • What action staff members take. • Which evacuation route / s is / are used. • How many people are evacuated. • Where they evacuate to. • Time taken to evacuate the premises. • Any concerns – e.g., fire door wedged open. Once the drill has begun and all staff have reacted, were continuous sounding of the alarm may disturb service users, the alarm may be silenced but the drill carried on to its conclusion.	

11.7	**After the drill:** On completion of the drill the fire alarm should be re-set, put back online, a debrief with staff carried out and the fire drill record form completed and sent to Fire Safety Advisor. Where the outcomes were not satisfactory a follow up drill should be organised by the Fire Safety Advisor. A debrief should take place and include: • What went well. • What did not go so well. • What will be done differently next time. • Any specific action that needs to be taken and by whom. • All are to be recorded on the fire drill record form.	
11.8	**Fire walkthroughs Desk top exercises:** Fire walkthroughs, tabletop exercises may be used as an alternative to a fire drill as determined by the Trusts Fire Safety Advisor overseeing the exercise.	

5.12 Fire Safety Protocol: 12. Maintenance of Fire Safety Systems

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

12	**Maintenance of Fire Safety Systems**	See also
12.1	**Introduction** All fire systems need regular testing and maintenance to ensure they are operating correctly and will continue to operate correctly in a fire and / or power loss incident. The Regulatory Reform (Fire Safety) Order 2005 requires that all fire safety equipment be “maintained in an efficient state, in efficient working order and in good repair”. All systems should be tested and maintained as per the relevant standards (British or equivalent) or as per a written, agreed, justified, variation (agreed between TEWV and the relevant maintenance contractor) if the testing regimes are outside the recommended guidance.	
12.2	**Who is responsible for maintenance?** • For TEWV owned premises – TEWV Estates / Capital team. • For PFI owned buildings – PFI estates or FM provider.	

	• For NHS Property Services owned buildings – NHS Property Services. • Any other buildings where TEWV staff work – The building owner / FM Contact. While maintenance of the alarm systems is the responsibility of estates departments, all staff have a responsibility to notice and report any defects that come to their attention.	
12.3	**Fire Alarms Testing.** Fire alarm systems should be tested weekly, by operating a manual call point. A different MCP should be tested in rotation and the results of the test (including the MCP number location) should be recorded in a logbook kept on site. In PFI sites, FM will usually undertake the test, in conjunction with Trust staff. The weekly test should be carried out when staff are in the building, and last long enough so staff can recognise the difference between continuous and intermittent sounds. If the fire alarm is linked to a monitoring company, the monitoring company should be informed that testing is taking place, so that the Fire Service is not called out by mistake. The monitoring company should be informed when the testing is completed.	BS 5839 – 1:2017. Fire detection and Fire alarm systems for buildings.
	Maintenance. Systems should also be examined and maintained over a 12 month period by a competent third-party accredited contractor, as detailed in BS 5839 – 1. Cause and Effect should also be checked for the area that is undergoing its weekly test and include any adjacent areas. If any parts of the fire alarm are required to be disabled or isolated during routine maintenance, this should be agreed with the persons responsible for maintenance (see above), a method statement produced and the building occupants informed, so that any extra procedures required can be put in place.	
12.4	**Emergency Lighting:** Emergency lighting should be tested: • Monthly - short test to ensure all units operate • Annually - full discharge to ensure batteries can provide power for the stated duration (either one or three hours) The results of the tests should be recorded in a suitable Logbook / Electronically and any defects reported and repaired. A list or plan should be produced by the relevant maintenance contractor to show which lights are emergency lights, and therefore, which lights have been tested.	BS5266-8:2016. Emergency escape lighting systems.

12.5	**Fire Doors/Exits:** Fire doors should be examined by the relevant estates department at six monthly intervals, to check for: • Damage to door / hinges / closer / frame • Excessive bowing • Deformation • Damaged, painted or missing intumescent strips / smoke seals. Any fire doors on hold-open devices, or fire exits that are locked and linked to the fire alarm should be checked regularly to ensure they release / unlock as per BS 7273-4.	BS 8214: 2016. Code of practice for fire door assemblies. BS 7273-4:2015 Actuation of release mechanisms for doors.
12.6	**Fire Extinguishers:** Fire extinguishers should be serviced annually by an accredited fire extinguisher maintenance company. .	BS5306-3:2017. Commissioning and maintenance of portable fire extinguishers
12.7	**Standby Generators:** Emergency standby generators should be load tested monthly.	HTM 06 – 01. Electrical services supply and distribution
12.8	**Sprinklers or mist systems:** Sprinklers or mist systems should be tested as per the relevant standards (see right) according to which type of system is fitted. BS EN 12845 systems – Weekly, monthly, quarterly and annually. BS 9251 systems – annually.	BS 9251:2021. Sprinkler systems for residential and domestic occupancies. BS EN 12845. Automatic Sprinkler Systems.
12.9	**Fire, Smoke and Ventilation Damper tests:** All dampers are to be tested by a competent person on completion of the installation and at least annually which includes spring operated dampers.	BS9999: 2017. EFA / DH 2014 / 008.

12.10	**Private fire hydrant testing:** Private fire hydrants should have a six-monthly pit inspection and test is to be completed. All hydrants are to be identified with appropriate “H” signage.	BS9990: 2015. Non-automatic Fire Systems.

5.13 Fire Safety Protocol: 13. Portable Appliance Testing

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

13	**Portable Appliance Testing**	See also
13.1	**Introduction:** The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. Most electrical safety defects can be found by visual examination, but some types of defects can only be found by testing.	Trust Electricity Safety Policy.
13.2	**What needs Portable appliance (PAT) testing?** Portable appliances include anything that is connected into the mains with a plug, and could be moved e.g.: • Kettles, • Toasters, • Microwave ovens, • Heaters, • Computers, • Charging equipment e.g., for mobile phones and laptops (but not the phones or laptops as they are battery operated), • Extension leads, • Fax machines • Vending machines • Water coolers, • Washing machines • Fridges, etc. Note: These are examples of items requiring PAT testing and the list is not exhaustive.	

13.3	**When does equipment need PAT testing?** The Trust policy is to PAT test on the next service schedule. New items of equipment (Trust, staff and patients) do not need to be tested until the next service schedule is due. A visual check should be carried out on all items before use to check for physical damage. See below for information on what to look for when carrying out a visual check. PAT testing only checks the equipment is safe on the day of testing. Equipment should be visually checked by the user regularly for signs of damage and reported or replaced as necessary. This is the responsibility of the user.	
13.4	**Visual Inspections:** Visual inspections can be carried out by any member of staff. Things to look for include: • Damage to the lead including fraying, cuts or heavy scuffing. • Damage to the plug e.g., to the cover or bent pins. • Tape applied to the leads to join them together. • Colored wires visible where the lead joins the plug. • Damage to the outer cover of the equipment itself, including loose parts or screws. • Signs of overheating, such as burn marks on the plug, lead or equipment, • Contamination such as dust, dirt or liquid. • Cables trapped under furniture.	
13.5	**Who is responsible for PAT testing?** • For TEWV owned premises – TEWV Estates / Capital team. • For PFI owned buildings – PFI estates or FM provider. • For NHS Property Services owned buildings – NHS Property Services. • Any other buildings where TEWV staff work – The building owner / FM Contact.	

5.14 Fire Safety Protocol: 14. Flammable and Medical Gases

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

14	**Flammable and Medical Gases**	See also
14.1	**Introduction:** The only medical gas in use in TEWV is Oxygen, delivered via portable cylinders. TEWV does not provide any bedhead / piped Oxygen.	

	In an Oxygen-enriched atmosphere, materials not normally considered be flammable may become flammable, flammable materials ignite and burn more vigorously.	
14.2	**Responsibilities:** Oil and grease, even in minute quantities, are liable to ignite spontaneously in the presence of high-pressure Oxygen. No oil or grease should be stored or used anywhere near Oxygen cylinders. Use clean hands or gloves when assembling Oxygen equipment, e.g., attaching the pressure regulator, making connections. Oxygen cylinders stored within buildings e.g., on wards should be in a room e.g., a Clinic room, having a fire door which must be self-closing or kept locked shut when not in use. Cylinders must be either chained upright to a wall, stored in a compliant holder or in an Oxygen cylinder trolley used to transport them and they must be stored away from other combustible items. A warning sign should be placed on the door to any room where Oxygen cylinders are stored.	
14.3	For more detailed information on the safe use and storage of Oxygen refer to the Oxygen safety procedure.	Oxygen – administration, prescribing, storage and safety. CLIN-0071-v2.
14.4	**Flammable Liquid Gases:** Flammable liquids and gas storage is covered by statutory requirements. If in doubt regarding these requirements Managers should seek advice from the Trusts Fire Safety Advisors. Where reasonably practicable replace with non-flammable substances.	
14.5	**Acetylene:** Acetylene is prohibited and not allowed on any site In very exceptional circumstances where it is not reasonably practicable to replace Acetylene with a safer alternative, a risk assessment is to be carried out by the Trusts fire safety advisers. The authorisation of the risk assessment can only be given by the Fire Safety Manager for the use of acetylene on any of the Trust's sites.	

5.15 Fire Safety Protocol: 15. Purchasing.

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

15	**Purchasing.**	See also
15.1	**Introduction:** All items of furniture fabrics and electrical equipment should be purchased via CARDEA or PFI partner.	
15.2	**Textiles and furnishings:** Textiles and furnishings contribute to the fire loading of a room or area. Textiles and furnishings include: • Upholstered furniture e.g., chairs, settees, cushions. • Bed bases, mattresses, pillows and bedding. • Curtains and drapes. All textiles and furnishings should comply with the flame retardancy standards specified in Health Technical Memorandum 05:03 Operational Provisions part C textiles and furnishings, to crib source 5 standards. No items of furniture should be brought in by service users or their relatives, however, Limited quantities of textiles e.g., bedding / pillows may be considered, to be acceptable.	
15.3	**Electrical equipment:** Electrical equipment includes: • Portable heaters. • Toasters. • Microwave ovens. • Irons. • Lamps. • Fans. • Washing machines / dryers. • Computers and ancillary equipment. • Heaters. Note The above list is not exhaustive. The only type of portable heater allowed is an oil filled radiator. Heaters should only be provided by estates or PFI partner. Approval to approach estates for a portable heater should be sought from the Manager / Clinical Lead or equivalent, who will first check there are no more suitable alternatives.	Electrical Safety Policy.

15.4	**Exceptions:** If exceptionally, there is the clinical need for a piece of equipment that does or may not meet the required standard, contact the Fire Safety Advisor for advice before ordering.	
15.5	**Storage of stock items:** Staff are to be mindful of the risks of storing large quantities of potentially flammable material (e.g., stocks of paper). Order no more than is necessary to maintain the smooth running of the service. Keep stores in a metal cabinet (ideally). Keep in a safe area, away from public access.	

5.16 Fire Safety Protocol: 16. Laundry

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

16	**Laundry:**	
16.1	All soft furnishings (curtains, bedding, upholstery, etc.) must meet the required crib source 5 standard and should usually be labelled as such. Providers should retain robust records that can evidence this information, in case a label is removed.	
16.2	All soft furnishings must be laundered by an approved contractor, to ensure that it is washed in the right way and properly aired and stored.	
16.3	Washing machines provided by the Trust are for service user clothes only.	
16.4	Dirty laundry should be considered as a fire risk and removed from clinical areas as soon as is practical or stored in a secure area.	
16.5	Frequent checks of tumble dryer filters should be carried out to prevent any build-up of lint.	

5.17 Fire Safety Protocol: 17. Information for the Fire and Rescue Service

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

17	**Information for the Fire and Rescue Service**	See also
17.1	**Introduction:** If the Fire Service attends an incident at one of our premises, information or equipment may be needed by them to help to deal with the incident quickly and safely. This information/equipment should be available to them. Information consists of staff meeting the Fire Service, available plans at fire alarm panels and in Trust larger premises a fire pack.	
17.2	**What information could be useful?** Information that is kept in the fire packs includes, but is not limited to: • Master key / keys for the building (labelled if more than one). • Other keys that may be needed e.g., window restrictor keys. • Swipe / access cards. • Spare fire alarm break glasses and Allen key. • Plans of the building (including roof void if appropriate) showing: Fire alarm panel(s), Gas / Electricity / Water cut offs etc.	
17.3	**How / where should the Fire Pack be kept?** The information / equipment should be kept in a strong plastic wallet, clearly labelled and kept at: • Hospital receptions or with local fire teams (where applicable) • If there are security issues with leaving keys available, local Managers should decide how / where they are kept and made available to the Fire Service.	
17.4	**Checking and updating the pack.** The Fire Safety Advisor should ensure were applicable, that the fire pack is checked regularly.	

5.18 Fire Safety Protocol: 18. Salvage and business continuity planning

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

18	**Salvage and Business Continuity Planning**	
18.1	**Business continuity plans** Business continuity plans (BCP) are in place for each care group and corporate areas. Business continuity is co-ordinated by the directorate business continuity lead and the associate director is responsible for the care group plans. The Emergency Planning and Business Continuity Manager will advise on business continuity matters. The business continuity plan addresses: • Building evacuation (extended period) • Failure of IT and telephone systems • Serious staff shortage (pandemic) • Transport failure • Another serious incident	Business Continuity Plan.
18.2	**items of critical importance** Any items of critical importance should be noted in the BCP, and Fire Service alerted as appropriate e.g., medical records	
18.3	**Alerting the Fire Service to critical items** Any items / equipment that need special attention during a fire situation, should be noted in the Fire Pack so that this information is readily available to the Fire Service.	

5.19 Fire Safety Protocol: 19. Electrical battery storage and charging

This protocol must read in conjunction with the Fire Safety Policy and other associated protocols.

19	**Electrical Battery Risks – Storage and Charging**	
19.1	**Introduction:** The risk - Any device which has an internal battery supply has the potential to pose a hazard. The size of the batteries can vary considerably, from those in an e-cigarette to those in an electric car or bike. Generally, the larger the battery, the greater the risk. Lithium-ion batteries have the highest energy density and utilise an organic solvent in the electrolyte. This means, if the battery overheats, it can cause a chemical reaction which in turn increases the risk of a serious fire or explosion. Most fires occur whilst batteries are being charged. The risk of an incident occurring increases if batteries are damaged, are subject to excess heat or are charged when thermally insulated e.g., instance under a duvet or blanket. Fire risk is further exacerbated when a battery is over-charged, short circuited or submerged in water. The following is a list of devices which may contain electrical batteries but is not exhaustive; E- cigarettes Mobile phones Laptop Computers Tablets Games controllers Electric toothbrushes Cordless hairdryers/tongs E-Bikes E-Scooters Cordless Tools	NHS Estates Technical Bulletin (NETB/2023/2): Risks of electrical batteries for the NHS Estate

19.2	**Risk Assessment:** All managers must risk assess the safe use, storage and charging of all electrical devices incorporating electrical batteries within their respective areas. The following hierarchy of control should be used where reasonably practicable: **Avoid** Consider if the risk can be avoided. For example, can you remove lithium-ion batteries from certain areas/operation. **Minimise** Where you cannot avoid their use, consider minimising the risk. Some of the ways you might minimise the risk is by ensuring patients and staff are advised on the safe use and charging of electrical devices with batteries, and ensuring you have local procedures in place for site specific operational requirements. **Rectify** Ensure, where reasonably practicable, battery charging is carried out within a fire protected area, such as a hazard room. This is especially important for large/higher capacity batteries. **Reduce** Ensure you have appropriate procedures in place should an electrical battery fire occur. Identify individuals who will be responsible for ensuring the safe use and charging of batteries at a local level (in a ward/department, or other area) for example fire wardens or local managers, and ensure they adhere to manufacturers' recommendations and guidance.	
19.3	**Safe Storage and Charging:** All batteries should be stored, charged, and used in accordance with the manufacturer's instructions. No flammable or combustible material, other than that associated with the chargers, should be stored within the vicinity of the charger in use. Batteries that are damaged should not be charged or used. Where batteries are left to charge in between use, it may be appropriate to use timers to control the charge to waking hours to prevent overheating and reduce the risk of fire. Where domestic items are bought into healthcare buildings by patients or visitors, staff should be alert to these, and ensure their safe use. Where a portable charger is in use it should be sited so that it is on a level, secure surface with the charging leads long enough to avoid placing them under stress and not near any fire hazard.	

	Managing risk - avoid storing devices with Lithium-Ion batteries in areas subject to high temperatures (e.g. hot vehicle or near a heat source). Keep batteries out of direct sunlight. Avoid dropping, crushing or otherwise damaging batteries. Should batteries appear to be not charging correctly or discharging too quickly, they should be replaced with a manufacturer recommended replacement. Only use manufacturer recommended charging equipment. Should a battery appear to be misshapen or show excessive heat, do not use and replace immediately. Further advice can be sought from a Trust Fire Safety Advisor as necessary.	
19.4	**Electric scooters, mobility scooters, electronic robots and electric bicycles:** Wherever possible, charging and storage areas should be located in a separate building reserved for this purpose, or in a specially designed charging area. Any area designated for charging should have the appropriate electrical equipment for this use. It should be kept clear of combustible material and not used for general storage. Where charging and storage of vehicles and batteries is in an occupied hospital, the charging of vehicles and batteries should be done in an area separated from the remainder of the building by fire-resisting construction. These should not be in patient access areas. Charging and storage of such devices should not take place in means of escape routes or circulation areas. These areas should be protected by the building's fire detection and alarm system and have suitable fire extinguishers provided. Charging areas should be ventilated directly to the outside. Electrical circuits should be easily and automatically isolated in the event of a fire i.e Residual Current Device (RCD protection). All products should be used in accordance with the manufacturer's instructions.	
19.5	**Electric car charging:** The charging for electric vehicles ranges from the use of cables designed for use from a domestic three pin socket to high powered dedicated chargers using either AC or DC current. The combination of the car batteries, which contain lithium-ion batteries, and a significant fire load in any car presents a potential risk. Electric vehicles should only be charged at designated vehicle charging stations and never by utilising three pin adaptors/cables.	

6 Terms and definitions

Term	Definition
Annual Fire Statement	An annual statement of fire safety to provide a clear indication in respect of the status of fire safety management within the organisation and a statement of assurance that adequate fire safety measures are in place.
Assembly point	A pre-determined area of safety where persons should assemble in the event of an emergency.
Authorising Engineer (Fire)	A chartered fire engineer, or a chartered member of an appropriate professional body, with extensive experience in healthcare fire safety or nominated contractor
Compartmentation	The fire-resisting elements including walls, floors, and where applicable, roofs and/or other structures used in the separation of one fire compartment from another.
Competence	Where a person is required to be competent, they must be able to demonstrate through training and experience or knowledge and other qualities that they have the ability to properly assist in undertaking the preventative and protective measures.
Competent Person (Fire)	A person who can provide skilled installation and/or maintenance of fire-related services (both passive and active fire safety systems).
Fire Authority	The Fire and Rescue Service
Firecode	Guidance documents from the Department of Health regarding fire safety in healthcare premises.
Fire evacuation plan	The pre-determined plan that describes the actions necessary in the event of a fire to protect relevant persons and facilitate their safe evacuation.
Fire-fighting equipment	The fire extinguishers, fire blankets and other equipment made available to trained personnel for the purpose of fighting fire.
Fire resistance	The ability of an element of building construction, component or structure to fulfil, for a stated period of time, the required load-bearing capacity, fire integrity and/or thermal insulation and/or other expected duty in a standard fire resistance test.

Fire risk assessment	The process of identifying fire hazards and evaluating the risks to people, property, assets and the environment arising from them, taking into account the adequacy of existing fire precautions, and deciding whether the fire risk is acceptable without further fire precautions.
Safety Advisor	A person who has sufficient training and experience or knowledge and other qualities to enable them too properly assist in undertaking preventative and protective measures.
Fire Safety Manager	The person within the organisation tasked with coordinating fire safety issues throughout the organisation's activities.
Fire safety management system	A robust framework of protocols and processes used to ensure that an organisation can fulfil all tasks required to achieve the fire safety objectives set out in the fire safety policy.
Preventative and protective measures:	The measures which have been identified by the responsible person in consequence of a risk assessment as the general fire precautions necessary to comply with the requirements and prohibitions imposed by the Fire Safety Order.
Protocol	Section of the policy providing guidance on a specific issue.
Responsible person:	The employer of persons working at the premises, a person who has control of the premises, or the owner of the premises.

7 How this procedure will be implemented

1.	The Chief Executive has ultimate accountability for this document. Specific responsibility for protocol implementation is delegated to respective Directors and Heads of Service etc. The Fire Safety Manager will adopt responsibility for controlling and managing any identified fire risks within the Trust.
2.	This procedure will be published on the Trust's intranet and external website.
3.	Line managers will disseminate this procedure to all Trust employees through a line management briefing.
4.	Appropriate training is an essential element of fire safety and Fire Safety Advisor who are suitably qualified, shall deliver face to face training and also supplemented by e-learning

7.1 Training needs analysis

Staff / Professional Group	Type of Training	Duration	Frequency of Training
All Staff	As per Protocol 5 above	As required	As required

8 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Performance will be monitored by incidents. Incidents include: - • Incidents of Actual Fire. • False alarms • Unwanted Fire Signals. Targets for Unwanted fire signals, will be set as per those identified in the Performance level grading chart of HTM 05-03 Part H. Reducing false alarms in healthcare premises p20	All fire Incidents will be investigated by the Trusts Fire Safety Advisors. All incidents will be logged, and information provided to relevant Governance Groups. All incidents and Fire Reports will be discussed at both the Fire Safety Advisors monthly meeting and at the Health & Safety Committee on a two-monthly basis. The Incident and Fire Report documents will form part of the Authorising Engineer (Fire) audit process.	Relevant Governance Group. Fire Reports to Health & Safety Committee on a two-monthly basis.
2	The Trust will produce an annual statement of fire safety to provide a	The Annual fire statement will be produced in April, by a Trusts Fire Safety Advisor.	An Annual Fire Statement is submitted to the CEO for signature.

	clear indication in respect of the status of fire safety management within the organisation and a statement of assurance that adequate fire safety measures are in place.	The outcome of any fire safety audit and internal reports should be used as the basis on which to formulate the annual statement of fire safety.	The annual statement of fire safety is to be retained by the fire safety section and may be presented to the Care Quality Commission along with supporting documentation as evidence of performance against Outcome 10 of the 'Essential standards of quality and safety'.
3	The Trust will produce Fire risk assessments and identify hazards to evaluate the risks to people, property, assets and the environment. considering the adequacy of existing fire precautions and deciding whether the fire risk is acceptable without further fire precautions. As identified in Article 14 of the Regulatory Reform Fire (Safety Order) 2005	All Fire Risk Assessments will be completed by the Trusts Fire Safety Advisors As required by building type (1-3 years). All significant findings will be identified and logged on the Fire Safety Database and brought to the attention of the Fire Safety Manager.	Fire Risk Assessments will be monitored at the Fire Safety Advisors Group on a Monthly basis.

9 References

This document identifies 24 different protocols each related to fire safety. The related documents for these protocols are listed below: -

- Regulatory Reform (Fire Safety) Order 2005.
- Building regulations 2010 approved document B, volume 2.
- Electricity and electrical equipment procedure.

- BS5266:2016 Emergency escape lighting systems.
- BS8214:2016 Code of Practice for Fire door assemblies.
- BS7273 part 4:2015 Actuation of release mechanisms for doors.
- BS5306 part 3:2017 Commissioning and maintenance of portable fire extinguishers.
- HTM06-01 Electrical services supply and distribution.
- BS9251:2021 Sprinkler systems for residential and domestic occupancies.
- BS 9999:2017 Fire safety in the design, management and use of buildings - code of practice.
- NHS Estates Technical Bulletin (NETB/2023/2): Risks of electrical batteries for the NHS Estate
- BSEN12845 Automatic sprinkler systems.
- BS5839 part 1:2017 Fire detection and fire alarm systems for buildings.
- HTM05-01 Managing healthcare fire safety.
- HTM05-02 Guidance in support of functional provisions for healthcare premises.
- HTM05-03 Operational provisions part F Arson prevention in NHS premises.
- HTM05-03 Operational provisions Part B Fire detection and alarm systems.
- HTM05-03 Part C Textiles and Furnishings.
- HTM 05-03 Part H. Reducing false alarms in healthcare premises.
- Fire Safety Policy Ref HS-0008-V4.
- Regulatory Reform (Fire Safety) Order 2005.
- Fire Safety department local document Personal Emergency Evacuation Plan (PEEP).
- Fire Safety Department Local Document Fire Risk Assessment.
- Locally held fire procedures and fire action notices.

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	16 August 2024
Next review date	19 November 2026
This document replaces	HS-0008-001-v1.1 Fire safety protocol
This document was approved by	Health safety security and fire working group
This document was approved	24 January 2024
This document was ratified by	EFM DMT
This document was ratified	16 August 2024
An equality analysis was completed on this policy on	31 July 2024
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
v1.1	March 2023	Full review with minor changes, includes: • Updated into new template • Added OGTC • Protocols updated • References updated • Updated implementation monitoring	Withdrawn
v.1.2	16 Aug 2024	Addition of New Protocol: 19. Electrical Battery Risks – Storage and Charging	Approved

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Estates and Facilities management
Title	Fire Safety Protocol
Type	Procedure / guidance
Geographical area covered	Trust Wide
Aims and objectives	The purpose of this document is to ensure that the potential risk from fire is managed, and a safe environment exists, whilst complying with relevant guidance and legislative requirements.
Start date of Equality Analysis Screening	27 December 2023
End date of Equality Analysis Screening	31 July 2024

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	This document benefits all employees, patients, visitors and contractors of the Trust
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	None
Describe any positive impacts	This document provides a framework of core safety measures across all of the Trust's property and premises with the function to provide guidance to all staff.

Section 3	Research and involvement
What sources of information have you considered? (e.g., legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See References section
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes Previous version was developed with engagement with the Fire and Rescue Service, Fire Safety Advisors, Estates staff. This version only has minor changes.
If you answered Yes above, describe the engagement and involvement that has taken place	This document has been discussed within the Estates department at managerial level, it is to be presented to various committees including the Fire Safety group and the Health Safety Security and Fire group
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	There are no training arrangements identified to assist in the implementation of this protocol document. Fire safety training is described in this document Protocol 5, there is a pre-programmed plan to train staff on fire safety via the learning and development department.
Describe any training needs for patients	Not Applicable all fire safety arrangements are conducted by staff including evacuation decisions.

Describe any training needs for contractors or other outside agencies	Control of Contractors Procedure CORP-0049-v3.1. Contractor induction given by Estates. All contractors are approved before working on any of the trust Estates or sites.

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee / group for consideration and approval.

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	Protocol
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Are people involved in the development identified?	YES	
	Has relevant expertise has been sought / used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	
	Have any related documents or documents that are impacted by this change been identified and updated?	YES	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are supporting documents referenced?	YES	
6.	**Training**		
	Have training needs been considered?	YES	
	Are training needs included in the document?	YES	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	YES	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	YES	
	Have Equality and Diversity reviewed and approved the equality analysis?	YES	31/07/2024 LC
9.	**Approval**		
	Does the document identify which committee / group will approve it?	YES	
10.	**Publication**		
	Has the policy been reviewed for harm?	YES	
	Does the document identify whether it is private or public?	YES	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	YES	