



National Ambulance
Resilience Unit
NARU



JESIP

National Ambulance Service Command and Control Guidance



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National Ambulance Resilience Unit NARU



JESIP

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FOREWORD

The development of this Guidance has considered lessons identified from recent major incidents and event responses across England, the UK and wider global events in addition to the updated practice among our Police and Fire and Rescue Service partners.

The aim of the Guidance is to assist the Ambulance Commander in taking appropriate and consistent considerations to inform decision making, based on sound risk management in making consistent and informed decisions based on the information available at the time.

This guidance is designed to provide a structured approach to managing major or complex incidents for the Ambulance Service, with a particular focus on multi-agency responses. It is recognised that each organisation has specific needs and considerations to ensure that their incident response and business continuity arrangements are addressed through appropriate plans.

This guidance should provide assurances to our multi agency partners of our commitment to learn from lessons of previous incidents and events and to ensure that the NHS Ambulance Service Providers remain an essential element of the civil protection capabilities across England.

It is important to recognise and thank the individuals who contributed to the development of this Guidance. It will undoubtedly provide further support and protection to staff enabling them to deliver the best possible care and service to the public. This Guidance has been developed in conjunction with and contributions from Northern Ireland, Scottish and Welsh Ambulance Services. The Scottish Ambulance Service endorses this publication but recognises that there are local differences which need to be taken into account in the context of NHS Scotland.

I commend this Guidance for adoption by your Service and believe it will further strengthen the resilience arrangements that exist within the Ambulance Service.



Anthony C. Marsh

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Chairman, Association of Ambulance Chief Executives (AACE)
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1.0 INTRODUCTION

1.1 The Ambulance Services of the National Health Service (NHS) deal on a day to day basis with thousands of diverse incidents, many of which are resolved without the need for the implementation of a dedicated Command and Control structure. However, when an incident becomes complex or resource intensive then such an agreed structure will be required to facilitate the efficient and successful management of the incident.

SCOPE

1.2 This document offers guidance to support the contract standards set within 'Standards for NHS Ambulance Service Command & Control' and should be read in conjunction with those provisions. As such, this guidance is subordinate to those contractual obligations. This Guidance document is designed to assist those responsible for planning, training and exercising, responding and recovering from a major incident.

NHS Mandate for this Document

- Legislation and Statutory Provisions
- Ministerial Mandate / Lead Government Department Directive
- National Multi-Agency Doctrine (if backed by Government)
 - NHS Standard Contract (Inc. Service Condition SC30 - EPRR)
 - NHS England EPRR Framework
 - NHS England EPRR Core Standards

- National Provisions for Interoperable Capabilities (the national safe system of work)
- **NHS Command & Control Guidance** (this document)

Since the publication of the first edition of this guidance, the JESIP program has been imbedded within the three blue light services and wider. This guidance fully adopts the models and principles of JESIP.

LEGAL DUTIES AND OBLIGATIONS

1.3 Further to the contract obligations, the following legal obligations apply to command and control by the NHS Ambulance Service:

- The Health and Safety at Work Act 1974 and its subsequent provisions requiring a safe system of work for Ambulance employees.
- The Civil Contingencies Act 2004 including the obligations placed upon Category 1 responders.
- Common law (tort of negligence), specifically the established duty of care between Ambulance Service and the patient. Potential liability arising from negligence or gross negligence. Negligence may also give rise to liability under the Corporate Manslaughter & Corporate Homicide Act 2007.

Post incident inquests, inquiries and legal action have concentrated their scrutiny on the quality of command decision making and the subsequent impact on patient outcomes.

Command decisions have a direct impact on clinical outcomes, survival rates and the safety of responding staff.



Over the last decade the duty of care for the NHS Ambulance Service has been legally clarified and the expectation of Coroner's, Inquest Chairman, and Judges has increased. High standards of Commander competence are now the starting point for any such inquiry particularly where the emergency event was within the contemplation of the National Risk Register for Civil Emergencies and where similar events have occurred in the past.

Command decisions have a direct impact on clinical outcomes, survival rates and the safety of responding staff. A key outcome of this guidance is, therefore, to increase the effectiveness of NHS Ambulance Service command by maintaining high standards of competence and credibility among NHS Ambulance Service Commanders. Both the public and the NHS Ambulance personnel that put their lives at risk to respond to complex emergency situations have a right to expect no less.



2.0 PREPARING TO COMMAND

AMBULANCE SERVICE RESPONSIBILITIES

2.1 NHS, Ambulance Service Providers have the responsibility for alerting, mobilising and coordinating the initial NHS response to short notice or sudden impact emergencies such as critical or major incidents. This includes:

- Initiate and maintain Ambulance Service command plans to provide appropriate support and guidance to all NHS responders and other agencies.
- Coordination of all NHS communications will be through the host/responding ambulance service provider[s].
- The management of the health, safety and welfare of all NHS responders at the scene of the incident.
- The provision of effective casualty triage, treatment and transport including the selection of appropriate receiving hospitals.
- Provision of specialist incident response capabilities, including hazardous area working, decontamination of casualties and response to terrorist incidents.
- Appropriately trained and competency assessed commanders with evidence of Continued Professional.
- Commander development as per the Standards for NHS Ambulance Service Command and Control.

- Ensuring all Strategic and Tactical Commanders contributing to an on-call rota should be appropriately Security Cleared to attend sensitive meetings and briefings implied by their role.

2.2 All Commanders must have an in-depth knowledge of their own organisation's Major Incident Plan and relevant procedures.

2.3 Command decisions have the greatest impact on the performance of the NHS at the scene of major and complex incidents. Those decisions also directly affect clinical outcomes, survivability and staff safety.

NHS Ambulance Service providers must ensure that the command roles set out in the diagram below (Figure 1) are maintained and available at all times within their service area. They create the fundamental chain of command. The National Ambulance Service Command and Control Guidance defines these roles in more detail.

The NHS Ambulance Service provider must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the appropriate required support roles set out in the diagram below (Figure1) at all times.

All roles within this structure must be staffed by competent and credible personnel that have been trained and exercised to discharge these functions to a suitable standard (defined by this Guidance and within the Standards).

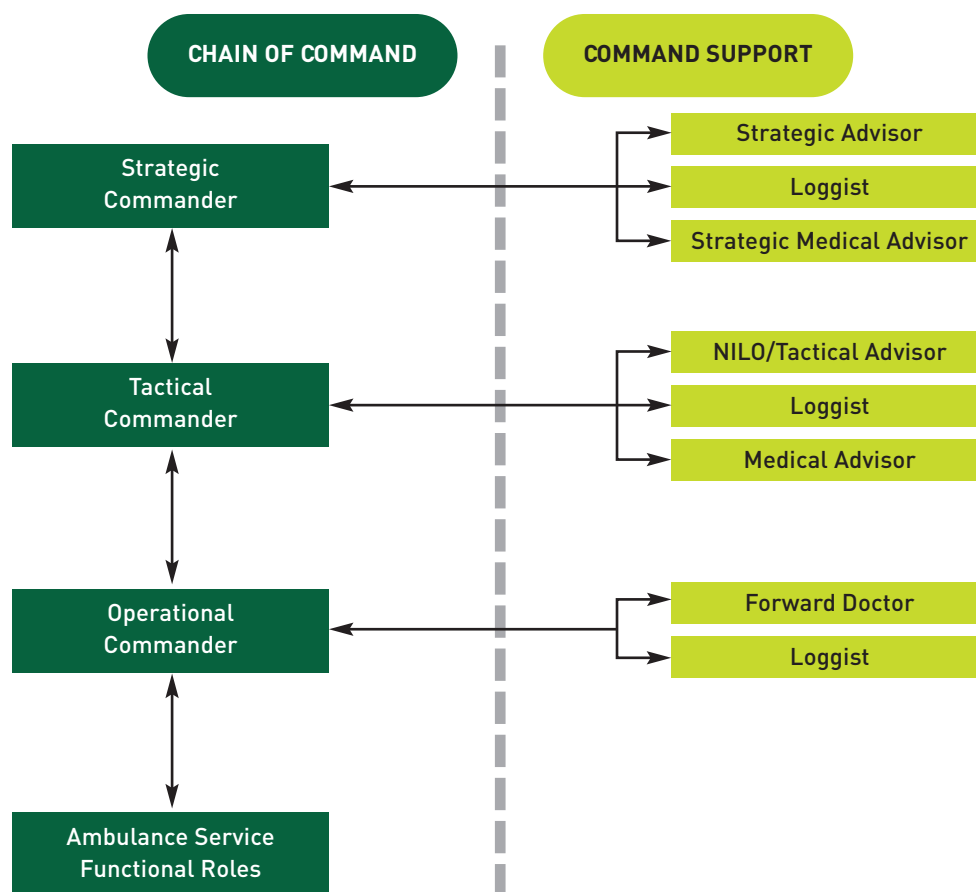


Figure 1 - The Chain of Command and Supporting Structures

INTEROPERABILITY

2.4 Interoperability is the extent to which organisations can work together coherently as a matter of routine. It is about working together to achieve a joint aim for the benefit of a group of people, community, or an organisation. Interoperability planning requires accounting for emergency management and incident response contingencies and challenges.

Using the JESIP Principles, the emergency services personnel will better understand the capabilities of their peers and will be competent in establishing, a joint understanding of risk shared situational awareness and the use of the Joint Decision Model.

JESIP KEY TASKS

- To establish joint interoperability principles and ways of working (doctrine).
- To develop greater understanding of roles, responsibilities and capabilities amongst tri-service responders.
- To improve the training for all levels of command.
- To implement a joint testing an exercising strategy for all levels of command to ensure lessons identified progress to lessons learned through procedural and cultural change.



THE PRINCIPLES FOR JOINT WORKING

- How Interoperability is achieved in the context of an operational response

Co-locate

Co-locate with commanders as soon as practicably possible at a single, safe and easily identified location near to the scene.

Communicate

Communicate clearly using plain English.

Co-ordinate

Co-ordinate by agreeing the lead service. Identify priorities, resources and capabilities for an effective response, including the timing of further meetings.

Jointly understand risk

Jointly understand risk by sharing information about the likelihood and potential impact of threats and hazards to agree potential control measures.

Shared situational awareness

Shared Situational Awareness established by using METHANE and the Joint Decision Model.

If the principles are followed then the result should be a jointly agreed working strategy where all parties understand what is going to happen when and by who, this strategy should include:

- **What** are the aims and objectives to be achieved?
- **Who by** - police, fire, ambulance and partner organisations?
- **When** - timescales, deadlines and milestones
- **Where** - what locations?
- **Why** - what is the rationale? Is this consistent with the overall strategic aims and objectives?
- **How** are these tasks going to be achieved?

2.5 Emergency Response Plans should include considerations of governance, Standard Operating Procedures (SOP), technology, training and exercises, and usage within the context of the stress and chaos of a major response effort; all of these should be jointly considered and assessed if they include assumptions of interoperability.

2.6 Coordinated decision making between agencies and departments is necessary to establish effective and coherent governance and is critical to achieving interoperability. Agreements and SOPs should follow JESIP models and principles to achieve interoperability.

LEADERSHIP

- 2.7** Leadership is a key attribute of an Ambulance Commander and one which they must display when carrying out their role during an emergency response. They must also be visible, confident and measured in their decision making.
- 2.8** Good communication is at the heart of an effective response. Communication is a key element at every level of command. Effective leaders will provide clear and effective communication and possess the skills to motivate staff during the response. Commanders must focus on the needs of the task, of the group and of the individuals under their command. Effective Commanders will maintain the highest levels of integrity, to gain the trust and ultimately, the respect of their colleagues and peers.
- 2.9** Commanders should consider the following factors which affect leadership:
- Effective leadership requires Commanders to have an honest understanding of who they are, what they know, and what they can do.
 - Not all staff will be the same; different people require different styles of leadership.
 - There will be assumptions made about the level of training received by staff and their abilities.
 - Leadership requires two-way communication.
 - Treat each incident on its merits.
- 2.10** A post incident inquiry will investigate the level of training and competence of any Commander involved with the response; Trust and individuals with command responsibilities must be able to demonstrate competence for the role, how they achieved, updated and maintained it.

- 2.11** Regulations require organisations to afford individuals in command roles the time to undertake training and exercise in line with the function that they are expected to carry out during an incident. When allocating roles, consideration should be given to the appropriateness of the task to the individual's training, experience and competence.

- 2.12** All Ambulance Service Providers have signed up to the existing National Occupational Standards (NOS) for Commanders and NHS England's Standards for NHS Ambulance Service Command & Control. Delivery of training and individual Continual Professional Development (CPD) against these Standards will help to ensure a consistent approach across the Ambulance Service Providers' emergency response.

HUMAN FACTORS

- 2.13** The term 'human error' is often used to describe the limitations of an individual in relation to the cause of an error, often setting the cause of an incident out of the reach and control of managers and executives. Society no longer views this personal approach as acceptable and organisation's must understand human performance and limitations (factors) as an individual element in the control and management of risks.
- 2.14** The Health and Safety Executive (HSE) defines human factors as 'the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work'. They list 3 key aspects which affect how individuals behave in relation to health and safety; these are:
- The job
 - The organisation
 - The individual



2.15 Commanders must ensure that all decisions they make on the use of resources are risk assessed. By thinking about these aspects, we are asking questions about the following:

- What are people being asked to do and where (the task and its characteristics)?
- Who is doing it (the individual and their competence)?
- Where are they working (the organisation and its attributes)?

2.16 A fourth element which should be considered is the actual situation under which the individual is being asked to perform the task.

2.17 Building on the HSE model a useful acronym for this is STOP:



Figure 2 - STOP acronym

Situation The situation or environment which a person is expected to work within has a big influence on how they will behave towards a given task. Influencing factors may include the presence or absence of Senior Officers, weather conditions or familiarity with the type of situation gained through experience or training.

Task People need to be trained to complete the tasks that they are being asked to undertake, an example would be the Tactical Commander role. Although the task may have some generic elements, application of the elements may be hindered or improved by the situation in which they are being applied.

Organisation Organisational factors have the greatest influence on individual and group behaviour. The organisation will dictate the environment and parameters within which the individual will work, be it through organisational culture, policies or procedures.

Person People bring to their job personal attitudes, skills, habits and personalities which can be strengths or weaknesses depending on the task demands. Individual characteristics influence behaviour in complex and significant ways. Their effects on task performance may be negative and may not always be mitigated by job design. Some characteristics, such as personality, are fixed and cannot be changed. Others, such as skills and attitudes, may be changed or enhanced.

BUSINESS CONTINUITY MANAGEMENT

2.18 Business Continuity Management (BCM) is a statutory requirement for all Ambulance Service Providers to undertake. The Civil Contingencies Act 2004 (CCA), the Health, Social Care Act 2008 (Regulated Activities) Regulations 2010, NHS England EPRR Framework 2015 and the NHS Core Standards and Standard Contract require Ambulance Service Providers to have Business Continuity Plans in place to ensure the Ambulance Service Provider is able to exercise its civil protection duties as defined by the CCA, in addition to being able to continue to perform its day to day functions. It is considered best practice for all Ambulance Service Providers to align to the ISO 22301 standard.

3.0 COMMAND AND CONTROL

- 3.1** Command is the exercise of vested authority which is associated with a rank or role within an organisation to give direction to achieve defined objectives.

Control is the application of authority combined with the capability to manage resources to achieve defined objectives.

The objectives for Command and Control are set within the Standards for NHS Ambulance Service Command & Control (2018).

- 3.2** The Ambulance Service, along with the other blue light emergency services, employ a 3-tier command system comprising of a Strategic Commander, Tactical Commander and an Operational Commander.

This is a hierarchical system whereby individuals are empowered through their role within the structure, providing them with specific authority over others for the duration of the incident or event. This is regardless of the individual's rank in the organisation's day to day structure. During an incident where the command structure is activated, the day to day rank of the individual changes into that person's role within the incident.

- 3.3** Selection for each role within the command structure should be based on an individual's command competence which must be demonstrated through the completion of appropriate training and exercises. There is a common acceptance that some day-to-day roles within an organisation require an individual to undertake specific command roles in the event of a major incident; where this is the rationale then the relevant command

training should be provided for that post holder.

Consequently, NARU has embarked on a comprehensive programme to maximise the benefits that National Occupational Standards and the Standards for NHS Ambulance Service Command & Control offer to commanders. Whilst NARU has produced action cards for the ambulance commanders and other roles, it is good and leading practice that there is a minimum set of standards for these commanders and the CPD scheme must be able to be evidenced should the need arise, for example post incident enquiry, public inquiry.

- 3.4** The Ambulance Service response to a major incident will be supplemented by other Health Service responders. NHS England EPRR Framework gives guidance on command, control and coordination arrangements required in planning, preparing and responding to emergencies. NARU Clinical Guidance: Medical Support Minimum Requirements for a Mass Casualty Incident provides guidance on the minimum medical support required to provide the clinical supervision and advice necessary – not only to maximise the clinical outcomes or those affected by the incident – but also to maximise the care available to the patients who would still require access to pre-hospital care and transport across the health community.

INCIDENT MANAGEMENT SYSTEM (IMS)

- 3.5** This Guidance provides Commanders with a clear and organised framework in which to operate safely and assists in the mobilisation, organisation and deployment of all resources under their command.



It defines the command structure which can be adapted to fit any incident of any size, regardless of the type and level of resources employed.

3.6 Ambulance Service Providers should ensure that the IMS is communicated to all relevant personnel and that the concept of its use and the terminology within it are fully embedded and understood.

3.7 The Strategic, Tactical and Operational system is the spine of Incident Management, with all additional roles feeding to and from the spine. Commanders must remain

focused on their level of responsibility in the command structure, without becoming involved unnecessarily with matters of the command tiers above or below. Everyone in the command structure must be disciplined and channel communications appropriately. For example, the Strategic Commander should not communicate directly with the Operational Commander or vice versa.

3.8 CSCATTT provides Ambulance Commanders with the key principles for dealing with any incident:

| | | |
|---------------------------------|--|---|
| C Command and Control | Commanders must ensure that they have command and control of the incident. This is achieved through the implementation of the command structure. | <div>Co-locate</div> <div>Communicate</div> <div>Co-ordinate</div> <div>Jointly understand risk</div> <div>Shared Situational Awareness</div> |
| S Safety | Commanders must ensure the safety of all responders, patients and members of the public. This is achieved through risk assessment and the identification and use of control measures. | |
| C Communication | Commanders must ensure effective communications at incidents, internally and externally, using plain English which is free of technical jargon and acronyms. The use of interoperable communication devices is a key part of this. Commanders must also provide information to inform the development of a Joint Doctrine. | |
| A Assessment | Using information, intelligence, risk assessments and available policies, plans and procedures, Commanders must make a full assessment of the incident. From this Commanders will develop the strategy and tactics for dealing with the incident. During the assessment phase Commanders will identify the level and types of resources required to manage the incident. This will include specialist resources such as HART and also the requirement for mutual aid. | |
| T Triage | In order that casualties are treated in the most appropriate manner a triage process will be used. This will consist of an initial triage sieve, with a further triage sort. During CBRNE or other types of terrorist incidents the triage process may have to be modified due to the environment and the levels of PPE required for responders. Initial clinical care (such as Catastrophic Haemorrhage control and basic airway manoeuvres) may be undertaken at this stage. | |
| T Treatment | Once casualty triage has taken place, patient care and treatment can commence and continue through to definitive care. | |
| T Transport | The availability of transport may vary so careful consideration must be given to the capability and suitability of transport types. | |

JESIP Principles for Joint Working

Table 1 – CSCATTT adapted from Major Incident Medical Management and Support (2011)

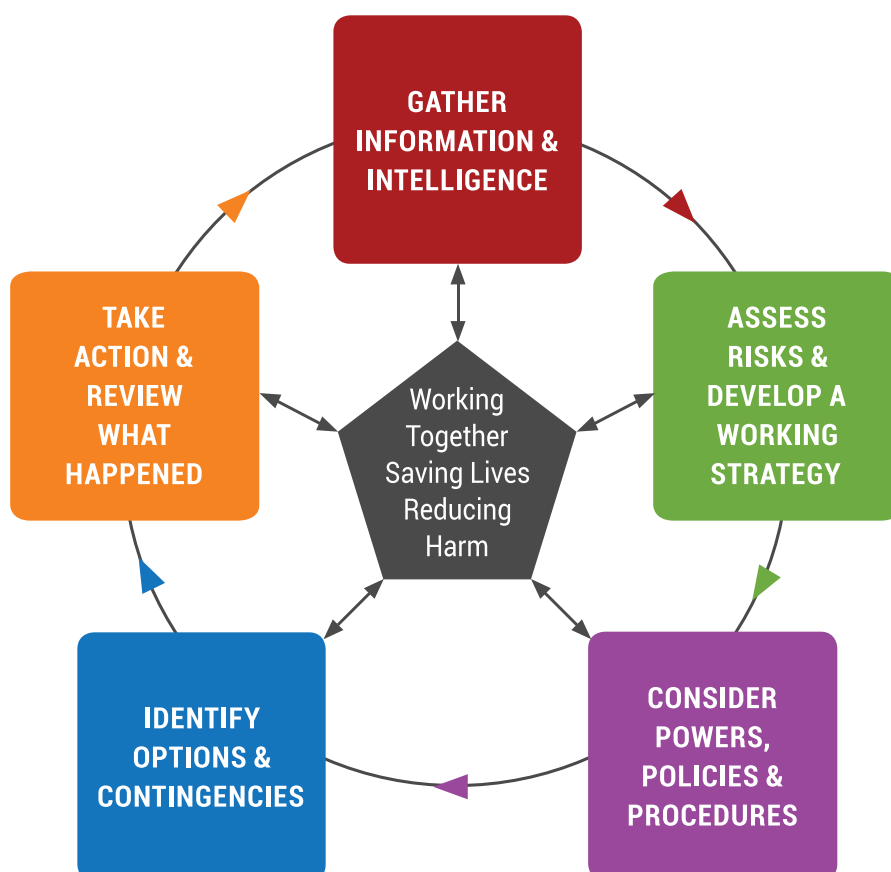


Figure 3 - Joint Decision Model (JDM)

DECISION MAKING

3.9 Effective Command and Control can only be achieved by Commanders who can make reasoned, lawful and justifiable decisions.

3.10 To support decision making The Joint Decision Model (JDM) is to be applied to decision making at any emergency incident and it is suitable for use by Commanders at all levels, regardless of role.

In the context of the Joint Decision Model, shared situational awareness becomes critically important. Shared situational awareness is achieved by sharing information and understanding between the organisations involved, to build a stronger, multi-dimensional awareness of events, their implications, associated risks and potential outcomes.

Decision making in the context of an emergency, including decisions involving the sharing of information, does not remove the statutory obligations of agencies or individuals, but it is recognised that such decisions are made against an overriding priority to save life and reduce harm.

The sharing of personal data and sensitive personal data (including Police intelligence) requires further consideration before sharing across agencies and the JDM can be used as a tool to guide decision making on what to release and to whom. In considering the legal and policy implications, the following are relevant:

- A legal framework to share information is required – in an ‘emergency’ situation this will generally come from Common



Law (save life/property), the Crime and Disorder Act 1998 or the Civil Contingencies Act 2004.

- Formal Information Sharing Agreements (ISA) may exist between some or all responding agencies, but such existence does not prohibit sharing of information outside of these ISAs.
- There should be a specific purpose for sharing information.
- Information shared needs to be proportionate to the purpose and no more than necessary.
- The need to inform the recipient if any of the information is potentially unreliable or inaccurate.
- The need to ensure that the information is shared safely and securely – it must comply with the Government Security Classifications (2018) if appropriate.
- What information is shared, when, with whom and why, should be recorded.
- Joint decisions must be made with reference to the overarching or primary aim of any response to an emergency: to save lives and reduce harm. This is achieved through a coordinated, multi-agency response. Decision makers should have this uppermost in their minds throughout the decision making process.

Gather and share information and intelligence

- 3.11** The following mnemonic should be used when passing information between emergency responders and Control Rooms to enable the establishment of shared situational awareness:

| | |
|----------|--|
| M | Major incident declared or standby? |
| E | Exact location; |
| T | Type of incident e.g. explosion, building collapse; |
| H | Hazards present, potential or suspected; |
| A | Access – routes that are safe to use; |
| N | Number, type, severity of casualties; |
| E | Emergency services now present and those required. |

Jointly assess risks, develop a working strategy

- 3.12** Understanding risk is central to emergency response. The Civil Contingencies Act places a requirement on all Category 1 responders to have an accurate and shared understanding of the risks which would or may affect the geographical area for which they are responsible.

The joint assessment of risk is the process by which commanders work towards a common understanding of threats, hazards and the likelihood of them being realised, in order to inform decisions on deployments and the risk control measures that are required.

Risk mitigation measures to be employed by individual services also need to be understood by the other responding organisations in order to ensure any potential for unintended consequences are identified in advance of activity commencing. A joint assessment of the prevailing risks also limits the likelihood of any service following a course of action in which the other services are unable to participate.

This therefore, increases the operational effectiveness and efficiency of the response as well as the probability of a successful resolution of the incident.

It is rare for a complete picture to exist and therefore a working strategy, for a rapid onset emergency, should be based on the information available at the time. The following should be considered when developing a working strategy:

- **Identification of hazards** – this will begin from the initial call received by a Control Room and will continue as first responders arrive on scene. Information gathered by individual agencies must be disseminated to all first responders and control rooms effectively. The use of the mnemonic METHANE will assist in a common approach.
- **Dynamic Risk Assessment** – undertaken by individual agencies, reflecting the tasks / objectives to be achieved, the hazards that have been identified and the likelihood of harm from those hazards.
- **Identification of the tasks** – each individual agency should identify and consider the specific tasks to be achieved according to its own role and responsibilities.
- **Apply control measures** – each agency should consider and apply appropriate control measures to ensure any risk is as low as reasonably practicable.
- **Integrated multi-agency operational response plan** – the development of this plan should consider the outcomes of the hazard assessment and service risk assessments, within the context of the agreed priorities for the incident.

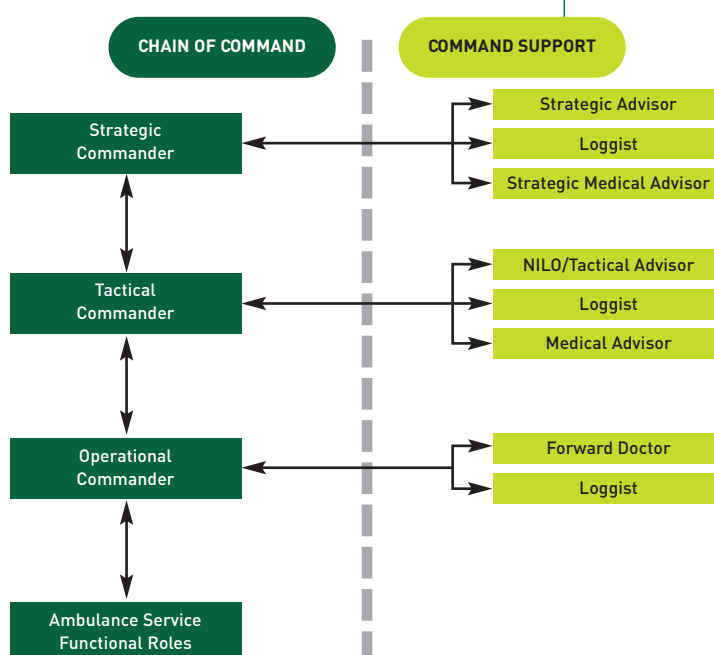
- **Recording of decision** – the outcomes of the joint assessment of risk should be recorded, together with the identified priorities and the agreed multi-agency response plan when resources permit.

It is acknowledged that in the early stages of the incident this may not be possible, but it should be noted that post-incident scrutiny inevitably focuses on the earliest decision making.

THE COMMAND AND CONTROL STRUCTURE

- 3.13** The efficiency of the Command and Control System relies on the discipline and effectiveness of each Commander within the Chain of Command; good discipline promotes cohesion within the system.
- 3.14** It is important that all those who have a role within the command structure are appropriately trained and exercised to understand what they have to do, how they have to do it and when.

3.15 Chain of Command





STRATEGIC COMMANDER

3.16 Personnel discharging the Strategic Commander role must be capable of directly representing the interests of the Trust Board. They must be capable of committing the Trust to a course or action without the need for further authority during an emergency situation (i.e. without making a phone call). Whilst this role and function may be supported by several people, the Strategic Commander must be a single individual that is easily identifiable as the person with overall Executive responsibility for the organisation at any point in time.

3.17 The Strategic Commander has overall responsibility for the command of the response and recovery of an incident or appropriate pre-planned event. The Strategic Commander will set the Ambulance Service Providers strategic aims (the Strategy) for the incident, providing a framework for the Tactical Commander(s) to work within.

3.18 To ensure multi-agency communication and coordination during a major incident or event, the Strategic Commander (or representative) will attend and effect command from the multi-agency Strategic Coordinating Group (SCG), and Health Coordination Groups if formed. However, where an incident affects only the Health Service then the Strategic Commander may decide to manage the incident from an Ambulance Service Provider location.

3.19 Whilst the Strategic Commander must not make tactical decisions, they maintain responsibility for ensuring that the tactics which are being employed are proportionate, appropriate and effective.

3.20 The Strategic Commander's responsibilities in line with their National Occupational Standard performance criteria can be found

in **ANNEX 1** Strategic Commander: Command and Control Roles, Performance Criteria and Responsibilities.

3.21 The key channels of communication for the Strategic Commander are as follows:

- Strategic level representatives of multi-agency partners e.g. Police, Fire, Military, Health, Maritime Coastal Agency, national and local government
- Tactical Commander
- Organisational Coordinating Centre or intelligence cell*
- Emergency Operations Centre (EOC)
- Strategic Medical Advisor*
- Executive on call*
- Media Liaison Officer*
- Command Loggist*
- Strategic Advisor or other specialist roles*
- Scientific Technical Advisory Cell (STAC) *

**Denotes where applicable*

3.22 TACTICAL COMMANDER

Personnel discharging the Tactical Commander role must have a thorough working knowledge of NHS Ambulance Service operations. They must have sufficient knowledge and experience to manage operational assets, including both general and specialist assets. It is critical that the Tactical Commander has a comprehensive knowledge of all tactical options available to them and the extent of the capabilities under their command. That will include an understanding of how to effectively balance the risks associated with deploying the following capabilities:

- General frontline Ambulance assets
- Air Operations and Helicopter Emergency Medical Services (HEMS)

- Critical Care / Advanced Paramedics
- Casualty Clearing Stations
- CBRN Decontamination Capabilities (SORT)

Hazardous Area Response Teams (HART) including:

- CBRN response
- Hazardous Materials
- Safe Working at Height
- Confined Space
- Unstable Terrain
- Water Operations and Flooding
- Tactical Medicine Operations (in addition to MTA)
- Marauding Terrorist Attack (MTA)
- National Mass Casualty Capabilities

The Tactical Commander does not need to be operationally trained or qualified as an operative in each of these capabilities, but they do need to be competent in their role as a Commander to oversee their deployment.

Tactical Commanders must provide comprehensive briefings to the Strategic Commander on the risks and benefits of all practices detailed in the National Ambulance Service Command and Control Guidance. It is not sufficient for the Tactical Commander to be reliant on the NILO / Tactical Advisor to cover gaps in their competence or to place the advisor in command of the incident. The NILO / Tactical Advisor should be able to provide (or facilitate access to) very detailed information on specific operational capabilities including those of other agencies to their Tactical Commander but the Commander is responsible for the decisions they make based on the advice they receive. They must be credible and competent to accurately interpret this information and make the necessary decisions.

3.23 The Tactical Commander has responsibility for developing the Tactical Plan and the Casualty Management Plan. The Tactical Plan will be developed within the framework of the Strategy and any available intelligence and associated risks.

3.24 Due to the dynamics of a major incident the Tactical Commander may put a Tactical Plan into place before the Strategy has been set. Where this is the case, the Tactical Plan should be reviewed against the Strategy once it becomes available.

3.25 The Tactical Commander will provide a framework and parameters for the Operational Commander to operate within (Tactical Plan). The Tactical Commander must support the Operational Commander to achieve their objectives and manage the incident effectively; however, they should not get involved in the direct operational management of the incident.

3.26 Co-location of multi-agency commanders is essential and allows those commanders to perform the functions of command, control and coordination, face to face, at a single and easily identified location. It is also desirable for more complex incidents at Tactical and Strategic levels.

3.27 The actual location of the Tactical Commander will be determined by the location of the Tactical Coordinating Group (TCG)/Joint Command Facility (JCF), which will usually be held at a pre-identified location or near the incident scene.

3.28 Some agencies with different command structures will send a representative to the TCG in a liaison capacity with the Incident Commander remaining at the scene. In cases of doubt over the location of the multi-agency TCG, the



Ambulance Tactical Commander should where possible locate themselves alongside the lead coordinating agency Tactical Commander (this is often the Police).

3.29 In circumstances where the Tactical Commander is delayed in getting to the TCG, consideration should be given to a request for an interoperability talk-group to be initiated. Such a request should not substitute the requirement for the Tactical Commander to attend a TCG and liaise with colleagues from other responding agencies in person.

3.30 If the Tactical Commander attends the incident scene without engaging with the multi-agency TCG, they risk operating in isolation, which would invariably complicate and prolong the incident unnecessarily. Where responders are able to rapidly co-locate, communicate and coordinate their activities, situational awareness is shared, risks jointly understood and pragmatic solutions developed to mitigate severe and time critical challenges.

3.31 The Tactical Commanders' responsibilities in line with their National Occupational Standard performance criteria can be found in **ANNEX 2** Tactical Commander: Command and Control Roles, Performance Criteria and Responsibilities.

3.32 The key channels of communication for the Tactical Commander are as follows:

- Strategic Commander
- Medical Advisor*
- NILO or Tactical Advisor*
- Tactical level representatives of multi-agency partners eg Police, Fire, Military, Health, Maritime Coastguard Agency, national and local government
- Operational Commander*
- Emergency Operations Centre (EOC)

- Incident Coordinating Centre*
- Command Loggist*

**Denotes where applicable*

OPERATIONAL COMMANDER

3.33 This role has responsibility for the activities undertaken at the scene. As such they will be located at the incident scene and ideally collocated with the Incident Commanders of the other responding agencies at a Forward Command Point. Where this is not possible, the Operational Commander must ensure regular multi-agency face to face briefings take place.

3.34 The Operational Commander ensures that the Tactical Commander's Plan is carried out and that they understand the Strategy. Importantly they must understand and be able to discharge their responsibilities within these.

3.35 As the Operational Commander they will provide leadership and management to the Functional Role Officers and any other direct reports.

3.36 Key responsibilities for the Operational Commander can be found in **ANNEX 3** Operational Commander: Command and Control Roles, Performance Criteria and Responsibilities.

3.37 The key channels of communication and partnerships for the Operational Commander are:

- Operational Commanders from multi-agency partners e.g. Police, Fire, Military and Local Authority
- Tactical Commander
- Emergency Operations Centre (EOC)
- Casualty Clearing Station
- Medical Lead
- Forward Doctors*
- Command Loggist*
- Other Functional Roles *

**Denotes where applicable*

3.38 It is imperative that each part of the incident is afforded appropriate attention. To assist with this, Commanders may assign key roles to other appropriately trained individuals. These are referred to as the Functional Roles.; for example an Ambulance Parking Officer.

COMMAND FUNCTIONS WITHIN EMERGENCY OPERATIONS CENTRE (EOC)

3.39 Control rooms play a vital role in managing the early stages of a multi-agency incident, they are key to building a coordinated, effective multi-agency response. In the initial stages of all incidents, some command and control will need to be provided by NHS Ambulance Service's EOC. In the event of a significant or major incident the command and control structure that would be expected to manage these incidents in Operations will need to be implemented in the EOC with the same command levels that would be expected in the operational environment.

These roles should be maintained until they are relieved by their Operational equivalent at the scene. If these operational roles are not fulfilled, then the responsibility to maintain this command and control level or position will remain with the relevant EOC Commander.

3.40 Operations Commander EOC:

- Initial response and resource allocation decisions based on the need and available capabilities balanced against demand.
- Single point of contact for Operational Commander for on scene updates and the agreed model for incident information sharing e.g. 'M/ETHANE'.

3.41 Tactical Commander EOC:

- Supports incident response

with resource.

- Link between organisation Command and Control structure: Operations and EOC.
- Responsible for internal and external escalation and communications with partner agencies.
- Ensures adequate resources are available to manage the impact of the incident on core business.

SPAN OF CONTROL

3.42 The span of control refers to the number of communication lines or direct reports an individual is expected to manage. Five reporting lines are commonly recognised to be the optimum number for one person. It is possible however that given consideration to the environment, type of incident and the level of resource, a Commander could manage up to seven lines, although due to the same factors this may be as low as two or three due to the nature, scale and complexity of the incident.

COMMAND SUPPORT ROLES

Strategic Advisor

3.43 Strategic Advisors are appointed by the Strategic Commander according to their field of expertise and the requirements of an event or emergency. The Strategic Advisor is not necessarily the same as a NILO or Tactical Advisor. Whilst the NILO or Tactical Advisor may provide direct advice to the Strategic Commander on certain matters such as mutual aid (as described in the Command and Control Guidance) their advice will usually be focused at the Operational and Tactical levels.

3.44 The Strategic Advisor will be selected by the Strategic Commander based on their expertise relevant to the strategic challenges of the incident.



For example, if public messaging is a key aspect, a Communications Director may fulfil this role. For this reason and to maintain flexibility for this role, a specific set of competences are not specified for this role.

Tactical Advisor

3.45 A Tactical Advisor is a member of staff who has the relevant depth of subject knowledge regarding Trust specialist and non-specialist capabilities and associated risks and the benefits of deploying / utilising such capabilities. The Tactical Advisor must be able to utilise that knowledge and provide concise advice to commanders regarding the risk and benefit of deploying Trust specialist and non-specialist capabilities during an incident response.

3.46 The Tactical Advisor is not a Commander or a decision maker. The responsibility for the decisions and course of action taken rests with the relevant Commander. However, the Tactical Advisor is both responsible and liable for the advice they provide. They must be credible and competent individuals.

They must have an in depth, current knowledge of specialist capabilities including; CBRN, HART (IRU, SWAH, Confined Space, Water Rescue and Support to Security Operations) and MTA. The Tactical Advisor must have in depth knowledge of the Trusts major incident response plan, and other relevant doctrine, policies and procedures. They must also have a good working knowledge of local partner agencies capabilities and that of the NHS.

National Interagency Liaison Officer (NILO)

3.47 A NILO should have a similar skill set to the Tactical Advisor but these individuals have undertaken

additional training to liaise with other responding agencies.

3.48 NILO's must maintain an up-to-date understanding of the response arrangements for other specialist agencies, particularly Police, Fire and Rescue, Military, Coastguard and the Security Services. NILO's will provide advice to various levels of the Command Structure on how to work effectively with the other agencies and help other agencies to interface effectively with the NHS aims and objectives. That means that NHS Ambulance NILOs may be deployed and imbedded within another agencies structure as required.

3.49 The NILO is not a Commander or a decision maker. The responsibility for the decisions and course of action taken rests with the relevant Commander. However, the NILO is both responsible and liable for the advice they provide. They must be credible and competent individuals with a recognised multi-agency NILO qualification and maintain their security clearance.

3.50 MEDICAL SUPPORT ROLES

The medical support roles (Strategic Medical Advisor, Medical Advisor and Forward Doctor) are not command roles. They are advisory roles and carry no command authority. Nevertheless, their advice will directly influence the command decisions taken so personnel discharging these functions must have the relevant skills and experience commensurate to the advisory role. Those providing medical advice are both responsible and liable for the advice they provide.

3.51 At the Strategic level, the Strategic Medical Advisor is principally responsible for monitoring overall hospital capacity and ensuring the tactical level has access to the clinical resources it requires,

particularly if national mutual aid is required from other sectors of the NHS.

3.52 At the Tactical level, the Medical Advisor is principally responsible for casualty distribution from the incident(s). They will support the Tactical and Strategic Ambulance Commanders to transfer patients from the scene into the appropriate medical facilities.

3.53 At the Operational level, the Forward Doctor(s) will coordinate and direct the clinical care provided at the Casualty Clearing Station (CCS) or equivalent. Where multiple Doctors are deployed at an incident, one Doctor will be appointed to the principle Forward Doctor role by the Medical Advisor to be their single point of contact.

3.54 No Doctor will deploy into the inner cordon or into the hot / warm zones of incidents without the express approval of the Tactical Commander and without passing through the entry control system (if established).

3.55 The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent. This competence must include specific knowledge and training in complex pre-hospital emergencies and the management of large casualty numbers (i.e. more than 20 patients).

3.56 The Medical Advisor attached to the Tactical Commander and the Forward Doctor(s) must have pre-hospital emergency experience. Further to that, both must have a good understanding of the following provisions (though they do not need to be qualified in them):

- JESIP
- NHS HART operations
- NHS MTA operations
- NHS CBRN operations
- NHS Mass Casualty capability and logistics
- Helicopter Emergency Medical Services (HEMS)
- NHS Ambulance Service critical care and advance Paramedic practice
- Toxic triage
- CBRN countermeasures
- Casualty decontamination procedures
- Pre-hospital analgesia
- Management of high velocity wounds and explosive injuries
- Submersion and hypothermia events
- Suspension trauma and crush injuries
- Recognition of life extinct in the forensic setting
- Management and onward distribution of over 200 casualties into the wider NHS
- NHS Ambulance Casualty Clearing Station (CasCS) logistics and capabilities

3.57 Personnel discharging the Medical Advisor role (attached to the Tactical Commander) and the Forward Doctor role must practice their functional role as 'player' during a relevant exercise every 12 months. This requirement can be substituted for reflective practice following attendance at a real emergency or operational incident.

LOGGIST

3.58 The maintenance of comprehensive decision logs is a critical part of Incident Management. Commanders are responsible for ensuring that all the decisions that they make are captured and recorded in an appropriate manner. This should include the actual decision taken, the rationale for such decisions and any actions outstanding as a result.



Where they are available, trained loggist's should be used to undertake this role.

OPERATIONAL COMMUNICATIONS ADVISOR

- 3.59** Where they exist, Operational Communications Advisors can provide reliable and consistent advice regarding the use of the emergency services digital radio system, and their advice should be sought.

They can facilitate the needs of the multi-agency responders during the initial planning phase of any event or operation, and during a spontaneous incident by providing operational and technical knowledge of all manner of communication systems including assisting in the development of a communications plan to ensure optimal use is made of available talk groups whilst remaining cognisant of coverage and capacity; they should be included in the response at the earliest opportunity.

FUNCTIONAL ROLES

- 3.60** In the early stages of a major incident the functional roles will need to be assigned to personnel (Trust employed) that are available at the scene to discharge them. However, their relative skills and experience must be considered by the Operational Commander before assigning those roles. The national action cards must be used by those appointed to these roles (or equivalent local action cards that are consistent with this specification). As soon as is reasonably practicable, the functional roles should be filled by personnel that have been trained to discharge them. This does not apply to the Decontamination Officer functional role which must only be discharged by trained and competent staff in the respective discipline.

- 3.61** The HART Team Leader functional role can only be discharged by a HART current and competent Team Leader who has previously qualified as a HART Operative.

- 3.62** Further roles are described in **ANNEX 4**, however this list is not exhaustive and other Functional Roles may be necessary dependent on the type and scale of the incident.

RECORD KEEPING AND LOGGING

- 3.63** There has been much emphasis on recording decisions following criticism directed at emergency services during high profile cases.
- 3.64** The incident log book is a record of the management and decision-making process for the specific command role from the onset of involvement of the incident, event or operation until its conclusion. This log will record the evolving process and provide a clear record of the causes and effects of any courses of action taken and communicated by the post holders.

The incident log book will form a definitive record of the post holder's role which they might have cause to rely on at a later date to justify their actions.

At the end of any incident, event or operation, the incident log book will be retained securely along with all other log books and associated records relating to the incident, event or operation in the appropriate Ambulance Service Archive store for a minimum of 25 years.

Commanders are responsible for the recording of all decisions that they make in relation to an incident in an appropriate command decision log. Logging is essential to facilitate operational debriefing, provide evidence for inquiries and identify lessons for the future.

3.65 Comprehensive logging should be made of all events, decisions (including those deferred and not taken) and the reasoning behind key decisions and actions taken.

NO ELBOW

E

Erasures

L

Leaves torn out of the log

B

Blank spaces

O

Overwriting

W

Writing above or below the lined area

3.66 Each organisation is responsible for maintaining and storing its own records and should be considerate of logging best practice when delivering or purchasing training in this skill.

3.67 Further guidance relating to record keeping can be found in:

- NHS England EPRR Framework
- NARU Incident Log Book
- Emergency Preparedness
- Emergency Response and Recovery, paragraphs 4.6.1 – 4.6.4
- Government Security
- Classifications April 2014

As soon as is reasonably practicable, the functional roles should be filled by personnel that have been trained to discharge them.



Command and Control

3



4.0 INCIDENT MANAGEMENT

AMBULANCE SERVICE STRATEGY

- 4.1** All major incidents that involve a multi-agency response and where an SCG is formed will have strategy in place. This will be developed by the Chair of the group but will be agreed by all partners. The multi-agency strategy will rarely offer specific organisational guidance to single agency Commanders. It will usually detail how the partners will work together to manage the incident in line with the JESIP Joint Doctrine.
- 4.2** The Ambulance Strategic Commander should produce a specific strategy for the Ambulance Service providing the guidance, parameters and justification for the Ambulance command structure to respond to the incident. An example can be found at **ANNEX 5**.
- 4.3** The strategy should be specific to a given incident and not generic, although some common themes will run through every strategy, such as the need to ensure the health, safety and welfare of responders.
- 4.4** The Strategic Commander may begin the development of the strategy on notification of the incident and they will build on it once further information and intelligence becomes available. The strategy should not be considered 'final' until the incident has closed. The strategy should be regularly reviewed throughout the incident, as a minimum at every meeting of the SCG.
- 4.5** In the development phase, the Commander should continually refer to the JDM (see Figure 3 on page 15) which will guide them through the points for consideration during the development of the strategy. The strategy must take account of the identified and anticipated risks identified during the threat and risk assessment process. Other drivers include the limitations and constraints of their own and others organisational and national policy, as well as the individual capability of the Commanders and other Ambulance resources, ensuring everyone remains within their scope of practice.
- 4.6** Whilst the strategy will provide objectives for the Incident Command and parameters for the Tactical Commander to work within, it should not be too constraining and prevent them from performing their role. The Tactical Commander should in fact be consulted on the development of the strategy, as they will add to the intelligence picture and can offer advice on the type of tactics which may be used.
- 4.7** The Strategic Commander sets the strategic intent and strategy and is ultimately accountable and responsible for its content and delivery. It is important that this strategy and associated decisions, including rationale, are written in the Commander's decision log.
- 4.8** The strategy should be in plain English to ensure it can be understood by all the relevant people (internally and externally). The use of overly technical terms and acronyms should be avoided wherever possible. The use of such terminology by the Emergency Services in their planning and management has been the subject of much criticism at public inquiries and inquests.
- 4.9** When issuing the strategy, a full and informative (though concise) briefing should be provided to the Tactical Commander to ensure the strategy

is understood, along with the parameters you are setting them to work within.

- 4.10** An example strategy can be found at **ANNEX 5** Ambulance Service Strategy and Health Service Strategy.

TACTICAL OPTIONS

- 4.11** The Tactical Plan will ideally be developed following receipt of the strategy from the Strategic Commander. However, due to the nature of incidents, it is unlikely that the Strategic Commander will be in place before the Tactical Commander.

- 4.12** Through the use of the JDM, the Tactical Commander will be able to identify the appropriate tactics to use in the management of the incident. This is a critical element of the cycle and the selection of the tactics will be reinforced by the fact due diligence should have been paid to the preceding factors of information, intelligence, threats, risks, policies and procedures.

- 4.13** Options and considerations will be dependent on the type and scale of incident presented. Other considerations will be existing pre-determined attendances, the environment within which the incident occurs, the number and types of casualties, and the capacity and capability of the resources available. Examples of tactical options include:

- The deployment of MTA (Marauding Terrorist Attack) responders wearing full tactical dress and ballistic protection into an active shooter incident.
- Where possible, the identification and use of separate hospitals for casualties from public order incidents.

- Deployment of CBRNE assets prior to an incident or event where there is an increased risk or evidence of a CBRNE occurrence.
- A dedicated command structure with appropriate support functions.
- The available Personal Protective Equipment (PPE) capabilities of the Ambulance Service can be found at **ANNEX 7** Ambulance Service Personal Protective Equipment Capabilities.

- 4.14** Communication of the Tactical Plan to the Operational Commander is essential. Briefings should follow a systematic method, such as the IIMARCH. An entry should be made in both the Operational and Tactical Commanders' logs that this briefing has taken place.

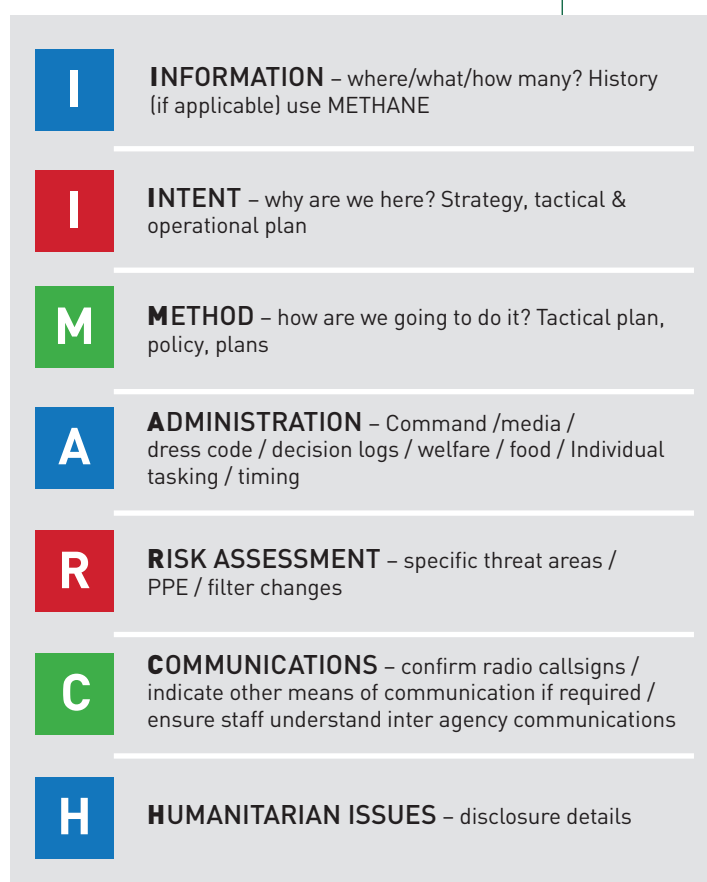


Figure 4 - IIMARCH Briefing Model





- 4.15** The Tactical Plan objectives should be recorded in a written command decision log. It is the Tactical Commander's responsibility to ensure that this takes place.

RISK IDENTIFICATION AND MANAGEMENT

- 4.16** Commanders need to identify and manage all the risks and hazards that pose a direct or indirect threat to the people under their command and those who may be affected by their

action or inaction (co-responders, patients and public). This is achieved through the application of recognised and documented risk assessments and the implementation of appropriate control measures. Not until this process has been completed can a decision be made on the tactics to be used.

- 4.17** The Dynamic Risk Assessment (DRA) (Figure 5) allows for a structured approach to risk management.

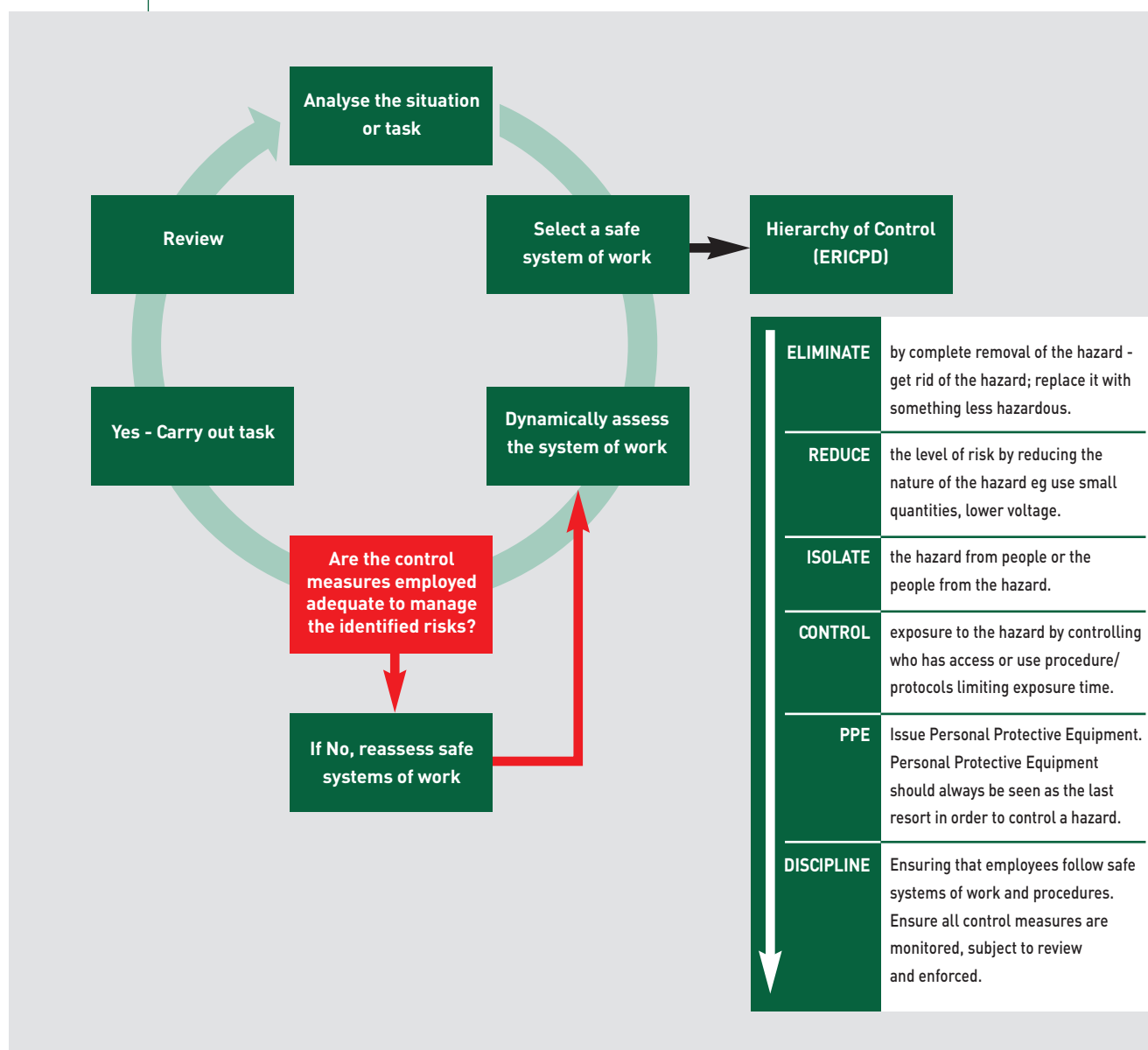


Figure 5 – Dynamic Risk Assessment / Hierarchy of Control

'ERICPD' continues as a hierarchy of risk control used by the emergency services in line with JESIP doctrine. However, the Health & Safety Executive and industry have moved to a variant called 'ESEAP' (Eliminate, Substitution, Engineering Controls, Administartion Controls, PPE), and a combined emergency service migration across to this model will follow in the future.

DYNAMIC RISK ASSESSMENT

● Analyse the Task

Step one of the risk assessment is to analyse the situation or task. Commanders will commence this process from the moment they are informed of the incident. This will take the form of analysing the information or intelligence, any identified hazards reported and knowledge of existing plans and procedures.

The intelligence picture will be further enhanced on arrival at the mobilisation point. Commanders will need to enhance their situational awareness. This will be achieved by considering the following:

- i. Available intelligence and information.
- ii. The type and nature of the incident and available resources (PDAs).
- iii. Incident specific plans and procedures (COMAH, CBRNE, Terrorist Attack).
- iv. Any significant hazards arising from the incident.
- v. The risks presented to:
 - The Ambulance Service Provider and NHS responders
 - Co-responders
 - The public

● Select a safe system of work

In order that Commanders can select a safe system of work they must review the available options in line with existing plans and

procedures. Selection of the appropriate course of action will be dependent on the availability of trained and competent resources and personnel. For example, to facilitate a decontamination response, a Commander must have available adequately trained CBRNE responders, PPE and individuals capable of erecting and operating decontamination showers.

● Dynamically assess the safe system of work

Once a Commander decides on a course of action they need to make judgement and assess whether or not the risks involved are adequately mitigated by the control measures employed.

● Are the control measures employed adequate to manage the identified risks?

The elimination or reduction of risks is the Commander's primary aim in the step towards ensuring responder safety. Where elimination or reduction are not possible then further control measures will need to be introduced.

● Yes, carry out task

Where appropriate mitigation and control measures exist then responders may be directed to carry out the identified task, but only through employment of the identified safe systems of work. This can only occur when:

- Appropriate command and operative briefings have taken place
- The identified control measures are in place
- Key roles have been allocated to appropriately trained individuals



- **Review and share**
The DRA is only effective if constantly reviewed. The incident will change and therefore so will the risks. Control measures may need to be increased or decreased; areas which were considered defensive tactically, may become offensive as the incident progresses and vice versa. The review also allows Commanders to reassess the systems of work and their appropriateness for the tasks in hand.

- 4.18** To assist in the risk identification and management process an Ambulance Safety Officer should be appointed. This should be an individual who has been given specific training to undertake this role. They will have responsibility for all Ambulance and NHS resources on site.

OPERATIONS AND RESOURCE MANAGEMENT

- 4.19** Initial identification of the incident and communication of this and the resource requirements will assist in mitigating the impact of the incident on the affected Ambulance Service Provider.
- 4.20** A universally accepted way of achieving this structured communication is through the use of a Sit-Rep (Situation Report). The mnemonic **M/ETHANE** is used throughout the Emergency Services.

The message should contain the following information:

M

MAJOR INCIDENT DECLARED OR STANDBY.

The person making the report should be explicit whether this is a major incident declaration or a standby in anticipation of the occurrence of a major incident.

E

EXACT LOCATION OF THE INCIDENT.

Where possible the grid reference or GPS coordinates should be included, along with any landmarks or iconic sites.

T

TYPE OF INCIDENT.

What is the exact nature of the incident? For example, a CBRNE incident, active shooter or road traffic collision?

H

HAZARDS.

What hazards are known to be present or those that could potentially manifest themselves?

A

ACCESS AND EGRESS.

What are the agreed or best routes to and from the scene, including any agreed blue routes and those which need to be avoided, including any pre-identified RVPs? For example, where a gas plume is present, information on avoiding this will be required.

N

NUMBER OF CASUALTIES.

How many casualties are there and if possible, what are the level and severity of injuries?

E

EMERGENCY SERVICES.

Which Emergency Services are present, and which are required? Include specialist resource request if known.

4.21 All incidents will offer their own challenges in terms of available resources; some will require large degrees of specialist resources, (for example CBRNE incidents may require significant numbers of decontamination practitioners, all of whom will probably come from the Ambulance Service Provider's core resource). Ambulance Service Providers will still be expected to maintain an appropriate response to core business as usual.

4.22 Early identification of the incident type, any hazards, numbers of casualties and resource requirements will assist the TACTICAL COMMANDER in planning for the resourcing of the incident. This is prevalent with the IOR operating model which emphasises early identification of potential high-risk incident. They will also ensure that a system is in place for the management of the resources.

4.23 The decision to request mutual aid should be taken by the Host Service's Strategic Commander, with support from the NILO / Tactical Advisor. The initial activation of Mutual Aid may, in extremis, be decided directly by the Strategic Commanders of the requesting (Host) Service and the Assisting Service(s), but further activity will be co-ordinated through the National Ambulance Coordinating Centre (NACC). All requests for mutual aid must include specific information pertaining to the level and types of resources required. For further information, please refer to Mutual Aid Memorandum of Understanding.

4.24 The Strategic Commander facilitates any requests for external agency assistance through the SCG where possible. Where a Strategic Commander decides to manage an incident from within Ambulance Service, then a Strategic Liaison Manager will attend the SCG as

the Strategic Commander's nominated deputy with specific delegated authority.

4.25 The Tactical Commander will make requests to the Strategic Commander for additional or specialist resources; where more than one scene exists (multi-sited incident) then the Strategic Commander will make the decision as to where to best use the available resources. In the absence of the Strategic Commander the decision will be taken by the Tactical Commander.

4.26 Ambulance Services employ a variety of resources in response to incidents. Some are specialists such as clinical decontamination. These all work alongside core Ambulance resources.

COMMUNICATIONS INTEROPERABILITY

4.27 Interoperability voice communications is the ability to operate and communicate with other agencies in the event of a multi-sited incident or in the absence of a TCG.

4.28 Interoperability will improve communications between Emergency Services and appropriate partners helping to inform decision-making through greater understanding of the incident and improved situational awareness.

4.29 The use of interoperability voice communications through the digital radio system should not replace face to face meetings between Commanders but complement them.

4.30 The request for interoperable voice communications will be made in line with locally agreed plans and SOPs for requesting Multi-Agency Interoperability.

Suitable qualified communications advisors should be consulted to



develop a communications plan for the incident at the earliest opportunity.

COMMAND BRIEFING

- 4.31** Briefing of the command team and staff is an important aspect of command. The IIMARCH model can be used for this, it is the first opportunity that the Commander will have to deliver their plan with subsequent rationale and decisions to those who are expected to carry out the orders.
- 4.32** The briefing should be a two-way process where Commanders welcome questions and feedback; this will allow the Commander to ensure that the plan has not only been received, but also understood and assimilated by those that have received it.
- 4.33** Where necessary, Commanders should ensure specialists or individuals who can add value to the briefing are included within it.
- 4.34** If a face to face briefing is not possible then additional methods can be employed. For example, written briefs, telephone or radio communication, or video conferencing. Commanders should be cognisant of relevant protective markings or sensitivity of information when choosing a briefing route and that all notes and logs made before, during and after briefings may be disclosable.
- 4.35** Regardless of the method used, a full and accurate record of the brief should be made and retained as part of the command decision log; including who delivered the brief, who received it, the date, time and location. This should be repeated for all subsequent briefings and updates.

INFORMATION SHARING

- 4.36** Information sharing is a crucial element of civil protection work that underpins all forms of cooperation. Information should be shared formally and as part of a culture. Ambulance Service Providers should consider it good practice as well as their duty to share information with other responders. Procedures are set out in the regulations to formally request information from other responders. The use of interoperability talk groups and agreed critical message structures in the form of pre agreed situation reports (SITREPS) given at regular intervals will aid the information sharing process and assist in the joint understanding of risk and shared situational awareness.
- 4.37** The initial presumption is that all information should be shared, with the exception of sensitive information which includes:
- Information prejudicial to national security
 - Information prejudicial to public safety
 - Commercially sensitive information
- 4.38** Ambulance Service Providers should have arrangements in place to mark, store, handle and transfer sensitive information (including transfer by electronic means). Ambulance Service Providers shall have regard to Government Security Classifications and any information sharing protocols of their LRFs.
- Effective information sharing can only take place if partnerships between responders are embraced. This underlines the importance of Ambulance Commanders ensuring that they are fully engaged with their partner responders at all the relevant levels through the Strategic and Tactical Coordinating Groups, and at the operational front end.

AMBULANCE SERVICE COMMAND AND CONTROL IN RESPONSE TO A TERRORIST ATTACK

4.39 The threat of a Terrorist Attack within the UK is determined by the security services.

Threat levels are produced by the security services, the current threat level is available at the following:
<https://www.mi5.gov.uk/threat-levels>

Threat levels are designed to give a broad indication of the likelihood of a terrorist attack.

| UK THREAT LEVEL | |
|-----------------|--|
| CRITICAL | An attack is expected imminently. |
| SEVERE | An attack is highly likely. |
| SUBSTANTIAL | An attack is a strong possibility. |
| MODERATE | An attack is possible, but not likely. |
| LOW | An attack is unlikely. |

Commanders must be aware of the current threat level and its meaning, including any special measures to be implemented by the Trust.

4.40 The Ambulance Service Response to a terrorist attack will be determined by the attack methodology and threat. A terrorist attack may involve the following attack methodologies;

- Bladed weapons
- Vehicle as a weapon
- Deliberate use of fire as a weapon
- Use of Improvised Explosive Devices (IED's) / grenades – vehicle or person borne
- Firearms (including a Marauding Terrorist Firearms Attack)
- Siege; including the taking of hostages to prolong an attack or impede rescue operations.
- The use of chemicals, e.g. acid or alkali, to cause death or injury
- Chemical Biological Radiological Nuclear

The above examples are not exhaustive, and an attack may involve more than one attack methodology.

4.41 Specific Emergency Service Joint Operating Principles (JOPS) have been developed to enable the emergency services to respond to a terrorist attack. These documents are available via individual Trust emergency preparedness departments. They are all built around the foundation of the JESIP principles.

Ambulance commanders, advisors and NILOs must have a thorough knowledge of the Joint Operating Principles and the capabilities of specialist and non-specialist ambulance responders.

Command and control arrangements for the Ambulance Service in response to a terrorist attack will be based upon the Command Guidance, JESIP and the JOPs. It is essential that the Ambulance Commanders at all levels of command are flexible, adaptable and demonstrate clear



leadership in response to a Terrorist Attack. An attack may be simple or complex in nature, however all attacks will require effective command and control to ensure that lives are saved and staff deployed appropriately and safely. Some attack methodologies will require command and control and decision making to be implemented in a greater capacity by on scene commanders, with a focus upon rapid deployment of responders in order to save life. Dependent on attack methodology there will be significant pressure placed upon commanders to assess information rapidly in order to make effective decisions, which must be communicated clearly and concisely.

POST INCIDENT PROCEDURES

4.42 A post incident debrief is a critical part of the incident life-cycle. It is normally the only recognised and structured opportunity the organisation will have to learn from an incident in respect of how their employees responded and acted, and how their policies and procedures stood up to the task.

4.43 The debriefing process can begin as soon as the first resources begin to leave the incident (the hot debrief phase); although dependent on the scale of the incident and the resources allocated, there may be a formal debrief at a later stage.

4.44 The debrief process will allow the organisation to:

- Address any identified health and safety issues
- Evaluate the effectiveness of policies and procedures
- Evaluate organisation, team and individual performance
- Identify training needs and improve training accordingly
- Demonstrate an auditable approach to incident management

4.45 Tactical Commanders must ensure that debriefs take place for all Ambulance personnel directly involved in the incident. Although they may not physically be able to do this themselves, they must ensure a process is in place for the capture of all lessons from Ambulance and, where appropriate, NHS staff; this may include debriefs by external facilitators.

4.46 In addition to an operational debrief, there should be a process for psychological debriefing, as the post incident debrief process is not in itself a welfare tool for managing staff welfare issues; however, these may become apparent throughout the debrief process. Where this is the case, then welfare arrangements need to be put in place. Support may also be required for staff not involved directly with the incident but who are affected psychologically by its impact (injury or death of a colleague).

4.47 All information recorded during the post incident process may also be disclosable.

4.48 Joint Organisational Learning (JOL) Online platform should be used to record any multi-agency lessons identified as part of the debriefing process.

5.0 COMPETENCIES AND TRAINING

NATIONAL OCCUPATIONAL STANDARDS (NOS)

- 5.1** National Occupational Standards are the mandatory system used to define what is expected of competent individuals. Ambulance Service Providers must provide those people who are expected to undertake a command role, with the training and exercise opportunities that are relevant to the role they will be performing.

Strategic

Strategic Commanders are to maintain their competencies as described in this framework. They must ensure that through personal development reviews, commanders under their responsibility are maintaining their competence portfolios and are attending learning events/training as described in the framework and Standards for NHS Ambulance Service Command & Control, and as appropriate providing release from normal duties to attend such events.

All Commanders

Accountable for ensuring their own continued professional development. As detailed in the framework, attending national, regional and local courses as required and supporting learning with practical experience of command e.g. exercises.

- 5.2** NOS are used as tools to assist in recruitment, appraisal, job evaluation and development of individuals, teams and organisations, they ensure that all personnel are aware of their own role and what they need to be able to perform it in a competent manner. They allow for easy reference for team composition, task allocation and can provide organisations with defence when competence is questioned. Tactical,

Operational and Functional roles where appropriate can use their compliance with NOS usefully if called to account for their skills.

- 5.3** Increasingly, in a litigious society, it might prove useful to be able to claim compliance with nationally recognised standards. NOS provide a framework for development and assessment.

- 5.4** There are three main types of training within the workplace designed to meet an individual's development needs:

- Continual Professional Development (CPD)
- Progression
- New Roles: expansion or change

- 5.5** In all these cases, National Occupational Standards accurately define and underpin roles and their desired outcomes.

AMBULANCE COMMANDERS CONTINUAL PROFESSIONAL DEVELOPMENT

- 5.6** Skills for Justice have provided the first rung to a consistent approach to Ambulance Service Command Development. In 2011 the Association of Ambulance Chief Executives (AACE) approved that these should be formalised into an Ambulance Commander NOS to be adopted by each Ambulance Service Provider. It was recommended Ambulance Services agree the principles of CPD, utilising the evidence record developed by NWS (ANNEX 9) which allows individuals to maintain a personal portfolio of evidence against each of the NOS applicable to their command level. Evidence is only valid on the last two years.





5.7 Every Ambulance Commander must be given the opportunity to undertake the NOS through their organisation embedding a consistent approach to the management of incidents that require a command structure.

5.8 In complement to the National Commander Guidance there is a National Commander Continual Professional Development Portfolio. The CPD Portfolio will be issued to Operational, Tactical and Strategic Commanders, together with the Tactical Advisor.

5.9 Following initial completion of the Portfolio evidence requirements, each Commander will have responsibility for undertaking continuing education within the command field, enough to demonstrate their knowledge on a recurring 24-month cycle.

5.10 A cycle of ongoing education will help Commanders to develop a better understanding of incident

management and enhance skills required to meet the challenges of special or major incidents. NHS Ambulance Trusts supported by NARU, should undertake an audit annually to ensure compliance with the Ambulance Commander NOS; this monitoring process will provide opportunities for sharing of best practice, skill practice and critique.

5.11 An additional benefit of the NOS lies with succession planning. Those individuals who aspire to take on command roles will, for the first time, have a set of standards to work towards in order to be prepared when the opportunity to progress arises.

5.12 Both the NOS and CPD sections above imply improvement in resilience of both organisational command and national structures when an organisation carries out their responsibility for providing development opportunities required by individuals.

THE SUITE OF STANDARDS

Strategic Commander

5.13 The following represents the suite of standards that a Strategic Commander is required to achieve. There are 9 mandatory standards and 6 optional ones:

Strategic Commander Mandatory Suite of Standards



Figure 6 – Strategic Commander Mandatory Suite of Standards

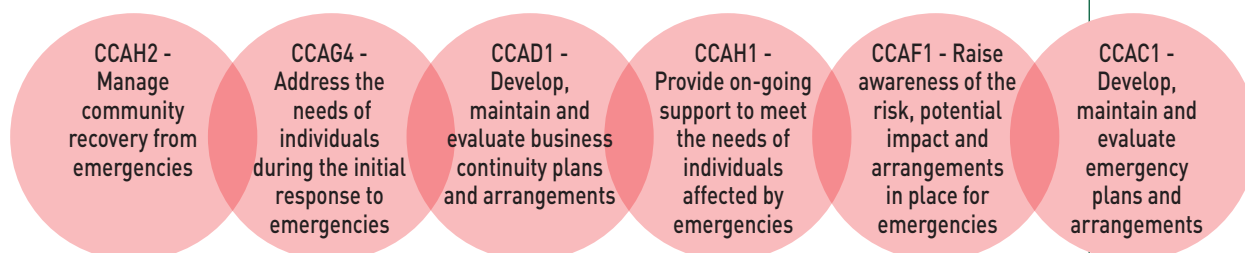


Figure 7 – Strategic Commander Optional Standards



Tactical Commander

5.14 Working at the tactical level, the Tactical Commander suite contains 8 mandatory and 6 optional standards. The Tactical Commander must demonstrate competence against the standards through the completion of their CPD.

Tactical Commander Mandatory Suite of Standards



Figure 8 – Tactical Commander Mandatory Suite of Standards

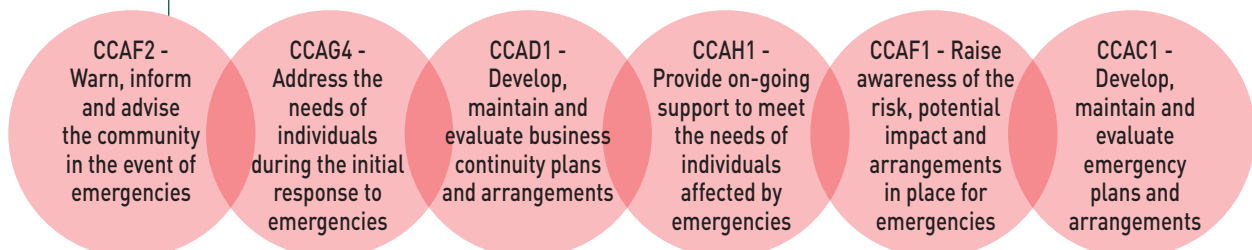


Figure 9 – Tactical Commander Optional Standards

Operational Commander

5.15 The Operational Commander suite contains 7 mandatory standards and 4 optional ones. The Operational Commander must demonstrate competence against the standards through the completion of their CPD.

Operational Commander Mandatory Suite of Standards

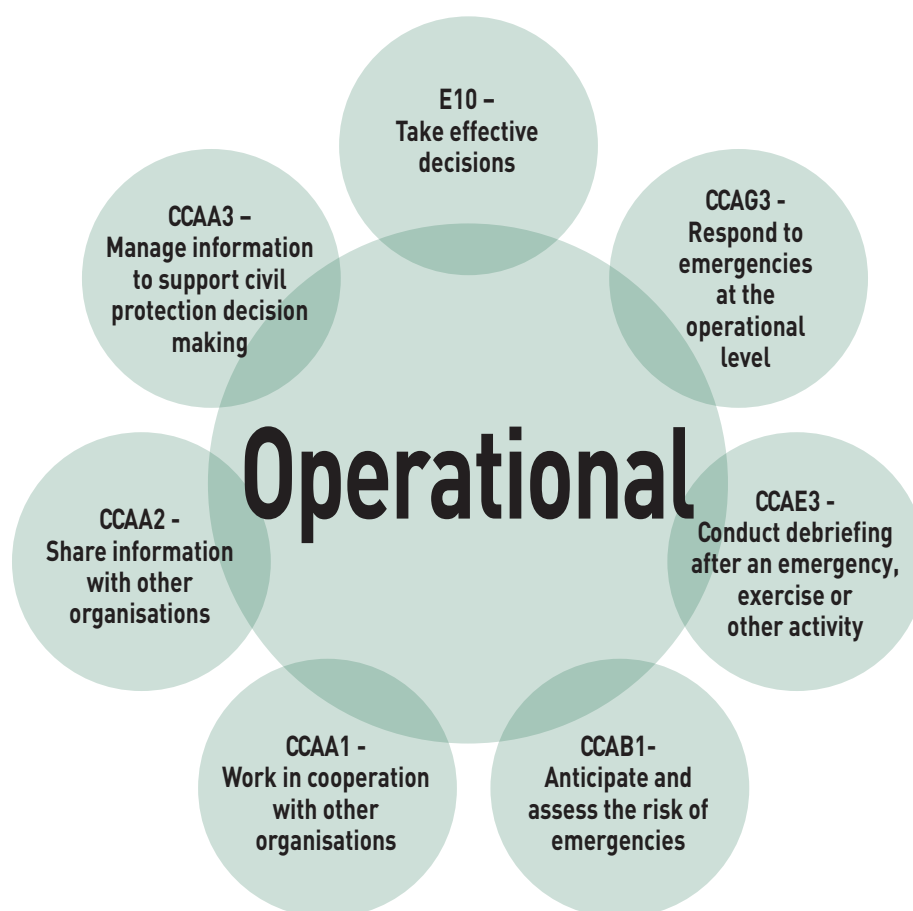


Figure 10 – Operational Commander Mandatory Suite of Standards

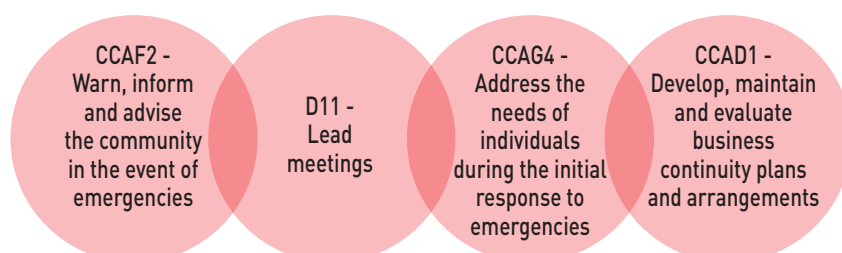



Figure 11 – Operational Commander Optional Standards





A suite of Command Assessment Tools have been developed and maintained by NARU. Current and up to date versions are available on www.Naru.org/Resources/Online

<https://naru.org.uk/document-category/naru-publications/>



**National e-Skills
Assessment**

NARU

NARU

Assessment Tool

| Description | Comments | Initials |
|---|----------|----------|
| <p>ICSP</p> <p>➤ Have they ensured an location of interfaith communication and adherence to ICSP?</p> | | |
| <p>➤ Have appropriate support been reported to ICSP officers, FIVE dependent on incident type</p> | | |
| <p>➤ Have appropriate questions been asked at ICSP</p> | | |
| <p>➤ Are they able to clear the ICSP if required</p> | | |
| <p>EDUCATIONAL ISSUES</p> | | |
| <p>➤ Have legal liabilities (including the duty of care) and potential safeguarding issues sufficiently covered</p> | | |
| <p>➤ Have the Islamic regulations been considered and agreed</p> | | |
| <p>➤ Have there been suitable engagement with the media – Muslim outreach</p> | | |
| <p>➤ Have they considered recovery (looking at IPV welfare)</p> | | |

Skill Education Centre Combined Response Assessment Tool – Version 1.0

DocId_34040000

www.skillseducationcentre.org.uk

[illegible][illegible][illegible][illegible]

Competencies and Training

ANNEX 1

STRATEGIC COMMANDER:

COMMAND AND CONTROL ROLES, PERFORMANCE CRITERIA AND RESPONSIBILITIES

The Strategic Commanders' responsibilities in line with their National Occupational Standard performance criteria are:

- | | |
|---|---|
| <ul style="list-style-type: none"> a) Obtain and analyse the available relevant information to inform decision making. b) Make effective decisions based on the best available information. c) Agree the policy and strategic framework within which the tactical level will work and ensure effective two-way communication with the tactical level. d) Work effectively in cooperation with partner organisations at a strategic level. e) Confirm strategic decisions agreed with responders and how these will be implemented. f) Take action to review the strategy, updating or varying the strategy in response to changing situations or information. g) Obtain and provide technical/ professional advice from suitable sources to inform decision-making where required. h) Ensure the strategy reflects any relevant policy, legal framework or protocols. i) Ensure the strategy takes account of the impact on individuals, communities and the environment. j) Engage effectively in the political decision-making process. | <ul style="list-style-type: none"> k) Review the scale of required resources and ensure their availability. l) Ensure that all relevant organisations have sufficient and accurate information with a suitable degree of urgency to enable effective coordination of response. m) Ensure the development and implementation of an effective communications strategy. n) Address medium and long-term priorities to facilitate the recovery of affected communities. o) Ensure provision of continued support for individuals affected by emergencies. p) Ensure effective delegation to the tactical level. q) Evaluate the effectiveness of the strategy and use this information to inform future practice. r) Fully record your decisions, actions, options and rationale in accordance with current information, policy and legislation. s) Ensure all Tactical Commanders are subject to a hot debrief. t) Provide a public relations link with the wider community. u) Follow any action cards specific to the Tactical Commander role as issued by the host Ambulance Service Provider. |
|---|---|



ANNEX 2

TACTICAL COMMANDER:

COMMAND AND CONTROL ROLES, PERFORMANCE CRITERIA AND RESPONSIBILITIES

The Tactical Commanders' responsibilities in line with their National Occupational Standard performance criteria are:

- a) Obtain sufficient information to determine the current status of the response. This should include ensuring that a detailed and formal handover is received from the acting Tactical Commander, and that the whole command chain is aware that such a handover has taken place and appropriate log entries are made.
- b) Formulate a Tactical Plan and Casualty Management Plan which takes account of all available information, including any pre-determined emergency plans, and anticipated risks.
- c) Implement tactics in a timely manner, confirming roles, responsibilities, tasks, and communication channels.
- d) Conduct on-going risk assessment and management in response to the dynamic nature of emergencies.
- e) Review tactics with relevant others including key personnel involved in command, control and coordination.
- f) Ensure actions to implement tactics are carried out, taking into account the impact on individuals, communities and the environment.
- g) Determine priorities for allocating available resources.
- h) Anticipate likely future resource needs, taking account of the possible escalation of emergencies.
- i) Work in cooperation and communicate effectively with other responders.
- j) Liaise with relevant organisations to address the longer-term priorities of restoring essential services and helping to facilitate the recovery of affected communities.
- k) Obtain and provide technical and professional advice from suitable sources to inform decision-making where required.
- l) Provide accurate and timely information to inform and protect communities, working with the media where relevant.
- m) Monitor and maintain the health, safety and welfare of individuals during the response.
- n) Review actions taken at operational level.
- o) Identify where circumstances warrant a strategic level of management and engage with the strategic level as required.
- p) Ensure that any individuals under your area of authority are fully briefed and debriefed.
- q) Evaluate the effectiveness of tactics and use this information to inform future practice.
- r) Fully record your decisions, actions, options and rationale in accordance with current information, policy and legislation.
- s) Ensure engagement with multi-agency responders, providing a joined up and proportionate response.
- t) Request digital radio interoperability where appropriate.

- u) Ensure appropriate control measures are employed to manage all identified risks, reviewing and updating logs and risk assessments as appropriate.
- v) Follow any action cards specific to the Tactical Commander role as issued by the host Ambulance Service Provider.



ANNEX 3

OPERATIONAL COMMANDER:

COMMAND AND CONTROL ROLES, PERFORMANCE CRITERIA AND RESPONSIBILITIES

The Operational Commanders' responsibilities in line with their National Occupational Standard performance criteria are:

- a) Make an initial assessment of the situation and report this to other responders in accordance with established procedures.
- b) Ensure a METHANE message is communicated to the relevant Emergency Operations Centre (EOC).
- c) Prepare and implement an initial plan of action.
- d) Ensure actions are carried out, considering the impact on individuals, communities and the environment.
- e) Conduct on-going risk assessment and management in response to the dynamic nature of emergencies.
- f) Work in cooperation and communicate effectively with other responders.
- g) Confirm the availability and location of relevant services and facilities.
- h) Identify any resources required and deploy them to meet the demands of the response.
- i) Ensure the establishment of the functional roles required to manage the incident and that appropriately trained individuals undertake each role.
- j) Communicate any resource constraints to the relevant person or find suitable alternatives.
- k) Monitor and protect the health, safety and welfare of individuals during the response.
- l) Deal with individuals in a manner which is supportive and sensitive to their needs.
- m) Liaise with relevant organisations as required for an effective response.
- n) Identify where circumstances warrant a tactical level of management and engage with the tactical level as required.
- o) Implement the Tactical Plan and Casualty Management Plan where applicable, within a geographical area or functional area of responsibility.
- p) Ensure that any individuals under your area of authority are fully briefed and debriefed.
- q) Fully record your decisions, actions, options and rationale in accordance with current information, policy and legislation.
- r) Follow any action cards specific to the Operational role as issued by the host Ambulance Service Provider.

ANNEX 4

FUNCTIONAL ROLES

● Ambulance - Safety Officer

Responsible for the health and safety of all NHS responders entering and working within the cordons of the incident. The Ambulance Safety Officer will work closely with the Operational Commander ensuring appropriate control measures are employed to mitigate against identified risks through the risk assessment process. The Safety Officer should, where possible, work alongside the Safety Officers of the other agencies.

● Ambulance - Primary Triage Officer

Responsible for coordinating the initial (SIEVE) triage of all casualties at the incident. The Triage Officer should work closely with the Casualty Clearing Officer (CCO). Dependent on the size of the incident, there may be a requirement to allocate an Officer for Primary and Secondary triage. The Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged.

● Ambulance - Casualty Clearing Officer (CCO)

Responsible for the management of the Casualty Clearing Station (CCS), they work closely with the Triage, Parking and Loading Officers and the Forward Medical Advisor (FMA) to ensure an efficient triage and treatment of all casualties, and the appropriate use of available transport resources. The CCO is responsible for keeping a log of the number and categories of casualties who pass through the CCS.

● Ambulance - Secondary Triage Officer

Responsible for coordinating the secondary (SORT) triage of all casualties within the Casualty Clearing Station (CCS). The Triage

Officer should work closely with the Casualty Clearing Officer (CCO) and Medical Advisor. The Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged and the regular re-triage of patients (at least every 15 minutes).

● Casualty Loading Officer

The Loading Officer works very closely with the Casualty Clearing Officer (CCO) to ensure that casualties who require transportation from the CCS are accommodated. The Loading Officer is responsible for keeping a log of the number and destinations of casualties transported from the CCS.

● Ambulance - Equipment Officer

The Equipment Officer will ensure the supply and re-supply of equipment to all responding NHS resources.

● Ambulance - Patient Liaison Officer

Responsible for communicating agreed messages to groups of patients. They will liaise with the Ambulance Command team to ensure consistent messages are relayed.

● Hospital Ambulance Liaison Officer (HALO)

Assists at A&E Departments to maintain efficient ambulance turnaround and re-equipping of ambulances. They will also liaise with the police documentation teams. An important role is to arrange relief for members of staff suffering from fatigue or stress on arrival at the hospital. The Hospital Ambulance Liaison Officer (HALO) will liaise with the Hospital Management Team to ensure it is aware of the hospital's capability to





receive casualties and relay information back to the Emergency Operations Centre. This officer's job is to also keep RCC updated with the current status of the hospital's Resus Bays, Theatres and ITU.

The HALO role will be subject to command resource availability and may not be available to all receiving hospitals.

- **Hazardous Area Response Team Leader (HART)**
The HART Team Leader will provide direct line management for all HART resources; they will report through to the Operational Commander ensuring they carry out the objectives of the Ambulance Service response in line with the Tactical Plan.
- **Casualty Clearing Station Medical Lead (CCSML)**
Responsible for coordinating, supporting and advising paramedics and medical staff in the Casualty Clearing Station (CCS) to maximise the clinical care of all patients attending the CCS and appropriate onward journeys to specialist receiving hospitals.
- **Ambulance - Forward Doctor**
Responsible for ensuring the most appropriate medical management of patients is undertaken within the area they are designated to (CCS or incident ground). Working closely with the Medical Advisor and Operational Commander and ensuring appropriate records are maintained for patients.

SUPPORT ROLES

- **Ambulance – Loggist**
Responsible for capturing key information and decision making made by the ambulance command team during an incident.
- **Ambulance - Communications Officer**
Responsibilities include the provision of robust communications at the scene of the incident. This may include the deployment of any mobile control units where available.
- **Ambulance - Decontamination Officer**
Where casualties require decontamination, a Decontamination Officer will be nominated to manage that facility. This will also require the appointment of a suitably trained individual to undertake the Entry Control Officer role (ECO).
- **Ambulance - Media Liaison Officer**
All incidents have the ability to attract media interest. The Media Liaison Officer will develop and coordinate the release of Ambulance Service Provider media statements. This will often be achieved in a multi-agency setting; however, it should always be done in line with the Ambulance Service Provider Strategy.
- **National Ambulance Coordination Centre (NACC)**
The NACC is hosted by West Midlands Ambulance Service and is facilitated by NARU Duty Officers. The NACC Plan identifies key objectives and benefits of this facility. The NACC is to provide the focal point for the collection, collation and assessment of data regarding all Ambulance Service Providers in the UK; specifically, their ability to provide mutual aid if called upon to do so.

ANNEX 5

AMBULANCE SERVICE STRATEGY

AMBULANCE SERVICE STRATEGY

It is the intention of the Ambulance Service Provider to respond to and manage the ongoing incident in a way which promotes and saves life, reduces humanitarian suffering and is compatible with the vision and values of the Ambulance Service Provider. Through effective coordination, sound planning and good leadership the Strategic Commander will:

1. Maintain public confidence and minimise the impact of the incident by ensuring that the Ambulance Service Provider is responding effectively to the incident.
2. Ensure that the Ambulance Service Provider response is coordinated and integrated with the wider health and responding agencies.
3. Maintain effective capacity management within the Emergency and Non-Emergency Service, and the Emergency Control Rooms, by:
 - a. Assessing and identifying any gaps in the response capability of the organisation for dealing with this incident.
 - b. Identification and request for mutual aid.
4. So far as is reasonably practicable, take all measures and employ all appropriately identified control measures to safeguard the following people under the terms of Health and Safety Legislation:

Ambulance staff and other responders
Local communities

5. Ensure public messages are coordinated with other agencies and partners.
6. Ensure effective Business Continuity and Recovery arrangements are in place across the organisation and review where necessary.
7. Provide support and representation at the sub-regional level where appropriate.
8. Create and maintain a well documented, auditable plan and decision log for the incident at all levels of command.
9. Review this strategy every 4 hours.

Signature

(STRATEGIC COMMANDER)

Date:

Time:





HEALTH STRATEGY

HEALTH STRATEGY

Aim

To ensure that the NHS in England provides a robust, integrated response to the emerging situation

Objectives

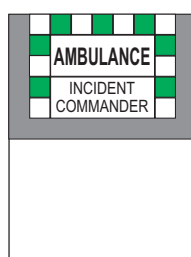
1. Saving and protecting human life
2. Relieving suffering
3. Containing the emergency – limiting its escalation or spread
4. Maintain, where possible, critical services
5. Protecting the health and safety of patients and NHS personnel
6. Providing patients and the public with information
7. Promoting self-help and recovery
8. Restoring normality as soon as possible
9. Facilitating investigations and inquires
10. Evaluating the response and identification of lessons

ANNEX 6

COMMAND TABARDS

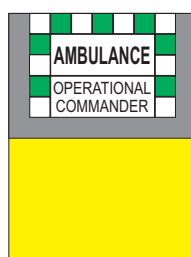
Tactical Commander (Ambulance Incident Commander)

White lower half with green & white checked shoulders.



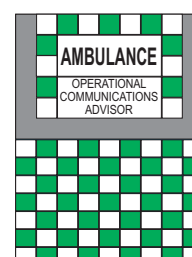
Ambulance Operational Commander and any functional role not individually listed

Yellow lower half and green & white checked shoulders.
Insert as per role.



Operational Communications Advisor

Green & white check.



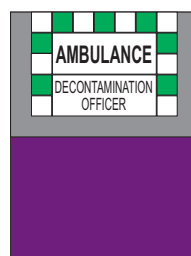
Ambulance Safety Officer (ASO)

Blue lower half with green & white checked shoulders.



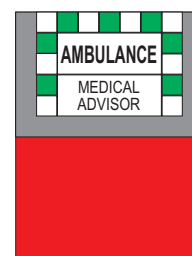
Decontamination Officer

Purple lower half with green & white checked shoulders.



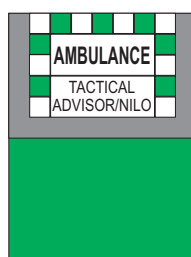
Doctor

Red lower half with green & white checked shoulders.



Strategic Advisor, Tactical Advisor or National Inter-Agency Liaison Officer (NILO)

Green lower half with green & white checked shoulders.
Insert as per role.



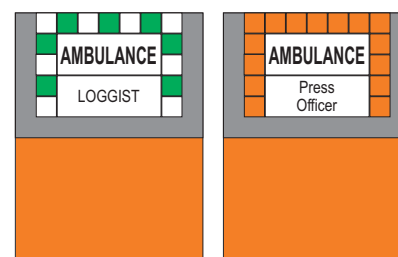
Ambulance Entry Control Officer (ECO)

Green & yellow all over check.



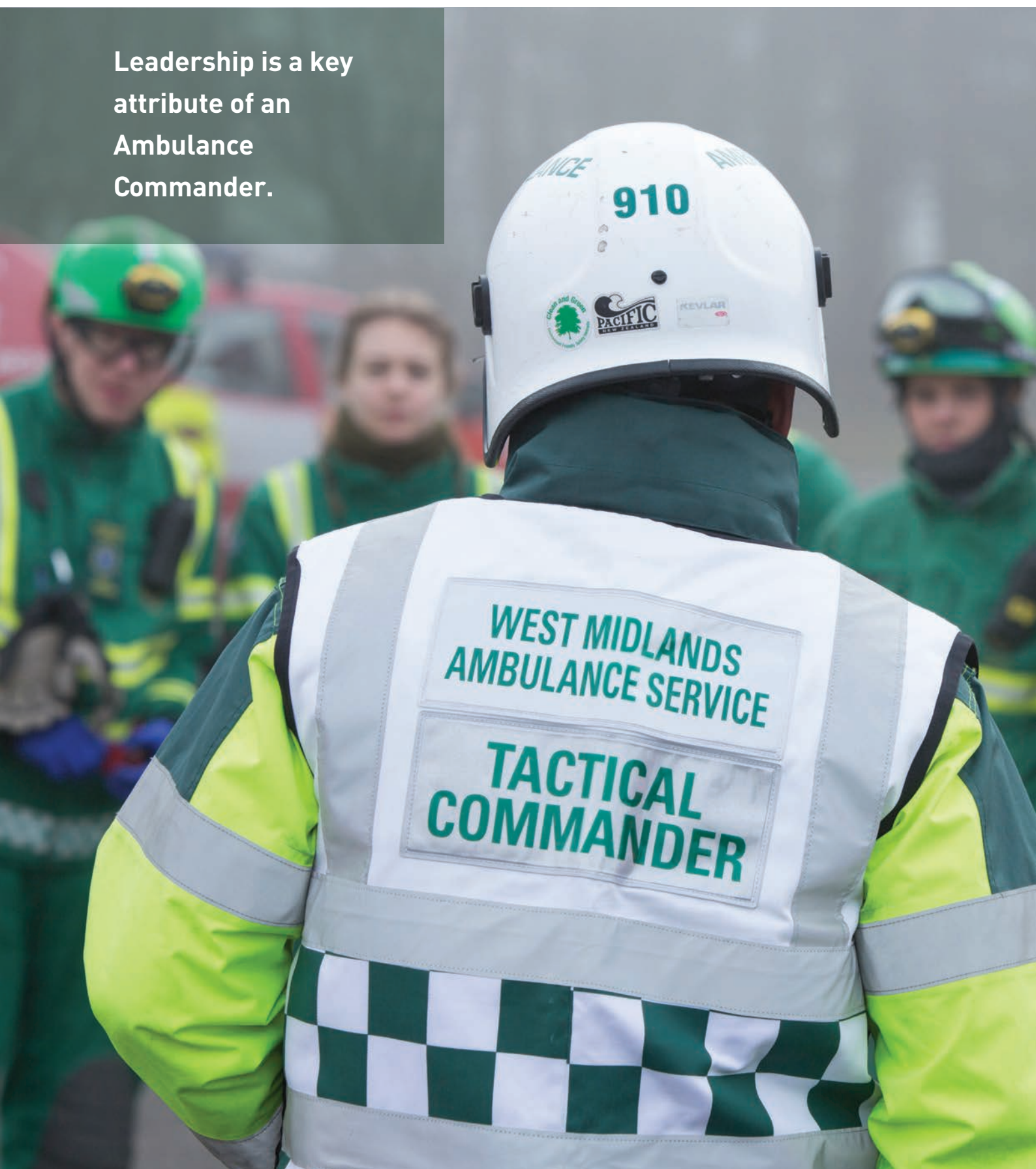
Loggist

Orange lower half and green & white checked shoulders. All orange is any support function.





Leadership is a key
attribute of an
Ambulance
Commander.



ANNEX 7

AMBULANCE SERVICE PERSONAL PROTECTIVE EQUIPMENT CAPABILITIES



Standard Ambulance Uniform



Standard Ambulance PPE



Hazardous Area Response Team Incident Ground PPE



Ballistic PPE



Quickdon PPE



Extended Duration Breathing Apparatus (EDBA) PPE



Gas Tight Suit & Extended Duration Breathing Apparatus (EDBA) PPE
Training suit displayed



Powered Respirator Protective Suit (PRPS) PPE
Training suit displayed



Safe Working at Height/Confined Space/Unstable Terrain PPE



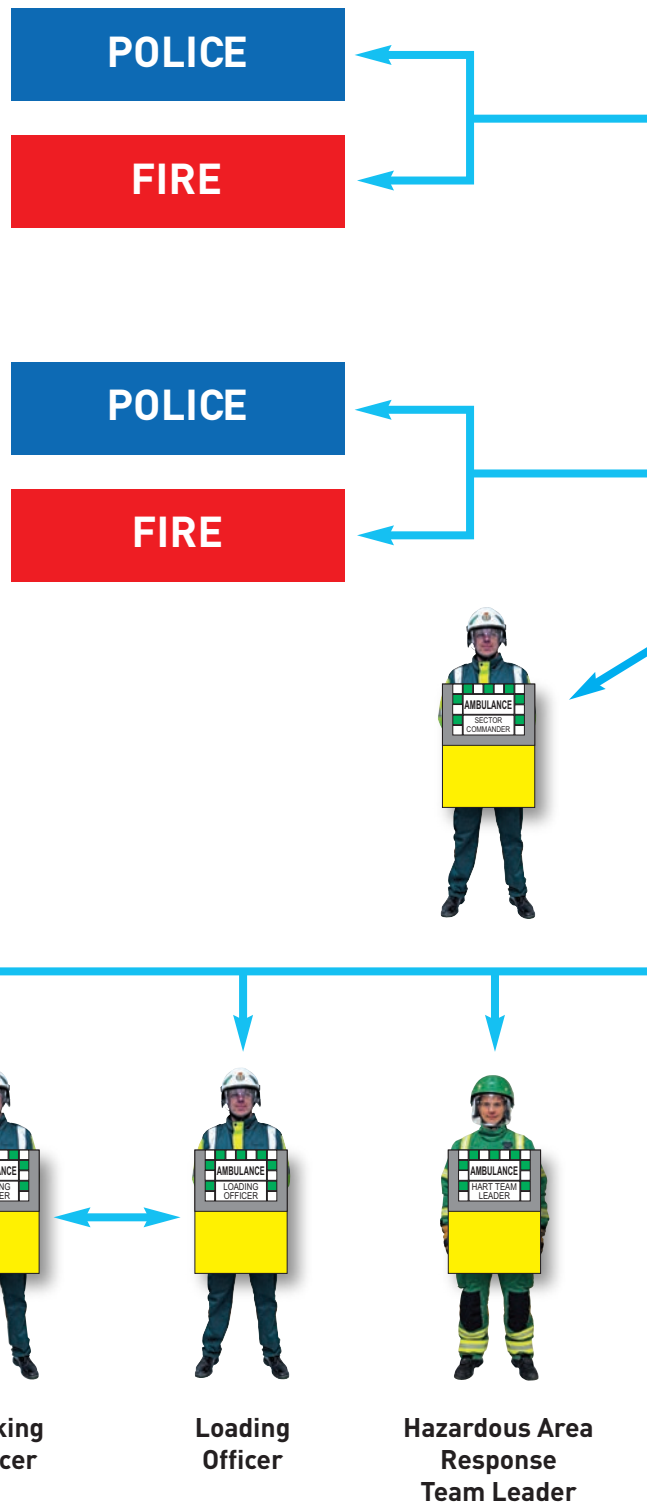
Water Operations PPE

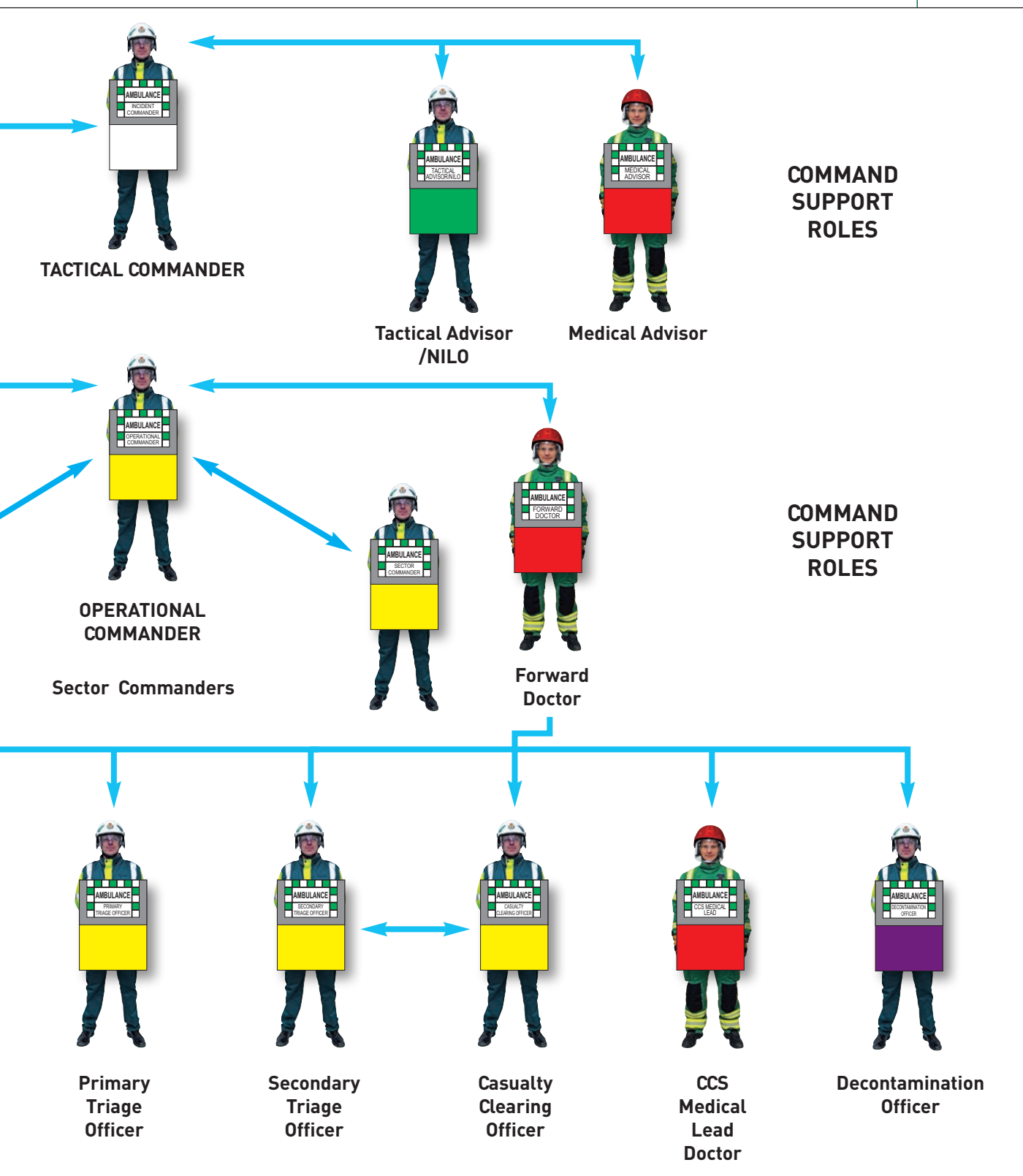


ANNEX 8

MODEL COMMAND STRUCTURE

Span of command needs to recognise that whilst numerous individuals will provide functional command to the Operational Commander, (such as Parking Officer and Equipment Officer) it is unlikely that all would be required at all incidents but the Operational Commander must not be overloaded.







ANNEX 9

NOS CPD Evidence Record

Screenshot illustrating the 'Introduction' tab within the document.

Screenshot illustrating the 'Evidence' tab within the document.

| NOS | Progress |
|-------|----------|
| CCAA1 | 0% |
| CCAA2 | 0% |
| CCAB1 | 0% |
| E10 | 0% |

ANNEX 10

AMBULANCE TACTICAL PLAN TEMPLATE



**National Ambulance
Resilience Unit
NARU**

NARU EDUCATION CENTRE TEMPLATE

Tactical Plan Template

This tactical plan template has been designed to assist tactical commanders in the development and delivery of a tactical plan in response to an incident. It is not exhaustive and should be treated as a guide. The plan will be developed and revised as the incident progresses, and will be informed by the JESIP Joint Decision Model (JDM). The tactical plan should be briefed across the command structure and when handing over using IIMARCH.

Using CSCATTT will enable the key principles for incident response to be followed in the tactical plan and [reference page 14 NARU Command and Control Guidance section 3.8] will aid the development of this plan.

This template is a guide and must not restrict commanders in their planning, thinking or decision making in order to resolve the incident.

Joint Emergency Services Interoperability Principles (JESIP) and the JDM are fundamental to the development and delivery of the tactical plan.

WHAT IS YOUR KEY OBJECTIVE:

COMMAND AND CONTROL

Command structure,
chain of command

Assigned roles

Functions

Locations

NILO / Tactical Advisor

(confirmation or implementation
of the above)

[illegible]

Tactical Plan Template

TEMPLATE

NARU Education Centre Tactical Plan Template, Version 1.1 April 2019
@NARU Education

www.narueducationcentre.org.uk



ANNEX 10

A10





SAFETY
UNDERSTAND RISK

Ensuring safety of responders and patients with specific roles and considerations added depending on incident type. eg flooding, MTFA

Confirmation of regular Dynamic Risk Assessment (DRA) using ERICPD

Assigned safety roles

COMMUNICATION

Confirmation or establishment of Interoperable talk group and / or Major Incident channel

Confirmation of call signs for command

Back up communications

Communication support

Communication chain of command

Confirm communications with Acute Trusts and other key partners

ASSESSMENT
SHARED
SITUATIONAL
AWARENESS

Scene assessment
flooding/MTFA/RTC

METHANE

Information available

Impact assessment

Scale / REAP Level / thinking ahead / mutual aid

Casualty typing, paediatrics/burn/geriatric/trauma



National Ambulance
Resilience Unit
NARU

NARU EDUCATION CENTRE TEMPLATE

| | | |
|------------------|---|--|
| TRIAGE | Where | |
| | Who | |
| | How | |
| | How often / for how long | |
| | Which algorithm | |
| TREATMENT | CCP CCS Locations of Confirmation of establishment | |
| | Use of clinical skills | |
| | CBRN antidotes | |
| | Advice PHE | |
| | Medical Incident Advisor | |
| | Coordination of treatment | |
| | Resources / consumables | |
| | Mass casualty vehicle | |
| | What treatment where | |
| TRANSPORT | Routes in and out RVP SHA locations | |
| | Confirm Casualty Loading Point (CLP) established and location | |
| | Parking officers (coordination of transport (lines of communication) | |
| | Receiving hospitals | |
| | Impact on core business | |
| | Voluntary Ambulance Service | |
| | Private Ambulance Service | |
| | Resources | |
| | Loss of key routes | |
| | Capacity and capability of receiving hospital | |
| | Assistance from police | |
| | Air assets / landing sites | |
| | Specialist assets to the scene | |

Tactical Plan Template

TEMPLATE

If required please continue on the next page





TRANSPORT
Continued

RESOURCES

Consideration of
specialist resources

HART

SORT

Air Assets

Mutual Aid including
Command Mutual Aid

NACC

Welfare patients and staff

Mass Casualty

VAS PAS

Drs

Receiving Hospitals

Local Authority

Supporting Information:

TEMPLATE

ANNEX 11

CASUALTY MANAGEMENT PLAN

A11



National Ambulance
Resilience Unit
NARU

CASUALTY MANAGEMENT PLAN

Casualty Management Plan:

Date: Time: Version:

Casualty Profiling

| Type of Injury/Illness | Casualty Numbers Actual/Estimated | | Potential at Risk Casualty Numbers | |
|------------------------|-----------------------------------|----------------------|------------------------------------|----------------------|
| | Adult | Paediatric | Adult | Paediatric |
| Trauma | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Medical | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Burns | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| CBRN/HAZMAT | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Special Circumstance | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Resources on Scene

| Type | Call Sign(s) |
|--------------------------|----------------------|
| DCA(s) | <input type="text"/> |
| HART | <input type="text"/> |
| Critical Care | <input type="text"/> |
| Air Ambulance | <input type="text"/> |
| MCV | <input type="text"/> |
| SORT | <input type="text"/> |
| MTFA | <input type="text"/> |
| Other (BASICS/MERIT etc) | <input type="text"/> |

Potential Additional Resources Required

| Type | Call Sign(s) | ETA |
|---------------|----------------------|----------------------|
| DCA(s) | <input type="text"/> | <input type="text"/> |
| HART | <input type="text"/> | <input type="text"/> |
| Critical Care | <input type="text"/> | <input type="text"/> |
| Air Ambulance | <input type="text"/> | <input type="text"/> |
| MCV | <input type="text"/> | <input type="text"/> |
| SORT | <input type="text"/> | <input type="text"/> |
| MTFA | <input type="text"/> | <input type="text"/> |
| Other | <input type="text"/> | <input type="text"/> |

Casualty Numbers:

Estimated Actual

Personnel Committed

| Organisation | Numbers |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> |









CASUALTY MANAGEMENT PLAN

Receiving Hospital:

| Hospital | Level | Priority Type Allocation | Distance by Road (KM) & Mins | Distance by Air (KM) & Mins | Transport type & call sign |
|----------|-------|--------------------------|------------------------------|-----------------------------|----------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Casualty Care Pathway Schematic

| Point of Injury (PoI) | Number at Risk | | | Key |
|-----------------------|----------------|--|--|--|
| | | | |  Incident Hazard Symbol |
| Self Aid/Buddy Aid | Name(s) & C/S | Catastrophic Haemorrhage & Airway Management Extrication if possible | |  Rendezvous Point (RvP) |
| Initial Care | Name(s) & C/S | CABC Extricate | |  Casualty Clearing Station |
| CCP/Critical Care | Name(s) & C/S | Advanced Clinical Care | |  Designated Receiving Hospital |
| CCS | Name(s) & C/S | S Continued Clinical Package for Transport | | |
| Hospital | Name(s) & C/S | Definitive Care & Secondary Transfer | | |

ANNEX 12

Standards for NHS Ambulance Service Command & Control available via
Ambulance.pro-clus.co.uk / Reference library / National Standards



Standards for NHS Ambulance Service Command & Control

Including the Joint Emergency Services
Interoperability Principles (JESIP)





GLOSSARY AND BIBLIOGRAPHY

- **Ambulance Safety Officer (ASO)**
The officer with specific responsibility for the safety of personnel at the scene of an incident.
- **Blue Routes**
A dedicated route for emergency vehicles to access and egress from the scene of an emergency or major incident.
- **Business Continuity Management (BCM)**
Holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if realised, might cause, and which provides a framework for building organisational resilience with the capability for an effective response.
- **Business Continuity Plan (BCP)**
Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level.
- **Casualty Loading Officer**
The Loading Officer is responsible for the management of vehicles and the controlled onward transportation of patients from the Casualty Clearing Station to definitive care.
- **Chemical, Biological, Radiological, Nuclear and Explosives (CBRNE)**
A term used to describe Chemical, Biological, Radiological, Nuclear and Explosive materials. CBRNE terrorism is the actual or threatened dispersal of CBRNE material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent.
- **Civil Contingencies Act 2004 (CCA)**
Act of 2004 which established a single framework for Civil Protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for Local Responders; Part 2 of the Act establishes emergency powers.
- **Casualty Clearing Officer (CCO)**
Ambulance officer who, in liaison with the Forward Doctor, ensures an efficient patient throughput at the Casualty Clearing Station.
- **Casualty Clearing Station (CCS)**
Entity set up at the scene of an emergency by the Ambulance Service in liaison with the Forward Doctor to assess, triage and treat casualties and direct their evacuation.
- **Control of Major Accident Hazards (COMAH)**
Regulations applying to the chemical industry and to some storage sites where threshold quantities of dangerous substances, as identified in the Regulations, are kept or used.
- **Continual Professional Development (CPD)**
The process by which an individual continues to develop their professional skills and knowledge.
- **Doctor**
A qualified doctor who will work with the Operational Commander to ensure medical resources are available and coordinated on the incident ground.
- **Dynamic Risk Assessment (DRA)**
Continuing assessment of risk in a rapidly changing environment.

- **Entry Control Officer (ECO)**
A trained officer who ensures that all NHS resources are logged in and out of an incident through an agreed Entry Control Point. This may be a Fire and Rescue Service Officer where local agreement is in place.
- **Entry Control Point (ECP)**
The point on the incident ground where trained responders will enter and exit the inner cordon.
- **Extended Duration Breathing Apparatus (EDBA)**
Self contained breathing apparatus used by HART staff which provides an extended deployment time over standard breathing apparatus.
- **Hospital Ambulance Liaison Officer (HALO)**
The Hospital Ambulance Liaison Officer will liaise with hospital medical and nursing staff regarding arrangements for reception/ discharge of patients and the availability of beds for casualties and ensure that this information is made available to the AIC and Police documentation team.
- **Hazardous Area Response Team (HART)**
Specially recruited and trained personnel who provide the Ambulance response to major incidents involving hazardous materials, or which present hazardous environments that have occurred as a result of an accident or have been caused deliberately.
- **Health and Safety at Work Act (HsaW)**
Primary piece of legislation covering occupational health and safety in the United Kingdom. The Health and Safety Executive is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment.
- **Health and Safety Executive (HSE)**
The Health and Safety Commission (HSC) and the HSE are responsible for the regulation of almost all the risks to health and safety arising from work activity in Great Britain.
- **Joint Command Facility (JCF)**
A location (building, mobile unit etc) that all agencies can assemble to manage an incident with appropriate methods of communication and IT infrastructure.
- **Joint Decision Model (JDM)**
A tool for Commanders to use in order that they can have a structured approach to the command decisions that they make.
- **Limit(s) Of Exploitation (LOE)**
A defined area within which Ambulance and NHS resources can be committed into an incident. The LOE may apply to all resources, or specific resources in a defined area of the incident (for example Ambulance Intervention Teams working at an active shooter incident).
- **National Inter-agency Liaison Officer (NILO)**
A trained and qualified officer who can advise and support Commanders, Police, medical, Fire, military and government agencies on the operational capacity and capability of their organisation.



- **National Occupational Standard (NOS)**
A set (or suite) of standards which provide a benchmark for Commanders. They set out performance and knowledge and understanding criteria that Commanders will be measured against.
- **Pre-Determined Attendance (PDA)**
A site specific initial resource requirement. Generally airports and chemical plants will have an agreed PDA.
- **Personal Protective Equipment (PPE)**
Protective clothing, helmets, goggles or other garments designed to protect the wearer's body from injury.
- **Situational Awareness (SA)**
The state of individual and/or collective knowledge relating to past and current events, their implications and potential future development. A Commander's awareness of what is happening around them.
- **Strategic Coordinating Group (SCG)**
Multi agency body responsible for coordinating the joint response to an emergency at the local strategic level.
- **Strategic, Tactical, Operational (STO)** The formal command structure used within the UK emergency services.
- **Tactical Advisor (TA)**
A trained officer who can provide Commanders with specific knowledge of special incidents such as CBRNE or HAZMAT.
- **Tactical Coordinating Group (TCG)**
A multi agency group of Tactical Commanders that meets to determine, coordinate and deliver the tactical response to an emergency.

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National Ambulance Service Command and Control Guidance

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