



National Ambulance
Resilience Unit
NARU



National Ambulance Service Command and Control Guidance



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JESIP

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Foreword



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Development of the Guidance has taken into consideration lessons identified from previous major incident and event responses across England over recent years in addition to the best practice models across our Police and Fire and Rescue Service partners. The aim of the Guidance is to assist the Ambulance (and the NHS) Commander in taking appropriate and consistent considerations to inform decision making, based on sound risk assessment.

This Guidance is designed to provide a structured process to assist in the Command and Control (not management) of the NHS response and recovery elements, as part of the multi-agency partnership. It is recognised that each organisation has specific needs and considerations to ensure that their roles and responsibilities, to both respond and recover and to maintain their own Business Continuity arrangements (such as protecting the wider NHS) are addressed through appropriate Strategic, Tactical and Operational Plans.

The **National Ambulance Command and Control Guidance** represents a significant development towards enhancing the quality and capability of each Ambulance Service Provider across both national pre-planned and mutual aid requirements. The Guidance will 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, through the Ambulance Service Provider, remains 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.

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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 large numbers 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 a structure will be required to facilitate the efficient and successful management of the incident.

SCOPE

- 1.2** This Guidance document is designed to assist those responsible for planning, training and exercising, responding and recovering from a major incident. The document complements current guidance on Command and Control. Whilst the Guide is primarily aimed at the Command and Control arrangements of the Ambulance Service, the themes, principles and tools discussed are also relevant to those in other NHS responder organisations. Since the publication of the first edition of this guidance, the JESIP programme has been imbedded within the three blue light services and wider. These principles have been adopted throughout this document and has now set the standard for multi-agency working, both in the preparedness and response phases.

LEGAL REQUIREMENTS

- 1.3** The Civil Contingencies Act 2004 (CCA) sets out specific duties and responsibilities for emergency responders. The Ambulance Service is listed as a Category 1 Responder in Schedule 1 of the CCA which requires Category 1 responders to maintain plans for preventing emergencies and reducing, controlling or mitigating the effects of emergencies once they occur¹. The Civil Contingencies Act applies in specific ways to the devolved administrations (Emergency Preparedness, Chapters 10-12). Northern Ireland has a Civil Contingencies Framework Document published by The Office of First Minister and Deputy First Minister (OFMDFM) 2005 which outlines civil contingency arrangements in the province.
- 1.4** The CCA and its associated regulations require Category 1 responders to have arrangements in place to respond to major incidents.
- 1.5** The CCA and its associated regulations place specific responsibilities on Category 1 responders to provide training and exercising opportunities for its responders.
- 1.6** For the NHS in England the NHS England Framework for Emergency Preparedness mandates further requirements for NHS organisations to ensure they are adequately able to prepare and respond to all aspects of EPRR.
- 1.7** Commanders need to also be aware of their responsibilities under the *Corporate Manslaughter Act and Corporate Homicide Act 2007*, *European Human Rights Act* and the *Health and Safety at Work Act 1974* as amended.

¹ *Emergency Preparedness*
(2011 update)



2.0 Preparing to Command

AMBULANCE SERVICE RESPONSIBILITIES

2.1 As the 'gatekeeper' to the NHS, Ambulance Service Providers have the responsibility for alerting, mobilising and coordinating the NHS response to short notice or sudden impact emergencies.² This includes:

- Initiate and maintain a Command and Control System to provide appropriate support and guidance to all NHS responders and other agencies
- All NHS communications on scene will be coordinated through the host responding Ambulance Service Provider(s)
- The management of the health, safety and welfare of all NHS responders
- The Ambulance Service Provider will provide 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 active shooter incident
- Appropriately trained and competency assessed commanders with evidence of Continued Professional Development

2.2 All Commanders must familiarise themselves with their own organisation's Major Incident Plan and procedures.

INTEROPERABILITY

2.3 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.

Emergency services personnel will better understand the capabilities of their peers and will be competent in jointly establishing situational awareness, understanding of risk and the use of command decision models.

JESIP KEY TASKS

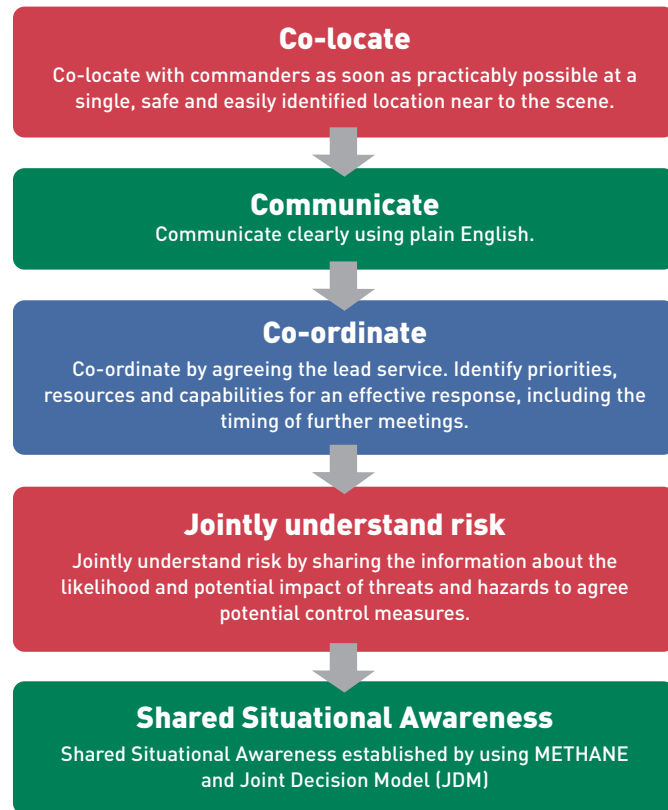
- To establish joint interoperability principles and ways of working (doctrine)
- To develop greater understanding of roles, responsibilities and capabilities amongst tri-service responders
- To improve training strategy for all levels of command
- To implement a joint testing and exercising strategy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

² The NHS England Framework for EPRR





Principles of Joint Working



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

- 2.4** Interoperability 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.
- 2.5** Coordinated decision making between agencies and departments is necessary to establish proper and coherent governance and is critical to achieving interoperability. Agreements and SOP should clearly articulate the procedures necessary to achieve interoperability.

LEADERSHIP

- 2.6** 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 authoritative and decisive in their decision making.
- 2.7** Good communication is at the heart of an effective response. Communication is a key element at every level of command. Effective leaders will communicate clearly and effectively 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, and gain the trust and respect of their colleagues.



2.8 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

2.9 The list of available leadership models runs into the hundreds, but a common theme remains. The leader is only a leader if people make the conscious decision to follow them. The Commander needs to be able to instil confidence in their staff and provide a clear defined direction from where they are, to where they need to be.

2.10 Commanders face situations which have significant implications for them, the organisation and the community. It is, therefore, essential that individuals with appropriate skills are selected, trained and supported. When allocating roles, consideration should be given to the appropriateness of the task to the individual's training, experience and competence.

2.11 A post incident inquiry will look into 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, in particular how they achieved, updated and maintained it. Regulations³ 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.

2.12 All Ambulance Service Providers have signed up to the existing National Occupational Standards (NOS) for Commanders. 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.

³ Regulation 25 of the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 and Regulation 23 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A Guide to Emergency Planning Arrangements in Northern Ireland Refurbished 2011, Department of Health Social Services and Public Safety Northern Ireland Emergency Response Plan 2013.





HUMAN FACTORS

2.13 The term 'human error' is often used to describe the failing of an individual in relation to the cause of an incident, often setting the cause of the incident out of the reach and control of managers and executives. Society no longer views this as acceptable and organisations must view human factors as an individual element in the control and management of risks.⁴

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 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 1): Situation, Task, Organisation and Person.



Figure 1 - STOP acronym

⁴ HSG48 Reducing Error and Influencing Behaviour (1999)



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 Ambulance Incident Commander (AIC) 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* and *The Northern Ireland Civil Contingencies Framework 2005* 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 standard.
- 2.19** BCM is a management led process that helps to identify and plan against risks that could affect the achievement of the Ambulance Service Provider's objectives, its infrastructure and associated services. The short-term objective of BCM is to ensure that during challenges or disruption, at the very least, its critical services may continue. The longer term objective of BCM is to ensure that the Ambulance Service Provider can resume normal services as quickly as possible in the aftermath of any disruptive challenge or emergency situation.





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 in order to achieve defined objectives. Control is the application of authority combined with the capability to manage resources in order to achieve defined objectives⁵.
- 3.2** The Ambulance Service, along with the other blue light emergency services (under JESIP), employ a 3 tier command system comprising of a Strategic Commander, Tactical Commander and an Operational Commander, previously referred to as Gold, Silver, Bronze (GSB)⁶. Following JESIP agreement and subsequent training, the abbreviation GSB will be phased out to be replaced by STO (Strategic, Tactical, Operational). 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 STO structure should be based on an individual's command competence and must be demonstrated through the completion of 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 capitalise on the benefits that National Occupational Standards offer to commanders. Whilst NARU has produced action cards for the STO commanders and other roles, it is best 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 for 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.

⁵ JESIP Joint Doctrine Interoperability Framework

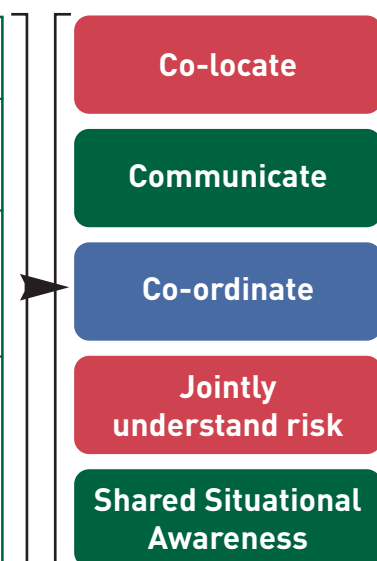
⁶ Emergency Response and Recovery Version 3 (2010)



INTEGRATED EMERGENCY MANAGEMENT (IEM)

- 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 IEM is communicated to all personnel and that the concept of its use and the terminology within it are fully embedded and understood.
- 3.7** The STO 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, where the STO structure exists, the Strategic Commander should not communicate directly with the Operational Commander or vice versa.
- 3.8** CSCATTT (Table 1) provides 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.
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. The use of digital radio interoperability is a key part of this. Commanders must also provide information to inform the development of a joint situation report.
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 Active Shooter incidents the triage process may have to be modified due to the environment and the levels of PPE required for responders.
T	Treatment	Once casualty triage has taken place treatment can commence.
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)



DECISION MAKING

- 3.9** Effective Command and Control can only be achieved by Commanders who are capable of making reasoned, lawful and justifiable decisions.
- 3.10** To support decision making The Joint Decision Model (JDM) (Figure 2) is to be applied to decision making at any emergency incident and it is suitable for use by Commanders throughout the chain of command.



Figure 2 - Joint Decision Model (JDM)

- **Working Together – Saving Lives, Reducing Harm**

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 co-ordinated, multi-agency response. Decision makers should have this uppermost in their minds throughout the decision making process.

- **Gather and share information and intelligence**

Situational awareness is about having appropriate answers to the following questions: what is happening, what are the



impacts, what are the risks, what might happen and what is being done about it? 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.

For major and complex emergencies, whether a rapid onset or a rising tide event, it is a simple fact that no one service can initially appreciate all relevant dimensions of an emergency. This deeper and wider understanding will only come from meaningful communication between the emergency services and other emergency responders. This should be built upon agreed procedures to share the required information and a commitment to use commonly understood terminology rather than service-specific terminology or jargon where this may impede understanding. In simple terms, commanders cannot assume other emergency service personnel see things or say things in the same way, and a sustained effort is required to reach a common view and understanding of events, risks and their implications.

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 particular, 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 Protective Marking Scheme (GPMS – replaced by the Classifications Policy in 2014) if appropriate
- What information is shared, when, with whom and why, should be recorded.

The following mnemonic should be used when passing information, in the initial stages, between emergency responders and Control Rooms to enable the establishment of shared situational awareness:

Major incident declared?

Exact location;

Type of incident e.g. explosion, building collapse;

Hazards present, potential or suspected;

Access – routes that are safe to use;

Number, type, severity of casualties;

Emergency services now present and those required.

- **Jointly assess risks, develop a working strategy**

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. A key task for commanders is to build and maintain a common understanding of the full range of risks and the way that those risks may be increased, reduced or controlled by decisions made and subsequent actions taken. In a major or complex emergency the blue light services will have unique insights into those risks and by sharing that knowledge, a common understanding can be established.

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 or perfect 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 taken into account when developing a working strategy:

- 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?

In order to deliver an effective integrated multi-agency operational response plan, the following key steps must be undertaken:

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.

A well-established method of recording the joint assessment of risk has been in use in the multi-agency Detection, Identification and Monitoring team since the mid-2000s. This form can be provided.

● Consider powers, policies and procedures

Decision making in an emergency will be focussed on how to achieve the desired end state and there will always be various constraints and considerations that will shape how this is achieved. Powers, policies and procedures relate to any relevant laws, operating procedures or policies that may impact on the desired response plan and the capabilities that are available to be deployed. They may impact on how individual services will need to operate and co-operate in order to achieve the agreed aims and objectives. In the context of a joint response, a common understanding of any relevant powers, policies, capabilities and procedures is essential in order that the activities of one service complement and do not compromise, the approach of the other services.

● Identify options and contingencies

There will almost always be more than one option to achieve the desired end state and it is good practice that a range of options are identified and rigorously evaluated. Any potential option or course of action should be evaluated with respect to:

Suitability – does it fit with the strategic direction?

Feasibility – in resource terms can it be done?

Acceptability – is it legal, morally defensible and justifiable?

An option may include deploying resources, briefing the public (mainstream and social media) or developing a contingency or emergency plan. Whichever options are chosen, it is essential that commanders are clear what they are required to carry out and there should be clearly agreed procedures for communicating any decision to defer, abort or initiate a specific tactic.

Contingencies relate to events that may occur and the arrangements that are put in place to respond to them should they occur. For example, strong evidence may suggest that an emergency is being successfully managed and the impacts safely controlled, but there remains a likelihood that the situation could deteriorate with significant impacts. Simply hoping for the best is not a defensible option and a contingency in this case may be to define measures to adjust the response should the situation deteriorate.



● Take action and review what happened

Building situational awareness, setting direction and evaluating options all lead to taking the actions that are judged to be the most effective and efficient in resolving an emergency and returning to a new normality. As the JDM is a continuous loop, it is essential that the results of those actions are fed back into the first box – Gather and share information and intelligence – which establishes shared situational awareness. This will, in turn, shape any revision to the direction and risk assessment and the cycle continues.

- 3.11** Although the cycle is described and displayed here in segments, it should be seen that from the receipt of information to the decision of what actions you are going to take is a seamless process that flows naturally with each previous element informing and complementing the next.

THE COMMAND AND CONTROL STRUCTURE

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

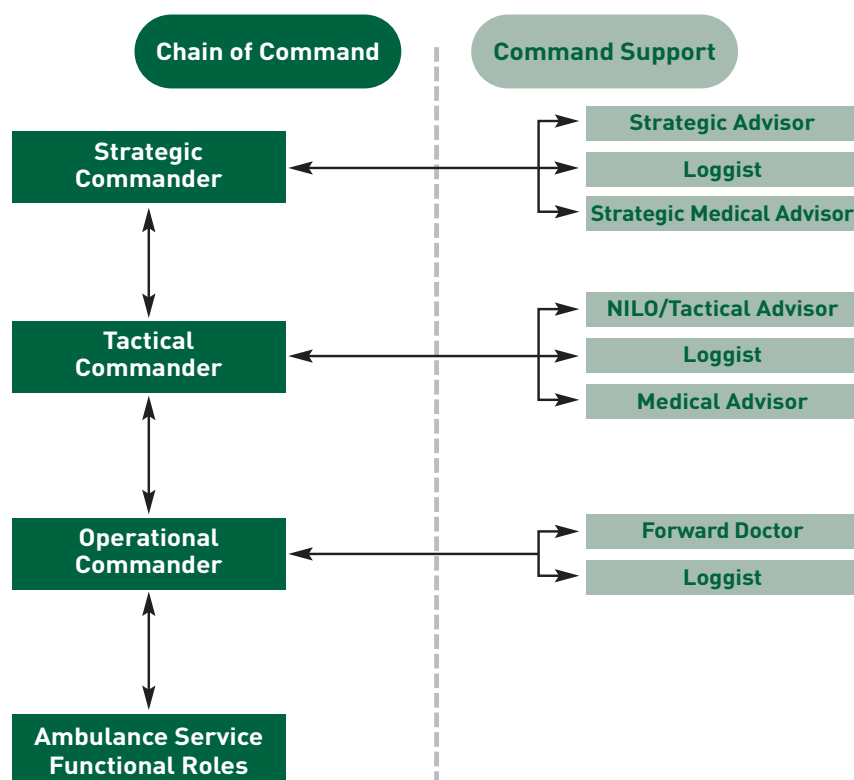


Figure 3 – The Chain of Command and Supporting Structures





STRATEGIC COMMANDER

- 3.14** The Strategic Commander has overall responsibility for the command, 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.
- 3.15** To ensure multi agency communication and coordination during a major incident or event, the Strategic Commander will attend and effect command from the multi agency Strategic Coordinating Group (SCG), if formed. However where an incident affects only the Health Service then the Strategic Commander may decide to manage the incident from a Ambulance Service Provider location.
- 3.16** Whilst the Strategic Commander must not make tactical decisions the Strategic Commander still has responsibility for ensuring that the tactics which are being employed are effective.
- 3.17** 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**.
- 3.18** The key channels of communication for the Strategic Commander are as follows:
- Strategic level representatives of multi agency partners eg 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*

TACTICAL COMMANDER

- 3.19** The Tactical Commander has responsibility for developing the Tactical Plan for the use of resources at the incident. The Tactical Plan will be developed within the framework of the Strategy and any available intelligence and associated risks. The Ambulance Incident Commander will be the Tactical Commander where present but if it can be managed at Operational level, the Operational Commander will be the Ambulance Incident Commander.



- 3.20** 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.
- 3.21** 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.
- 3.22** Co-location of multi-agency commanders at scene 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.
- 3.23** 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.
- 3.24** 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 other emergency services Tactical Commander (the Police will usually coordinate the response).
- 3.25** 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.
- 3.26** 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.
- 3.27** 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**.





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

- Strategic Commander
- Medical Advisor*
- NILO/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*
- Media Liaison Officer*
- Command Loggist*

**Denotes where applicable*

OPERATIONAL COMMANDER

3.29 This functional role works as the Ambulance Incident Commander at an operational level and has responsibility for the activities undertaken at the scene. As such they will be located at the incident scene and ideally alongside the Incident Commanders of the other responding agencies at a Forward Command Post. Where this is not possible, the Operational Commander must ensure regular multi agency face to face briefings take place.

3.30 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.

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

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

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

- Operational Commanders from multi agency partners
eg Police, Fire, Military and Local Authority
- Tactical Commander
- Emergency Operations Centre (EOC)
- Casualty Clearing Station Medical Lead
- Casualty Clearing Officer



- Primary Triage Officer
- Secondary Triage Officer
- Ambulance Parking Officer
- Ambulance Loading Officer
- Ambulance Safety Officer
- Hazardous Area Response Team (HART) Leader
- Decontamination Officer*
- Equipment Officer
- Medical Advisor*
- Media Liaison Officer*
- Command Loggist*

**Denotes where applicable*

SPAN OF CONTROL

3.34 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 complexity and instability of the incident.⁷

3.35 The Ambulance Incident Commander (AIC) will allocate functional roles for example Ambulance parking.

3.36 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.

FUNCTIONAL ROLES

3.37 These appointed persons should have appropriate training in how to discharge the responsibilities of that role adequately. Where this is not the case there is a danger that the level of support required for that individual will result in the Operational Commander micro-managing them or undertaking the role themselves.

3.38 A list of the functional roles can be found in **ANNEX 4 Functional and Additional Support Roles**.

ADDITIONAL ROLES

3.39 In order to further support the AIC a number of supporting roles can be employed. A list of these can be found in **ANNEX 4 Functional and Additional Support Roles**.

⁷ Fire and Rescue Manual Volume 2:
Fire Service Operations Incident
Command, 3rd Edition (2008)





NO ELBOW

Erasures

Leaves torn out of the log

Blank spaces

Overwriting

Writing above or below
the lined area

RECORD KEEPING AND LOGGING

3.40 There has been much emphasis on recording decisions following criticism directed at emergency services during high profile cases.

3.41 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 postholders.

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

At the conclusion 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.

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

3.43 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.

3.44 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



4.0 Incident Management

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.
- 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 9.
- 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.
- 4.5** In the development phase, the Commander should continually refer to the JDM model (see Figure 2 on page 12) 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 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 owns the 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 1 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. Where this is the case, the Tactical Commander should discuss initial thoughts and direction with the Strategic 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 Ambulance Intervention Teams (AIT) wearing full tactical dress and ballistic protection into an active shooter incident



- 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 8 Ambulance Service Personal Protective Equipment Capabilities**.

4.14 Communication of the Tactical Plan to the Operational Commander will ideally be through a face to face briefing. This provides the opportunity for ensuring the intention of the Plan is understood and assimilated, but also for any necessary challenge to be made by the Operational Commander. 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.

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.

INITIAL	ITEM
I	Information – where/what/how many? history (if applicable) use METHANE
I	Intent – why are we here? strategy, tactical & operational plan
M	Method – how are we going to do it? tactical plan, policy, plans
A	Administration – Command /media / dress code / decision logs / welfare / food / individual tasking / timing
R	Risk Assessment – specific threat areas / PPE / filter changes
C	Communications – confirm radio callsigns / indicate other means of communication if required / ensure staff understand inter agency communications
H	Human Rights disclosure details



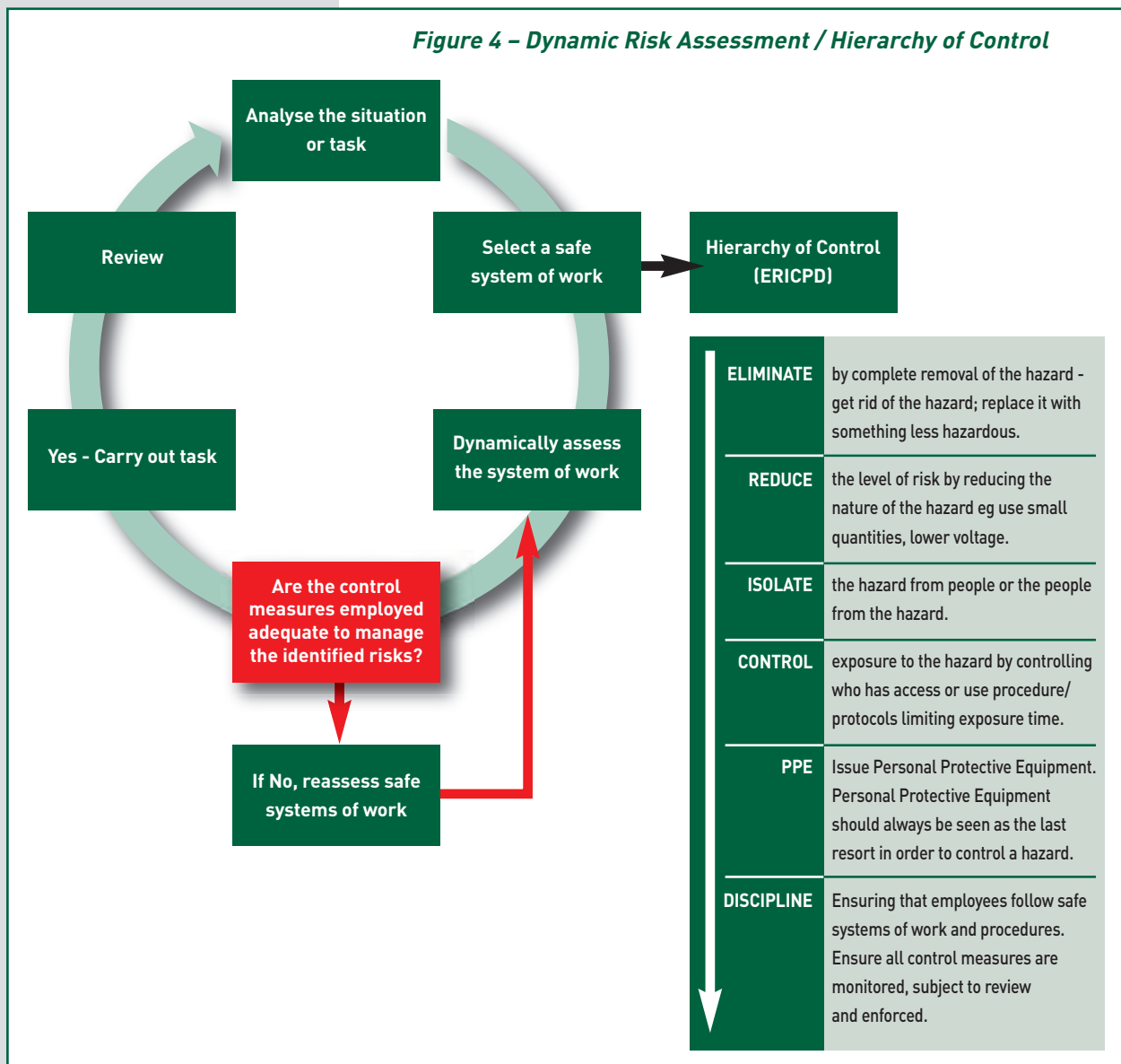


RISK IDENTIFICATION AND MANAGEMENT

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 4) allows for a structured approach to risk management. During the selection of the safe system of work, the mnemonic ERICPD can be applied to assist in choosing the appropriate course of action.

Figure 4 – Dynamic Risk Assessment / Hierarchy of Control





- **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 (SA). 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, active shooter)
 - 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
- During the selection of a safe system of work, Commanders should consider the mnemonic ERICPD (Institution of Occupational Safety and Health – IOSH). This provides for a structured approach to applying control measures to identified risks in a hierarchical manner.
-
- **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





- **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** 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 will 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 critical message. Following the JESIP programme the mnemonic **METHANE**⁸ is used throughout the Emergency Services.

The message should contain the following information:

⁸ NARU Major Incident Action cards and JESIP documentation.



- **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
- **Exact location of the incident.** Where possible the grid reference or GPS coordinates should be included, along with any landmarks or iconic sites
- **Type of incident.** What is the exact nature of the incident? For example a CBRNE incident, active shooter or road traffic collision?
- **Hazards.** What hazards are known to be present or those that could potentially manifest themselves?
- **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
- **Number of casualties.** How many casualties are there and if possible what are the level and severity of injuries?
- **Emergency Services.** Which Emergency Services are present and which are required? Include specialist resource request if known

TIME OF CALL:		DATE:
ORGANISATION:		
NAME OF CALLER:		TEL NO:
M ajor Incident	Declared or Standby (Inc Date & Time of Declaration)	
E xact location	Exact location / geographical area of incident	
T ype of Incident	Flooding / Fire / Utility failure / HazMat / Disease outbreak etc	
H azards	Present and potential	
A ccess	Effective routes for access and egress / Inaccessible routes / RVPs	
N umber of C asualties	Numbers and Types (P1, P2, P3 and dead)	
E mergency S ervices	Required / On-scene	
S tart a log	Intentions / Actions	
	Support / Mutual Aid required	
SIGNATURE (once completed) :		<i>Restricted when complete</i>

Figure 5 – Incident Initiation Form, Major Incident Action Cards





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 AIC 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.

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.

4.26 Ambulance Services employ a variety of resources in response to incidents. Some are specialists such as Urban Search and Rescue (USAR) or chemical 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.

The Interoperability voice communication can be found in **ANNEX 7 Communications Interoperability Flowchart**.

COMMAND BRIEFING

- 4.31** Briefing of the command team and staff is an important aspect of command. 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.
- 4.36** Briefings will always work better if they are structured; under JESIP there is an IIMARCH template available for the delivery of briefings.





INFORMATION SHARING

4.37 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 (Battle Rhythm) will aid the information sharing process and assist in the joint understanding of risk and shared situational awareness.

4.38 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

4.39 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.

4.40 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.

POST INCIDENT PROCEDURES

4.41 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.

4.42 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.



4.43 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

4.44 AICs 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.

4.45 Briefing systems are available to all Ambulance Service Providers. It is recommended that all Ambulance Service Providers utilise briefing systems and failing that, ensure that reports of lessons identified, along with a relevant action plan, are forwarded to the Response and Recovery Workstream on a minimum of a quarterly basis (or following an incident).

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.







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.

Ensure, through personal development reviews, that commanders under their responsibility are maintaining their competence portfolios and are attending learning events/training as described in the framework, 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.

Emergency Preparedness, Response and Recovery

Responsible for maintaining the framework itself and delivering the competency assessments as described in the Framework. Make sure that training courses whether national, regional or local are available to commanders at each level of command; these may be internal or external, single agency or multi-agency in design.

- 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. Safety critical roles such as drivers, firearms officers and others 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 NWAS (ANNEX 10) 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. AACE, with support from NARU, will provide 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

5.13 Strategic Commander The following represents the suite of standards that a Strategic Commander is required to achieve. There are 9 mandatory standards (Figure 5) and 6 optional ones (Figure 6).



Figure 5 – Strategic Commander Mandatory Suite of Standards

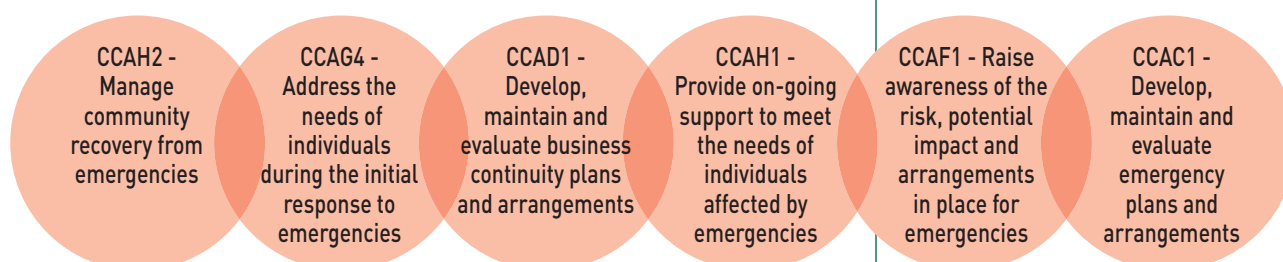


Figure 6 – Strategic Commander Optional Standards





5.14 Tactical Commander Working at the tactical level, the Tactical Commander suite contains 8 mandatory (Figure 7) and 6 optional standards (Figure 8). The Tactical Commander must demonstrate competence against the standards through the completion of their CPD.



Figure 7 – Tactical Commander Mandatory Suite of Standards

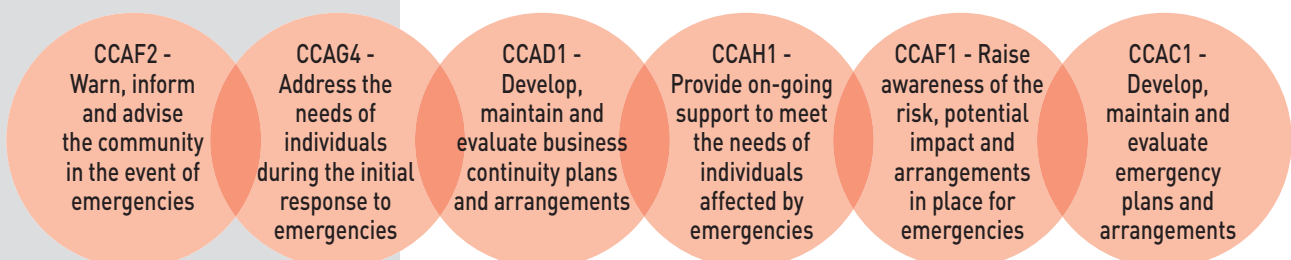


Figure 8 – Tactical Commander Optional Standards



5.15 Operational Commander The Operational Commander suite contains 7 mandatory standards (Figure 9) and 4 optional ones (Figure 10). The Operational Commander must demonstrate competence against the standards through the completion of their CPD.

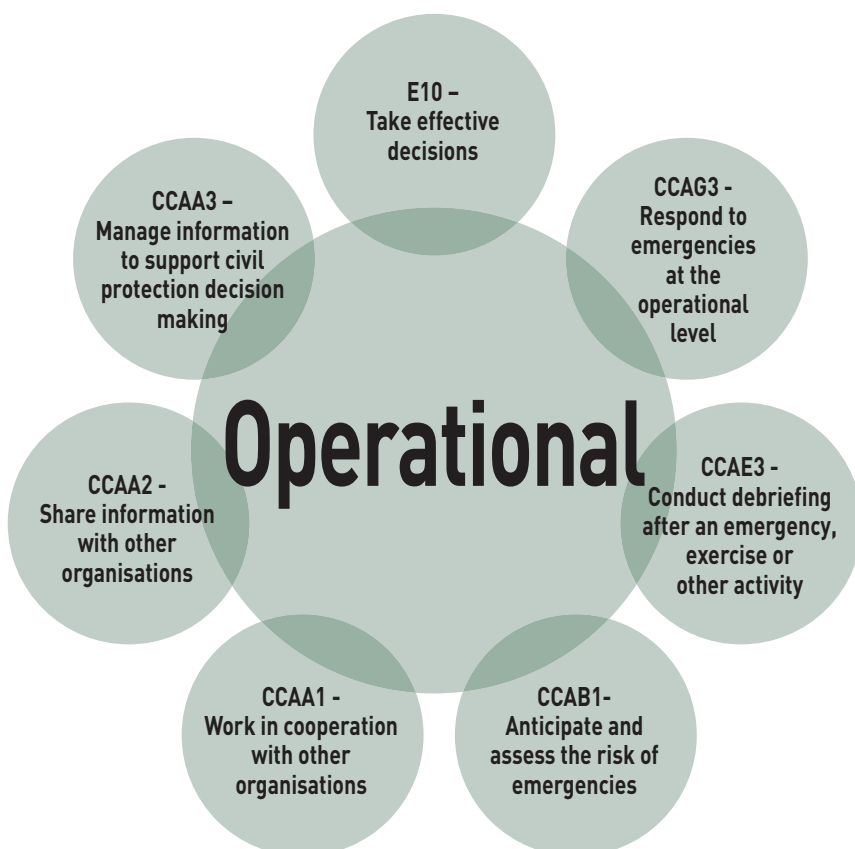


Figure 9 – Operational Commander Mandatory Suite of Standards

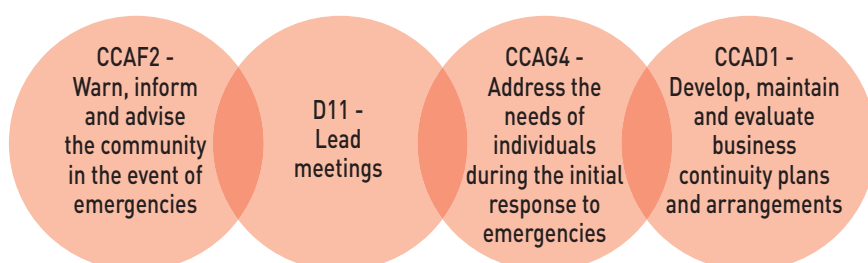


Figure 10 – Operational Commander Optional Standards





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:

- 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.
- 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 Ambulance Incident Commander (AIC), 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 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, taking into account 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 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 AND ADDITIONAL SUPPORT ROLES

Airwave Tactical Advisor Where they exist, Airwave Tactical Advisors (ATA) can provide reliable and consistent advice regarding the use of the Airwave radio system, and their advice should be sought. ATAs 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 Airwave including assisting in the development of a communications plan to ensure optimal use is made of available talkgroups whilst remaining cognisant of coverage and capacity⁹.

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.

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

Ambulance Loading Officer The Loading Officer works very closely with the CCO and FMA 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 Parking Officer The Parking Officer is responsible for the facilitation of a clear and functional parking area. They will ensure vehicles and crews are logged into the area and will, at the request of the CCO, move appropriate resources up to the CCS to effect the transportation of casualties.

⁹ NPIA Standard Operating Procedure
Guide on Multi-Agency Airwave
Interoperability 2010



Ambulance Safety Officer (ASO) 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 ASO should, where possible, work alongside the Safety Officers of the other agencies.

Ambulance Triage Officer Responsible for coordinating the 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.

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.

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.

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.

Loggist 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 loggists should be used to undertake this role.





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.

Medical Advisor (MA) The Medical Advisor will work with the Tactical Commander and provide support and advice on the management of casualties, including the sourcing of further medical support from appropriate medical teams.

Tactical Advisor The Tactical Advisor has expertise to provide specialist advice on matters relating to the organisational major incident response.

National Ambulance Coordination Centre (NACC) 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

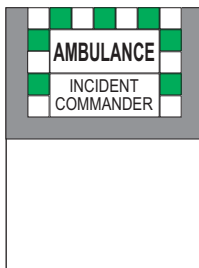
1. To ensure patients continue to receive high quality care and to minimise the impact of incident.
2. To ensure spectators are kept safe and able to access appropriate healthcare if required.
3. To assist multi-agency partners in delivering a successful event through minimising the implications for health and provide enhanced support where necessary.
4. To enable healthcare organisations to plan appropriately to minimise disruption from the incident.
5. To ensure consistent sharing of relevant information to health partners, their staff and patients.
6. To influence multi-agency partners to ensure health concerns and opportunities are considered as part of the planning process.
7. To ensure plans for responding to incidents during the incident are appropriate and reflect any increased risk ratings.
8. To establish the command, control and communications arrangements for health during the incident.



ANNEX 6
COMMAND TABARDS

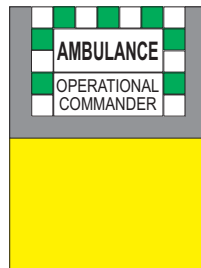
**Tactical Commander
(Ambulance Incident
Commander)**

White lower half with green
& white checked shoulders.



**Ambulance Operational
Commander and any functional
role not individually listed**

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



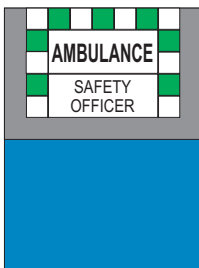
**Airwave
Tactical Advisor**

Green & white check



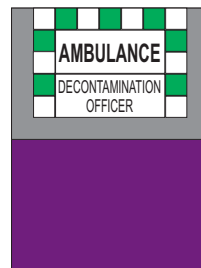
Ambulance Safety Officer (ASO)

Blue lower half with green &
white checked shoulders.



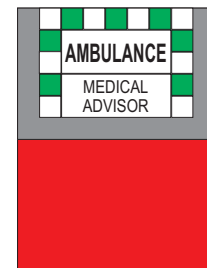
Decontamination Officer

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



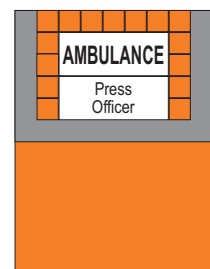
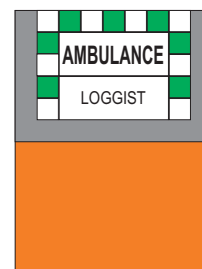
**Ambulance Entry Control
Officer (ECO)**

Green & yellow all over check.



Loggist

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





ANNEX 7

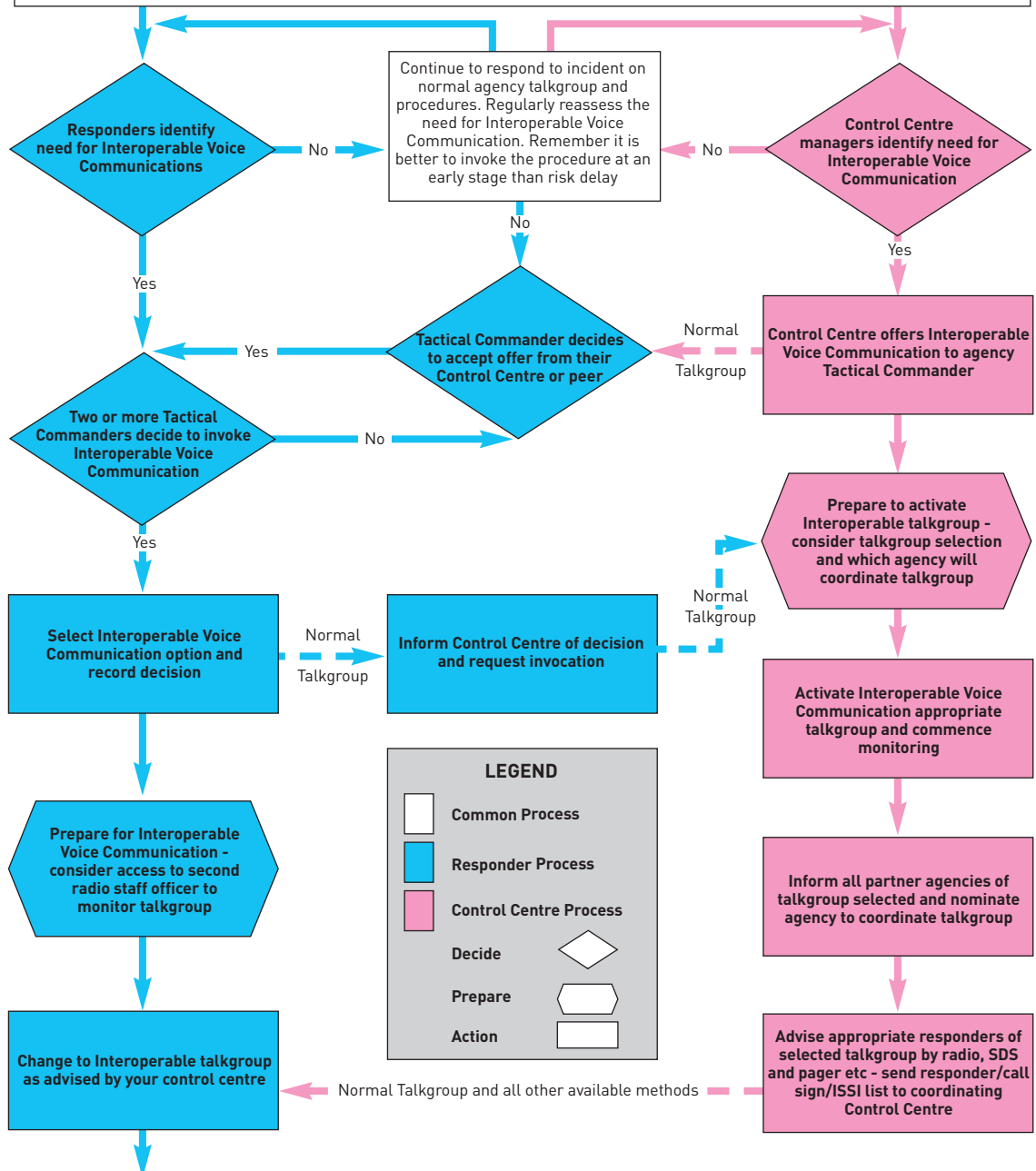
COMMUNICATIONS INTEROPERABILITY FLOWCHART

Generic Template to Invoke Multi Agency Interoperable Voice Communication

Responder Pathway

Control Centre Pathway

During a multi agency response, each agency alerts their responders (including FOATA or agency Airwave Teams as appropriate) following their recognised procedures. Other Responder Agencies are notified as required. This may include Airwave Solutions Ltd to allow their response capabilities to deploy in a timely manner.



Use the Interoperable Voice Communication talkgroup to pass all urgent safety messages and mission critical information across the incident site following the principles of accuracy, brevity, clarity and radio discipline with call signs messages in 'plain speak' until informed otherwise. Normal procedures for the Tactical coordinating group meetings must be observed. Use of the Interoperable talkgroup must not bypass an agency's chain of command with all decisions and transmitted messages logged following normal procedures.



ANNEX 8
AMBULANCE SERVICE PERSONAL PROTECTIVE EQUIPMENT
CAPABILITIES



**Standard Ambulance
Uniform**



**Standard Ambulance
PPE**



**Hazardous Area
Response Team
Incident Ground PPE**



**Ambulance
Intervention Team
Ballistic PPE**



**Civil Responder
(CR1) 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 (SWaH) PPE**



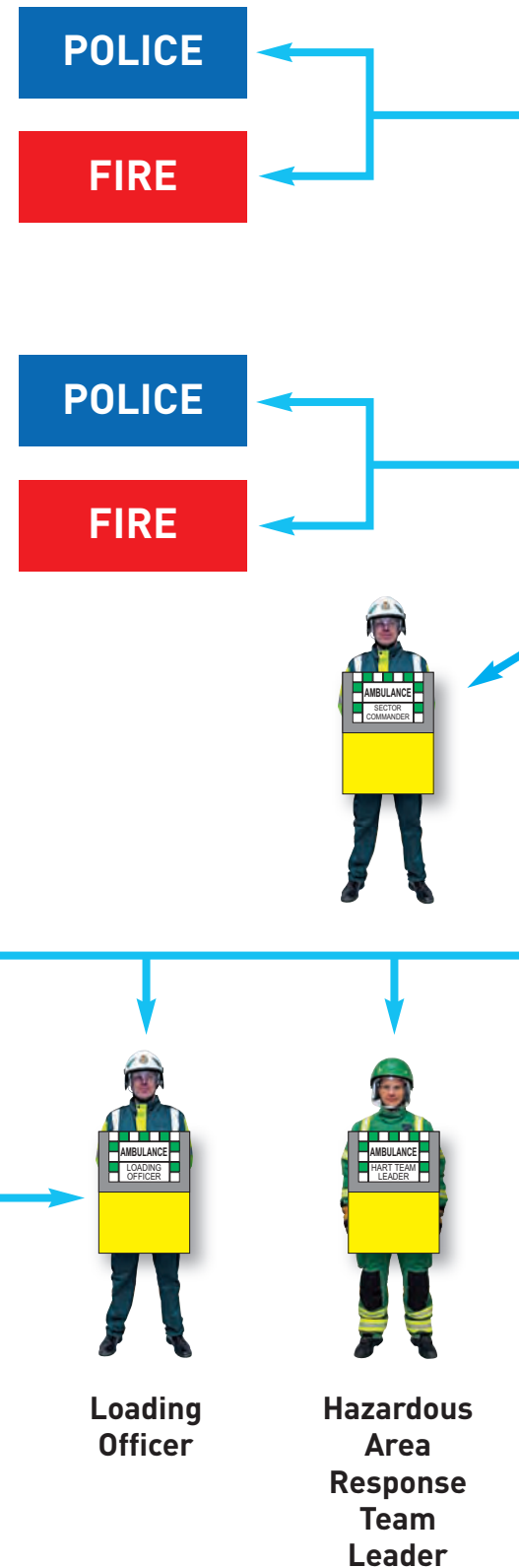
**Inland Water
Operations PPE**

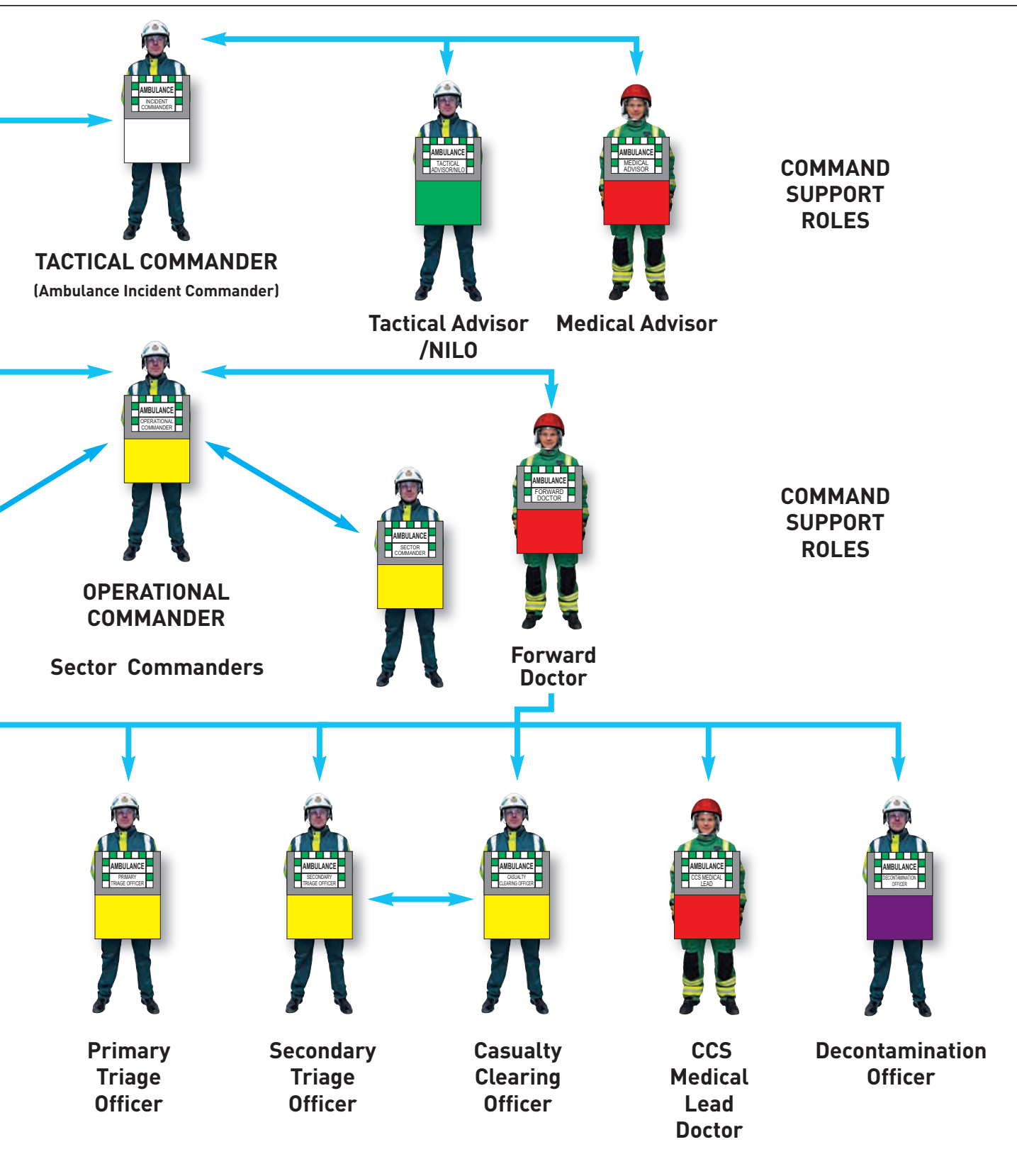




ANNEX 9 MODEL COMMAND STRUCTURE

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







ANNEX 10 NOS CPD Evidence Record

The screenshot shows the 'Introduction' tab of the 'National Occupational Standards (NOS) Continuing Professional Development Evidence Record'. The header includes the NHS logo and the title 'National Occupational Standards (NOS)'. The main content area contains the following text:

**Ambulance Commander
Continuing Professional Development
Evidence Record**

Use this document to record details of your personal portfolio of evidence to show knowledge of performance criteria against each of the National Occupational Standards (NOS) applicable to your command level.

Below the text are two buttons: 'Select Command Level and Optional Units' and 'Add Evidence'. A 'Help' button is located in the bottom right corner. The footer contains the copyright notice: 'Copyright © 2013 NNAS Resilience Team'.

Screenshot illustrating the 'Introduction' tab within the document.

The screenshot shows the 'Evidence' tab of the document. It features a 'Help' button in the top right corner. Below the header, there are input fields for 'Ambulance Service:', 'Name:', 'Command Role:', and 'Job Role:'. To the right of these fields is a text box containing the following instructions:

- Enter details of evidence that demonstrates achievement of Performance Criteria or Knowledge & Understanding of any of the NOS
- Each row should be a single piece of evidence
- Evidence is only valid if it is from within the last 2 years

Below the input fields are three buttons: 'Add Record' (green), 'Amend Record' (blue), and 'Delete Record' (red). At the bottom, there is a table with the following headers: 'Row ID', 'Evidence Number', 'Evidence Date', 'Description of Activity', 'Evidence Available', and 'Notes'. The 'Amend Personal Details' button is located to the left of the table.

Screenshot illustrating the 'Evidence' tab within the document.

The screenshot shows the 'Summary' tab of the document. It features a 'Help' button in the top right corner. Below the header, there are input fields for 'Ambulance Service:', 'Name:', 'Command Role:', and 'Job Role:'. To the right of these fields is a large grey box. Below the input fields, there is a table with the following headers: 'NOS' and 'Progress'.

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

Screenshot illustrating the 'Summary' tab within the document.



GLOSSARY AND BIBLIOGRAPHY

Airwave Tactical Advisor – Individuals trained by the National Policing Improvement Agency (NPIA) to undertake the role of the Airwave Tactical Advisor. Once trained individuals will have knowledge to provide reliable and consistent advice regarding the use of Airwave at the time of planning events, and when there are communication issues during ongoing incidents.

Ambulance Incident Commander (AIC) – The AIC is the nominated and competent Tactical Commander who has responsibility for all tactics and resources.

Ambulance Intervention Team (AIT) – AITs are Ambulance staff who have undergone additional training in responding to active shooter incidents.

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.

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).

Local Resilience Forum (LRF) – Process for bringing together all the category 1 and 2 responders within a Police Force area for the purpose of facilitating cooperation in fulfilment of their duties under the Civil Contingencies Act.

Medical Advisor (MA) – Lead medical officer responsible for clinical management at the scene of an emergency.

Medical Emergency Response Incident Team (MERIT) – Team of appropriately trained and equipped medical and/or nursing staff provided by a local Acute Trust or Foundation Trust hospital to attend the scene of an emergency.





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.

Urban Search and Rescue (USAR) – A function of HART with specific training for working with Fire and Rescue USAR teams in a USAR environment.

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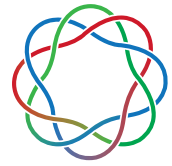
Acknowledgements

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National Ambulance
Resilience Unit
NARU



JESIP

National Ambulance Service Command and Control Guidance

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: www.naru.org.uk

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