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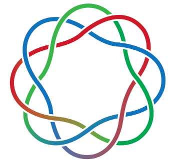

JESIP

National Ambulance Service Command and Control Guidance

January 2024
Version 5.0

National Ambulance Resilience Unit
NARU

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Summary of Amendments	• For full summary see 'Summary of Amendments, v5.0' Page 68 NB the up-to-date version of this document is available via the Proclus website.		

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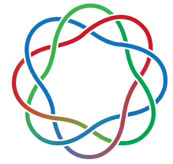

National Ambulance Service Command and Control Guidance

UPDATE TABLE

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FOREWORD

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

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

This guidance is designed to provide a structured approach to managing major or complex incidents for the ambulance service, to ensure that we are able to meet the expectations of legislation and guidance, our multi-agency partners and the needs of the public we serve by saving as many lives as possible. It is recognised that each organisation has specific needs and considerations to ensure that their incident response and business continuity arrangements are addressed through appropriate plans.

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

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.

I commend this Guidance for adoption by your Service and that ambulance service commanders at all levels are familiar, competent and confident with its contents. I believe it will further strengthen the resilience and response arrangements that exist within the Ambulance Service.

Anthony C. Marsh
Chief Executive Officer, West Midlands Ambulance Service University NHS Foundation Trust
Chairman, Association of Ambulance Chief Executives (AACE)
National Ambulance Chief Executive Lead for Emergency Preparedness

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1.0 INTRODUCTION

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

SCOPE

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

NHS Mandate for this Document

- Legislation and Statutory Provisions
- Ministerial Mandate / Lead Government Department Directive
- National Multi-Agency Doctrine (if backed by Government)
  - NHS Standard Contract (Inc. Service Condition SC30 - EPRR)
  - NHS England EPRR Framework
  - NHS England EPRR Core Standards
    - National Provisions for Interoperable Capabilities (the national safe system of work)
    - **NHS Command & Control Guidance** (this document)

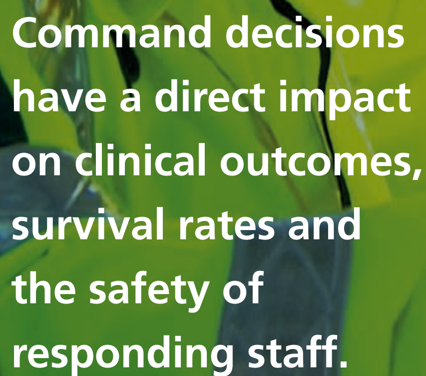
Since the publication of the first edition of this guidance, the JESIP program has been imbedded within the three blue light services and wider. This guidance fully adopts the models and principles of JESIP.

LEGAL DUTIES AND OBLIGATIONS

1.3 Further to the contract obligations, the following legal obligations are also important for ambulance service command and control.

- The Health and Safety at Work Act 1974 and its subsequent provisions requiring a safe system of work for Ambulance employees.
- The Civil Contingencies Act 2004 including the obligations placed upon Category 1 responders.
- Common law (tort of negligence), specifically the established duty of care between NHS ambulance services and the patient or casualty. Potential liability arising from negligence or gross negligence.

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



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

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

A key outcome of this guidance is, therefore, to increase the effectiveness of NHS ambulance service command by maintaining high standards of competence and credibility among NHS ambulance service commanders. Both the public and the NHS ambulance personnel who put their lives at risk to respond to complex emergency situations have a right to expect no less.

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Of fundamental importance for commanders is the need to balance the safety aspects of the response against the need to take risk in order to save life. The following duty of care diagram will assist in getting that balance right:

Duty of Care Requirement		Steps to Take	Explanation
Duty of Care to Staff	Take all reasonable and practical steps to keep employees safe.	Perform approved activities and apply the controls specified in procedures. Ensure there is a generic risk assessment already in place. Ensure you are trained and competent to undertake the activity. Ensure the minimum equipment mandated by procedures is available and used (including your Personal Protective Equipment (PPE).	These are statutory duties under the Health and Safety at Work Act 1974 and associated regulatory provisions. These steps will help ensure you have a safe system of work. Most of these provisions should already be established prior to the incident.
Duty of Care to the Patient	Provide a reasonable standard of care without any unreasonable delay.	Undertake a dynamic risk assessment and determine the action you need to take as quickly as possible. Continually review the position and deliver care as soon as possible. If you need specialist support, make sure you request it as soon as possible.	This is an established duty at common law. It is a positive duty on the ambulance service to provide a reasonable standard of care without unreasonable delay. This duty is unique to the ambulance service. The police and fire services have duties to the public at large but their duty to individual patients is largely discretionary (Kent v Griffith [2001] QB 36).
Article 2 Right to Life	Take steps to protect people from harm which may lead to loss of life.	Balance the two duties set out above.	If the correct balance is achieved (staff safety but also avoiding unreasonable delay in treating patients) this duty will be discharged. If the rescue is too dangerous for the responders, Art. 2 positive duties can be temporarily avoided.

Duty of Care Requirement		Steps to Take	Explanation
Risk Assess the Activity	Assess the risks for both staff and patients.	Supplement the pre-existing generic risk assessment with a dynamic risk assessment at the scene considering the situation and hazards. Mitigate the risks as best you can. The risk to patients must be included in that assessment. Regularly review the risk assessment.	**If the activity is likely to result in death or serious injury to you or a member of your team despite the controls, do not commit. Statutory health and safety obligations provide justification for the temporary delay in care.** **If the risk of death or serious injury to you or your team can be mitigated by a safe system of work, making the likelihood low but accepting some residual risk, you must avoid unreasonable delay in committing and providing emergency care.** **For complex or major incidents, ambulance commanders are responsible for balancing these principles.**
Multi-Agency Joint Doctrine	Contribute to the joint risk assessment as part of JESIP and ensure a common understanding of the risks.	For complex incidents involving a multi-agency response, ensure there is a joint risk assessment using the JESIP tools. Ensure the ambulance service duty of care is considered as part of this joint risk assessment.	

2.0 PREPARING TO COMMAND

AMBULANCE SERVICE RESPONSIBILITIES

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

- Initiate and maintain Ambulance Service command plans to provide appropriate support and guidance to all NHS responders and other agencies.
- Coordination of all NHS communications will be through the host/responding ambulance service provider[s].
- The management of the health, safety and welfare of all NHS responders at the scene of the incident.
- The provision of effective casualty triage, treatment and transport including the selection of appropriate receiving hospitals.
- Provision of specialist incident response capabilities, including hazardous area working, decontamination of casualties and response to terrorist incidents.
- Appropriately trained and competency assessed commanders with evidence of Continued Professional Development.
- Commander development as per the Standards for NHS Ambulance Service Command and Control.
- Ensuring all Strategic, Tactical Commanders and NILO's contributing to an on-call rota should be appropriately Security Cleared to attend sensitive meetings and briefings implied by their role.
- Ensure incidents are managed following the five principles of JESIP.

2.2 Organisations must ensure that all Commanders have an in depth knowledge of; Trust Major Incident Plan, associated plans and procedures and their own organisations capabilities including specialist assets and multi-agency capabilities. They should not be reliant on the Tactical Advisor or NILO for this.

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

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

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

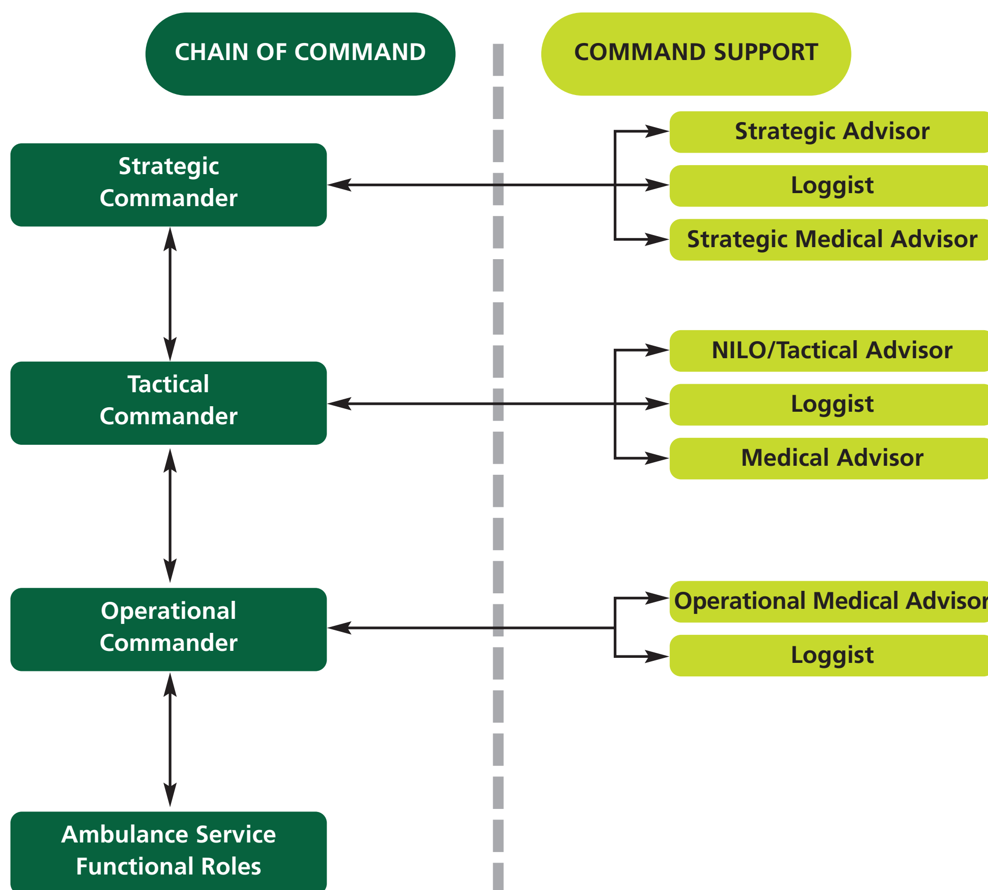


Figure 1 - The Chain of Command and Supporting Structures

INTEROPERABILITY

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

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

JESIP KEY TASKS

- JESIP models and principles have become the standard for interoperability in the UK. JESIP is the thread that should run through all plans and subsequent incidents, and recovery from these.
- To develop greater understanding of roles, responsibilities and capabilities amongst tri-service responders.
- To improve the training for all levels of command.
- To implement a joint testing an exercising strategy for all levels of command to ensure lessons identified progress to lessons learned through procedural and cultural change.

THE PRINCIPLES FOR JOINT WORKING

CO-LOCATE

Co-locate with other responders as soon as practicably possible at a single, safe and easily identified location.

COMMUNICATE

Communicate using language which is clear, and free from technical jargon and abbreviations.

CO-ORDINATE

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

JOINTLY UNDERSTAND RISK

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

SHARED SITUATIONAL AWARENESS

Establish shared situational awareness by using M/ETHANE and the Joint Decision Model.

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

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

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

LEADERSHIP

2.6 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 visible, confident and measured 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 provide clear and effective communication and possess the skills to motivate staff during the response. Commanders must focus on the needs of the task, of the group and of the individuals under their command. Effective Commanders will maintain the highest levels of integrity, to gain the trust and ultimately, the respect of their colleagues and peers.

2.8 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 and cannot 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 A post incident inquiry will investigate the level of training and competence of any Commander involved with the response; Trust and individuals with command responsibilities must be able to demonstrate competence for the role, how they achieved, updated and maintained it.

2.10 Regulations including the CCA 2004 require organisations to afford individuals in command roles the time to undertake training, exercising and maintaining CPD in line with the function that they are expected to carry out during an incident. When allocating roles, consideration should be given to the appropriateness of the task to the individual's training, experience and competence.

2.11 Ambulance Service Providers must ensure that the training of Commanders and the maintenance of Continual Professional Development (CPD) is aligned to the Core Standards for ambulance Command and Control, Training Information Sheets (TIS) and sub-competencies. Compliance with these standards will ensure a consistent approach across the Ambulance Service Providers' emergency response.

HUMAN FACTORS

2.12 The term 'human error' is often used to describe the limitations of an individual in relation to the cause of an error, often setting the cause of an incident out of the reach and control of managers and executives. Society no longer views this personal approach as acceptable and organisation's must understand human performance and limitations (factors) as an individual element in the control and management of risks. The NARU Action Cards have been developed to mitigate as far as possible any potential human error.

2.13 All Commanders have a personal responsibility to identify any gaps in knowledge or understanding that would impact in their ability to undertake their command role or apply a plan. If in doubt, "ask."

2.14 The Health and Safety Executive (HSE) defines human factors as 'the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work'. They list 3 key aspects which affect how individuals behave in relation to health and safety; these are:

- **The job**
- **The organisation**
- **The individual**

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

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

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

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

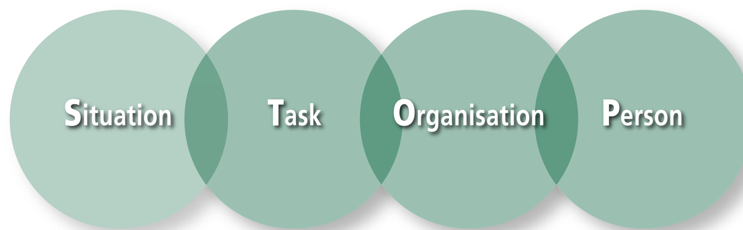


Figure 2 - STOP acronym

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

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

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

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

BUSINESS CONTINUITY MANAGEMENT

2.18 Business Continuity Management (BCM) is a statutory requirement for all Ambulance Service Providers to undertake. The Civil Contingencies Act 2004 (CCA), the Health, Social Care Act 2012, NHS England EPRR Framework 2022 and the NHS Core Standards and Standard Contract require Ambulance Service Providers to have Business Continuity Plans in place to ensure the Ambulance Service Provider is able to exercise its civil protection duties as defined by the CCA, in addition to being able to continue to perform its day to day functions. It is considered best practice for all Ambulance Service Providers to align to the ISO 22301 standard.

3.0 COMMAND AND CONTROL

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

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

The objectives for Command and Control are set within the Core Standards for Ambulance Service Command and Control.

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

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

3.3 Selection for each role within the command structure should be based on an individual's command competence which must be demonstrated through the completion of appropriate training and exercising. There is a common acceptance that some 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, relevant command training should be provided for that post holder.

NARU has embarked on a comprehensive program to maximise the benefits that the Standards for NHS Ambulance Service Command & Control, NARU Training Information Sheets (TIS) and sub-competencies offered to Commanders. 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. NHSE Clinical Guidance for use in Major Incident v2 2020 provides guidance on the minimum medical support required to provide the clinical supervision and advice necessary – not only to maximise the clinical outcomes or those affected by the incident – but also to maximise the care available to the casualties who would still require access to pre-hospital care and transport across the health community.

INCIDENT MANAGEMENT SYSTEM (IMS)

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

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

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

3.7 The Strategic, Tactical and Operational system is the spine of Incident Management, with all additional roles feeding to and from the spine. Commanders must remain focused on their level of responsibility in the command structure, without becoming involved unnecessarily with matters of the command tiers above or below. Everyone in the command structure must be disciplined and channel communications appropriately. For example, the Strategic Commander should not communicate directly with the Operational Commander or vice versa.

3.8 **CSCATTT** provides Ambulance Commanders with the key principles for dealing with any incident. These actions can be taken concurrently rather than chronologically.

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, casualties and members of the public. This is achieved through risk assessment and the identification and use of control measures.
C Communication	Commanders must ensure effective communications at incidents, internally and externally, using plain English which is free of technical jargon and acronyms. The use of interoperable communication devices is a key part of this. Commanders must also provide information to inform the development of a Joint Doctrine.
A Assessment	Using information, intelligence, risk assessments and available policies, plans and procedures, Commanders must make a full assessment of the incident. From this Commanders will develop the strategy and tactics for dealing with the incident. During the assessment phase Commanders will identify the level and types of resources required to manage the incident. This will include specialist resources such as HART and also the requirement for mutual aid.
T Triage	In order that casualties are treated in the most appropriate manner a triage process will be used. This will consist of Ten Second Triage (TST) and Major Incident Triage Tool (MITT).
T Treatment	Once casualty triage has taken place, patient care and treatment can commence and continue through to definitive care.
T Transport	The availability of transport may vary so careful consideration must be given to the capability and suitability of transport types.

JESIP Principles for Joint Working (applied to C, S, C, A):

- Co-locate
- Communicate
- Co-ordinate
- Jointly understand risk
- Shared Situational Awareness

Table 1 – CSCATTT adapted from Major Incident Medical Management and Support (2023)

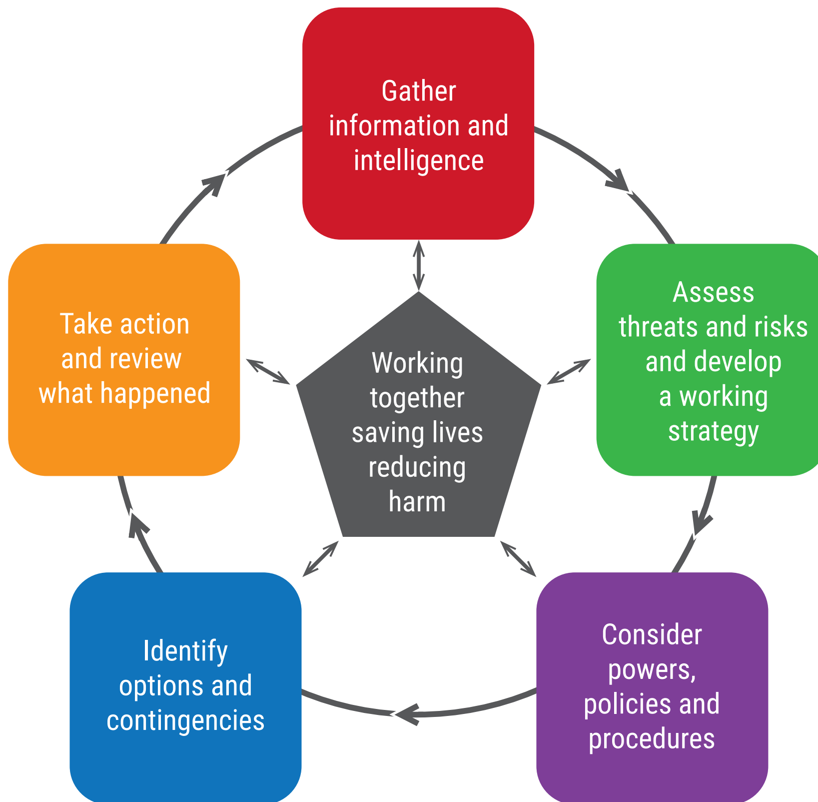


Figure 3 - Joint Decision Model (JDM)

DECISION MAKING

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

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

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

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

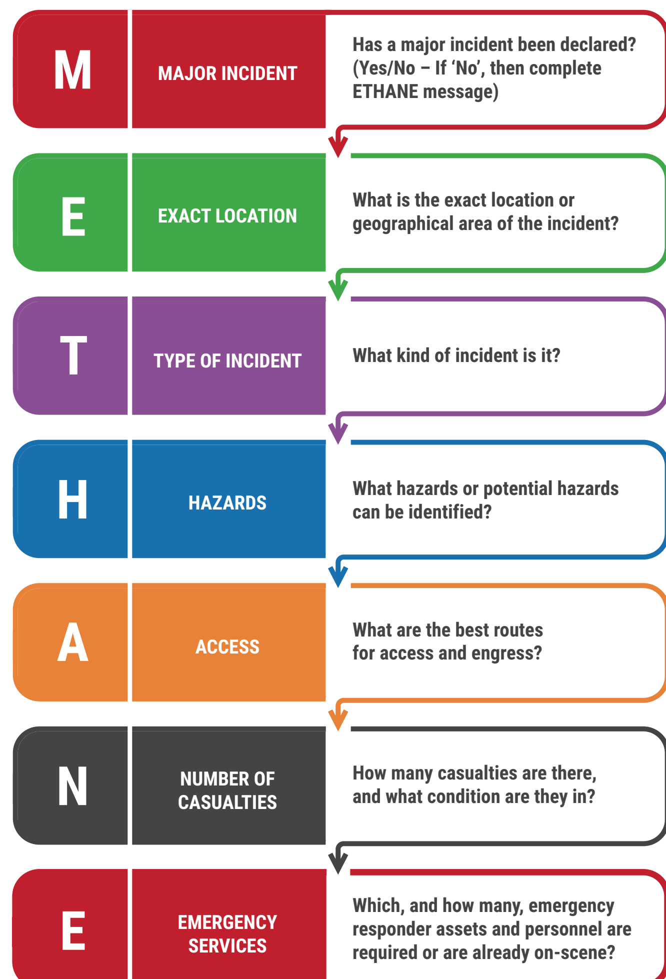
The sharing of personal data and sensitive personal data (including Police intelligence) requires further consideration before sharing across agencies and the JDM can be used as a tool to guide decision making on what to release and to whom. In considering the legal and policy implications, the following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

- A legal framework to share information is required – in an 'emergency' situation this will generally come from Common Law (save life/property), the Crime and Disorder Act 1998 or the Civil Contingencies Act 2004.

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

Gather and share information and intelligence

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



NHS

Jointly assess threats and risks and develop a working strategy

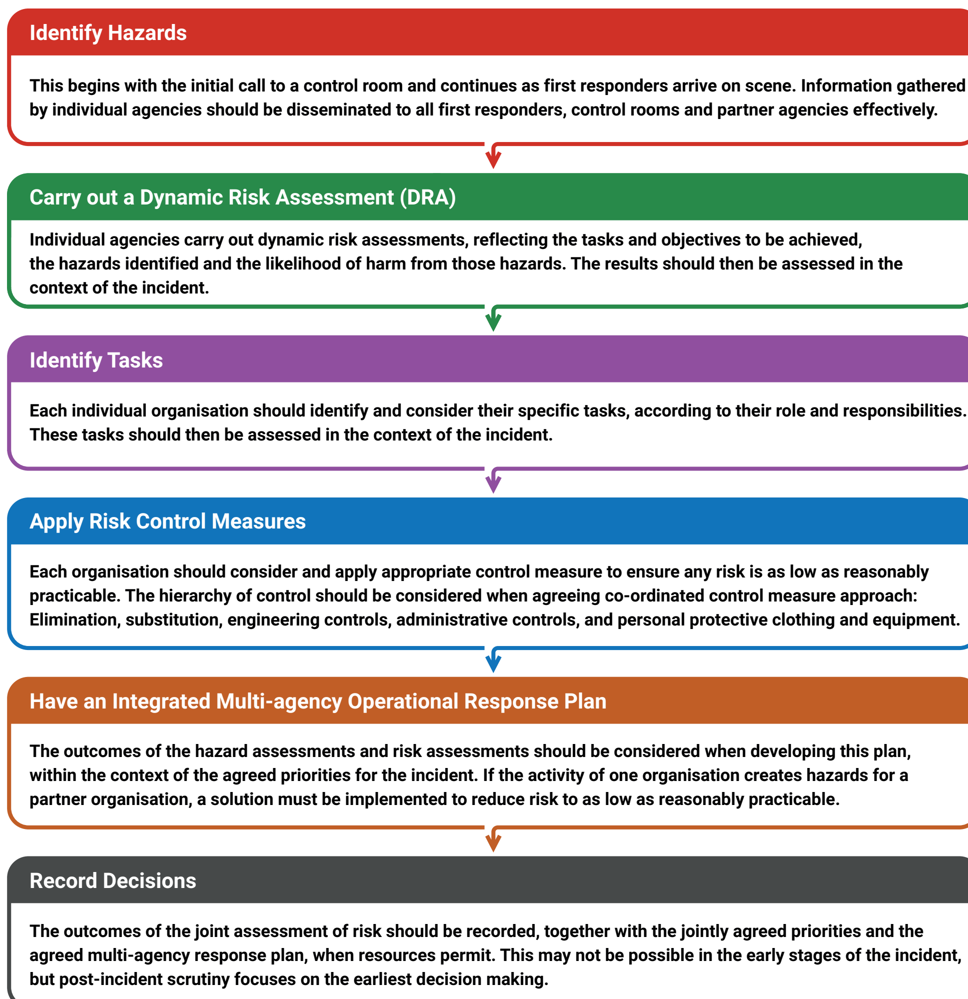
3.12 Understanding risk is central to emergency response. The Civil Contingencies Act 2004 places a requirement on all Category 1 responders to have an accurate and shared understanding of the risks which would or may affect the geographical area for which they are responsible.

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

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

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

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



It is essential that the assessment of risks are documented. 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 and assessment of risk.

OPERATIONAL DISCRETION

3.13 The term 'operational discretion' is used within the emergency services to describe decisions made by individuals which may depart from organisational protocol or standard operating procedures.

Clinicians are used to using their professional discretion to apply clinical practice guidelines to a range of different situations. In the context of complex or major incidents, operational discretion is usually used to describe command decisions.

Emergency plans and procedures are written generically to cover anticipated incidents. However, by their nature, emergencies are often dynamic with unique features.

When managing an incident, emergency service commanders or responders may need a degree of flexibility to adapt plans and procedures to achieve a desired outcome. This will often be within the context of life saving operations or situations where events are deteriorating despite existing plans and procedures being put in place.

Operational discretion should be used to provide some flexibility within a defined scope of practice. Organisations should have a policy or framework which defines the use of operational discretion by their commanders or front-line responders whilst still allowing the individual to tailor their decisions in response to the unique characteristics of the incident.

Operational discretion should not be used where existing plans and procedures fit the circumstances. Discretion is not a substitute for gaps in knowledge of what is already covered by existing provisions or what existing capabilities can achieve.

Organisations plan carefully for emergency incidents. Preparations include risk assessments, training, equipment provisions and operational procedures. Specialist capabilities also provide an increased range of capability options. These things combine to create a safe system of work which the organisation has a duty of care to maintain for its staff. Using discretion to depart from these carefully considered provisions is not without risk. Use of discretion by individuals who are employed professionals within an organisation is, therefore, limited. Any departure from approved plans and procedures will be subject to considerable post incident scrutiny. The use of operational discretion needs to be proportionate and justifiable. The amount of discretion used by an individual and the amount of flexibility exercised should also be in direct proportion to the individual's experience and competence.

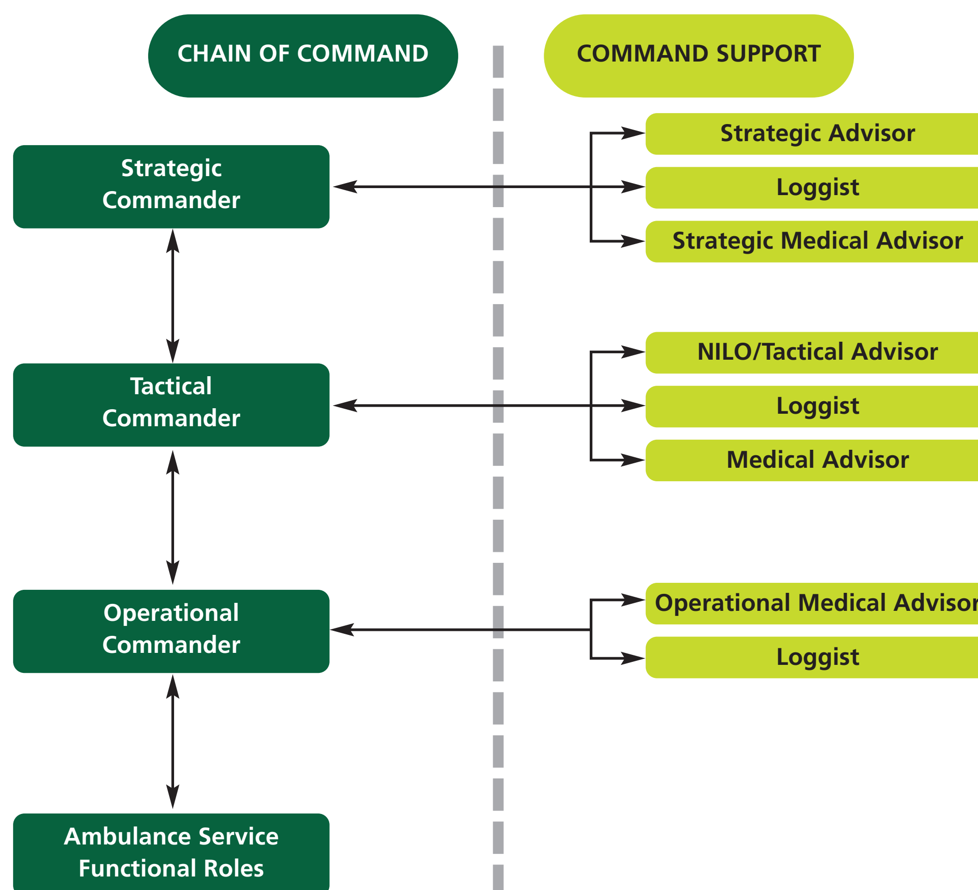
The duty of care balance between providing a safe system of work for responders and taking carefully considered risks to save life or improve clinical outcomes for patients provides an important basis for justifying the use of operational discretion [note the duty of care table on page 8 of this C2 guidance].

THE COMMAND AND CONTROL STRUCTURE

3.14 The efficiency of the Command and Control System relies on the discipline and effectiveness of each Commander within the Chain of Command; good discipline and the ability to problem solve promotes cohesion within the system.

3.15 It is important that all those who have a role within the command structure are appropriately trained and exercised to understand what they have to do, how they have to do it and when.

3.16 Chain of Command



STRATEGIC COMMANDER

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

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

3.19 To ensure multi-agency communication and coordination during a major incident or event, the Strategic Commander (or representative) will attend and effect command from the multi-agency Strategic Coordinating Group (SCG), and Health Coordination Groups if formed. A face-to-face SCG remains the optimal solution. It is recommended that a SCG is established at the earliest opportunity but within 2 hours of the declaration of a major incident and remotely if necessary. It is possible for an Ambulance Strategic Commander to initiate this Local Resilience Forum (LRF) process. However, where an incident affects only the Health Service then the Strategic Commander may decide to manage the incident from an Ambulance Service Provider location.

3.20 Whilst the Strategic Commander must not make tactical decisions, they maintain responsibility for ensuring that the tactics which are being employed are proportionate, appropriate and effective. In the event of protracted incidents or other circumstances which require the handover of command, ensure there is a robust process in place at all levels of command, included a documented handover.

3.21 The Strategic Commander's responsibilities in line with their NHS England EPRR Core Standards in Command and Control and Minimal Occupational Standards for Emergency Preparedness Resilience and Response (EPRR) version 1.0 2022 can be found in **ANNEX 1** Strategic Commander: Command and Control Roles, Performance Criteria and Responsibilities.

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

- Strategic level representatives of multi-agency partners e.g. Police, Fire, Military, Health, Maritime Coastal Agency, national and local government
- Tactical Commander
- Organisational Coordinating Centre or intelligence cell*
- Multi Agency Information Cell (MAIC)*
- 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) *
- Staff Officer *

**Denotes where applicable*

TACTICAL COMMANDER

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

- General frontline Ambulance assets
- Air Operations and Helicopter Emergency Medical Services (HEMS)
- Critical Care / Advanced Paramedics
- Casualty Clearing Stations
- Mass Casualty Vehicles
- Trust Major Incident assets

Special Operations Response Team (SORT)
- Clinical Decontamination
- Marauding Terrorist Attack (MTA)

Hazardous Area Response Team (HART)
- CBRN response
- Hazardous Materials
- Marauding Terrorist Attack (MTA)
- Support to Security Operations (SSO)
- Safe Working at Height (SWaH)
- Confined Space
- Unstable Terrain
- Water Operations and Flooding

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

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

3.24 The Tactical Commander has responsibility for the Tactical Plan **(Annex 11)** and the Casualty Management Plan **(Annex 12)**. The Tactical Plan will be developed within the framework of the Strategy and any available intelligence and associated risks.

3.25 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.

3.26 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.

3.27 Co-location of multi-agency commanders is a core JESIP principle which enables joint decision making and shared situational awareness, face-to-face, at a single and easily identified location.

3.28 The actual location of the Tactical Commander will depend on the nature and geography of an incident. Where the operational response is concentrated around a single incident scene the Tactical Commander is best placed co-locating with partners near to that scene, with a Tactical representative attending the remote Tactical Coordination Group (TCG) if one is convened. The Tactical representative at a TCG must be Tactical command trained or a NILO.

3.29 Where the impacts of an emergency are more widespread it's generally appropriate for the Tactical Commander to attend the TCG themselves however, in the event of multiple TCGs a Tactical representative or NILO may attend the TCG.

3.30 In circumstances where it's not possible for the Ambulance Tactical Commander to meet face-to-face with **all** of their Tactical counterparts it's advisable to co-locate (in person, via liaison officer, interoperability talkgroup or phone if necessary) with the lead coordinating agency's Tactical Commander (this is often the police).

3.31 The Tactical Commanders' responsibilities in line with their NHS EPRR Core Standards in Command and Control and Minimal Occupational Standards for Emergency Preparedness Resilience and Response (EPRR) version 1.0 2022. NARU Training Information Sheets (TIS) and sub-competencies. Performance criteria can be found in **ANNEX 2** Tactical Commander: Command and Control Roles, Performance Criteria and Responsibilities.

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

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

**Denotes where applicable*

OPERATIONAL COMMANDER

3.33 This role has responsibility for the activities undertaken at the scene. As such they will be collocated with the on scene commanders from other responding agencies at a Forward Command Point. The Operational Commander must ensure regular multi-agency face-to-face briefings take place.

3.34 The Operational Commander ensures that the Tactical Commander's Plan is carried out. They must understand their responsibilities and be able to apply the Tactical Plan and problem solve within the parameters of the Plan.

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

3.36 Key responsibilities for the Operational Commander can be found in **ANNEX 3** Operational Commander: Command and Control Roles, NHS EPRR Core Standards in Command and Control and Minimum Occupational Standards for Emergency Preparedness Resilience and Response (EPRR) version 1.0 2022, NARU TIS and Sub-Competencies Performance Criteria and Responsibilities.

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

- Operational Commanders from multi-agency partners e.g. Police, Fire, Military and Local Authority
- Tactical Commander
- NILO
- Emergency Operations Centre (EOC)

- Casualty Clearing Station*
- Operational Medical Advisor
- Functional roles
- Command Loggist*

**Denotes where applicable*

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

COMMAND FUNCTIONS WITHIN EMERGENCY OPERATIONS CENTRE (EOC)

3.39 Control rooms play a vital role in managing the early stages of a multi-agency incident, they are key to building a coordinated, effective multi-agency response. In the initial stages of all incidents, some command and control will need to be provided by NHS Ambulance Service's EOC.

Provision must be made for equipment to record any decisions made or actions taken (including any options considered and discounted based on the information available at the time by any remote command functions undertaken by EOC staff.

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

Operations Commander EOC:

3.40
- Initial response and resource allocation decisions based on the need and available capabilities balanced against demand.
- Single point of contact for Operational Commander for on scene updates and the agreed model for incident information sharing e.g. 'M/ETHANE'.

Tactical Commander EOC:

3.41
- Supports incident response with resources until the responding Tactical Commander is in a position to take command.
- Link between organisation Command and Control structure: Operations and EOC.
- Responsible for internal and external escalation and communications with partner agencies.
- Ensures adequate resources are available to manage the impact of the incident on core business.

SPAN OF CONTROL

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

COMMAND SUPPORT ROLES

Strategic Advisor

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

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

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

Tactical Advisor

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

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

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

National Interagency Liaison Officer (NILO)

3.47 A NILO should have a similar skill set to the Tactical Advisor but these individuals have undertaken additional nationally recognised training to liaise with other responding agencies.

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

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

MEDICAL SUPPORT ROLES

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

3.51 At the Strategic level, the Strategic Medical Advisor is principally responsible for;

- Monitoring overall NHS system capacity.
- Ensuring that patient safety throughout the wider Ambulance Trust is maintained at an acceptable level.
- They must ensure the tactical level has access to the clinical resources it requires, particularly if national mutual aid is required from other sectors of the NHS.

3.52 At the Tactical level, the Medical Advisor is principally responsible for;

- Casualty distribution from the incident(s).
- Support to the Tactical and Strategic Ambulance Commanders to transfer casualties from the scene into the appropriate medical facilities.

This role may only be required for multi-site incidents within the same system and therefore may not be required at single site incidents.

3.53 At the Operational level, multiple advanced clinical assets may be deployed in a variety of roles to optimise casualty care. The roles may include supporting clinical decision making including triage and delivery of enhanced and critical care. Where multiple advanced clinical teams are deployed a clinician will be appointed to be the Operational Medical Advisor to act as a single point of contact for Operational Commander.

The Medical Advisor will oversee and coordinate the advanced clinical practitioners which will include forward clinical teams and clinical teams within the CCP and the CCS if established.

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

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

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

- JESIP
- NHS HART operations
- NHS SORT operations
- NHS Mass Casualty capability and logistics
- NHS Major Incident Triage algorithms
- Casualty distribution within established NHS systems; such as Major Trauma Networks
- Enhanced and critical care assets including Helicopter Emergency Medical Services (HEMS) and NHS Ambulance Service critical are and advance Paramedic practice
- CBRN countermeasures
- Clinical decontamination procedures
- Pre Hospital Emergency Medicine (IBTPHEM curriculum)
- Recognition of life extinct in the forensic setting
- Management and onward distribution of over 200 casualties into the wider NHS
- NHS Ambulance Casualty Collection Point (CCP) and Casualty Clearing Station (CCS) function

3.57 Personnel discharging the Medical Advisor role (attached to the Tactical Commander) and the Operational Medical Advisor role must practice their functional role as 'player' during a relevant exercise at least every 18 months. This requirement can be substituted for reflective practice following attendance at a real emergency or operational incident.

LOGGIST

3.58 The maintenance of comprehensive decision logs is a critical part of Incident Management. Commanders are responsible for ensuring that all the decisions that they make are captured and recorded in an appropriate manner. This should include the actual decision taken, the rationale for such decisions, actions considered but discounted and any actions outstanding as a result. Where they are available, trained loggist's should be used to undertake this role. Where not available commanders are responsible for recording all decisions and actions.

COMMUNICATIONS TACTICAL ADVISOR

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

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

3.60 FUNCTIONAL ROLES

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

3.61 The HART Team Leader functional role can only be discharged by a current and competent HART Team Leader.

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

RECORD KEEPING AND LOGGING

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

3.64 In the absence of a Loggist, or digital recording format, Commanders are still expected to make and maintain contemporaneous notes.

Those contemporaneous notes should be written up in full as soon as possible, no later than 24 hours post incident.

3.65 The incident log book is a record of the decision-making process for the specific command role from the onset of involvement of the incident, event or operation until its conclusion. This log will record the evolving process and provide a clear record of the causes and effects of any courses of action taken and communicated by the post holders.

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

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

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

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

3.67 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.

3.68 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 2018

NO ELBOW

E – **E**rasures

L – **L**eaves torn out of the log

B – **B**lank spaces

O – **O**verwriting

W – **W**riting above or below the lined area

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

4.0 INCIDENT MANAGEMENT

AMBULANCE SERVICE STRATEGY

4.1 All major incidents that involve a multi-agency response and where an SCG is formed will have strategy in place. This will be developed by the Chair of the group but will be agreed by all partners. The multi-agency strategy will rarely offer specific organisational guidance to single agency Commanders. It will usually detail how the partners will work together to manage the incident in line with the JESIP Joint Doctrine.

4.2 The Ambulance Strategic Commander should produce a specific strategy for the Ambulance Service providing the guidance, parameters and justification for the Ambulance command structure to respond to the incident. An example can be found at **ANNEX 5**.

4.3 The strategy should be specific to a given incident and not generic, although some common themes will run through every strategy, such as the need to ensure the health, safety and welfare of responders.

4.4 The Strategic Commander may begin the development of the strategy on notification of the incident and they will build on it once further information and intelligence becomes available. The strategy should not be considered 'final' until the incident has closed. The strategy should be regularly reviewed throughout the incident, as a minimum at every meeting of the SCG.

4.5 In the development phase, the Commander should continually refer to the JDM (see Figure 3 on page 15) which will guide them through the points for consideration during the development of the strategy. The strategy must take account of the identified and anticipated risks identified during the threat and risk assessment process. Other drivers include the limitations and constraints of their own and others organisational and national policy, as well as the individual capability of the Commanders and other Ambulance resources, ensuring everyone remains within their scope of practice.

4.6 Whilst the strategy will provide objectives and parameters for the Tactical Commander to work within, it should not be too constraining and prevent them from performing their role. The Tactical Commander should in fact be consulted on the development of the strategy, as they will add to the intelligence picture and can offer advice on the type of tactics which may be used.

4.7 The Strategic Commander sets out the strategic intent within 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 recorded 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 concise IIMARCH 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.

National Ambulance Resilience Unit
NARU

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

TACTICAL OPTIONS

4.11 The Tactical Plan will be developed at the earliest opportunity and reviewed following receipt of the strategy from the Strategic Commander. Due to the nature of incidents, it is unlikely that the Strategic Commander will be in place before the Tactical Commander.

4.12 By using the JDM the Tactical Commander will be able to identify appropriate tactics to manage the incident in conjunction with multiagency partners. 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 contingencies will be dependent on the type and scale of incident presented. Other considerations will be existing pre-determined attendances, the environment within which the incident occurs, the number and types of casualties, and the capacity and capability of the resources available. Examples of tactical options include:

- The deployment of MTA (Marauding Terrorist Attack) responders wearing ballistic protection.
- Where necessary, the identification and use of separate hospitals for casualties. For example, Public Order incidents.
- Deployment of CBRN assets prior to an incident or event where there is an increased risk or evidence of a CBRN occurrence.
- A dedicated command structure with appropriate support functions.
- The available Personal Protective Equipment (PPE) capabilities of the Ambulance Service can be found at **ANNEX 7** Ambulance Service Personal Protective Equipment Capabilities.

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

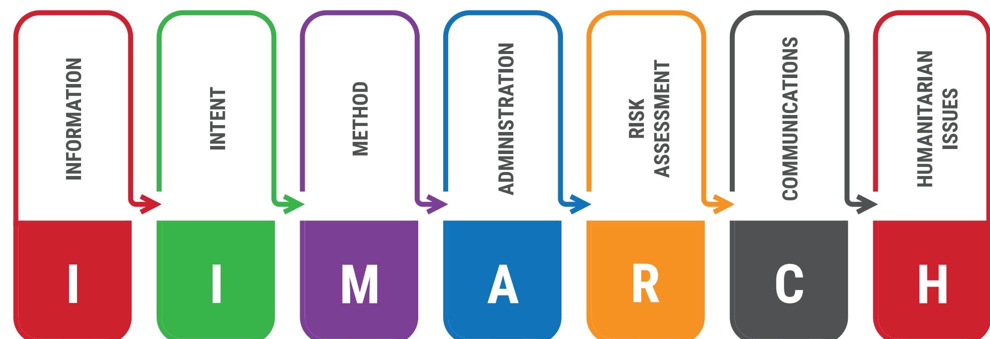


Figure 4 - IIMARCH Briefing Model

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

RISK IDENTIFICATION AND MANAGEMENT

4.16 Commanders need to identify and manage all the risks and hazards that pose a direct or indirect threat to the people under their command and those who may be affected by their action or inaction (co-responders, casualties and public). This is achieved through the application of recognised dynamic 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.

DYNAMIC RISK ASSESSMENT

4.17 Analyse the Task

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

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

i. Available intelligence and information.

ii. The type and nature of the incident and available resources (PDAs).

iii. Incident specific plans and procedures (COMAH, CBRN, Terrorist Attack).

iv. Any significant hazards arising from the incident.

v. The risks presented to:
- The public
- The Ambulance Service Provider and NHS responders
- Co-responders

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 CBRN responders, PPE and individuals capable of erecting and operating Clinical Decontamination Units.

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 operational discretion should be considered.

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

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

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

4.18 To assist in the risk identification and management process an Ambulance Safety Officer should be appointed. They will have responsibility for all Ambulance and NHS resources on site.

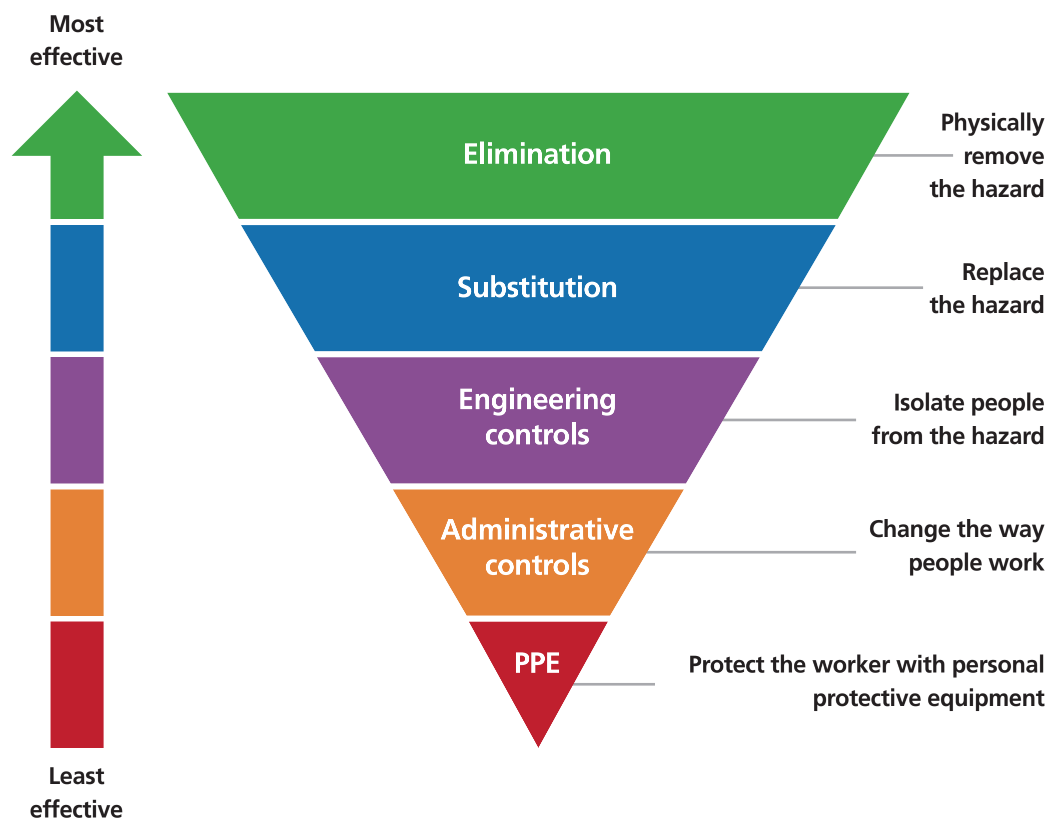


Figure 5 - Hierarchy of controls

An Analytical Risk Assessment should be completed and recorded at the earliest opportunity. This should be reviewed and where necessary revised on a regular basis.

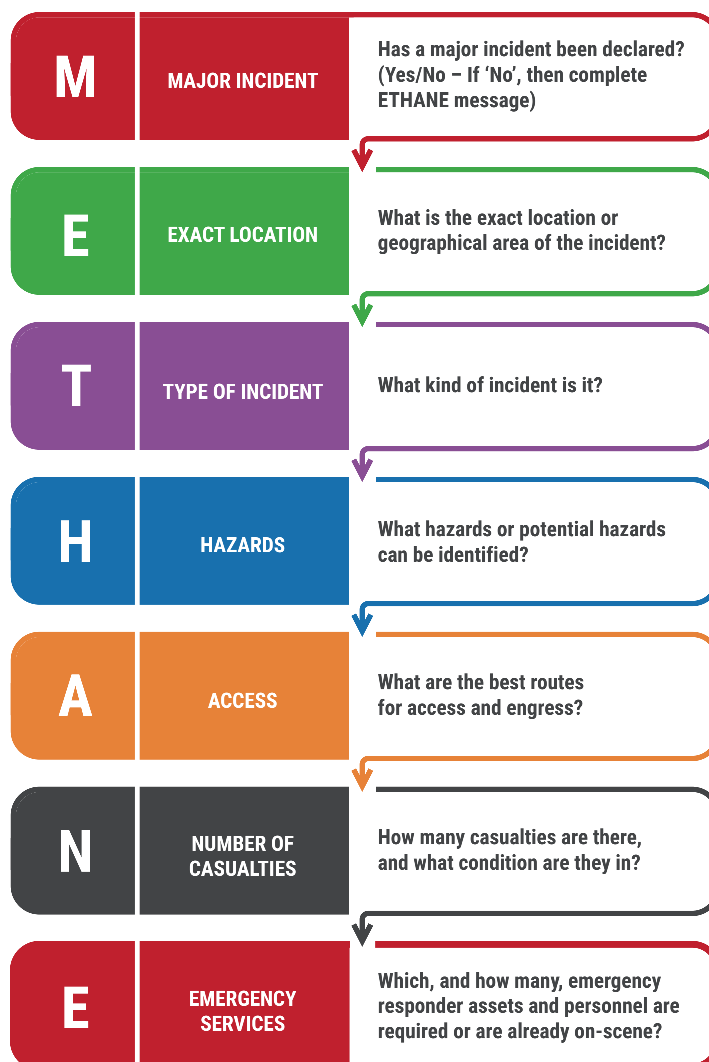
NHS

OPERATIONS AND RESOURCE MANAGEMENT

4.19 Initial identification of the incident and communication of this and the resource requirements will assist in mitigating the impact of the incident on the affected Ambulance Service Provider.

4.20 A universally accepted way of achieving this structured communication is through the use of a Sit-Rep (Situation Report). The mnemonic **M/ETHANE** is used throughout the Emergency Services.

The message should contain the information: as shown in the **JESIP Expanded M/ETHANE.**



4.21 All incidents will offer their own challenges in terms of available resources; some will require large degrees of specialist resources, (for example CBRN 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 Commander in planning for the resourcing of the incident. This is compatible with the Initial Operational Response (IOR) operating model which emphasises early identification of potential high-risk incident.

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 (due to widespread or multiple incidents resulting in multiple SCGs) to manage an incident from within Ambulance Service, then a Strategic Representative will attend the SCG as the Strategic Commander's nominated deputy with specific delegated authority.

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

COMMUNICATIONS INTEROPERABILITY

4.26 Interoperable 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.

4.27 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.

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

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

Suitably qualified communications advisors should be consulted to develop a communications plan for the incident at the earliest opportunity.

COMMAND BRIEFING

4.30 Briefing of the command team and staff is a critical aspect of command. The IIMARCH model can be used for this, it is the first opportunity that the Commander will have to deliver their plan with subsequent rationale and decisions to those who are expected to carry out the tasks.

4.31 The briefing should be a two-way process where Commanders welcome questions and feedback, however the deployment should not be unreasonably delayed, 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.

4.32 Where necessary, Commanders should ensure specialists or individuals who can add value to the briefing are included within it.

4.33 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.

4.34 Regardless of the method used, a full and accurate record of the brief should be made and retained as part of the command decision log; including who delivered the brief, who received it, the date, time and location. This should be repeated for all subsequent briefings and updates.

INFORMATION SHARING

4.35 Information sharing is a crucial element of civil protection work that underpins all forms of cooperation. Information should be shared formally and as part of a culture. Ambulance Service Providers should consider it good practice as well as their duty to share information with other responders. Procedures are set out in the regulations to formally request information from other responders. The use of interoperability talk groups and agreed critical message structures in the form of pre agreed situation reports (SITREPS) given at regular intervals will aid the information sharing process and assist in the joint understanding of risk and shared situational awareness.

4.36 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

4.37 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 including the MAIC.

Effective information sharing can only take place if partnerships between responders are embraced. This underlines the importance of Ambulance Commanders ensuring that they are fully engaged with their partner responders at all the relevant levels through the Strategic and Tactical Coordinating Groups, and at the operational front end.

AMBULANCE SERVICE COMMAND AND CONTROL IN RESPONSE TO A TERRORIST ATTACK

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

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

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

UK THREAT LEVEL				
LOW	MODERATE	SUBSTANTIAL	SEVERE	CRITICAL
Means an attack is highly unlikely.	Means an attack is possible, but not likely.	Means an attack is likely.	Means an attack is highly likely.	Means an attack is highly likely in the near future.

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

4.39 The Ambulance Service response to a terrorist attack will be influenced by the attack methodology and threat. A terrorist attack may involve the following attack methodologies;

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

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

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

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

Command and control arrangements for the Ambulance Service in response to a terrorist attack will be based upon the Command Guidance, JESIP and the JOPs.
It is essential that the Ambulance Commanders at all levels of command are flexible, adaptable and demonstrate clear leadership in response to a Terrorist Attack. An attack may be simple or complex in nature, however all attacks will require effective command and control to ensure that lives are saved and staff deployed appropriately and safely. Commanders must be prepared to accept some risk to deliver effective care to patients in the pre-hospital setting. They must act quickly where life is at risk, with a focus on rapid deployment of responders in order to save life. Dependent on attack methodology there will be significant pressure placed upon commanders to assess information rapidly in order to make effective decisions, which must be communicated clearly and concisely.

- **Improvised Explosive Devices (IED)**

IEDs can be hidden to maximise effect and it could take any shape or size. Context is key; consider what is normal for the location or situation. Treat all IEDs as REAL until you know differently.
IEDs usually contain certain key components (e.g. packaging, switch or timer, power source, initiator and main charge). Not all the components may be visible.

- **Check RVP area by conducting 5 and 20 metre check**

  - 5 Metre checks should be completed when you are going to be on scene for a limited time with limited resources.
  - 20 Metre checks should be completed when time on scene will be extended and/or there are a number of resources on scene.

- **Person Borne IED (PBIED)**
  - Maintain your minimum cordon safety distance during any movement of the subject.
  - Use hard cover if available but maintain observations.
  - Direct and / or disperse public from the immediate area and any anticipated direction of travel taken by the subject(s).

- **IED / PBIED Minimum cordon distances**

  Cordons should not be in direct line of sight. Use hard cover avoiding glass or parked vehicles.

  - **100m** for smaller items (e.g. rucksack, briefcase or PBIED).
  - **200m** for medium items (e.g. suitcase, wheelie bin or car).
  - **400m** for larger items(e.g. vans or lorries).

- **Be aware of your electronic signature:**

  Minimum safe transmission distances:

  - **15m** handheld radios, mobile phones, smart watches and PDAs.
  - **50m** vehicle radios.

- **IED Detonation and grenades**

- **Post or partial detonation**
  - For any 'Explosion' put a minimum of **100m** cordon as there may be a remaining explosive hazard.

    However, where there are casualties the situation may be too dynamic to achieve immediately.

    The rapid treatment and extrication of casualties will remain the priority.
  - Don't touch or move anything.
  - Move people away from the seat of the explosion as quickly as possible (accepting that casualties may make this a slower process).
  - Essential personnel may go forward to protect and save life, following a JDM assessment.
  - Utilise available hardcover.
  - Spend the minimum amount of time in the area as possible and keep numbers to a minimum.
  - Consider the need for respiratory protection measures. Dust, smoke, debris and CBRN hazards may be present.

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. It is imperative that a comprehensive list of all staff involved in the response to an incident is created and maintained.

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
- Share any lessons on Joint Organisational Learning (JOL) and Lessons Identified Debriefing (LID)

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

4.45 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).

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

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

5.0 COMPETENCIES AND TRAINING

NHS England EPRR Core Standards in command and control, Minimum Occupational Standards for Emergency Preparedness Resilience and Response (EPRR) version 1.0 2022, NARU Training and Information Sheets (TIS) and Sub-competencies are the mandatory system used to define what is expected of competent individuals. Ambulance Service providers must provide those people who are expected to undertake a command role, with the training and exercise opportunities that are relevant to the role they will be performing.

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

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

5.1 NHS England EPRR Core Standards in Command and Control, NHS England Minimum Occupational Standards for EPRR version 1.0 2022, NARU TIS and sub-competencies are used as tools to assist in recruitment, appraisal, job evaluation and development of individuals, teams and organisations, they ensure that all personnel are aware of their own role and what they need to be able to perform it in a competent manner. They allow for easy reference for team composition, task allocation and can provide organisations with defence when competence is questioned. Tactical, Operational and Functional roles where appropriate can use their compliance with NHS Ambulance Service Core Standards, TIS and sub-competencies usefully if called to account for their skills.

5.2 Increasingly, in a litigious society, it might prove useful to be able to claim compliance with nationally recognised standards. NHS Ambulance Service Core Standards, TIS and sub-competencies provide a framework for development and assessment.

5.3 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

5.4 In all these cases, the Occupational Standards accurately define and underpin roles and their desired outcomes.

AMBULANCE COMMANDERS CONTINUAL PROFESSIONAL DEVELOPMENT

5.5 NHS England EPRR Core Standards in Command and Control, NHS England Minimum Occupational Standards for EPRR version 1.0 2022 and NARU TIS and Sub-Competencies have provided the first rung to a consistent approach to Ambulance Service Command Development. Evidence is only valid for two years.

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

5.7 To complement to the NARU Command and Control Guidance there are National Command Assessment Tools for all levels of Command.

5.8 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 two year basis.

5.9 A cycle of ongoing education will help Commanders to develop a better understanding of incident management and enhance skills required to meet the challenges of special or major incidents. NHS Ambulance Trusts supported by NARU, should undertake an audit annually to ensure compliance with the Ambulance Commander NHS England EPRR Core Standards in Command and Control, NHS England Minimum Occupational Standards for EPRR version 1.0 2022, TIS and sub-competencies; this monitoring process will provide opportunities for sharing of best practice, skill practice and critique.

5.10 An additional benefit of the NHS England EPRR Core Standards in Command and Control, NHS England Minimum Occupational Standards for EPRR version 1.0 2022, TIS and sub-competencies 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.

5.11 Both the NHS England EPRR Core Standards in Command and Control, NHS England Minimum Occupational Standards for EPRR version 1.0 2022, TIS and sub-competencies 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.

ANNEX 1

COMMAND ASSESSMENT TOOLS

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

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

Strategic Commander Assessment Tool

Tactical Commander Assessment Tool

Operational Commander Assessment Tool

ANNEX 2

STRATEGIC COMMANDER:

Performance criteria

The Ambulance Service Strategic Commander must be able to:

1. Develop and review response, recovery and communications strategies for your organisation with appropriate stakeholders and multi-agency partners.
2. Coordinate and communicate effectively at tactical and strategic level, across health and with multi-agency partners.
3. Gather and share information and intelligence to inform effective decision-making.
4. Make effective decisions based on the best available information (e.g. through use of the Joint Decision Model).
5. Brief the strategic plan, appropriately delegate to tactical level and regularly review.
6. Ensure sufficient, appropriate resources are available to support the response.
7. Identify the long-term and medium-term recovery priorities.
8. Ensure effective and timely handover of command.
9. Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.
10. Ensure post incident support is in place.

Knowledge and understanding

The Ambulance Service Strategic Commander must know and understand:

1. The legal basis of their authority and the powers that derive from this (e.g. statute, contract, policy etc).
2. The principles of 'Emergency Response and Recovery' and the 'NHS Emergency Preparedness Resilience and Response Framework'.
3. The command and control structures for health and multi-agency emergency response.
4. The roles and responsibilities of key emergency response partners (i.e. emergency services, local authorities and other health partners).
5. The key elements of organisational and multi-agency incident and emergency plans.
6. The factors relevant to setting and reviewing the response strategy, identified in point 1 of the Performance Criteria (e.g. risk assessment, community impact, environmental impact and the longer-term recovery process).
7. The financial arrangements that are needed to enable an emergency response.
8. How to assess the short- and long-term human impact of the incident or emergency and identify the most vulnerable groups.
9. How to ensure the provision of continued support for individuals affected by an incident or emergency.
10. How to access sources of technical and professional advice
11. The information needs of the various organisations involved in the response
12. The Joint Services Interoperability Principles (JESIP) joint doctrine.

ANNEX 3

TACTICAL COMMANDER:

Performance criteria

The Ambulance Service Tactical Commander must be able to:

1. Work in co-operation with and communicate effectively with other health and multi-agency partners at the tactical level.
2. Gather and share information and intelligence to inform effective decision-making.
3. Make effective decisions (e.g., through use of the Joint Decision Model).
4. Undertake an ongoing assessment of the risks to the health of the community and to the delivery of healthcare to the community.
5. Develop tactical plans, aligned to the strategic plan, based upon available information, incident and emergency plans and the assessed risks.
6. Implement and brief tactical plans, reviewing them on an ongoing basis, in consultation with key staff and partners.
7. Determine and prioritise the resources required for the response in both the short and longer term.
8. Provide accurate and timely information to inform and protect the community, working with the media where relevant, and within the agreed organisational communication strategy.
9. Coordinate responses from the operational level.
10. Identify where circumstances warrant a strategic level of management and ensure fully briefed as required.
11. Ensure effective and timely handover of command.
12. Maintain the health, safety and welfare of individuals during the response.
13. Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.

Knowledge and understanding

The Ambulance Service Tactical Commander must know and understand:

1. The legal basis of their authority and the powers that derive from this (e.g., statute, contract, policy etc).
2. The principles of 'Emergency Response and Recovery' and the 'NHS Emergency Preparedness Resilience and Response Framework'.
3. The command and control structures for health and multi-agency emergency response.
4. How to undertake an ongoing risk assessment.
5. The roles and responsibilities of key emergency response partners (i.e., emergency services, local authorities and other health partners).
6. The key elements of organisational and multi-agency emergency plans (i.e., aim & objectives, activation process and roles and responsibilities of responding agencies).
7. The range of tactical options available and how they should be communicated.
8. How to assess the short- and long-term human impact of the incident or emergency and identify the most vulnerable groups.
9. The information needs of the various organisations involved in the response.
10. The Joint Services Interoperability Principles (JESIP) joint doctrine.

ANNEX 4

OPERATIONAL COMMANDER:

Performance criteria

The Ambulance Service Operational Commander must be able to:

1. Assess the situation and report to other responders and to tactical level
2. Identify risks and conduct a dynamic risk assessment (an Analytical Risk Assessment should be completed at the earliest opportunity).
3. Prepare, implement and review a plan of action based upon the dynamic risk assessment and tactical plan, within own operational area of responsibility.
4. Ensure that any individuals under your command are fully briefed and de-briefed.
5. Work in co-operation with, and communicate effectively with, other responders.
6. Assess resources required and deploy them to meet the needs of the response.
7. Identify resource constraints and communicate to tactical level.
8. Monitor and protect the health, safety and welfare of individuals during the response.
9. Identify where circumstance warrant a tactical level of management.
10. Make effective decisions (e.g., through use of Joint Decision Model).
11. Ensure effective and timely handover of command.
12. Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation.

Knowledge and understanding

Ambulance Service Operational Commander must know and understand:

1. Current legislation, policy and procedures relevant to the response role being undertaken, including that relating to health, safety and welfare.
2. Their relevant organisational incident and emergency plans and arrangements.
3. How they fit into the wider command and control structure (organisational & multi-agency).
4. The communication channels to be used to liaise with other responders and the chain of command.
5. The organisational policy on dealing with the media.
6. The correct procedures for handing over responsibility.
7. The purpose of recording information and the types of records that must be kept.

ANNEX 5

RECORD DECISIONS (LOGGIST):

The Loggist is responsible for ensuring that appropriate decision logs are recorded for a specified Decision Maker.

Performance criteria

The Loggist must be able to:

1. Fully record decisions, actions, options and rationale in accordance with current guidance, policy and legislation as specified by nominated Decision Maker
2. Ensure effective and timely handover of Logging.

Knowledge and understanding

The Loggist must know and understand:

1. Current legislation, policy and procedures relevant to the role of the Loggist.
2. Log keeping requirements including ways of working with the decision maker and the purpose of decision logs.

National Ambulance Resilience Unit
NARU

ANNEX 6

FUNCTIONAL ROLES

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

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

- **Ambulance - Casualty Clearing Officer (CCO)**
  A Casualty Clearing Station (CCS) should only be considered if there is an unacceptable delay in patient transportation. Responsible for the management of the CCS, they work closely with the Triage, Parking and Loading Officers and the Casualty Clearing Medical Lead (CCSML) to ensure an efficient triage and treatment of all casualties, and the appropriate use of available transport resources. The CCO is responsible for keeping a log of the number and categories of casualties who pass through the CCS.

- **Ambulance - Secondary Triage Officer**
  Responsible for coordinating the secondary triage using NHS Major Incident Triage Tool (MITT) of all casualties within the CCS. The Triage Officer should work closely with the CCO and Operational Medical Advisor. The Secondary Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged and the regular re-triage of casualties (at least every 15 minutes).

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

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

- **Ambulance – Casualty Liaison Officer**
  Responsible for communicating agreed messages to groups of casualties. They will liaise with the Ambulance Command team to ensure consistent messages are relayed.

- **Hospital Ambulance Liaison Officer (HALO)**
  Assists at A&E Departments to maintain efficient ambulance turnaround and re-equipping of ambulances. They will also liaise with the police documentation teams. An important role is to arrange relief for members of staff suffering from fatigue or stress on arrival at the hospital. The Hospital Ambulance Liaison Officer (HALO) will liaise with the hospital Management Team to ensure it is aware of the hospital's capability to receive casualties and relay information back to the Emergency Operations Centre. This officer's job is to also keep EOC updated with the current status of the hospital's Resus Bays, Theatres and ITU.

- **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.

- **Sector Commander**
  It may be necessary to divide an incident into different sectors. Where this is the case each sector should have a sector commander. This will reduce the number of reporting lines into the Operational Commander ensuring the span of control is not exceeded. When deploying a sector commander to a complex incident involving the interoperable capabilities (HART / SORT) such as a collapsed structure or working at height, the sector commander must be qualified and competent in the specific capability being deployed.

- **Casualty Clearing Station Medical Lead (CCSML)**
  Responsible for coordinating, supporting and advising paramedics and medical staff in the Casualty Clearing Station (CCS) to optimise the clinical care of all casualties attending the CCS and appropriate onward journeys to suitable receiving hospitals.

SUPPORT ROLES

- **Ambulance - Operational Medical Advisor**
  Responsible for ensuring the most appropriate medical management of casualties is undertaken within the area they are designated to (CCP, CCS or incident ground). Working closely with the Medical Advisor and Operational Commander and ensuring appropriate records are maintained for casualties.

- **Ambulance - Loggist**
  Responsible for capturing key information and decision making made by the ambulance command team during an incident.

- **Ambulance - Communications Officer**
  Responsibilities include the provision of robust communications at the scene of the incident. This may include the deployment of any mobile control units where available.

- **Ambulance - Decontamination Officer**
  Where casualties require decontamination, a Decontamination Officer will be nominated to manage that facility. This will also require the appointment of a suitably trained individual to undertake the Entry Control Officer role (ECO).

- **Ambulance - Media Liaison Officer**
  All incidents have the ability to attract media interest. The Media Liaison Officer will develop and coordinate the release of Ambulance Service Provider media statements. This will often be achieved in a multi-agency setting; however, it should always be done in line with the Ambulance Service Provider Strategy.

- **National Ambulance Coordination Centre (NACC)**
  The NACC is hosted by West Midlands Ambulance Service and is facilitated by NARU Duty Officers. The NACC Plan identifies key objectives and benefits of this facility. The NACC is to provide the focal point for the collection, collation and assessment of data regarding all Ambulance Service Providers in the UK; specifically, their ability to provide mutual aid if called upon to do so.

ANNEX 7

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

Aim

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

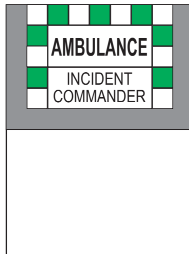
Objectives

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

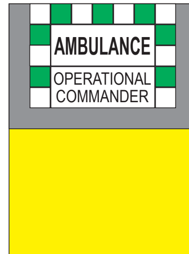
ANNEX 8

COMMAND TABARDS

Tactical Commander (Ambulance Incident Commander)
White lower half with green & white checked shoulders.

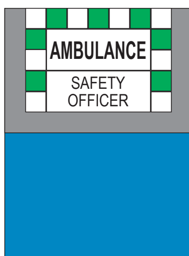


Ambulance Operational Commander and any functional role not individually listed
Yellow lower half and green & white checked shoulders.
Insert as per role.

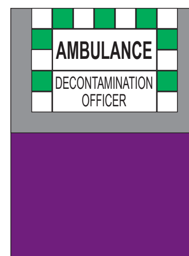


Communications Tactical Advisor
Green & white check.

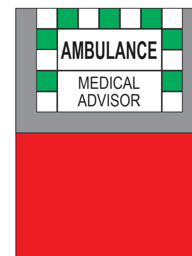
Ambulance Safety Officer (ASO)
Blue lower half with green & white checked shoulders.



Decontamination Officer
Purple lower half with green & white checked shoulders.



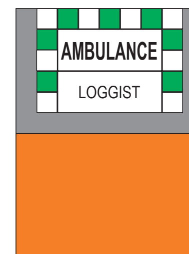
Doctor
Red lower half with green & white checked shoulders.

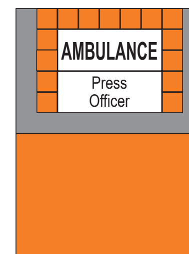


Strategic Advisor, Tactical Advisor or National Inter-Agency Liaison Officer (NILO)
Green lower half with green & white checked shoulders.
Insert as per role.

Ambulance Entry Control Officer (ECO)
Green & yellow all over check.

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





ANNEX 9

AMBULANCE SERVICE PERSONAL PROTECTIVE EQUIPMENT CAPABILITIES

Standard Ambulance Uniform

Standard Ambulance PPE

Hazardous Area Response Team Incident Ground PPE

Ballistic PPE

NXGEN PPE

Extended Duration Breathing Apparatus (EDBA) PPE

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

Powered Respirator Protective Suit (PRPS) PPE
Training suit displayed

Safe Working at Height/Confined Space/Unstable Terrain PPE

Water Operations PPE

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ANNEX 10

MODEL COMMAND STRUCTURE

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

POLICE

FIRE

POLICE

FIRE

Safety Officer

Parking Officer

Loading Officer

Hazardous Area Response Team Leader

TACTICAL COMMANDER

Tactical Advisor /NILO

Medical Advisor

COMMAND SUPPORT ROLES

OPERATIONAL COMMANDER

Sector Commanders

Operational Medical Advisor

COMMAND SUPPORT ROLES

Primary Triage Officer

Secondary Triage Officer

Casualty Clearing Officer

CCS Medical Lead

Decontamination Officer

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ANNEX 11

AMBULANCE TACTICAL PLAN TEMPLATE

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TEMPLATE

Tactical Plan Template

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

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

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

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

Tactical Plan Template

WHAT IS YOUR KEY OBJECTIVE:

OTHER AGENCIES INFORMATION:

COMMAND AND CONTROL JESIP	Command structure, chain of command Assigned roles Functions Locations NILO / Tactical Advisor (confirmation or implementation of the above)	

TEMPLATE

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Tactical Plan Template

SAFETY UNDERSTAND RISK	Ensuring safety of responders and patients with specific roles and considerations added depending on incident type. eg flooding, MTA Confirmation of regular Dynamic Risk Assessment (DRA) using ERICPD Assigned safety roles	
COMMUNICATION	Confirmation or establishment of Interoperable talk group and / or Major Incident channel Confirmation of call signs for command Back up communications Communication support Communication chain of command Confirm communications with Acute Trusts and other key partners	
ASSESSMENT SHARED SITUATIONAL AWARENESS	Scene assessment flooding/MTA/RTC METHANE Information available Impact assessment Scale / REAP Level / thinking ahead / mutual aid Casualty typing, paediatrics / burn / geriatric / trauma	

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

Tactical Plan Template

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Tactical Plan Template

TRANSPORT Continued		
RESOURCES	Consideration of specialist resources HART SORT Air Assets Mutual Aid including Command Mutual Aid NACC Welfare patients and staff Mass Casualty VAS PAS Drs Receiving Hospitals Local Authority	

Supporting Information:

TEMPLATE

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ANNEX 12

CASUALTY MANAGEMENT PLAN

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CASUALTY MANAGEMENT PLAN

Casualty Management Plan:					
Date:		Time:		Version:	

Casualty Profiling

Type of Injury/Illness	Casualty Numbers Actual/Estimated		Potential at Risk Casualty Numbers	
	Adult	Paediatric	Adult	Paediatric
Trauma				
Medical				
Burns				
CBRN/HAZMAT				
Special Circumstance				

Resources on Scene

Type	Call Sign(s)
DCA(s)	
HART	
Critical Care	
Air Ambulance	
MCV	
SORT	
Other (BASICS/MERIT etc)	

Potential Additional Resources Required

Type	Call Sign(s)	ETA
DCA(s)		
HART		
Critical Care		
Air Ambulance		
MCV		
SORT		
Other		

Casualty Numbers:

Estimated		Actual	

Personnel Committed

Organisation	Numbers

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CASUALTY MANAGEMENT PLAN

Receiving Hospital:

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

Casualty Care Pathway Schematic

Point of Injury (PoI)	Number at Risk	
Self Aid/Buddy Aid	Name(s) & C/S	Catastrophic Haemorrhage & Airway Management Extrication if possible
Initial Care	Name(s) & C/S	CABC Extricate
CCP/Critical Care	Name(s) & C/S	Advanced Clinical Care
CCS	Name(s) & C/S	S Continued Clinical Package for Transport
Hospital	Name(s) & C/S	Definitive Care & Secondary Transfer

Key

- TEXT — Incident Hazard Symbol
- RVP (P F A) — Rendezvous Point (RvP)
- CasCS — Casualty Clearing Station
- DRH — Designated Receiving Hospital

ANNEX 13

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

Standards for NHS Ambulance Service Command & Control

Including the Joint Emergency Services Interoperability Principles (JESIP)

ANNEX 14
GLOSSARY AND BIBLIOGRAPHY

- **Ambulance Safety Officer (ASO)**
  The officer with specific responsibility for the safety of personnel at the scene of an incident.

- **Blue Routes**
  A dedicated route for emergency vehicles to access and egress from the scene of an emergency or major incident.

- **Business Continuity Management (BCM)**
  Holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if realised, might cause, and which provides a framework for building organisational resilience with the capability for an effective response.

- **Business Continuity Plan (BCP)**
  Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level.

- **Casualty Loading Officer**
  The Loading Officer is responsible for the management of vehicles and the controlled onward transportation of casualties from the Casualty Clearing Station to definitive car.

- **Chemical, Biological, Radiological, Nuclear and Explosives (CBRN)**
  A term used to describe Chemical, Biological, Radiological, Nuclear and Explosive materials. CBRN terrorism is the actual or threatened dispersal of CBRN 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 Operational Medical Advisor, 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 Operational Medical Advisor 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.

- **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.

- **Hospital Ambulance Liaison Officer (HALO)**
  The Hospital Ambulance Liaison Officer will liaise with hospital medical and nursing staff regarding arrangements for reception/ discharge of casualties 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 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)**
  The furthest point to which emergency responders will operate within MTA zones.

- **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.

- **NHS England EPRR Core Standards in Command and Control, NHS England Minimum Occupational Standards for EPRR version 1.0 2022, TIS and sub-competencies**
  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**
  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 CBRN or HAZMAT.

- **Tactical Coordinating Group (TCG)**
  A multi agency group of Tactical Commanders that meets to determine, coordinate and deliver the tactical response to an emergency.

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http://www.cabinetoffice.gov.uk/resource-library/emergency-preparedness

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252341/Expectation_and_Indicators_of_Good_Practice_Set_for_category_1_2_Responders.pdf

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Health and Safety at Work etc Act 1974
http://www.legislation.gov.uk/ukpga/1974/37/contents

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
http://www.legislation.gov.uk/uksi/2010/781/contents/made

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https://www.gov.uk/search?q=emergency+response

HSG48 Reducing Error and Influencing Behaviour (1999)
http://www.hse.gov.uk/pubns/priced/hsg48.pdf

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https://www.jesip.org.uk/uploads/media/pdf/Joint%20Doctrine/JESIP_Joint_Doctrine_Document.pdf

Lexicon of UK civil protection terminology – Version 2.1.1
https://www.gov.uk/government/publications/emergency-responder-interoperability-lexicon

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http://www.alsg.org/uk/node/10

NARU National Ambulance Service CBRN/HAZMAT Guidance

NARU National Incident Action Cards

National Risk Register of Civil Emergencies (2013 Edition)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211867/NationalRiskRegister2013_amended.pdf

NHS England Command and Control Framework for the NHS during significant incidents and emergencies
http://www.england.nhs.uk/wp-content/uploads/2013/01/comm-control-frame.pdf

NHS England Emergency Preparedness Framework
http://www.england.nhs.uk/wp-content/uploads/2013/03/eprr-framework.pdf

NHS England Standards for Emergency Preparedness, Resilience and Response (EPRR)
http://www.england.nhs.uk/wp-content/uploads/2014/07/eprr-core-standards-0714.pdf

College of Policing Guidance on Command and Control
https://www.app.college.police.uk/app-content/operations/command-and-control/

Acknowledgements
This document is the intellectual property of the National Ambulance Resilience Unit (NARU).

SUMMARY OF AMENDMENTS, v5.0

Version, date updated.
Preceded document updated from v1.2 to v3.1.
Related documents and cross references updated.
Lead NARU contact title updated to Head of Operations.
Foreword updated.
Format changed to full page width.
References to IEM changed to IMS.
Standards for NHS Ambulance Service Command & Control updated to Change to EPRR Core Standards for Command and Control .
2.1 updated to include managing incidents in line with JESIP.

NILO included in SC requirements.

2.2 updated to:
Organisations must ensure that all Commanders have an in depth knowledge of Trust's Major Incident Plan Associated plans and procedures, their own organisations capabilities including specialist assets Multi-agency capabilities. They should not be reliant on the Tactical Advsor or NILO for this.

2.3 Updated to remove first paragraph.

2.4 addition of 'and other JESIP tools and products.'

JESIP Key tasks updated to; JESIP models and principles have become the standard for interoperability in the UK. JESIP is the thread that should run through all plans and subsequent incidents, and recovery from these.

Updated graphic for JESIP Principles for joint working.

Addition of JESIP graphic for Key Tasks.

Previous 2.5 Emergency Response Plans paragraph removed.

2.8 – updated to include what they 'cannot' do.

2.10 updated to add CPD.

Prev. 2.11 (now 2.10) changed to specific to CAA 2004.

Prev. 2.12 (now 2.11) Updated to: Ambulance Service Providers must ensure that the training of Commanders and the maintenance of Continual Professional Development (CPD) is aligned to the Core Standards for ambulance Command and Control, Training Information Sheets (TIS) and sub-competencies.

Compliance with these standards will ensure a consistent approach across the Ambulance Service Providers' emergency response.

Prev. 2.13 (now 2.12) updated to include: The NARU Action Cards have been developed to mitigate as far as possible any potential human error.

2.13 New paragraph added: All Commanders have a personal responsibility to identify any gaps in knowledge or understanding that would impact in their ability to undertake their command role or apply a plan. If in doubt, "ask."

2.18 Updated and inclusion of The Health and Care Act 2022 and removal of '(Regulated Activities) Regulations 2010'.

3.1 Updated to remove 'rank' and updated 'Core Standards for Ambulance Service Command and Control'.

3.2 Removal of 'day to day'.

3.3 Update to format and grammar.

Updated with change from 'Whilst NARU has produced action cards for the ambulance commanders and other roles.' To 'NARU has embarked on a comprehensive program to maximise the benefits that the Standards for NHS Ambulance Service Command & Control, Training Information Sheets (TIS) and sub-competencies offered to Commanders'

Change from; 'good and leading' to 'best'.

3.4 Change 'NARU Clinical Guidance Medical Support Minimum Requirements for a Mass casualty Incident' to 'NHS England Clinical Guidelines for use in Major Incident Version 2.0 2020'.

Change of reference of 'patients' to 'casualties'.

Prev 3.49 (now 3.50)
Removal for medical Advisor titles.

Prev 3.50 (now 3.51)
Change of format to bullet points.
'hospital' replaced with ''system' and addition of 'ensuring that patient safety throughout the trust is maintained at an acceptable level. They must ensure the…'

Prev 3.51 (now 3.52)
Change of format to bullet points.
Addition of 'This role may only be required for multi-site incidents within the same system and therefore may not be required at single site incidents.'

Prev 3.52 (now 3.53)
Updated to:
Change of format to bullet points.
Inclusion of 'Operational Medical Advisor'.
Inclusion of 'Oversee the advanced clinical practitioners, which will include forward clinical teams and clinical teams within the CCP and CCS if one is required.'

'Where multiple advanced clinical teams are deployed, one clinician will be appointed to the Operational Medical Advisor role.

Prev 3.53 (now 3.54)
Change of 'Doctor' to ' advanced clinician' and 'Tactical' to Ambulance'.

Prev. 3.54 (now 3.33)
Inclusion of 'Executive" and 'all tiers of medical advisor' to replace names roles.

Prev 3.55 (now 3.56)
Change of 'Forward Doctor' to 'Operational Medical advisor'. Inclusion of a medicine' and that they must have '' rather than 'both.

Prev 3.55 (now 3.56)
Bullet points updated:
Change of HEMS to 'Enhanced and Critical care assets including HEMS
List updated
Pre-Hospital Emergency Medicine (IBTPHEM curriculum)
Inclusion of CCP

Prev 3.56 (now 3.57)
Replacement of 'Forward Doctor' with 'Operational Medical Advisor' and inclusion of 'at least'.

3.7 Updated Triage section within CSCATTT – Check new 2023 MIMMS Table against suggested wording.

3.8 Addition of: 'These actions can be taken concurrently rather than chronologically'.

JDM graphic updated to latest JESIP version.

METHANE graphic updated to latest JESIP version.

3.10 Updated to include sentence inserted in joint decision section on ambulance commanders responsibility to ensure focus on casualties.

3.11 updated to: 'Jointly assess threats and risks and develop a working strategy'.

3.12 Removal of bullet points (previously laying out considerations such as 'Identification of Hazards etc) removed and replaced with new graphic from JESIP inserted detailing 'Process for developing a working strategy'.

Addition of requirement for documentation of assessments of risk.

3.13 – New paragraph with the inclusion of Operation discretion and description.

Pre.3.13 (now 3.14) inclusion of: 'and the ability to problem solve'.

Reordering of format from Strategic, Tactical then Operational - to - Operational, Tactical and Strategic.

Prev 3.18 (now 3.19) updated to include: A face to face SCG remains the optimal solution. This supports the recommendation from the Kerslake Report and the Manchester Area Inquiry, to establish an SCG at the earliest opportunity but within 2 hours of the declaration of a major incident and remotely if necessary. It is possible for an Ambulance Strategic Commander to initiate this LRF process.

3.19 – Removal of reference to Kerslake and Manchester Arena Inquiry.

3.20 – Command handover requirements added.

Prev 3.20 (now 3.21)
Updated to now read: 'NHS EPRR Core Standards and Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

Prev 3.22 (now 3.23)
New section included for Special Operations Response Teams (SORT) including:
Clinical decontamination
Marauding Terrorist Attack (MTA)

References to TMO replaced with SSO.

Removal of National Mass casualty capabilities from HART – new section:
Mass casualty Arrangements:
National Mass Casualty Vehicles
Trusts' Major Incident assets

Staff Officer added.

Tactical Commander paragraph updated to include: 'competent in their knowledge of these capabilities and their role as a commander.'.

NILO/Tactical Advisor term 'competence' replaced with 'knowledge'.

Removal of word 'developing' in paragraph describing the Tactical Commanders responsibilities for the Tactical and Casualty management Plan.

Multi-Agency Information Cell (MAIC) added

Prev 3.23 (now 3.24) updated to remove 'developing'.

Prev 3.27 through to 3.30 removed and replaced with: Co-location of multi-agency commanders is a core JESIP principle which enables joint decision making and shared situational awareness, face to face, at a single and easily identified location.

The actual location of the Tactical Commander will depend on the nature and geography of the incident. Where the operational response is concentrated around a single incident scene the Tactical Commander is best placed co-locating with partners near to that scene, with a Tactical-level representative attending the remote Tactical Coordination Centre (TCG) if one is convened.

Where the impacts of an emergency are more widespread it's generally appropriate for the Tactical Commander to attend the TCG themselves.

In circumstances where it's not possible for the Ambulance Tactical Commander to co-locate with each of their Tactical counterparts it's advisable for them to co-locate (face to face or via interoperability talkgroup or phone if necessary) with the lead coordinating agency's Tactical Commander (this is often the police).

3.20 – updated to include multiple TCGs and Tac Command rep.

3.20 – Inclusion of requirements for a Tactical Representative for a TCG.

3.31 Updated to: 'NHS EPRR Core Standards in Command & Control, Training Information Sheets (TIS) and sub-competencies and Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

Removal of 'Incident Coordinating Centre' from bullet points.

3.33 Updated with the text: 'As such they will be collocated with the on scene commanders from other responding agencies'.

3.34 Updated with the text: 'They must understand their responsibilities and be able to apply the Tactical Plan and problem solve within the parameters of the Plan.'

3.36 'NHS EPRR Core Standards in Command & Control, Training Information Sheets (TIS) and sub-competencies and Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

3.37 Removal of: 'Forward doctors' and 'other' from functional roles from list.
Inclusion of Medical Advisor and Tactical Advisor.

3.38 – updated to remove 'trained'.

3.39 New paragraph inserted: 'Provision must be made for equipment to record any decisions made or actions taken (including any options considered and discounted based on the information available at the time0 by any remote command functions undertaken by Control Room staff.'

Updated to remove same command levels requirement.

3.46 Updated to 'SORT (CBRN & MTA)'.

Updated to include Tac Ad have the means to access the information required.

3.41 – Updated to include 'until the responding Tactical Commander is in a position to take over command.

3.47 Inserted 'nationally recognised'.

3.53 – Updated Medical Advisor descriptor.

3.56 Bullet point list updated to 'NHS SORT operations'.
Toxic triage removed.
'Casualty' decontamination updated to 'Clinical'.

3.57 Updated to every 18 months.

3.58 Updated to include 'actions considered but discounted'. Addition od requirement for Commanders to be responsible for recording decisions and actions in the absence of a Loggist.

3.59 Updated to 'Communications Tactical Advisor'.

3.61 Updated to HART Team leader and removal of requirement to be previously qualified as a HART Operative.

Prev 3.64 now 'In the absence of a Loggist, or digital recording format, Commanders are still expected to make and maintain contemporaneous notes.
Those contemporaneous notes should be written up in full as soon as possible, no later than 24 hours post incident.'

Prev 3.64 now 3.65 now includes ''explain' replacing 'justify'.

Prev 3.67 (now 3.68) Updated to remove a bullet point and updated Classifications to 2018.

4.6 Removal of 'for the Incident Command'.

4.7 Updated to: 'The Strategic Commander sets out the strategic intent within the strategy'.

4.9 Updated to: 'When issuing the strategy, a concise IIMARCH briefing should be provided to the Tactical Commander.'.

4.11 – updated to incide review of Tactical Plan

4.12 Updated to: 'By using the JDM the Tactical Commander will be able to identify appropriate tactics to manage the incident in conjunction with multiagency partners.'.

4.13 Updates:
Removal of 'full tactical dress and'.
'Where possible' changed to 'where necessary'.
Inclusion of 'for example' before public order.
Removal of 'e' from CBRNe.
Removal of 'active shooter'.

4.14 IIMARCH graphic updated to latest JESIP version.

4.17 Removal of previous text and figure 5 for ERICPD.
List updated to Public first.
Replaced 'decontamination showers' with Clinical decontamination Units'.
Changed 'other control measures will need to be introduced' to 'operational discretion should be considered.'.

Prev 4.18 now part of 4.17.

4.17 – updated to include HSE Hierarchy of Controls model.

4.18 – updated to include Analytical Risk assessment and

4.20 METHANE graphic updated to latest JESIP version.

4.22 Remove 'Tactical' and reformat commander to lower case.
'relevant' replaced with 'compatible'.
Removal of 'they will also ensure that a system is in place for the management of resources.'.

4.24 – updated io include example of when multiple SCGs may occur. Terminology standardised throughout the document (Strategic Rep).

4.26 removed.

Prev 4.27 (now 4.26) 'Interoperability' changed to 'Interoperable'.

Prev 4.29 (now 4.28) 'Interoperability' changed to 'Interoperable'.

Prev 4.30 (now 4.29) 'Suitable' changed to 'Suitably'.

Prev 4.31 (now 4.30) 'important' changed to 'critical' and 'orders' changed to 'tasks'.

Updated to include requirement for no unreasonable delay to deployment.

Prev 4.38 (now 4.37) inclusion of 'including the Multi-Agency Information Cell (MAIC)'.

Prev 4.39 (now 4.38) Updated Threat level descriptors and graphic.

Prev 4.40 (now 4.39) replaced' determined' with 'influenced'.

From bullet point list, removal of 'Deliberate use of' and updated to MTA terminology.

Prev 4.41 (now 4.40) Updated to 'Commanders must be prepared to accept some risk to deliver effective care to patients in the pre-hospital setting. They must act quickly where life is at risk, with a focus on rapid deployment of responders to save life.'.

Inclusion of list of staff involved to be created and maintained.

4.43 – updated to include JOL and LID
5.0 Updated to include the prefix:
'NHS England EPRR Core Standards in Command & Control, NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022 and NARU Training Information Sheets (TIS) and sub-competencies are the mandatory….'

4.44 – updated to remove 'tactical' so applicable to any Commander.

Prev 5.1 now included in 5.0.

Changed throughout sections: 'NOS' to 'NHS England EPRR Core Standards in Command & Control, NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022 and NARU Training Information Sheets (TIS) and sub-competencies'.

Prev 5.5 (now 5.4) 'National' removed and replaced with 'the'.

Frequency updated to two years.

Prev 5.6 (now 5.5) updated to 'NHS England EPRR Core Standards in Command & Control, NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022 and NARU Training Information Sheets (TIS) and sub-competencies have provided the first rung to ambulance service command development. These have ben adopted by each ambulance service provider. Evidence is only valid for 18 months.

Prev 5.7 (now 5.5) 'NOS replaced with 'CPD'.

Prev 5.8 (now 5.7) Updated to: 'To compliment the NARU Command and Control Guidance there are National Command Assessment Tools for all levels of command.

Prev 5.9 (now 5.8) Updated to a recurring 2 year basis.

Command assessment Tools examples inserted as Annex 1

Prev Annex 1 (now Annex 2) Update to remove NOS and replace with 'NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

Prev Annex 2 (now Annex 3) Update to remove NOS and replace with 'NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

Point 1 = Inclusion of 'and recovery'
New Point 10 included to describe post incident support requirement.

Prev Annex 3 (now Annex 4) Update to remove NOS and replace with 'NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

Point 2 - Added identify risks and requirement for an analytical risk assessment.

Prev Annex 4 (now annex 5) Updated to include TST.
Inclusion of: 'A CCS should only be considered if there is an unacceptable delay in patient transportation.'.
'Forward medical Advisor' replaced with 'Casualty Clearing Medical Lead (CCSML)'.
Update to Ambulance Secondary Triage Officer to Include MITT triage.
Ambulance 'Patient' Liaison officer updated to term 'Casualty' throughout.
HALO role updated to replace 'RCC' with 'EOC'.

Prev Annex 5 (now Annex 6).

HALO updated to remove specifically identifying that will not always be appointed.

Prev Annex 6 (now Annex 7).

Updated to Minimum rather than National.

Includes an update to tabard title to 'Communications Tactical Advisor'.

Prev Annex 7 (now Annex 8).
Updated pictures of HART PPE ensembles.

Prev Annex 8 (now Annex 9).

Prev Annex 9 – removed.

Annex 11 – Casualty management Plan updated to Version 4.0

Annex 12 – Updated to 'NHS England Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) Version 1.0, June 2022'.

Glossary and bibliography updated.

National Ambulance
Resilience Unit

NARU

National Ambulance Service Command and Control Guidance

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