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National Ambulance Service Command and Control Guidance

Approved by:
Association of Ambulance Chief Executives

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

Foreword

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

The **National Ambulance Command and Control Guidance** represents a significant development towards enhancing the quality and capability of each Ambulance Service across both national pre-planned and mutual aid requirements. The Guidance will provide assurances to our multi agency partners of our commitment to learn from lessons of previous incidents and events and to ensure that the NHS, through the Ambulance Service, remains an essential element of the civil protection capabilities across England.

It is important to recognise and thank the individuals who contributed to the development of this Guidance. It will undoubtedly provide further support and protection to staff enabling them to deliver the best possible care and service to the public.

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

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For use by:
PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Ambulance Trust Chief Executives.

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1.0 Introduction

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

SCOPE

1.2 This Guidance document is designed to assist those responsible for planning, training and exercising, responding and recovering from a major incident. The document complements current guidance on Command and Control. Whilst the Guide is primarily aimed at the Command and Control arrangements of the Ambulance Service, the themes, principles and tools discussed are also relevant to those in other NHS responder organisations.

LEGAL REQUIREMENTS

1.3 The Civil Contingencies Act 2004 (CCA) sets out specific duties and responsibilities for emergency responders. The Ambulance Service is listed as a Category 1 Responder in Schedule 1 of the CCA which requires Category 1 responders to maintain plans for preventing emergencies and reducing, controlling or mitigating the effects of emergencies once they occur[1].

1.4 The CCA and its associated regulations require Category 1 responders to have arrangements in place to respond to major incidents.

1.5 The CCA and its associated regulations place specific responsibilities on Category 1 responders to provide training and exercising opportunities for its responders.

1.6 Commanders need to also be aware of their responsibilities under the *Corporate Manslaughter Act and Corporate Homicide Act 2007* and the *Health and Safety at Work etc Act 1974* as amended.

[1] *Emergency Preparedness (2011 update)*

2.0 Preparing to Command

AMBULANCE SERVICE RESPONSIBILITIES

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

- Initiate and maintain a Command and Control System to provide appropriate support and guidance to all NHS responders and other agencies.
- All NHS communications on scene will be coordinated through the host responding Ambulance Trusts.
- The management of the health, safety and welfare of all NHS responders.
- The Ambulance Service will provide casualty triage, treatment and transport, including the selection of appropriate receiving hospitals.
- Provision of specialist incident response capabilities, including hazardous area working, decontamination of casualties and active shooter incident.

2.2 All Commanders must familiarise themselves with their own organisation's Major Incident Plan and procedures as it is too late when the major incident is declared.

INTEROPERABILITY

2.3 Interoperability is about working together to achieve a joint aim for the benefit of an organisation, a community or a group of people. Interoperability planning requires accounting for emergency management and incident response contingencies and challenges.

2.4 Interoperability Plans should include considerations of governance, Standard Operating Procedures (SOP), technology, training and exercises, and usage within the context of the stress and chaos of a major response effort.

2.5 Coordinated decision making between agencies and departments is necessary to establish proper and coherent governance and is critical to achieving interoperability. Agreements and SOP should clearly articulate the processes, procedures, and protocols necessary to achieve interoperability.

[2] *The NHS Emergency Planning Guidance 2005 and Emergency Response and Recovery Version 3 (2010)*

LEADERSHIP

2.6 Leadership is a key attribute of an Ambulance Commander and one which they must display when carrying out their role during an emergency response. They must also be authoritative and decisive in their decision making.

2.7 Good communication is at the heart of an effective response. Communication is a key element at every level of command. Effective leaders will communicate clearly and effectively and possess the skills to motivate staff during the response. Commanders must focus on the needs of the task, of the group and of the individuals under their command. Effective Commanders will maintain the highest levels of integrity, and gain the trust and respect of their colleagues.

2.8 Commanders should consider the following factors which affect leadership:

- Effective leadership requires Commanders to have an honest understanding of who they are, what they know, and what they can do.
- Not all staff will be the same; different people require different styles of leadership.
- Staff may not be as well trained or equipped as believed.
- There will be assumptions made about the level of training received by staff and their abilities.
- Leadership requires two-way communication.
- Treat each incident on its merits.

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

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

2.11 A post incident inquiry will look into the level of training and competence of any Commander involved with the response; individuals with command responsibilities must be able to demonstrate competence for the role, in particular how they achieved, updated and maintained it. Regulations[3] require organisations to afford individuals in command roles the time to undertake training and exercise in line with the function that they are expected to carry out during an incident.

2.12 All Ambulance Trusts have signed up to the existing National Occupational Standards (NOS) for Commanders. Delivery of training and Continual Professional Development (CPD) against these Standards will help to ensure a consistent approach across the Ambulance Service emergency response.

HUMAN FACTORS

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

2.14 The Health and Safety Executive (HSE) defines human factors as 'the environmental, organisational and job factors and human and individual characteristics which influence behaviour at work'.[4] 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 This can be applied to the way Commanders will perceive tasks in an incident since rarely do the decisions they make on how to use resources come without an element of risk. 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)?

[3] *Regulation 25 of the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 and Regulation 23 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.*

[4] *HSG48 Reducing Error and Influencing Behaviour (1999)*

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

2.17 Building on the HSE model a useful acronym for this is STOP (Figure 1): Situation, Task, Organisation and Person.

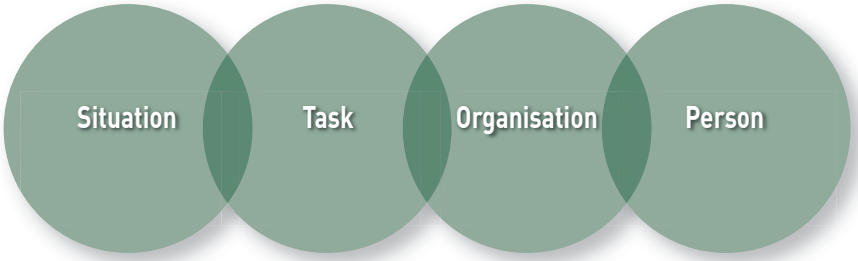


Figure 1 - STOP acronym

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

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

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

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

Some characteristics such as personality are fixed and cannot be changed. Others, such as skills and attitudes, may be changed or enhanced.

BUSINESS CONTINUITY MANAGEMENT

2.18 Business Continuity Management (BCM) is a statutory requirement for all Trusts to undertake. *The Civil Contingencies Act 2004* (CCA) and the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* require Trusts to have Business Continuity Plans in place to ensure the Trust 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.

2.19 BCM is a management led process that helps to identify and plan against risks that could affect the achievement of the Trust's objectives, its infrastructure and associated services. The short-term objective of BCM is to ensure that during challenges or disruption, at the very least, its critical services may continue. The longer term objective of BCM is to ensure that the Trust can resume normal services as quickly as possible in the aftermath of any disruptive challenge or emergency situation.

3.0 Command and Control

3.1 Command and Control is defined as the principles adopted by an organisation acting with full authority for the deployment and utilisation of its resources[5].

3.2 The Ambulance Service employs a 3 tier command system comprising of a Strategic (Gold) Commander, Tactical (Silver) Commander and an Operational (Bronze) Commander, also referred to as GSB[6]. This is a hierarchical system whereby individuals are empowered through their role within the structure, providing them with specific authority over others for the duration of the incident or event. This is regardless of the individual's rank in the organisation's day to day structure. During an incident where the command structure is activated, the day to day rank of the individual changes into that person's role within the incident.

3.3 Selection for each role within the GSB structure should be based on an individual's command competence demonstrated through the completion of training and exercise. There is a common acceptance that some roles require an individual to undertake specific command roles; where this is the rationale then the relevant command training should be provided to that post holder.

3.4 The GSB system is widely understood and adopted by partner agencies, although its application and location of certain Commanders may be open to local influence.

3.5 The Ambulance Service response to a major incident will be supplemented by other Health Service responders. *Strategic Command Arrangements for the NHS During a Major Incident (2007)* gives guidance on command, control and coordination arrangements required in planning, preparing and responding to emergencies.

INCIDENT MANAGEMENT SYSTEM (IMS) AND PRINCIPLES

3.6 The Incident Management System (IMS) 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.

[5] *NPIA Guidance on Command and Control (2009)*
[6] *Emergency Response and Recovery Version 3 (2010)*

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

3.8 The GSB system is the spine of the IMS, with all additional roles feeding to and from the spine. Commanders must remain focussed on their level of responsibility in the command structure, without becoming involved unnecessarily with matters of the command tiers above or below. Everyone in the command structure must be disciplined and channel communications appropriately. For example, where the GSB structure exists, the Gold Commander should not communicate directly with the Bronze Commander or vice versa.

3.9 CSCATTT (Table 1) provides Commanders with the key principles for dealing with any incident:

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.
Safety	Commanders must ensure the safety of all responders, patients and members of the public. This is achieved through risk assessment and the identification and use of control measures.
Communication	Commanders must ensure effective communications at incidents, internally and externally. The use of Airwave interoperability is a key part of this. Commanders must also provide information to inform the development of a Common Recognised Information Picture (CRIP).
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.
Triage	In order that casualties are treated in the most appropriate manner a triage process will be used. This will consist of an initial triage sieve, with a further triage sort. During CBRN or Active Shooter incidents the triage process may have to be modified due to the environment and the levels of PPE required for responders.
Treatment	Once casualty triage has taken place treatment can commence.
Transport	The availability of transport may vary so careful consideration must be given to the capability and suitability of transport types.

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

DECISION MAKING

3.10 Effective Command and Control can only be achieved by Commanders who are capable of making reasoned, lawful and justifiable decisions.

3.11 To support decision making there are many models available which provide a structured process. The Dynamic Decision Making Cycle (DDMC) (Figure 2) can be applied to decision making at any emergency incident and it is suitable for use by Commanders throughout the chain of command.

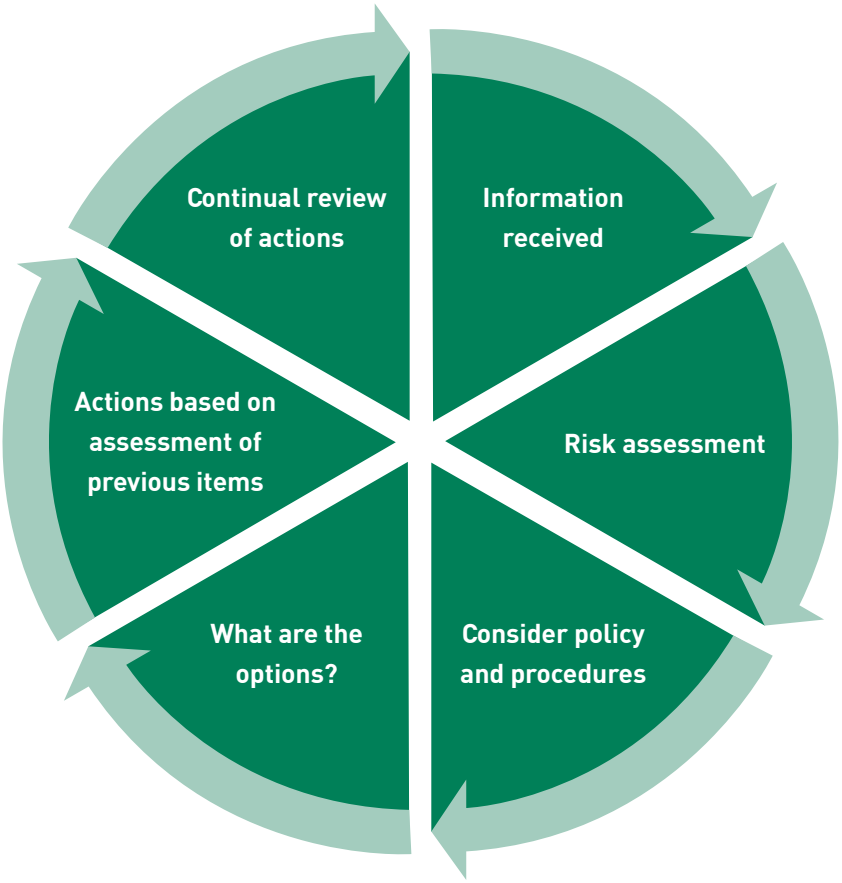


Figure 2 - Dynamic Decision Making Cycle

3.12 Constant review is provided by the receipt of new information which drives the cycle. The review process ensures the most up to date information is used to shape the response to the given incident or event.

- **Information Received** The DDMC is a dynamic model which relies on information and intelligence to inform all the following sections of the cycle. For example, in order to perform a risk assessment we must first have some information to assess. The gathering of this information and intelligence is the most important aspect of the DDMC.

Information comes in many formats from various agencies, however it is unlikely that there will be a full intelligence picture early on in an incident. All Trusts should have in place processes for the receipt, collation, evaluation, recording and, where appropriate, the sharing of information. Where information needs to be shared due diligence should be paid to any protective markings and to the clearance level of those receiving the information.

It is important that all information used in decision making is the most up to date possible and available at that time.

- **Risk Assessment** The risk assessment is an analysis of the known and perceived risks identified through the available information. A Commander will assess the likelihood of the given threat or risk occurring and if it does what the consequences would be.

  Appropriate assessment of the risks will allow the Commander to employ a number of control measures to mitigate against the consequences. The level of response and deployment will be informed by the findings of the risk assessment.

  It is important that Commanders manage the risks once identified in order that patient care is not avoidably delayed.

- **Consider Policy and Procedures** All decisions should take account of the relevant organisations' policies and procedures to ensure an appropriate and governed response.

  Reference to the relevant policies will assist the development of the Ambulance strategy for the incident. This will also ensure that the response is measured and appropriate and will support the decisions in any legal challenge.

- **What are the Options?** This includes what options are available to us? The tactical options will be developed by the Silver Commander. They should take account of any available Gold Strategy, parameters set by the Gold Commander, the type of incident, the available resources and, where available, advice from specialist advisors. For example, advice from the Tactical Advisors and the Health Protection Agency (HPA) will be relevant in CBRN incidents. The final decision as to which tactics are used always lies with the Silver Commander.

The tactical options will form part of the Tactical Plan which in turn will provide a clear description of what the chosen tactics are including any contingency arrangements and review schedules. It will also detail the roles, responsibilities and accountabilities of the Silver and Bronze Commanders.

The Tactical Plan may need to be developed in the absence of a Gold Commander since an incident/event may not have invoked a full command structure, or a Gold Commander/Strategy may not yet be in place.

A record of all considered options must be kept, whether chosen or not, together with the reasons for choosing or discarding them.

- **Actions based on assessment of the previous items** The relevant course of action can now be communicated to the appropriate resources, providing a clear directive and instruction. Where deployment is chosen then briefing of the appropriate resources must take place detailing what is expected of them. Responding resources need to understand the specific tactical option being employed, including the contingency arrangements should the situation change (for example the evacuation signal); Commanders should ensure the response parameters are explained and understood. For example, in an active shooter incident, the Limit of Exploitation (LoE) must be communicated and understood prior to deployment of resources into the incident.

- **Continual Review of Actions** Once decisions have been made Commanders now need to ensure the regular review of these decisions to ensure they remain reasoned, lawful, justifiable and current.

  Commanders may schedule a time bound review of decisions. However, reviews may take place outside the set times if new information is received or there is a change in the incident dynamics or available resources.

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

THE COMMAND AND CONTROL STRUCTURE

3.14 The efficiency of the Command and Control System relies on the discipline of each Commander within the GSB roles; good discipline 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 understand what they have to do, how they have to do it and when.

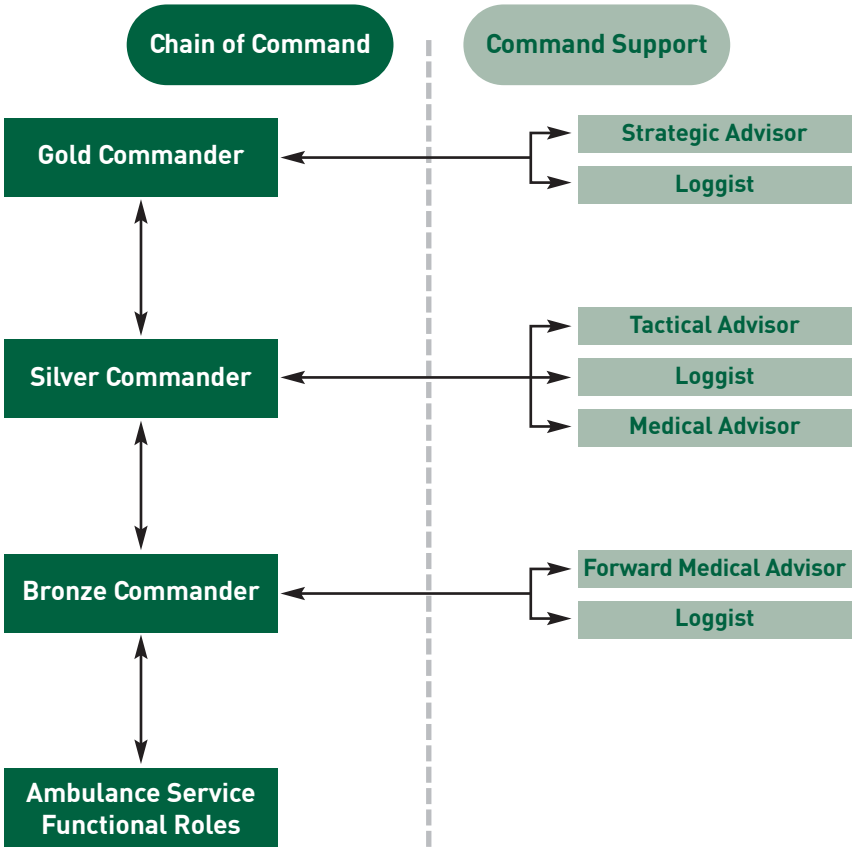


Figure 3 – The Chain of Command and Supporting Structures

STRATEGIC COMMANDER (GOLD)

3.16 The Gold Commander works at the strategic level and has overall responsibility for the command, response and recovery of an incident or appropriate pre-planned event. The Gold Commander will set the Trust's strategic aims (the Gold Strategy) for the incident, providing a framework for the Silver Commander(s) to work within.

3.17 To ensure multi agency communication and coordination during a major incident or event, the Gold Commander will attend and effect command from the multi agency Strategic Coordinating Group (SCG), if formed. However where an incident affects only the Health Service

and no SCG (or Health Gold Group) is sitting then the Gold Commander may decide to manage the incident from a Trust location.

3.18 Whilst it is not the responsibility of the Gold Commander to make tactical decisions the Gold Commander still has responsibility for ensuring that the tactics which are being employed are effective.

3.19 The Gold Commander's responsibilities in line with their National Occupational Standard performance criteria can be found in **ANNEX 1 Gold Commander:** *Command and Control Roles, Performance Criteria and Responsibilities.*

3.20 The key channels of communication for the Gold Commander are as follows:

- Gold level representatives of multi agency partners eg Police, Fire, Military, Health, national and local government
- Silver Commander (Tactical)
- Organisational Coordinating Centre or intelligence cell*
- Emergency Control Centre
- Strategic Medical Advisor*
- Executive on call*
- Media Liaison Officer*
- Command Loggist*
- Strategic Advisor or other specialist roles*
- Scientific Technical Advisory Cell (STAC)

**Denotes where applicable*

TACTICAL COMMANDER (SILVER)

3.21 The Silver Commander works at the tactical level and is also known as the Ambulance Incident Commander (AIC). The Silver Commander has responsibility for developing the Tactical Plan for the use of resources at the incident. The Tactical Plan will be developed within the framework of the Gold Strategy and any available intelligence and associated risks.

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

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

3.24 It is critical that the Silver Commander can effectively manage the incident and coordinate the Ambulance response. With this in mind they should locate themselves alongside the Silver Commanders of the other emergency services and responding agencies in order to ensure a multi agency approach to the resolution of an incident.

3.25 The actual location of the Silver Commander will be determined by the location of the Tactical Coordinating Group (TCG), which will usually be held at a local Police Station or near the incident scene.

3.26 Some agencies with different command structures will send a representative to the TCG in a liaison capacity with the AIC remaining at the scene. In cases of doubt over the location of the multi agency TCG, the Ambulance Silver Commander should where possible locate themselves alongside the Police Silver Commander (the Police will usually coordinate the response).

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

3.28 If the Silver Commander attends the incident scene without engaging with the multi agency TCG, they risk operating in isolation, which would invariably complicate and prolong the incident unnecessarily.

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

3.30 The key channels of communication for the Silver Commander are as follows:

- Silver level representatives of multi agency partners eg Police, Fire, Military, Health, national and local government
- Gold Commander (Strategic)
- Tactical Advisor/Inter Agency Liaison Officer*

- Bronze Commander (Operational)
- Tactical Medical Advisor*
- Operations Coordinating Centre*
- Emergency Control Centre
- Media Liaison Officer*
- Command Loggist*

**Denotes where applicable*

OPERATIONAL COMMANDER (BRONZE)

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

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

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

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

3.35 The key channels of communication and partnerships for the Bronze Commander are:

- Bronze Commanders from multi agency partners eg Police, Fire, Military and local authority
- Silver Commander (Tactical)
- Casualty Clearing Officer
- Primary Triage Officer
- Ambulance Parking Officer
- Ambulance Loading Officer
- Ambulance Safety Officer
- Hazardous Area Response Team (HART) Leader

- Decontamination Officer*
- Equipment Officer
- Forward Medical Advisor*
- Media Liaison Officer*
- Command Loggist*

**Denotes where applicable*

SPAN OF CONTROL

3.36 The span of control refers to the number of communication lines or direct reports an individual is expected to manage. Five reporting lines are commonly recognised to be the optimum number for one person. It is possible however that given consideration to the environment, type of incident and the level of resource, a Commander could manage up to seven lines, although due to the same factors this may be as low as two or three due to the complexity and instability of the incident.[7]

3.37 The AIC may allocate certain tasks to other individuals to undertake for example Ambulance parking. The Bronze Commander will often be tasked with delegating these roles.

3.38 It is imperative that each part of the incident is afforded appropriate attention. To assist with this, Commanders may assign key roles to other appropriately trained individuals. These are referred to as the functional roles.

FUNCTIONAL ROLES

3.39 Once the AIC has nominated a Bronze Commander, they (the Bronze) may be delegated the responsibility to then assign the functional roles.

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

3.41 The roles are aligned to a specific function within the Incident Management System. A list of the functional roles can be found in **ANNEX 4 Functional and Additional Support Roles**.

ADDITIONAL ROLES

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

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

RECORD KEEPING AND LOGGING

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

3.44 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.

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

3.46 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.

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

- *Strategic Command Arrangements for the NHS During a Major Incident*, paragraph 39
- *Emergency Preparedness*, paragraph 7.83
- *Emergency Response and Recovery*, paragraphs 4.6.1 – 4.6.4

4.0 Incident Management

AMBULANCE SERVICE STRATEGY

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

4.2 The Ambulance Gold 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.

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 Gold Commander may begin the development of the strategy on notification of the incident and they will build on it once further information and intelligence becomes available. The strategy should not be considered 'final' until the incident has closed. The strategy should be regularly reviewed throughout the incident.

4.5 In the development phase the Commander should continually refer to the DDMC model (see Figure 2 above) which will guide them through the points for consideration during the development of the strategy. The strategy must take account of the identified and anticipated risks identified during the threat and risk assessment process. Other drivers include the limitations and constraints of organisational and national policy as well as the individual capability of the Commanders and other Ambulance resources, ensuring everyone remains within their scope of practice.

4.6 Whilst the strategy will provide objectives for the incident command and parameters for the Silver Commander to work within, it should not be too constraining and prevent them from performing their role. The Silver 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 Gold Commander owns the strategy and is ultimately accountable and responsible for its content and delivery. It is imperative that all

aspects of the strategy and associated decisions are logged in the Commander's decision log, including the rationale for these and any amendments.

4.8 The strategy should be in plain English to ensure it can be understood by all the relevant people (internally and externally). The use of overly technical terms and acronyms should be avoided wherever possible. The use of such terminology by the emergency services in their planning and management has been the subject of much criticism at public inquiries and inquests.

4.9 When issuing the strategy, a full and informative (though concise) briefing should be provided to the Silver Commander to ensure the strategy is understood along with the parameters you are setting them to work within.

4.10 An example strategy can be found at **APPENDIX 1 Ambulance Service Gold Strategy**.

TACTICAL OPTIONS

4.11 The Tactical Plan will ideally be developed following receipt of the strategy from the Gold Commander. However, due to the nature of major incidents it is unlikely that the Gold Commander will be in place before the Silver Commander. Where this is the case, the Silver Commander should discuss initial thoughts and direction with the Gold Commander.

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

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

- The deployment of Ambulance Intervention Teams (AIT) wearing full tactical dress and ballistic protection into an active shooter incident.
- Identification and use of separate hospitals for casualties from incidents where there have been rival factions.

- Deployment of CBRN assets prior to an incident or event where there is an increased risk or evidence of a CBRN occurrence (party political conference for example).

4.14 Communication of the Tactical Plan to the Bronze Commander will be through an oral briefing. This provides the opportunity for ensuring the intention of the Plan is understood and assimilated, but also for any necessary challenge to be made by the Bronze Commander. Briefings should follow a systematic method, such as the IIMARC or 9 point briefing (see 4.36 - 4.37 below). An entry should be made in both the Bronze and Silver Commanders' logs that this briefing has taken place.

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

RISK IDENTIFICATION AND MANAGEMENT

4.16 Commanders need to identify and manage all the risks and hazards that pose a direct or indirect threat to the people under their command and those who may be affected by their action or inaction (co responders, patients and public). This is achieved through the application of recognised and documented risk assessments and the implementation of appropriate control measures. Not until this process has been completed can a decision be made on the tactics to be used.

4.17 The Dynamic Risk Assessment (DRA) (Figure 4) allows for a structured approach to risk management. During the selection of the safe system of work, the mnemonic ERICPD (Table 2 overleaf) can be applied to assist in choosing the appropriate course of action.

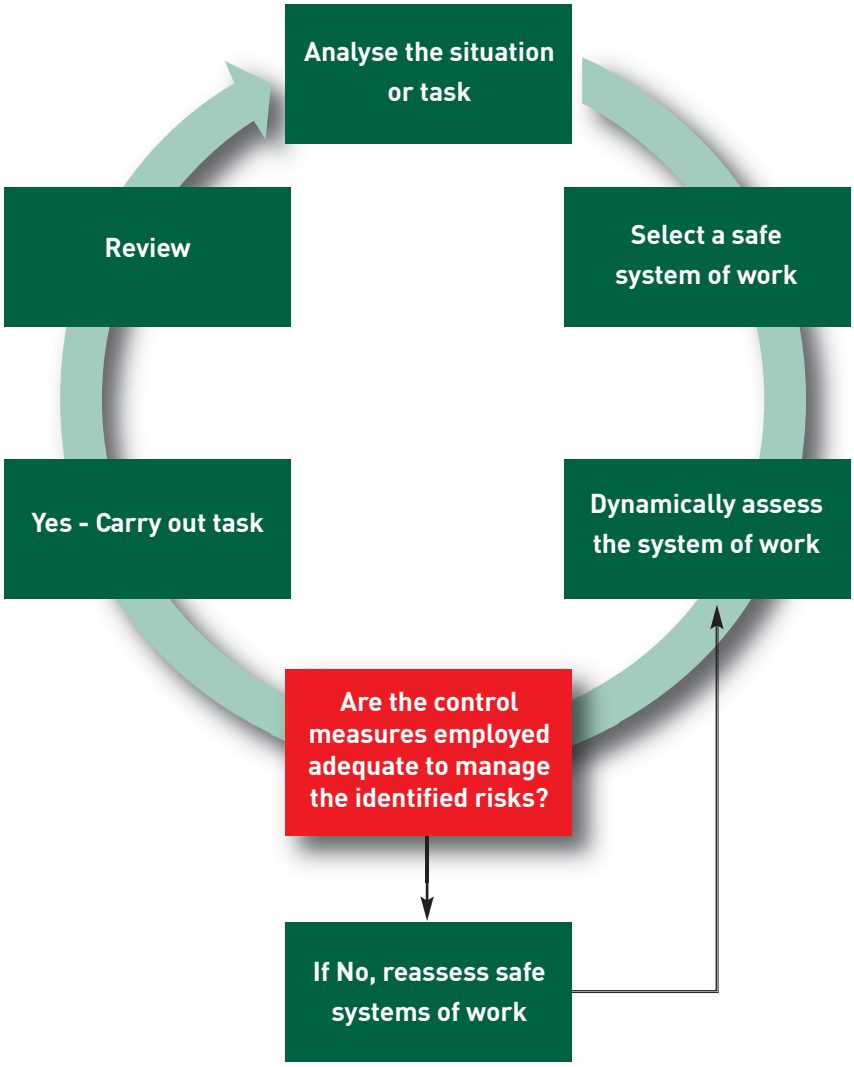


Figure 4 – Dynamic Risk Assessment

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

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

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

- **Select a safe system of work** In order that Commanders can select a safe system of work they must review the available options in line with existing plans and procedures. Selection of the appropriate course of action will be dependent on the availability of trained and competent resources and personnel. For example to facilitate a decontamination response a Commander must have available adequately trained CBRN responders, PPE and individuals capable of erecting and operating decontamination showers.

  During the selection of a safe system of work Commanders should consider the mnemonic ERICPD (Table 2 overleaf) (Institution of Occupational Safety and Health – IOSH). This provides for a structured approach to applying control measures to identified risks in a hierarchical manner.

ELIMINATE	by complete removal of the hazard - get rid of the hazard; replace it with something less hazardous.
REDUCE (by substitution)	the level of risk by reducing the nature of the hazard eg use small quantities, lower voltage.
ISOLATE	the hazard from people or the people from the hazard.
CONTROL	exposure to the hazard by controlling who has access or use procedure/protocols limiting exposure time.
PPE	Issue Personal Protective Equipment. Personal Protective Equipment should always be seen as the last resort in order to control a hazard.
DISCIPLINE	Ensuring that employees follow safe systems of work and procedures. Ensure all control measures are monitored, subject to review and enforced.

Table 2 - ERICPD

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

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

- **Yes, carry out task** Where appropriate mitigation and control measures exist then responders may be directed to carry out the identified task, but only through employment of the identified safe systems of work. This can only occur when:
  - Appropriate command and operative briefings have taken place
  - The identified control measures are in place
  - Key roles have been allocated to appropriately trained individuals

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

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

OPERATIONS AND RESOURCE MANAGEMENT

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

4.20 A universally accepted way of achieving this initial communication is through the use of a critical message. In the Ambulance Service the mnemonic **METHANE**[8] is used. The message should contain the following information:

- **M**ajor incident declared or standby. The person making the report should be explicit whether this is a major incident declaration or a standby in anticipation of the occurrence of a major incident.
- **E**xact location of the incident. Where possible the grid reference or GPS coordinates should be included, along with any landmarks or iconic sites.
- **T**ype of incident. What is the exact nature of the incident? For example a CBRN incident, active shooter or road traffic collision?
- **H**azards. What hazards are known to be present or those that could potentially manifest themselves?
- **A**ccess and egress. What are the agreed or best routes to and from the scene, including any agreed blue routes and those which need to be avoided? For example where a gas plume is present, information on avoiding this will be required.
- **N**umber of casualties. How many casualties are there and if possible what are the level and severity of injuries?
- **E**mergency Services. Which emergency services are present and which are required? Include specialist resource request if known.

[8] *Major Incident Medical Management and Support (MIMMS) – Advance Life Support Group*

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 Trust's core resource. Trusts will still be expected to maintain an appropriate response to core business and potentially achieve performance targets.

4.22 Early identification of the incident type, any hazards, numbers of casualties and resource requirements will assist the AIC in planning for the resourcing of the incident. They will also ensure that a system is in place for the management of the resources.

4.23 Requests for mutual aid should be made through the relevant control centres, providing information pertaining to the incident and the numbers and types of resources required. For example where an incident requires HART resources, then this should be stipulated in the request.

4.24 The Gold Commander facilitates any requests for external agency assistance through the SCG where possible. Where a Gold Commander decides to manage an incident from within Trust, then a Gold Liaison Manager will attend the SCG as the Gold Commander's nominated deputy.

4.25 The Silver Commander will make requests to the Gold Commander for additional or specialist resources; where more than one scene exists (multi sited incident) then the Gold Commander will make the decision as to where to best use the available resources.

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

COMMUNICATIONS INTEROPERABILITY

4.27 Interoperability voice communications is the ability to operate and communicate with other agencies in a Command and Control scenario.

4.28 Interoperability can improve communications between emergency services and appropriate partners helping to inform decision making through greater understanding of the incident and improved situational awareness.

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

4.30 The request for interoperable voice communications will be made in line with locally agreed plans and procedures, which follow the NPIA SOP for requesting Multi Agency Interoperability.

The Interoperability voice communication can be found in **APPENDIX 3 Communications Interoperability Flowchart**.

COMMAND BRIEFING

4.31 Briefing of the command team and staff is one of the single most important aspects of command. It is the first opportunity that the Commander will have to deliver their plan with subsequent rationale and decisions to those who are expected to carry out the orders.

4.32 The briefing should be a two way process where Commanders welcome questions and feedback; this will allow the Commander to ensure that the plan has not only been received, but also understood and assimilated by those that have received it.

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

4.34 If a face to face briefing is not possible then additional methods can be employed. For example written briefs, telephone or radio communication or video conferencing. Commanders should be cognisant of relevant protective markings or sensitivity of information when choosing a briefing route and that all notes and logs made before, during and after briefings may be disclosable.

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

4.36 Briefings will always work better if they are structured; there are many templates available for the delivery of briefings, such as the 9 point brief and IIMARC.

4.37 The specific elements of the IIMARC are:

- **I**nformation. An overview of the incident, what is involved, the location and any specific intelligence which pertains to the incident. When did the incident occur, what is the likely continued duration?
- **I**ntentions. What are our objectives for managing the incident? What we will do and also what we won't do (parameters).
- **M**ethod. How will we achieve our objectives for the incident, what tactics will we employ? Who has what roles and responsibilities?
- **A**dministration. Record keeping, logs, welfare arrangements, entry control.
- **R**isks. What are the known risks and hazards, are there existing control measures in place, what actions are required, who is the nominated Safety Officer? Are there any contingency plans in place in case any new hazards become present?
- **C**ommunications. What talk groups will be used, is Airwave interoperability in place, are mobile phones communications permitted, what are the arrangements for further briefings and briefing new Commanders and crews arriving at the incident? What are the debriefing arrangements for the close of the incident?

4.38 The DDMC above can also be used as a briefing process. By following the cycle, a natural review of the briefing and inclusion of further information will occur.

INFORMATION SHARING

4.39 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 Services 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.

4.40 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

4.41 Ambulance services should have arrangements in place to mark, store, handle and transfer sensitive information (including transfer by electronic means). Ambulance Services shall have regard to *Security Vetting and Protective Markings: A Guide for Responders (2009)* and any information sharing protocols of their LRFs.

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

POST INCIDENT PROCEDURES

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

4.44 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.

4.45 The debrief process will allow the organisation to:

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

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

4.47 The Lessons Identified Debrief (LID) is a system available to all Ambulance Trusts. The LID process must be initiated within 24 hours of the incident occurring to ensure the capture of all lessons.

4.48 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).

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

SPECIALIST RESOURCES

4.50 The NHS Ambulance Services offer many specialist resources in respect of incident management and response. These include:

- A dedicated command structure with appropriate support functions
- Chemical, Biological, Radiological and Nuclear decontamination
- Dedicated teams for the response to active shooter incidents
- Hazardous Area Response Teams

4.51 The available Personal Protective Equipment (PPE) capabilities of the Ambulance Service can be found at **APPENDIX 4 Ambulance Service Personal Protective Equipment Capabilities**.

5.0 Competencies and Training

NATIONAL OCCUPATIONAL STANDARDS (NOS)

5.1 National Occupational Standards are the mandatory system used to define what is expected of competent individuals. Trusts 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.

5.2 Used as tools to assist in recruitment, appraisal, job evaluation and development of individuals, teams and organisations, they ensure that all personnel are aware of their own role and what they need to be able to perform it in a competent manner. They allow for easy reference for team composition, task allocation and can provide organisations with defence when competence is questioned. Safety critical roles such as drivers, firearms officers and others can use their compliance with NOS usefully if called to account for their skills.

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

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

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

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

AMBULANCE COMMANDERS CONTINUAL PROFESSIONAL DEVELOPMENT

5.6 Skills for Justice have provided the first rung to a consistent approach to Ambulance Service commanding. In 2011 the Association of Ambulance Chief Executives (AACE) approved that these should be formalised into an Ambulance Commander NOS to be adopted by each Ambulance Trust.

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

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

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

5.10 A cycle of ongoing education will help Commanders to develop a better understanding of incident management and enhance skills required to meet the challenges of special or major incidents. The AACE will provide an audit annually to ensure compliance with the Ambulance Commander NOS; this monitoring process will provide opportunities for sharing of best practice, skill practice and critique.

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

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

THE SUITE OF STANDARDS

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

Figure 5 – Gold Commander Mandatory Suite of Standards

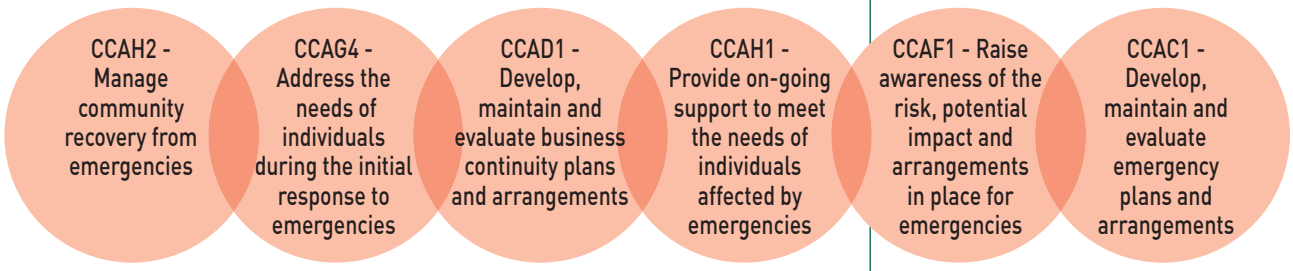


Figure 6 – Gold Commander Optional Standards

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

Figure 7 – Silver Commander Mandatory Suite of Standards

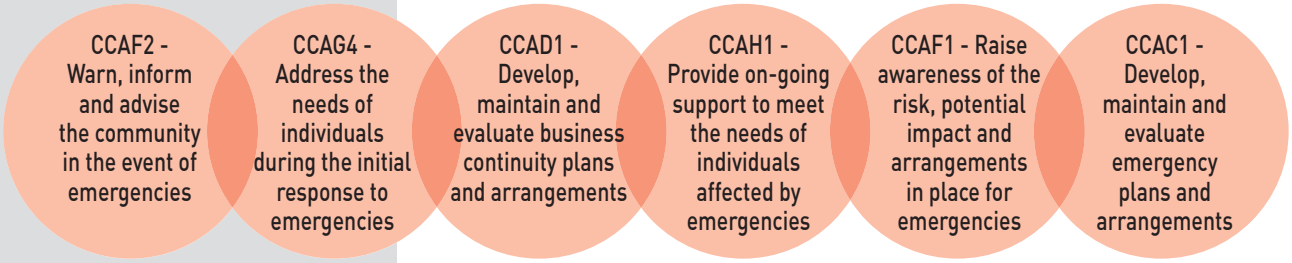


Figure 8 – Silver Commander Optional Standards

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

Figure 9 – Bronze Commander Mandatory Suite of Standards

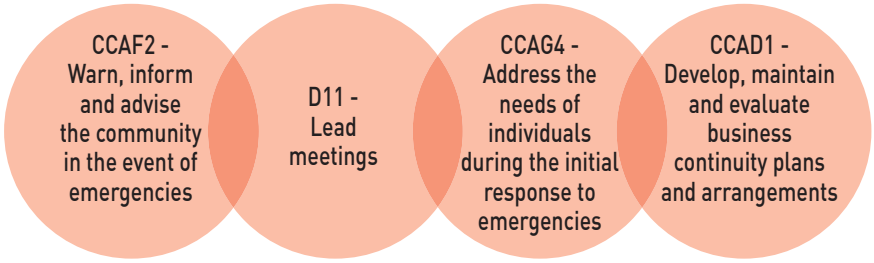


Figure 10 – Bronze Commander Optional Standards


FIRE AND RESCUE
AMBULANCE MILITARY LIAISON OFFICER

ANNEX 1 GOLD COMMANDER: COMMAND AND CONTROL ROLES, PERFORMANCE CRITERIA AND RESPONSIBILITIES

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

a) Obtain and analyse the available relevant information to inform decision making.

b) Make effective decisions based on the best available information.

c) Agree the policy and strategic framework within which the tactical (Silver) level will work and ensure effective two way communication with the tactical level.

d) Work effectively in cooperation with partner organisations at a strategic level.

e) Confirm strategic decisions agreed with responders and how these will be implemented.

f) Take action to review the strategy, updating or varying the strategy in response to changing situations or information.

g) Obtain and provide technical and professional advice from suitable sources to inform decision making where required.

h) Ensure the strategy reflects any relevant policy, legal framework or protocols.

i) Ensure the strategy takes account of the impact on individuals, communities and the environment.

j) Engage effectively in the political decision making process.

k) Review the scale of required resources and ensure their availability.

l) Ensure that all relevant organisations have sufficient, accurate information with a suitable degree of urgency to enable effective coordination of response.

m) Ensure the development and implementation of an effective communications strategy.

n) Address medium and long-term priorities to facilitate the recovery of affected communities.

o) Ensure provision of continued support for individuals affected by emergencies.

p) Ensure effective delegation to the tactical level.

q) Evaluate the effectiveness of the strategy and use this information to inform future practice.

r) Fully record your decisions, actions, options and rationale in accordance with current information, policy and legislation.

s) Ensure all Tactical Commanders are subject to a hot debrief.

t) Provide a public relations link with the wider community.

u) Follow any action cards specific to the Silver Commander role as issued by the host Ambulance Trust.

ANNEX 2 SILVER COMMANDER: COMMAND AND CONTROL ROLES, PERFORMANCE CRITERIA AND RESPONSIBILITIES

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

a) Obtain sufficient information to determine the current status of the response. This should include ensuring that a detailed and formal handover is received from the acting Ambulance Incident Commander (AIC) and that the whole command chain is aware that such a handover has taken place and appropriate log entries are made.

b) Formulate a Tactical Plan which takes account of all available information, including any pre determined emergency plans, and anticipated risks.

c) Implement tactics in a timely manner, confirming roles, responsibilities, tasks, and communication channels.

d) Conduct on-going risk assessment and management in response to the dynamic nature of emergencies.

e) Review tactics with relevant others including key personnel involved in command, control and coordination.

f) Ensure actions to implement tactics are carried out, taking into account the impact on individuals, communities and the environment.

g) Determine priorities for allocating available resources.

h) Anticipate likely future resource needs, taking account of the possible escalation of emergencies.

i) Work in cooperation and communicate effectively with other responders.

j) Liaise with relevant organisations to address the longer-term priorities of restoring essential services and helping to facilitate the recovery of affected communities.

k) Obtain and provide technical and professional advice from suitable sources to inform decision making where required.

l) Provide accurate and timely information to inform and protect communities, working with the media where relevant.

m) Monitor and maintain the health, safety and welfare of individuals during the response.

n) Review actions taken at operational (Bronze) level.

o) Identify where circumstances warrant a strategic (Gold) level of management and engage with the strategic level as required.

p) Ensure that any individuals under your area of authority are fully briefed and debriefed.

q) Evaluate the effectiveness of tactics and use this information to inform future practice.

r) Fully record your decisions, actions, options and rationale in accordance with current information, policy and legislation.

s) Ensure engagement with multi agency responders, providing a joined up and proportionate response.

t) Request Airwave interoperability where appropriate.

u) Ensure appropriate control measures are employed to manage all identified risks, reviewing and updating logs and risk assessments as appropriate.

v) Follow any action cards specific to the Silver Commander role as issued by the host Ambulance Trust.

ANNEX 3 BRONZE COMMANDER: COMMAND AND CONTROL ROLES, PERFORMANCE CRITERIA AND RESPONSIBILITIES

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

a) Make an initial assessment of the situation and report this to other responders in accordance with established procedures.

b) Ensure a METHANE message is communicated to the relevant Emergency Control Centre.

c) Prepare and implement an initial plan of action.

d) Ensure actions are carried out, taking into account the impact on individuals, communities and the environment.

e) Conduct on-going risk assessment and management in response to the dynamic nature of emergencies.

f) Work in cooperation and communicate effectively with other responders.

g) Confirm the availability and location of relevant services and facilities.

h) Identify any resources required and deploy them to meet the demands of the response.

i) Ensure the establishment of the functional roles required to manage the incident and that appropriately trained individuals undertake each role.

j) Communicate any resource constraints to the relevant person, or find suitable alternatives.

k) Monitor and protect the health, safety and welfare of individuals during the response.

l) Deal with individuals in a manner which is supportive and sensitive to their needs.

m) Liaise with relevant organisations as required for an effective response.

n) Identify where circumstances warrant a tactical (Silver) level of management and engage with the tactical level as required.

o) Implement the Tactical (Silver) Plan where applicable, within a geographical area or functional area of responsibility.

p) Ensure that any individuals under your area of authority are fully briefed and debriefed.

q) Fully record your decisions, actions, options and rationale in accordance with current information, policy and legislation.

r) Follow any action cards specific to the Bronze role as issued by the host Ambulance Trust.

ANNEX 4 FUNCTIONAL AND ADDITIONAL SUPPORT ROLES

Airwave Tactical Advisor Where they exist, Airwave Tactical Advisors (ATA) can provide reliable and consistent advice regarding the use of the Airwave radio system, and their advice should be sought. ATAs can facilitate the needs of the multi agency responders during the initial planning phase of any event or operation and during a spontaneous incident by providing operational and technical knowledge of Airwave and assist in developing a communications plan ensuring optimal use is made of available talkgroups whilst remaining cognisant of coverage and capacity[9].

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

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

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

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

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

Ambulance Military Liaison Officer (AMLO) A person trained and equipped to liaise with the military advising on Ambulance Service requirements and capabilities.

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

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

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

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

Forward Medical Advisor (FMA) A Forward Medical Advisor will work closely with the Bronze Commander to ensure that the medical provision on-scene is coordinated and appropriate.

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 Bronze Commander ensuring they carry out the objectives of the Ambulance Service response in line with the Tactical Plan.

Hospital Ambulance Liaison Control Officer (HALCO) Where it is possible, a HALCO should be dispatched to receiving hospitals. The HALCO's prime responsibility is to liaise with the hospital coordination team to maintain communications.

Hospital Ambulance Liaison Officers (HALO) Based at receiving hospitals and working closely with the hospital management team (medical and operations), the HALO will ensure that capacity issues are addressed early on, advising the Ambulance Incident Commander (AIC) of the requirement to find alternative hospitals. They will also facilitate the swift handover and turnaround of Ambulance resources.

Inter Agency Liaison Officer (ILO) A trained and qualified officer who can advise and support Commanders, Police, medical, Fire, military and government agencies on the operational capacity and capability of their organisation.

Loggist The maintenance of comprehensive decision logs is a critical part of the IMS. Commanders are responsible for ensuring that all the decisions that they make are captured and recorded in an appropriate manner. This should include the actual decision taken, the rationale for such decisions and any actions outstanding as a result. Where they are available trained loggists should be used to undertake this role.

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

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

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

APPENDIX 1
AMBULANCE SERVICE GOLD STRATEGY

AMBULANCE SERVICE GOLD STRATEGY

It is the intention of the Ambulance Trust 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 Trust. Through effective coordination, sound planning and good leadership the Gold Commander will:

1. Maintain public confidence and minimise the impact of the incident by ensuring that the Ambulance Trust is responding effectively to the incident.

2. Ensure that the Ambulance Trust response is coordinated and integrated with the wider health and responding agencies.

3. Ensure that the Ambulance Trust response is coordinated and integrated with the other responding agencies where applicable.

4. Maintain effective capacity management within the Emergency and non-emergency Service and the Emergency Control Centres 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.

5. 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

6. Ensure public messages are coordinated with other agencies and partners.

7. Ensure effective Business Continuity and Recovery arrangements are in place across the organisation and review where necessary.

8. Provide support and representation at the RCCC where appropriate.

9. Create and maintain a well documented, auditable plan and decision log for the incident at all levels of command.

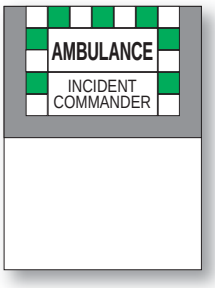
10. Review this strategy every 4 hours.

Signature **(GOLD COMMANDER)**

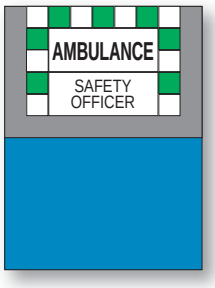
Date: **Time:**

APPENDIX 2
COMMAND TABARDS

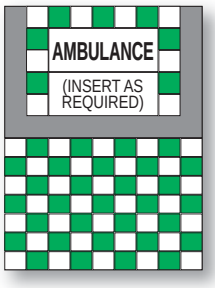
Ambulance Incident Commander (AIC)
White lower half with green & white checked shoulders.



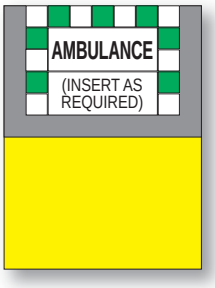
Ambulance Safety Officer (ASO)
Blue lower half with green & white checked shoulders.



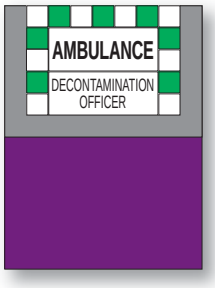
Command Support or Airwave Tactical Advisor
Green & white check



Ambulance Bronze Commander and any functional role not individually listed
Saturn yellow lower half and green & white checked shoulders.

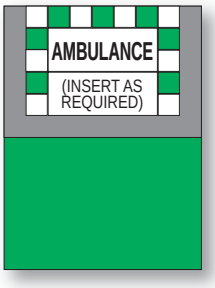


Decontamination Officer
Purple lower half with green & white checked shoulders.



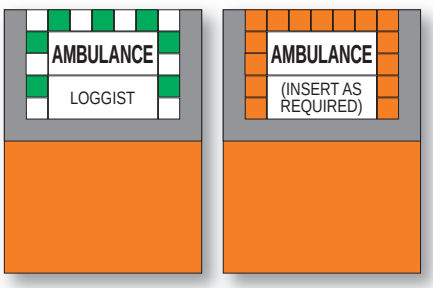
Medical Advisor (Doctor)
Red lower half with green & white checked shoulders.

Strategic Advisor, Tactical Advisor or Inter agency Liaison Officer (ILO)
Green lower half with green & white checked shoulders.

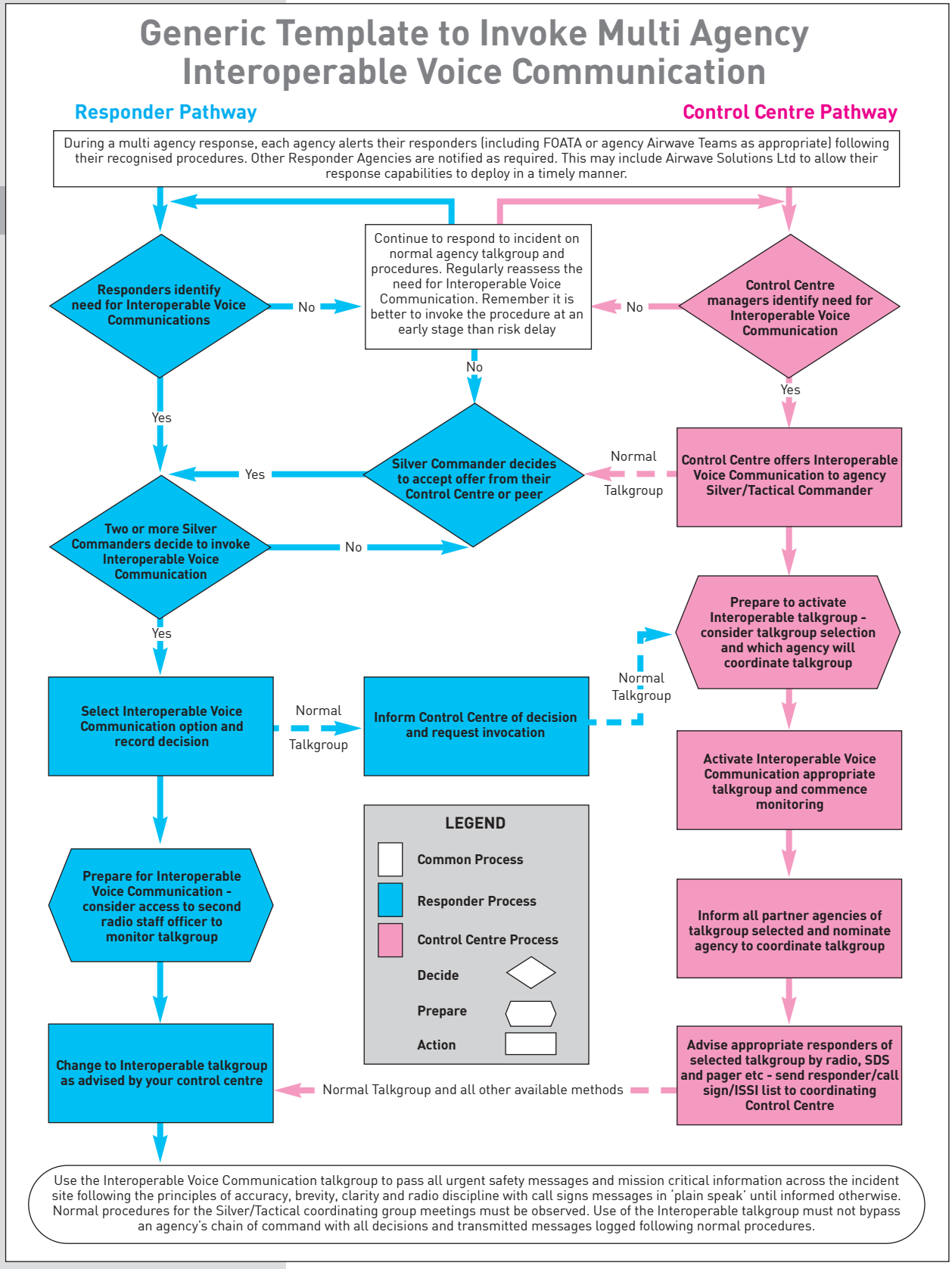


Ambulance Entry Control Officer (ECO)
Green & yellow all over check.

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



APPENDIX 3
COMMUNICATIONS INTEROPERABILITY FLOWCHART



APPENDIX 4
AMBULANCE SERVICE PERSONAL PROTECTIVE EQUIPMENT CAPABILITIES

Standard Ambulance Uniform

Standard Ambulance PPE

Hazardous Area Response Team Incident Ground PPE

Ambulance Intervention Team Ballistic PPE

Civil Responder (CR1) PPE

Extended Duration Breathing Apparatus (EDBA) PPE

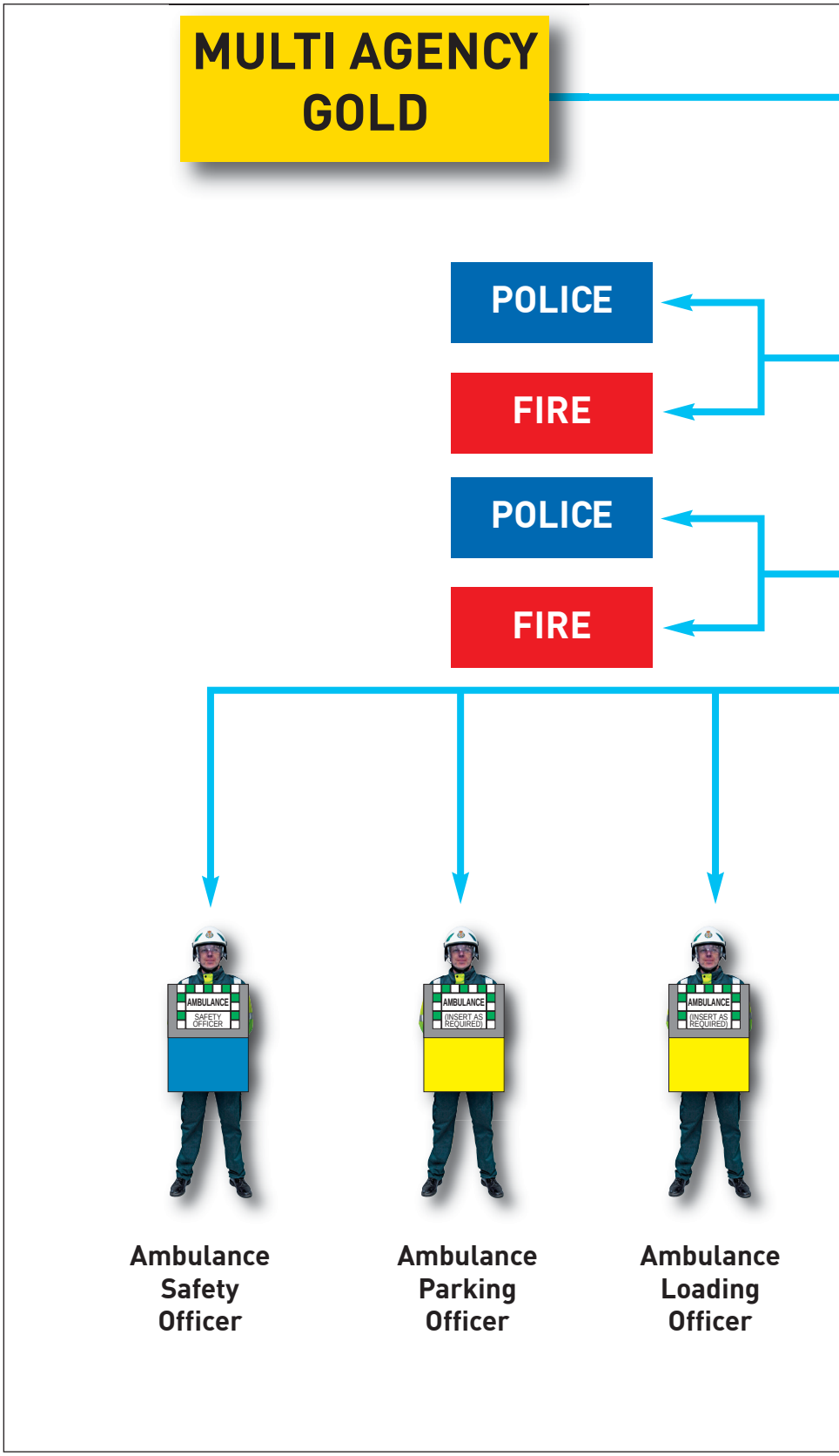
Gas Tight Suit & Extended Duration Breathing Apparatus (EDBA) PPE
Training suit displayed

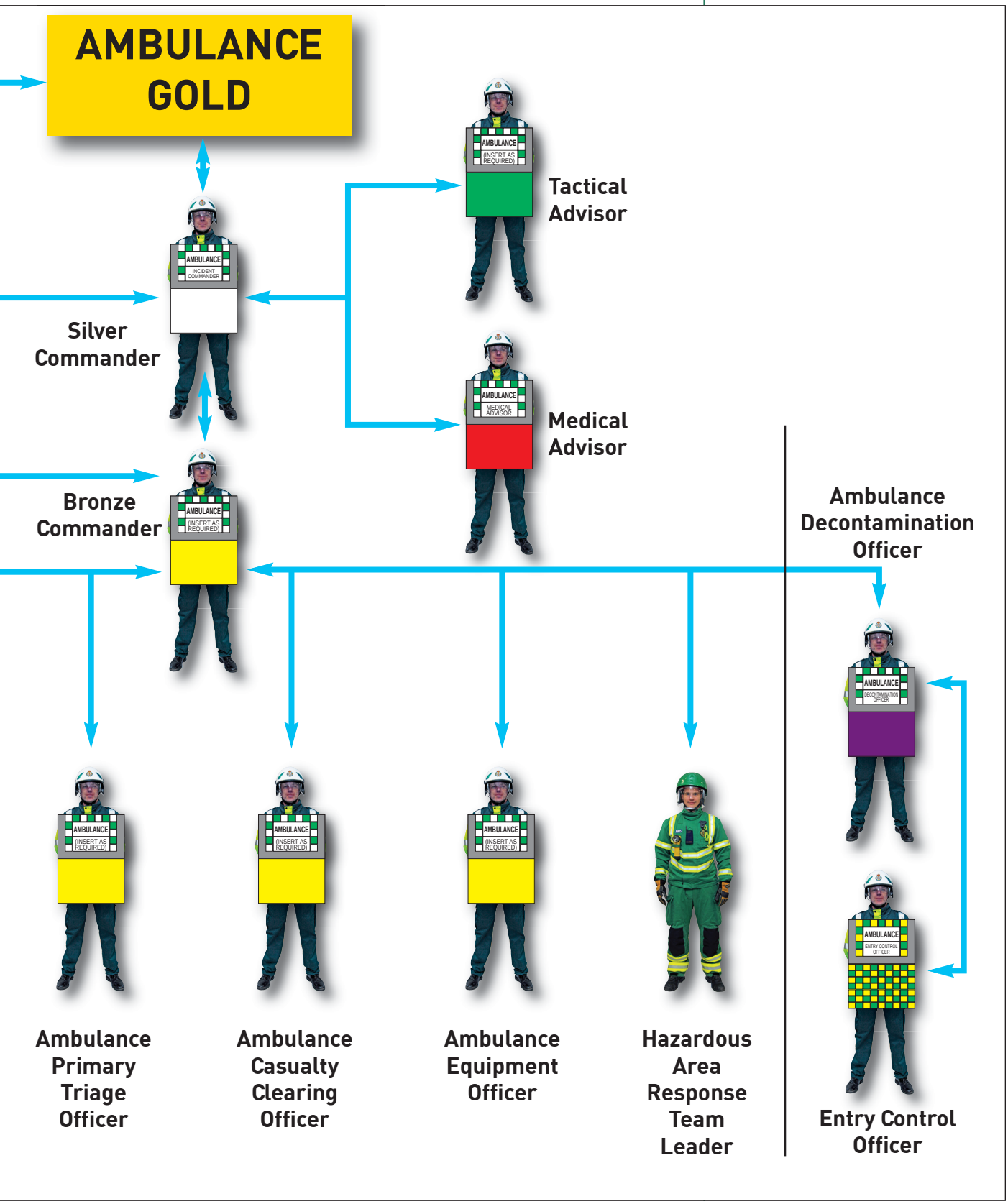
Powered Respirator Protective Suit (PRPS) PPE
Training suit displayed

Safe Working at Height (SWaH) PPE

Inland Water Operations PPE

APPENDIX 5
MODEL COMMAND STRUCTURE




AMBULANCE GOLD
Tactical Advisor
Silver Commander
Medical Advisor
Bronze Commander
Ambulance Decontamination Officer
Ambulance Primary Triage Officer
Ambulance Casualty Clearing Officer
Ambulance Equipment Officer
Hazardous Area Response Team Leader
Entry Control Officer

National Ambulance Resilience Unit
NARU

GLOSSARY AND BIBLIOGRAPHY

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

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

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

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

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

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

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

Chemical, Biological, Radiological, Nuclear and Explosives (CBRNE) - A term used to describe Chemical, Biological, Radiological, Nuclear and Explosive materials. CBRNE terrorism is the actual or threatened dispersal of 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 Forward 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 Forward Medical Advisor to assess, triage and treat casualties and direct their evacuation.

Conflict Management Model (CMM) – The CMM is a scalable model that can be used before and during any pre-planned event or incident.

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 Decision Making Cycle (DDMC) – A tool for Commanders to use in order that they can have a structured approach to the command decisions that they make.

Dynamic Risk Assessment (DRA) – Continuing assessment of risk in a rapidly changing environment.

Entry Control Officer (ECO) – A trained officer who ensures that all NHS resources are logged in and out of an incident through an agreed Entry Control Point. This may be a Fire and Rescue Service Officer where local agreement is in place.

Entry Control Point (ECP) – The point on the incident ground where trained responders will enter and exit the inner cordon.

Extended Duration Breathing Apparatus (EDBA) – Self contained breathing apparatus used by HART staff which provides an extended deployment time over standard breathing apparatus.

Forward Medical Advisor (FMA) – A qualified doctor who will work with the Bronze Commander to ensure medical resources are available and coordinated on the incident ground.

Gold, Silver, Bronze (GSB) – The formal command structure used within the UK emergency services.

Hospital Ambulance Liaison Officer (HALO) – The Hospital Ambulance Liaison Officer will liaise with hospital medical and nursing staff regarding arrangements for reception/discharge of patients and the availability of beds for casualties and ensure that this information is made available to the AIC and Police documentation team.

Hazardous Area Response Team (HART) – Specially recruited and trained personnel who provide the Ambulance response to major incidents involving hazardous materials, or which present hazardous environments that have occurred as a result of an accident or have been caused deliberately.

Health and Safety at Work Act (HSaW) - Primary piece of legislation covering occupational health and safety in the United Kingdom. The Health and Safety Executive is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment.

Health and Safety Executive (HSE) – The Health and Safety Commission (HSC) and the HSE are responsible for the regulation of almost all the risks to health and safety arising from work activity in Great Britain.

Inter agency Liaison Officer (ILO) – 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.

Incident Management System (IMS) – The Incident Management System (IMS) 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.

Limit(s) Of Exploitation (LOE) – A defined area within which Ambulance and NHS resources can be committed into an incident. The LOE may apply to

all resources, or specific resources in a defined area of the incident (for example Ambulance Intervention Teams working at an active shooter incident).

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

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

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

National Occupational Standard (NOS) – A set (or suite) of standards which provide a benchmark for Commanders. They set out performance and knowledge and understanding criteria that Commanders will be measured against.

Pre-Determined Attendance (PDA) – A site specific initial resource requirement. Generally airports and chemical plants will have an agreed PDA.

Personal Protective Equipment (PPE) – Protective clothing, helmets, goggles or other garments designed to protect the wearer's body from injury.

Situational Awareness (SA) – The state of individual and/or collective knowledge relating to past and current events, their implications and potential future development. A Commander's awareness of what is happening around them.

Strategic Coordinating Group (SCG) – Multi agency body responsible for coordinating the joint response to an emergency at the local strategic level.

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.

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

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NOTES

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Approved by:
Association of Ambulance Chief Executives