London Ambulance Service NHS
NHS Trust

# Incident Response Procedures


## Department for Emergency Preparedness Resilience and Response

JESIP
JOINT EMERGENCY SERVICES INTEROPERABILITY PRINCIPLES
*Working Together – Saving Lives*

Emergency Preparedness Resilience & Response
E P R R
London Ambulance Service NHS Trust

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The London Ambulance Service NHS Trust Incident Response Procedures are comprised of the following documents:

| Document | Scale of Issue | Image |
|---|---|---|
| EPRR Framework | Framework published on the Pulse, EPRR Pages | |
| Incident Response Plan | Published on the Pulse, EPRR Pages | |
| Special Contingencies | Published on the Pulse, EPRR Pages | |
| Internal Major Incident Plan | Published on the Pulse, EPRR Pages | |
| Site Specific Contingency Plans | Issues to Service Vehicles and Emergency Operations Centre | |
| Operational Action Cards & Guidelines | A5 pocket book Personal Issue to each operational member of staff |  |
| Control Services Action Cards | A5 binder, personal issue to each Control Services member of staff |  |
| Business Continuity Framework | Published on the Pulse, EPRR Pages | |

For more information contact the Department for Emergency Preparedness Resilience & Response at [redacted]@lond-amb.nhs.uk or [redacted] (office hours) or look on The Intranet/Pulse/Operational/Emergency Preparedness

## Out of Hours and in an emergency contact the On-Call Tactical Advisor via the Emergency Operations Centre

LAS On Call Tactical Advisor Single Point Of Contact – [redacted]

**DOCUMENT PROFILE and CONTROL.**

**Purpose of the document:**

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**Author/Reviewer: Liam Lehane**

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## Chief Executive Officer and Chairman Endorsement

The London Ambulance Service NHS Trust (the Trust) has a statutory obligation to be prepared to deal with Incidents of all types and sizes. In such cases there may be little or no warning. This Incident Response Plan has been prepared in light of guidance from the Department of Health, Home Office and builds on the Civil Contingencies Act 2004 guidance, Lessons identified by the LAS, Coroner's Inquests and subsequent guidance, the "Rule 43" requirements (now referred to as Regulation 28, Prevention of future deaths ) and in particular the findings of the inquest into the events of the London Bombings on the 7th July 2005.

The Trust is committed to continue engagement with its partner agencies and with the Local and Regional Resilience Forums to ensure joined up multi-agency emergency preparedness and resilience.
London has 33 Borough Resilience Forums. The Forums fulfil the requirement, for all relevant responders to work together to meet, discuss and agree a common multi-agency strategic approach to risk assessment, emergency planning, training and exercising, response and recovery at a local level, in accordance with the requirements of the Civil Contingencies Act, 2004, and as determined by the Borough risks and needs.

BRF's meetings are held a minimum of four times annually (on a quarterly basis) and additional meetings can be also held on an ad hoc basis following an incident or exercise.

An annual multi-agency exercise is also held to allow responders an opportunity to rehearse their response to an incident. The BRF's are also responsible for the maintenance of the Hounslow Community Risk Register via the Risk Assessment Working Group

The Trust will also continue to work closely with multi-agency partners and this plan incorporates the Joint Emergency Services Interoperability Program doctrine.

The arrangements outlined in this document form the basis of responding to an incident occurring in the operational area covered by the Trust or in support of other Trusts and organisations in the immediate area. It should be emphasised that the operational area contains a wide variety of hazards and that no two incidents will produce the same scenario. It is important therefore, to remember that it will be necessary to fit or adjust the plan to the incident.

Through the Trust Risk, Compliance and Assurance Group, the trust risk register is monitored and reviewed regularly and ensures a consistent approach to risk management and mitigation throughout the organisation.

The Department for Emergency Preparedness Resilience & Response maintains a risk register based on the London Community Risk Register and this is used as a basis for prioritising planning and response capabilities.

All Staff, Managers and Directors should be aware of this plan's existence and their particular role within it. There are a series action cards that are provided as aide memoirs.

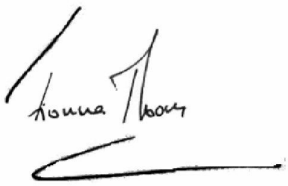
These procedures will be validated by training, exercising and use in actual Incidents. They will be reviewed annually or more frequently if required by the Resilience Department, and amendments will be issued where applicable to ensure best practice.

Lessons identified and notable practice will be recorded by the Department for Emergency Preparedness Resilience & Response and progressed to ensure they are included in future response. Where appropriate it will be shared with other agencies and included within the JESIP Joint Organisational Learning system.

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector (including private and voluntary sector where appropriate). The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, Public Health England (PHE) and local authority (LA) representatives on the LRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matter.

The key responsibilities of the LHRP are to:

- Facilitate the production of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning;
- Provide support to NHS England EPRR Team and PHE in assessing and assuring the ability of the health sector to respond in partnership to emergencies at an LRF level.



**Dr Fionna Moore MBE**
**Chief Executive Officer**
**London Ambulance Service NHS Trust**

**Heather Lawrence OBE**
**Chairman, London Ambulance Service**
**NHS Trust Board**

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# Introduction

## Why do we need a plan?

### Civil Contingencies Act 2004

The London Ambulance Service NHS Trust is defined as a Category one responder under the Civil Contingencies Act 2004 and as such has a primary role in the response to incidents.

The CCA places a statutory duty on the Trust to:

- Assess the risk of emergencies occurring and use this to inform contingency planning
- Put in place emergency plans
- Put in place Business Continuity Management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency

### NHS England Emergency Preparedness Framework – November 2015

The NHS needs to be able to plan and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the CCA 2004 and the NHS Act 2006 (as amended).

This work is referred to in health service terms as 'emergency preparedness, resilience and response' (EPRR).

The framework aims to enable the NHS in England to ensure effective arrangements are in place to deliver appropriate care to patients affected during an emergency (as defined by the CCA 2004) or incident.

The key objectives of the Emergency Preparedness framework are:

- To prepare for the common consequences of emergencies rather than for every individual emergency scenarios
- To have flexible arrangements for responding to emergencies, which can be scalable and adaptable to work in a wide range of specific scenarios
- To supplement this with specific planning and capability building for the most

concerning risks in the National Risk Register

- To ensure that plans are in place to recover from incidents and to provide appropriate support to affected communities

Governance for EPRR may be best achieved through the linkage of EPRR and Business Continuity to the organisation's Risk Management Framework. The identification and management of risk must be linked to the Community Risk Register (CRR) and the NRR as appropriate.

**NHS England Core Standards for Emergency Preparedness Resilience & response 2015**

The NHS England Core Standards for emergency preparedness, resilience and response (EPRR) set out clearly the minimum EPRR standards which NHS Organisation's and providers of NHS-funded care must meet.

The Core Standards will also enable agencies across the country to share a common purpose and to co-ordinate EPRR activities in proportion to the organisation's size and scope; and provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

**Public Health Core Standard C24**

Healthcare organisation protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

**Lessons Identified**

In order to meet these requirements the Trust maintains an Incident Response Plan that is current and regularly reviewed and updated. The plans is a live document which is continually reviewed and updated to take into account of organisational changes to ensure that it remains in line with all current legislation and guidance

These plans must be built on the principles of Risk Assessment and co-operation with partners. (NHS EPRR Framework 2015)

Historically the London Ambulance Service has been involved in the response to major incidents on many occasions, for example:

- The terrorist bombings on July 7th 2005
- The global influenza pandemic in 2009/10
- The fire at Headquarters leading to power failure to critical systems in October 2010

- The annual seasonal severe weather pressures such as heatwave, winter pressures and surges in demand.

This document will demonstrate how the Trust works to protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services. (Public Health Core Standard 24).

This Plan outlines the operational arrangements undertaken by the London Ambulance Service NHS Trust (the Trust) at the time of a Major incident or emergency as defined in the Civil Contingencies Act 2004 (CCA). The Trust along with its partners, Fire Brigade, Police and Local Authorities is a Category 1 responder as defined by the CCA. This plan has been written in conjunction with our partner agencies, and takes into consideration the overarching principles set out in the London Emergency Services Liaison Panel (LESLP) manual.

This document is to be read in conjunction with the Trusts' Business Continuity Plan and supporting documents, for example: Surge Plan, Resourcing Escalation Action Plan (REAP) and Lockdown plan. The Special contingencies plan has now been incorporated to form an appendix to the Major incident Plan a further document that should be read in conjunction with this plan is the Catastrophic Incident Plan. This plan will be available for staff to view via the Intranet /Pulse and on complex held by the station management teams.

It is the nature of Major Incidents or emergencies that they are by definition unpredictable and each will present a unique set of challenges. The Trust forms part of the National Health Service (NHS) response to such incidents and acts as the gateway to the wider health network. It is principally geared to the immediate medical needs of those involved and their subsequent transportation to appropriate treatment centres.

**Accountable Emergency Officer (AEO)**

The NHS Act 2006 (as amended) places a duty on relevant services providers to appoint an individual to be responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO).

NHS England expects all NHS funded organisations to have an AEO with regard to EPRR. It is the responsibility of the Chief Executive to designate the responsibility for EPRR as a core part of the organisations governance and its operational delivery programmes. Chief Executives will be able to delegate this responsibility to a named director, the AEO. In the case of the LAS the AEO has been delegated to the Executive Director of Operations.

The AEO will be a Board level director responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the Board that strategies, systems, training,

policies and procedures are in place to ensure an appropriate response for their organisation in the event of an incident.

Further information regarding the AEO role can be found in the NHS EPRR Framework 2015 and the LAS EPRR Framework 2016.

**Who is the plan for?**

This document outlines the framework that exists with the Trust that supports a high level of preparedness to any business-disrupting event or Major Incident, regardless of source. All LAS staff must familiarise themselves with the contents of this plan. The plan is supported by action cards, contingency plans and site specific action cards.

Full adherence to this framework will ensure there are arrangements in place that will enable the Trust to respond to major incidents/business disruptions, continue its critical functions and essential services provide support to patients and provide and receive mutual aid on a local, regional and national level. The Framework supports a whole health economy approach to resilience where critical and interdependent healthcare systems are prioritised to ensure the ongoing delivery of the services stakeholders and community rely upon, regardless of circumstance.

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LONDON AMBULANCE SERVICE NHS TRUST
OPERATIONAL ARRANGEMENTS

SECTION 1

London Ambulance Service NHS
NHS Trust

# Incident Response Plan

# OFFICIAL - SENSITIVE

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Decision Making Log

| Decision Log Number | 1 | Date & Time of Decision | |
|---|---|---|---|
| 1) Gather Information and Intelligence (What happened? What do we know so far?) | | | |
| 2) Assess risks & develop a working strategy (Do I need to take action immediately? Do I need to seek more information? Where can I get it from? What could go wrong?) | | | |
| 3) Consider Powers Policies & Procedures | | | |
| 4) Options & contingencies What options are open to me? Consider immediacy of any risk/threat, limits of information etc) | | | |
| 5) Take Action Record the decision made and the rationale | | | |
| 6) Review what happened | | | |
| Name of Person Making Decision | | | |
| Name of Person Recording Decision | | | |

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## Key to using the Plan:

Items highlighted **Red** – these relate to the **Rule 43** actions and recent lessons identified through the LAS EPRR Lessons identified process

Items highlighted **Green** – these are actions/Key information for London Ambulance Service Staff

| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Incident Response Plan | 1 – Information | Official Sensitive |

## 1.1 Definition of a Significant Incident

The London Ambulance Service has a definition for incidents that fall short of a Major Incident (MI) but that are identified as requiring a number of resources or specialist assets.

**A Significant Incident is any incident which from initial intelligence will require an attendance of a number of resources along with a management presence or will require a specialist or dedicated response (London Ambulance Service 2015).**

For example:

- Persons Reported Fire calls 6/10 pumps and above or large scale evacuation
- Explosions
- Single location incidents with 6>patients
- Train stuck in tunnel/railway incidents
- Public order
- Multi-casualty incidents at high profile sites
- COMAH sites
- Marine/waterways/river accidents
- Declared MI by other agency

## 1.2 Definition of a Major Incident

The London Ambulance Service uses the NHS Major Incident definition as the criteria for declaration of a Major Incident (MI).

Other emergency services have their own definitions of a Major Incident: a declaration by one emergency service may not necessarily require a declaration by the other Emergency Services

**For the NHS a Major Incident is defined as:-**

***"A major incident is any occurrence that presents serious threat to the health of the community, or causes such numbers or types of casualties, as to require special arrangements to be implemented".***

***(NHS EPRR Framework 2015)***

**In LESLP terms: a Major Incident is an event or situation requiring the implementation of special arrangements by one or more of the emergency services. Typically, a Major Incident involves one or more the following:**

- **Involvement, either directly or indirectly, of large numbers of people:**
- **The rescue and transportation of a potentially large number of casualties;**
- **The large scale combined resources of the Police, London Fire Brigade and the London Ambulance Service;**
- **The mobilisation and organisation of the emergency services and support services, for example: local authority, to cater for the threat of death, serious injury or homelessness to a large number of people; and transport operators actively managing the road and rail networks to support emergency response;**
- **The handling of a large number of enquiries likely to be generated both from the public and the news media – usually made to the police.**

**Acts of terrorism, including a large number suspected involvement of chemical, biological, radiological and nuclear devices, are subject to specific multi-agency response supported by HM Government. This response is response is reinforced by the principles contained in this Manual.**

**(London Emergency Service Liaison Panel 2015, section 2.1 Definition, page 8)**

**Emergency: Under section 1 of the Civil Contingencies Act 2004 an "Emergency" means**

a) **"An event or situation which threatens serious damage to human welfare in a place in the United Kingdom**
b) **An event or situation which threatens serious damage to the environment of a place in the United Kingdom**
c) **War, or terrorism, which threatens serious damage to the security of the United Kingdom"**

**is defined as an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK or war or terrorism which threatens serious damage to the security of the UK. (CCA 2004)**

**'A catastrophic incident is a major incident where, following advice of the emergency services, the designated minister is of the opinion that it is of such a magnitude that it will require specific, or exceptional response from members of the London Resilience Forum. Their strategic priorities will be to assist with both the immediate issues and achieving a return to normality. In doing so it is recognised that full H.M. Government involvement will be required' (CCA 2004).**

## 1.3 NHS Incident Classifications

- For the NHS incidents are classified as described in the NHS England EPRR Framework 2015: **Business Continuity** – A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (this could be surge in demand requiring resources to be temporarily redeployed)

- **Critical** – A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing is ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measure and support from other agencies, to restore normal operating functions.

- **Major Incident** – A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

## 1.4 NHS Incident Levels

| Incident level | |
|---|---|
| Level 1 | An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners. |
| Level 2 | An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office. |
| Level 3 | An incident that requires the response of a number of health organisations across geographical areas within a NHS England region.<br><br>NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level. |
| Level 4 | An incident that requires NHS England National Command and Control to support the NHS response.<br><br>NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level. |

## 1.5 Types of Incident

The following list provides commonly used classifications of types of incident. The list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate incident levels.

- **Business continuity/internal incidents** – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime
- **Big bang** – a serious transport accident, explosion, or series of smaller incidents
- **Rising tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action
- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about an impending situation, reputation management issues
- **Chemical, biological, radiological, nuclear and explosives (CBRNE)** – 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

- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials
- **Cyber-attacks** – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
- **Mass casualty** – typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures

## 1.6 Declaration of a Major Incident

- Other Emergency Services: An Major Incident can be declared by any member of the emergency services; however if one individual service declares a Major Incident which is not a major incident to the other services, then the others will respond appropriately in support. In this case there is no need for the other services to declare a Major Incident.

## 1.7 Operational Objectives

- Save life together with the other emergency services.
- Provide treatment, stabilisation and care of those injured at the scene.
- Treat those involved as individuals and respond to their needs as such.
- Provide appropriate transport, medical staff, equipment and resources.
- Establish an effective triage sieve and triage sort system to determine the priority evacuation needs of those injured and to establish a safe location for casualty clearing i.e. triage sort area.
- Provide a focal point at the incident for all National Health Service (NHS) and other medical resources.
- Provide communication facilities for NHS resources at the scene.
- Nominate and alert the receiving hospitals including major trauma centres.
- Arrange the most appropriate means of transporting those injured to the receiving and specialist hospitals.
- Maintain emergency cover throughout the Trust area and return to a state of normality at the earliest time.
- Act as a portal into the wider health services including Public Health England.

## 1.8 Internal Major Incident

Internal Major Incidents will be declared by the on call trust Strategic Commander (Gold) based upon advice from the Strategic Advisor, when an incident meets the criteria, such as floods, fire, excessive increase in demand and other exceptional circumstances. Activation of this procedure is a method of alerting others and our own organisation of the seriousness of the situation. There are a number of internal incident risks which may cause disruption to the service and business continuity plans are in place to ensure that continued service delivery is maintained. The Internal Major Incident Plan can be found at Section 3.
A dynamic risk assessment needs to be undertaken of the information received to ascertain if the situation/incident can be managed using business as usual arrangements or if specialist

arrangements are required. Gold will determine the most appropriate level of response. Gold will authorise escalation, de-escalation and stand down based upon on-going DRAs Gold should consider the implications of their decision and the wider impact it may have on delivery of health services.

The response to an Internal Major incident will be co-ordinated from the Strategic Command suite supported by the Support team.

## 1.9 Resourcing Escalation Action Plan (REAP)

The Trust recognises that over capacity can occur at any time of the year and has introduced the philosophy of 'Whole System Capacity Planning'. The response by the Service has been to produce a Capacity Plan which triggers specific measures when the Service is operating at over capacity.
Within the Capacity Plan is a Resourcing Escalation Action Plan (REAP) which is used to identify the level of pressure the Service is under at any given time, and provides a range of tactical options to deal with the over capacity situation.
Each of the pressure levels within the REAP plan are outlined from level 1 normal service to level 4 Extreme Pressure. A copy of REAP is available on the Pulse.

| | |
|---|---|
| REAP Level One | Steady State |
| REAP Level Two | Moderate Pressure |
| REAP Level Three | Severe Pressure |
| REAP Level Four | Extreme Pressure |

## 1.10 Surge Management

The Surge Plan provides a framework in which the activities of Control Services may respond to period of high demand with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service.

All of the plans highlighted in this section are designed to work in collaboration with each other to provide a series of actions and options to assist in managing an effective response to the incident and users of the Service.

## 1.11 National Ambulance Co-ordination Responsibilities

The National Ambulance Service Co-ordination Centre (NaCC) provides coordination for the UK ambulance service mutual aid arrangements. The centre is activated when one or more Ambulance Services are:

- at REAP 3,
- under extreme pressure,
- request mutual aid,
- or at the request of National Directors of Operations Group (NDOG) in preparation for severe weather or pandemic flu etc.

The NaCC pulls together performance information from trusts prior to sharing via email for discussion in the briefing style conference call. There are links to DH and other interested parties as required.

Requests for mutual aid are coordinated by the NDOG, this is to ensure that resilience is not stripped away from other Trusts that may also be experiencing pressure, thus putting them at risk.

The Trust facilitates the NaCC and provides staff and facilities at the Service HQ Waterloo, initially for the first week, and then if it is required to continue support is provided from other trusts. There are fall back arrangements with an NaCC based in the West Midlands Ambulance Service NHS Trust, should the Trust HQ Waterloo become inoperable for any reason.

## 1.12 Critical National Infrastructure

The Service has a Policy and Procedure (refer to Business Continuity Framework) providing the ability to lockdown critical sites if security is threatened or information is received to suggest those sites may be at risk. This plan may be used in conjunction with the Major Incident Plan as part of the response to certain types of incidents.

## 1.13 Joint Emergency Services Interoperability Principles (JESIP)

The JESIP principles are embedded into all LAS Incident Response plans and training, Operational and Tactical Commanders attend multi-agency training sessions to promote the JESIP principles.

The need for joint guidance for emergency services was a key finding following the reviews into the London bombings and various other major incidents and complex emergencies.

The JESIP Joint Doctrine focuses on the interoperability of Police, Fire and Ambulance services in the early stages of a response to a major or complex emergency. It is also

acknowledges that the emergency response is a multi-agency activity and the resolution of an emergency will usually involve collaboration with other Category 1 and 2 responders.

The purpose of the Joint Doctrine is to provide Operational and Tactical commanders with a framework to enable them to effectively respond together.

The Joint Doctrine sets out what responders should do and how they should do it in a multi-agency working environment to achieve a successful joint response

## 1.14 Responsibilities of the other Emergency Services

We jointly prepare and plan through the London Resilience structures supported locally by Borough Event Safety Advisory Groups(SAG) and SAGs for High Risk sites (Eg. COMAH, Stadia, Airports etc.)

Procedures and arrangements for effective co-ordination at the scene of a Major Incident can be found in the London Emergency Services Liaison Panel (LESLP) Major Incident Procedure Manual. The responsibilities for the other emergency services are as follows:

**Police**

- Saving of life together with the other emergency services.
- Co-ordination of the emergency services, local authorities and other organisations acting in support at the scene of the incident.
- Secure, protect and preserve the scene and to control sightseers and traffic through the use of cordons.
- Investigation of the incident and obtaining and securing of evidence in conjunction with other investigative bodies where applicable.
- Collection and distribution of casualty information.
- Identification of the dead on behalf of Her Majesty's (HM) Coroner.
- Prevention of crime.
- Family liaison; and short-term measures to restore normality.

**Fire Brigade**

- Life-saving through search and rescue.
- Fire fighting and fire prevention.
- Rendering humanitarian services.
- Management of hazardous materials and protecting the environment.
- Provision of qualified scientific advice in relation to HAZMAT incidents via scientific advisors.
- Salvage and damage control.
- Safety management within the inner cordon.

**The Local Authority**

Although not considered an Emergency Service they have a statutory responsibility to have arrangements in place to respond effectively to an emergency. This will include:

- Support to the emergency services
- Providing support and care for the local and wider community
- Using resources to mitigate the effects of an emergency
- Lead on the recovery stage.

During a Major Incident the local authorities will maintain their normal day to day services to the local community.

The Local Authority Liaison Officer (LALO) is the representative of the affected borough and is able to react to requests for local authority assistance. The LALO is required to attend the multi-agency co-ordination meetings on scene at the Joint Emergency Service Command Centre if established and to represent the local authority.

All emergency services must work together during an incident with the aim of:

## Saving Lives, Reducing Harm

Scene Commanders must work together using the Joint Decision Model to develop an agreed multi-agency plan.

## Principles for Joint Working

**Co-locate**

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

**Communicate**

Communicate clearly using plain English

**Coordinate**

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

**Jointly understand risk**

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

**Shared Situational Awareness**

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

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## 2.1 Planning for the risk to London

To ensure the London Ambulance Service's ability to respond to incidents is measured and proportionate to the level of risk they are tied to the London Risk Register (LRR).

The Risk Register is used by the London Resilience Partnership to help the prioritisation of resilience activities towards higher rated risks. This is taken from the National Risk Assessment.

Communities and businesses are also encouraged to use the London Risk Register to inform their own resilience arrangements and business continuity plans. It is for this reason that the London Risk Register is made publically available.

The risks included in the London Risk Register represent 'reasonable worst case scenarios' and their inclusion in the register does not mean that they are going to happen, or that if they did do that they would be as serious as the descriptions included within it.

"Reasonable worst case scenarios" are nationally developed and informed by historical and scientific data, modelling, trend surveillance and professional expert judgment.

The London Risk Register provides an assessment of the likelihood and impact of these scenarios for London.

The London Risk Register does not include reference to pre-planned events, which are covered under separate guidance and risk assessments.

## 2.2 The 6 Stage Risk Assessment Process

**Contextualisation**

Rather than reproduce it here, the document called *"London's Risks in Context"* is available separately, and summarises a range of factors which influence the assessment of both likelihood and impact of risks in London, such as demographics, transportation and environmental factors.

**Hazard Identification and allocation for assessment**

London Risk Advisory Group identifies the threats and hazards that, in their view, could give rise to an emergency within London in the next 5 years. Identified lead assessors then

undertake Individual Risk Assessments for each risk prior to multi-agency discussion. Risks included in the London Risk Register are subject to a scheduled review programme to ensure that each risk is revisited and updated periodically.

**Risk analysis**

Drawing on guidance from Government, other research and local knowledge, the lead assessor considers the likelihood of the risk over the next five-year period. Individual Risk Assessments are then provided to the London Risk Advisory Group for discussion and approval.

**Risk evaluation**

Individual Risk Assessments are confirmed and summary information collated into the London Risk Register. LRAG incorporates into CRR threat statements provided by central government within the Local Risk Assessment Guidance, but does not assess likelihood or impact.

**Risk treatment**

Gaps in capability, compared to the Reasonable Worst Case Scenario risks are assessed periodically by the London Resilience Forum. Options for additional risk management are developed, and agreed by the London Resilience Forum.

**Monitoring and Review**

Risk assessment is not a static process and is subject to constant review. At a minimum, each Individual Risk Assessment is formally reviewed on a 2 year cycle. An annual update of the London Risk Register is published each summer.

*London Resilience Partnership, London Risk Register, V3.0, February 2014*

## 2.3 LAS Assessment of London Community Risk Register

The London Ambulance Service Department for Emergency Planning, Resilience and Response whilst having a representative on the London Risk Advisory Group has also carried out an assessment of all the risks on the London Risk Register.

This review has looked at the impact of each of the risks both to the Trust and its response capability. Planning and response development is targeted towards the higher risks and the gap analysis.

EPRR carry out a monthly assessment of risks which includes any:

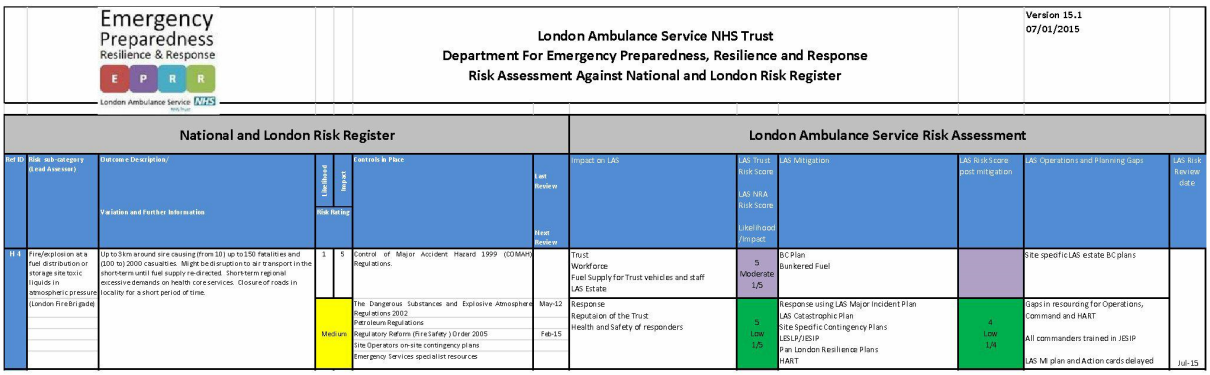
- New risks or evolving threats
- Risks previously rated as very high

- A selection of other risks along from the register (approximately 5 each month)

This process allows for all risks currently on the London Community Risk Register to be reviewed by the LAS at least annually.

The LAS reviews are be fed back in to the London Resilience Partnership Risk Advisory Group chaired by London Resilience Team to meet the requirements of the act with regard to publishing and informing the public.

Example of LAS Risk Matrix



Emergency Preparedness Resilience & Response
London Ambulance Service NHS

London Ambulance Service NHS Trust
Department For Emergency Preparedness, Resilience and Response
Risk Assessment Against National and London Risk Register

Version 15.1
07/01/2015

| National and London Risk Register | | | | | | | | London Ambulance Service Risk Assessment | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ref ID | Risk sub-category (Lead Assessor) | Outcome Description/ Variation and Further Information | Likelihood | Impact | Risk Rating | Controls in Place | Last Review / Next Review | Impact on LAS | LAS Trust Risk Score / LAS NRA Risk Score / Likelihood / Impact | LAS Mitigation | LAS Risk Score post mitigation | LAS Operations and Planning Gaps | LAS Risk Review date |
| H 4 | Fire/explosion at a fuel distribution or storage site toxic liquids in atmospheric pressure (London Fire Brigade) | Up to 3km around site causing (from 10) up to 150 fatalities and (100 to) 2000 casualties. Might be disruption to air transport in the short-term until fuel supply re-directed. Short-term regional excessive demands on health care services. Closure of roads in locality for a short period of time. | 1 | 5 | | Control of Major Accident Hazard 1999 (COMAH) Regulations. | | Trust<br>Workforce<br>Fuel Supply for Trust vehicles and staff<br>LAS Estate | 5<br>Moderate<br>1/5 | BC Plan<br>Bunkered Fuel | | Site specific LAS estate BC plans | |
| | | | | | Medium | The Dangerous Substances and Explosive Atmosphere Regulations 2002<br>Petroleum Regulations<br>Regulatory Reform (Fire Safety ) Order 2005<br>Site Operators on-site contingency plans<br>Emergency Services specialist resources | May-12<br>Feb-15 | Response<br>Reputation of the Trust<br>Health and Safety of responders | 5<br>Low<br>1/5 | Response using LAS Major Incident Plan<br>LAS Catastrophic Plan<br>Site Specific Contingency Plans<br>LESLP/JESIP<br>Pan London Resilience Plans<br>HART | 4<br>Low<br>1/4 | Gaps in resourcing for Operations, Command and HART<br>All commanders trained in JESIP<br>LAS MI plan and Action cards delayed | Jul-15 |

## 2.4 LAS Assessment of Risk during an incident

### Risk Management Authority

Authority to manage risks identified at an incident is delegated according to the level of risk assessed; all risks will require a risk assessment and risk mitigation to be put in place.

| Risk Colour & Level | Responsible Officer | Responsibility to review the management or acceptance of risks | Risk Register Level |
|---|---|---|---|
| Low (Score 1 - 6) | Team Leader equivalent | Bronze Commander / Safety / Officer | N/A |
| Medium (Score 8 – 12) | Operational Commander | Trust Risk & Safety Register | N/A |
| High (Score 15 – 25) | Tactical Commander | Strategic Commander | N/A |

## 2.5 Joint Understanding of Risk (JESIP)

**Achieving Joint Understanding of Risk**

**Identification of hazards**

Individual agencies should identify hazards and then share appropriate information cross-agency with first responders and control rooms. Use (S/M) ETHANE to ensure a common approach.

**Dynamic Risk Assessment**

Undertaken by individual agencies, reflecting tasks/objectives to be achieved, hazards identified and likelihood of harm from those hazards.

**Identification of tasks**

Each individual agency should identify and consider the specific tasks to be achieved according to its own role and responsibilities.

**Apply control measures**

Each agency should consider and apply appropriate control measures to ensure any risk is as low as reasonably practicable.

**Multi agency response plan**

Consider hazards identified and service risk assessments within the context of the agreed priorities for the incident. Develop an integrated multi-agency operational response plan.

**Recording of decisions**

Record the outcomes of the joint assessment of risk, the identified priorities and the agreed multi-agency response plan.

| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Incident Response Plan | 3 – Intention | Official Sensitive |

## 3.1 Aim

To ensure London Ambulance Service NHS Trust can provide an effective and co-ordinated response to a range of incidents and emergency situations.

## 3.2 Objectives

- To ensure that we treat those involved as individuals and in the enormity of the situation ensure that we do not lose sight of the needs of individual patients.
- To ensure an effective and co-ordinated response to an incident.
- To ensure all staff have an understanding of their role in an incident.
- To provide an effective command structure.
- To ensure that the London Ambulance Service responds as part of the wider NHS team.
- To form a basis for Incident Training
- To assist in the identification and mobilisation of specialist resources.
- Work as part of the multi-agency response.
- Making sure that plans are in place to deal with threats identified by the National and London Risk Registers

Work together with the other emergency services with the aim of:

**Saving Lives, Reducing Harm**

JESIP
JOINT EMERGENCY SERVICES INTEROPERABILITY PRINCIPLES
*Working Together – Saving Lives*

## 3.3 Training

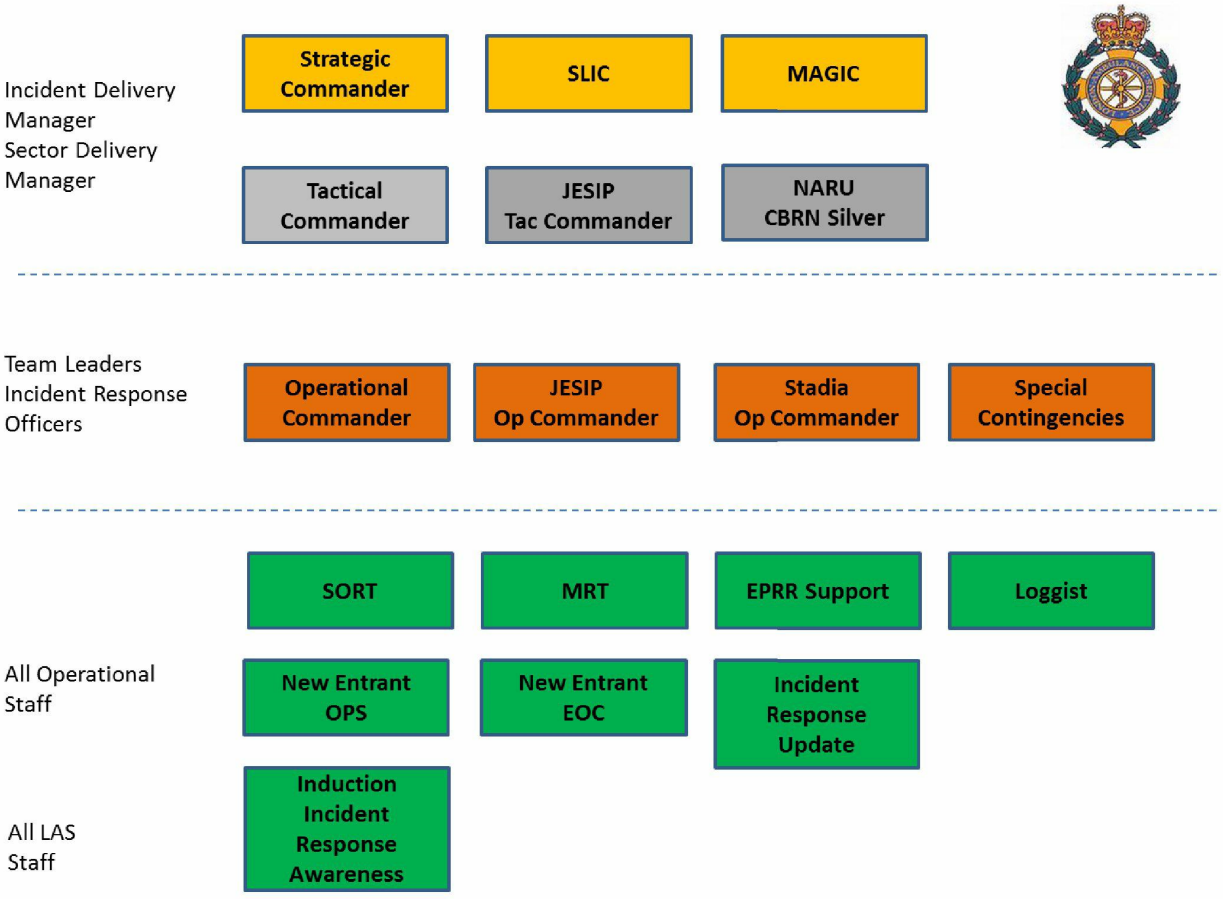
Incident response training is delivered by the Department for Emergency Preparedness Resilience & Response and other external providers.

All new staff joining the trust receive Incident Response Awareness with Operational and Control Services staff receiving further input during initial training.

Operational and Tactical Commander training is measured against the National Occupational Standards and is consolidated with reflective practice, table top exercises and scenarios.

Multi-agency training is afforded via the London Resilience Partnership Training & Exercising Group and the JESIP programme.

Course Hierarchy:




Please refer to the LAS Annual Training & Exercise Framework for further information.

## 3.4 Testing & Exercises

Plans must be tested regularly using recognised and agreed processes such as table top or live exercises. Roles within the plan are exercised to ensure that it is fit for purpose and encapsulates all the necessary functions and actions required during an incident.

This process allows individuals the opportunity to practise their skills and increase their confidence, knowledge in preparation for responding at the time of a real incident.

The NHS EPRR Framework (2015) defines timescales in which this has to be achieved. The minimum expectation is that a communications exercise takes place every 6 months, a table top exercise every year and a live Exercise every 3 years.

EPRR maintain a record of all testing and exercising to ensure the minimum standards are met.

Scenarios, Aims and objectives for exercises are informed by the EPRR review of Risks, lessons identified and notable practice.

## 3.5 Assurance

The Trust provides evidence to **NHS England** (London Region) as part of the annual EPRR assurance process to ensure that our contingency plans are fit for purpose, in line with national guidance and recognised best practise including evidence of multi-agency interaction.

In additional to NHS England EPRR the trust provide monthly reporting and assurance in regarding to the various EPRR Service specification to the North West London CCG who are the lead commissioner for the LAS on behalf of the London CCG's.

**The Care Quality Commission** is the independent regulator of health and social care in England. Their role is to make sure health and social care services provide people with safe, effective, compassionate, high quality care and encourage care services to improve.

CQC will monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and will publish their findings, including performance ratings.

**National Ambulance Resilience Unit (NARU)** role is to ensure that the Ambulance sector is ready and equipped to responded to emergencies, work together in a co-ordinated manner, influence national policy direction and setting, standardisation of practice, co-ordinate mutual aid during an emergency and to provide peer review, audit and assurance within the ambulance sector and to NHS England and Department of Health.

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## 4.1 Capabilities

### 4.1.1 Resilience Team (formerly Emergency Planning Unit)

Emergency Planning & Resilience is part of the Department for Emergency Preparedness Resilience & Response and is a specialist team of operational officers that provide advice on matters relating to emergency planning, resilience and response for all LAS operational resources.

The role of EPRR is to ensure a co-ordinated response from the Trust in the event of any Incidents. This involves supporting a pan-London strategic approach to the provision of emergency planning and resilience advice and liaison with senior managers, officers and civil servants from other emergency services, industry, the armed forces, local authorities and government departments.

They support the Trusts' management at the highest level in co-ordinating the services response to emergencies. They organise and evaluate training exercises, audit the response to incidents, horizon and social media scanning, and use lessons learned from these assessments to promote best practice. To compliment these activities, the unit attempts to anticipate emerging risks and to present plans or new strategies to combat them.

### 4.1.2 Incident Response Action Cards

All LAS staff have a responsibility to ensure that they make themselves aware of the LAS procedures listed in the LAS incident response action cards. The cards have been designed to assist all staff at the incident. **These cards must be carried by all operational staff.**

All ambulance responders who could be activated to the scene of a potential incident should refresh themselves of the required procedures by reading through the Trust's incident response action cards on a regular basis.

Control Services staff are issued with a set of control services action cards which detail the actions required during the response to an incident.

### 4.1.3 Hazardous Area Response Team (HART)

HART is the specialised team of Service staff who have been trained to administer lifesaving medical care in hostile environments such as industrial accidents, natural disasters, terrorist incidents and CBRN/Hazmat incidents.

They are capable of delivering this care whilst using a range of Personal Protective Equipment (PPE) which is not normally available to Ambulance Personnel and supplement the LAS response to an incident as part of the wider team.

**Triggers**

The role of the Hazardous Area Response Team (supported by technical and scientific advice) is to provide a rapid response to;

- Any HAZMAT/CBRN incidents, including Steps 123.
- Any Major/Catastrophic/Critical Incident (non-CBRN/HAZMAT) which requires a combined response from all three emergency services and where the assessment, incident and casualty management is within a potentially hazardous area.
- Any pre-planned event requiring a tactical CBRN response to support the overall multi-agency incident plan.
- Suspect packages/explosive devices.
- Unsafe or collapsed structures with known or suspected patients trapped.
- Working at height.
- Confined spaces or areas of difficult access with known or suspected patient involvement.

**The role of the Hazardous Area Response Team is to provide:**

- Health input to the initial assessment of the scene.
- Undertake a scene assessment directly related to the needs of the ambulance and other health services.
- In collaboration with partners identify the Inner Cordon and the Hot Zone.
- Initial triage and immediate lifesaving treatment.
- Hazard Identification.
- Casualty confirmation.
- Estimation of the resources required.

**In a CBRN/Hazmat Hot/Warm Zone, overseeing**

- On-going resource requirements.
- Casualty management.
- Evacuation.

### 4.1.4 British Association of Immediate Care (BASICS)

BASICS London is a voluntary group of doctors with pre-hospital experience who are available 24/7 via EOC. BASICS doctors support to ambulance clinicians on scene by providing advanced patient assessment skills, analgesia and surgical procedures to patients during accidents, medical emergencies and major incidents.

Many BASICS doctors will respond for the Trust during a Major Incident and will assume roles such as the Scene Medical Advisor, Casualty Clearing Station Medical Lead or as part on an Enhanced Care Team.

### 4.1.5 Enhanced Care Teams – Medical Emergency Response Incident Team (MERIT)

An Enhanced Care Team comprises of an experienced pre-hospital care trauma doctor and paramedic. Teams can be provided by either London's Air Ambulance or an on call pool of Emeritus Doctors, BASICS Doctors and Emeritus Paramedics.

The first Enhanced Care Team on scene will be provided by the on duty London's Air Ambulance crew, should this team be unavailable or additional teams be required the Strategic Medical Advisor and/or the Scene Medical Advisor will request further resources. Additional resources will be tasked from the London Air Ambulance on-call arrangements, BASIC's London and though mutual aid form surrounding ambulance trusts.

The roles of the Enhanced Care Team is to provide specialist medical care above that of the current levels of ambulance practice; to assist within the Casualty Clearing Station (CCS) with the treatment and stabilization of patients prior to transportation to definitive care and to support ambulance crews with patients who are trapped or in extremis.

Doctors should not perform advanced procedures within casualty clearing unless the staffing and casualty flow allows & after consultation with the Medical Advisor.

### 4.1.6 Special Operations Response Team (SORT)

Previously called the CBRN team, this is a group of staff from across the Trust who are trained to provide a decontamination response to incidents.

Staff maintain a normal shift pattern and can be called to provide the function when required.

Decontamination Equipment and PPE is maintained by EPRR at sites across London.

### 4.1.7 Equipment Support

EPRR maintains a fleet of Equipment Support Vehicles to provide medical consumables and other equipment at incident scenes.

Equipment Support Vehicles (ESV) – 6 vehicles across London.

Mass Casualty Equipment Vehicles (MCEV) – 3 vehicles across London as part of a National capability.

Casualty Management Vehicles (CMV) – 4 vehicles across London.

### 4.1.8 Logistics Department

In the event of a major incident the role of the Logistics Department is to provide additional equipment, drugs, disposable blankets, medical gasses and consumables as requested by SOC. In addition, logistics staff will liaise closely with suppliers and procurement to place emergency orders and ensure stocks are replenished.
In the event of a prolonged incident, the department will arrange refreshments for operational staff.

**Initial Actions by Logistics**

The on-call Logistics Manager will have overall responsibility for co-ordinating the Logistics response and, if instructed, will report to the Gold Command Suite. The on-call Logistics Manager will continue to have overall responsibility until the Head of Operational Support or their nominated deputy takes charge. The Officer in Charge for the Logistics Department will delegate tasks to relevant Logistics Managers as necessary.

**Post incident Activities**

- Replenishment of drugs and consumable stocks
- Recovery of equipment left at scene
- Restocking of pod vehicles
- Replenishment of hot cans/packs and water

### 4.1.9 The wider NHS

**NHS England National EPRR Team**

The generic EPRR role and responsibilities of NHS England are:

- To set a risk based EPRR strategy for the NHS
- To ensure there is a comprehensive NHS EPRR system and assure itself and DH that the system is fit for purpose
- Lead the mobilisation of the NHS in the event of an emergency
- Work together with PHE and DH, where appropriate, to develop joint response arrangements
- Undertake its responsibilities as a Category 1 responder under the CCA 2004

**At a national level NHS England will:**

- Support the AEO to discharge EPRR duties

- Participate in national multi-agency planning processes including risk assessment, exercising and assurance
- Provide leadership and coordination to the NHS and national information on behalf of the NHS during periods of national incidents
- Provide assurance to DH of the ability of the NHS to respond to incidents including assurance of capacity and capability to meet National Risk Assessment (NRA) requirements as they affect the health service
- Provide support to DH in their role to UK central government response to emergencies
- Action any requests from NHS organisations for military assistance

**Hospital and Ambulance Service Trusts** are responsible for deploying the correct healthcare resources to care for casualties either at the scene or at a hospital site. Each will mobilise local resources to the maximum extent, consistent with maintaining essential care.

**Clinical Commissioning** will be notified by NHS England, but as a CAT 2 responder will not be engaged in the response but will mobilise to sustain patients in the community should hospital services be reduced or compromised for a period. All CCG have an on call director function and work with NHS England (London).

**NHS England (London Region)** will take strategic control of any incident that affects, or seems likely to affect, several hospitals, or have a significant impact on primary care. NHS England London Region will utilise a web based situational report tool (SitRep) which facilitates communication between the local area team and wider NHS Partners. A specific action card is included in section 5 on the process to be followed on the SitRep reporting.

**The Department of Health** is responsible for national oversight and monitoring of all incidents that result in activation of a major incident plan.

**Public Health England** will provide specialist health emergency advice to the DH, Local area teams & the wider NHS. They will provide both advice and capacity to deal with communicable diseases and chemical incidents and their Radiological Protection Division (RPD) will work to create similar capability for nuclear and radiological incidents.

**Trauma Network – Major Trauma Centres (MTC) and Trauma Units (TU)**

London's trauma system has been designed to ensure that seriously injured patients in the capital receive world-class specialist care. This is achieved through a network of four major trauma centres, located at The Royal London Hospital (Whitechapel), King's College Hospital (Denmark Hill), St George's Hospital (Tooting) and St Mary's Hospital (Paddington). There, specialist teams provide treatment for major trauma injuries 24 hours a day, seven days a week. These centres are supported by a number of trauma units located in A&E departments, where patients with less serious injury will receive their treatment.

- Patients will be brought out of the scene and sorted at a casualty clearing station to identify those most seriously injured.
- Initially Priority 1s will be triaged to a declared MTC.
- If further capacity is required other MTCs will be declared and Priority 1s will go to declared MTCs.
- Other MTCs will be notified and put on standby if required.
- MTCs will also receive Priority 2 and Priority 3 patients.
- As necessary TUs will receive Priority 1 patients in addition to Priority 2 and Priority 3 patients once the capacity for Priority 1 patients at the MTCs is reached.
- The MTCs need to have a nominated Trauma Coordinator (TU senior clinician) who can provide real-time advice to trauma units for the management of Priority 1 patients and to coordinate a list of seriously injured patients in their network who need / may need transfer and approximate time frames for transfer into the MTC.
- LAS will continue to monitor capacity in all declared hospitals.
- Transfers must be logged through LAS to aid capacity management.
- Capacity management system will be kept up to date on a regular basis.

**Major Trauma Network Communications**

- Major Incident declared.
- Any declared MTC or TU will receive a direct phone call from LAS Incident Control Room.
- LAS support sent to these hospitals (HALO ).
- All 4 MTCs notified by LAS (to inform of MI, inform which MTCs are receiving and to alert the others to potential of increased non MI work).
- NHS England (London) informed by LAS via NHS01 pager.
- NHS England (London) will notify all London Hospitals via Directors pager group – informed of MI, location of incident, nominated receiving hospitals including MTCs and for non-declared to expect increase in non MI patients.
- NHS England London informs adjacent NHS England Region as appropriate.
- NHS England London will set up major incident email notification and updates as appropriate.
- Capacity at MTCs and TUs managed by LAS through the Capacity Management System.
- MTCs use cascade pager system to alert TUs in their network of a MI (for information) *NB Networks will need to set up this system in advance.*
- Alert boarding ambulance trusts when a MTC/TU are declared as receiving hospitals

London Ambulance Service
NHS Trust

EMERGENCY Preparedness

NHS London

## Outline Trauma Network Major Incident Plan

### Communication Channels

Major Incident declared

NHS London notified via [redacted] pager by LAS Control

LAS nominate declared MTCs and TUs and put supporting hospitals on standby

NHS London may alert some or all organisations (including PCT clusters) of incident via Page One messaging system

All other MTCs notified of incident by LAS for information only

Other hospitals not declared a receiving hospital should expect additional non major incident patients

Co-ordination desk liaises with TUs re transfers out. All transfers must be logged through LAS to aid capacity management

### Patient Destination

Initial P1 casualties sorted to declared MTCs until capacity reached. LAS coordinate this process by liaison with HLO and ALO at declared MTCs until all MTCs declared

P2s and P3s to be distributed amongst all declared receiving hospitals including MTCs

P1s will be distributed across declared TUs as necessary

Senior clinical network co-ordinator established within each declared MTC (designated clinical trauma liaison role) to liaise with network TUs

All patient transfers managed through London Ambulance Service

*NB Established processes for communication with areas adjacent to London will be activated*

### 4.1.10 London's Air Ambulance

London's Air Ambulance (LAA) is a charity which provides pre-hospital medical care to critically injured people at the scene of an incident. The service operates 24/7 and responds by helicopter during daylight hours and a rapid response car at night. LAA delivers an advanced trauma team, comprising of a Senior Trauma Doctor and specially trained paramedic, to victims of serious injury anywhere within the M25 and is dispatched by a dedicated trauma paramedic working within the LAS Emergency Operations Centre (EOC).

LAA will provide the initial Pre-hospital Medical Support at a Mass Casualty Incident. On arrival at scene the Doctor, assisted by the Paramedic, will assume the role of Medical Advisor working alongside the Ambulance Scene Commander until relieved by the on call LAS Medical Advisor. At this point they will fulfil the role of the first Enhanced Care Team and be based primarily within the CCS unless required by the Ambulance Scene Commander/Incident Medical Advisor to move forward to assist with advanced patient care and extraction.

For incidents occurring during daylight hours the helicopter G-EHMS can be used for the transportation of medical personnel and equipment. Should a patient require removal from scene by air the helicopter can be requested by the Casualty Clearing Station Medical Lead or Enhanced Care Teams via the Incident Medical Advisor / Ambulance Scene Commander. Decision to use this method of transportation will be dependent on availability of an appropriately trained LAA crew to escort the patient and any on-going requirements at the incident. SOC, Bronze Loading and the Ambulance Incident Commander will be notified in order to maintain a log of all patient movements

### 4.1.11 National Burns Plan

Any incident, which produces a large number of patients with burns, will challenge the National Bed capacity for burns patients. In order to reduce the effect and manage patient dispersal there now exists a National Burns Major Incident Plan.

The Trust Resilience Team and Medical Directorate hold a copy of the Major Incident Burns Plan. The Burns Major Incident Plan many be activated by;

- The Ambulance Service
- The Receiving Hospitals

The Ambulance Incident Commander or Medical Advisor may estimate the number or severity of burns injuries to warrant the Burns Incident Plan being instigated via EOC.

Receiving hospitals will initiate the relevant Major Incident Response.

Where there are 5 or more casualties at scene with major burns (e.g. >20% TBSA) EOC may regard this as major incident standby and inform the burn service accordingly.

Although it is accepted patients may be sent to multiple receiving hospitals, attempts should be made to cluster burns patient, who may need specialist opinion, into the fewest number of Emergency Departments, ideally with the burns service.

### 4.1.12 Voluntary Organisations and Private Providers

**Use of VAS resources**

The LAS will maximise the use of the support offered by the Voluntary Aid Societies (VAS) during a major incident. Generally this support will fall into two areas:

- In support of core fleet operations.
- At the scene (in certain circumstances).

The Salvation Army and the British Association of Immediate Care (BASICS) are usually called immediately to the scene to provide assistance. The Salvation Army have a number of catering units that support LAS staff with the provision of refreshments. BASICS assist the LAS with the provision of additional doctors who provide extended care skills in support of LAS staff.

The role of St. John Ambulance is to assist with core fleet duties i.e. 999 calls when requested. St. John Ambulance may be already involved if the incident is centred around a stadia or public event. The LAS Silver Medic will provide guidance on how and where the VAS resources should be utilised at the scene.

The role of the British Red Cross is to assist with core fleet duties i.e.999 calls when requested, when called to the scene it will provide resources for the evacuation of P3 casualties. The British Red Cross hold contracts with many local authorities for the provision of support services during an incident. Note if BRC are deployed for the local authority they do not come under LAS command and control.

Both organisations will deploy a duty officer to SOC for liaison purposes during the major incident.

All resources will be activated from SOC early in consultation with the Tactical Commander (AIO/Silver) and Tactical Advisor for BRC P3 buses, following a Gold decision.

**Use of Private Provider resources**

These are accredited third party resources that could be used by the LAS. These types of resources will be utilised at the discretion of the Gold Commander to back fill core fleet during a major incident.

## 4.2 Structured Approach to Incident Management

The first response will be put under a considerable amount of pressure, so it is important that staff remain focused and follow structured procedures. Staff should not deal with casualties in the first instance – they should carry out first on scene action points.

It is important to stress that incident management should remain flexible allowing local freedom to adapt and develop responses in an uncertain and complex environment.

Staff should use the 'CSCATTT' mnemonic to remind them of the structured approach to incident management.

| | |
|---|---|
| **C** | **Command**<br>Appoint a scene commander as quickly as possible, Co-locate with other agency commanders. Use the Joint Decision Model. Appoint further roles as required. Use Incident Response Action Cards and tabards. |
| **S** | **Safety**<br>Don PPE. Consider the safety of all on scene, use cordons. Work with other agencies to jointly understand the risks. Survivors to place of safety |
| **C** | **Communication**<br>Instigate communications with other agencies on scene.<br>Ensure communications with Red Base are maintained. Start a Log. |
| **A** | **Assessment**<br>Carry out an assessment of the incident site and update Red Base using the (S/M)ETHANE reporting mnemonic. Share the information with other agencies on scene. |
| **T** | **Triage**<br>Instigate Triage Sieve and initial treatment as soon as possible.<br>Arrest Catastrophic Haemorrhage and secure airways where required. |

| | |
|---|---|
| T | **Treatment**<br>Commence extended treatment of casualties once moved to a safe Casualty Clearing Area. |
| T | **Transport**<br>Arrange transport for casualties appropriate to presenting complaint. Consider the use of buses. Red Base will nominate hospitals. |

## 4.3 Actions

### Windscreen Report

LAS staff are encouraged to provide immediate on scene reports, the Windscreen report has been designed to remind staff to "say what they see" when arriving on scene.

The description of activity on scene will assist other responding assets and control services build a picture of the incident.


The Initial Actions outlined below are written for First, 2nd and 3rd Ambulance persons to arrive on scene, this allows for a variety of single or double crewed resources to arrive on scene.

### First Ambulance Service Person On-Scene

On arrival at the scene, the first ambulance service person will provide reports and act as a focal point. Using their Action Cards they will undertake the following:

- Park as near to the scene as safety permits
- If not already complete pass a Windscreen Report to the Emergency Operations Centre (callsign REDBASE)

- Don high visibility PPE and protective helmet
- Stay focused on your role – Do not attempt rescue or advanced treatment of casualties
- Start a timed log of occurrences and your actions
- Leave blue lights on to signify Ambulance initial command point until relieved.
- Provide EOC with an initial visual report, confirming attendance of other emergency services (see S/METHANE).
- Remain with your vehicle and act as a focal point for all further health resources and any P3 (Walking Injured) casualties
- On arrival of additional resources, task them to Survey the incident site and report back and the next person to establish a Casualty Clearing area
- Provide dressings and advice for P3 casualty self-help (consider the Major Incident Dressing Packs provided at major transport hubs)
- Continue to provide reports to Red Base, update the 1st Ambulance officer to arrive on scene.
- Provide a S/METHANE report to Red Base as quickly as possible.
- In the absence of an officer allocate further tasks to arriving staff using the action cards.

**Second Ambulance Service Person On-Scene**

On arrival at the scene, the second ambulance service person will undertake a survey of the incident site and provide reports back. Using their Action Cards they will undertake the following:

- If in a separate vehicle from 1st Person On-Scene, turn vehicle blue lights off (where safe to do so)
- Liaise with 1st Person On-Scene.
- Don Hi-Viz PPE and protective helmet, go forward and undertake a rapid assessment of the incident scene where safe to do so.
- Identify areas, types of buildings, vehicles etc. that are involved
- Identify any hazards
- Identify approximate numbers of casualties
- Report back to 1st Person On-Scene
- Work with 1st Person On-Scene and provide a S/METHANE report to red base
- May undertake the role of Bronze Sector using the Action Cards

**Provide a S/METHANE report as soon as possible.**
**Further reports should be sent when information becomes available or every 20mins.**

**Third Ambulance Service Person on-scene**

- If in a separate vehicle from 1st Person On-Scene, turn your blue lights off. (where safe to do so)
- Liaise with 1st Person on scene.
- Don Hi-Viz PPE and Protective Helmet, Identify a safe area and commence treatment of any P3 (Walking Injured casualties)
- Collect dressings and other equipment for the treatment of any P3 (Walking Injured) casualties. Consider the use of NHS Major Incident Dressing packs kept at transport hubs.
- Provide updates to 1st Person on scene of the number of casualties you have.
- Continue to treat Casualties and assist with the setting up of a Casualty Clearing Station if required.
- May undertake the role of Bronze Clearing using the Action Cards.

**Subsequent Resources**

On arrival at the scene, subsequent resources should adopt the following procedures:

- Be prepared to take a command role in the initial stages of the incident.
- Proceed as instructed by Red Base, normally to the parking point.
- Report arrival to Red Base on Airwave.
- Switch off all blue lights (where safe to do so)
- Keys to remain with vehicle, radio sets to be turned to low volume and driver's window left open**.**
- Don high-viz PPE and protective helmet.

Report on arrival to Bronze Parking if in place, if not report to Bronze Medic at the Ambulance Initial Command Point indicated by its blue lights flashing. Carry out tasks as directed.

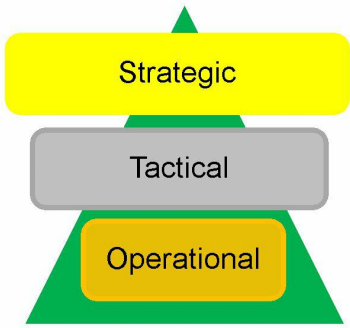
| C | S | C | A | T | T | T |
|---|---|---|---|---|---|---|
| Command | Safety | Communication | Assessment | Triage | Treatment | Transport |

## 4.4 Command

### 4.4.1 Command Structure

Each individual incident will, by its nature, determine whether one or more tiers of the structure are implemented. On the majority of occasions, needs will be determined from an operational level and then move onto Tactical and finally on rare occasions the Strategic level.

The command structure is designed to work on three levels – Strategic, Tactical and Operational.




**GOLD – Strategic level.** This is the senior tier of management usually based within the LAS Gold Suite. On occasions a Gold representative (Gold Level Commander) may be based with senior officers of the other emergency services or the health authority, for example at New Scotland Yard or the designated Strategic Co-ordination Centre (SCC).

**SILVER – Tactical level**. The Ambulance Incident Commander will normally be located in the Incident Control Room and will direct the overall management of the incident(s). It should be noted that some incidents may require a Silver on scene. The role of Silver is to determine priority in allocating resources, planning and co-ordinating tasks and obtaining other resources as required.

**BRONZE – Operational level.** Those staff who are managing the operational work at the incident site. Each bronze functional role will concentrate on their specific task within their areas of responsibility as directed by the Ambulance Incident Commander.

All staff in the command structure must wear the appropriate incident management tabards.

Action Cards containing details of the roles and responsibilities have been issued and should be used by all Service personnel on scene of an incident.

**Tactical Advisors** (inter-agency Liaison Officer – ILO). This role is performed by a group of emergency planning and resilience officers that will advise and support both strategic and tactical commanders. The role is to advise of any specialist personnel or equipment that may be necessary to assist in the management of a major incident, provide advice and support on matters relating to the Service's Major Incident plan, emergency planning at a Regional & National level and other ambulance service or NHS requirements.

The Tactical Advisor can also offer advice regarding the assistance of outside agencies e.g. Local authority, military aid and site specific information.

**NHS/MEDICAL Resources attending the scene:**

The London Ambulance Service are the gatekeepers to the wider NHS, in the event of a major incident it is the role of the LAS to co-ordinate all medical resources attend the scene. All medical resources will fall under the command of the Ambulance Incident Commander.

### 4.4.2 Strategic Command

**Strategic Commander** (known as Gold Medic)

The Gold Commander will set the strategic aim and objectives for the incident and will take strategic command of the Trust during a major incident and will ensure that service policy is adhered to. Decisions at this level will be communicated to senior officers from other emergency services and communicated via the command structure for implementation by the AIC – Silver.

The Gold Commander must take into account the normal workload of the Service and the recovery phase of the incident and if necessary invoke the LAS Business Continuity Plan/group.

The Gold Commander will develop a communication strategy to inform other ambulance Trusts/NHS Partners of the situation and is responsible for activating the deployment of national assets as appropriate (National Mass Casualty Vehicles held within London); they will invoke the request for mutual aid as required, and will have oversight of the arrangements for receiving VIPs Ministers, MPs etc.

**Strategic Advisor**

An Emergency Planning Resilience Officer (EPRO) will advise the Strategic Commander of any specialist personnel or equipment that may be necessary to assist in the management of a major incident and provide advice and support on matters relating to emergency planning and other ambulance service or NHS requirements. They are also available to offer advice regarding the assistance of outside agencies e.g. Local Authority, Military Aid and site-specific information.

### Strategic Medical Advisor

The role of Strategic Medical Advisor will be fulfilled by the on call Gold doctor from the Medical Directorate. The Strategic Medical Advisor will provide advice and support to both the Gold Command Suite and Incident Control Room. The role of the Strategic Medical Advisor is to ensure that appropriate clinical resources are available at the scene of the incident as well as providing guidance to the Strategic Ambulance Commander (Gold) on clinical issues as required.

More specifically the Strategic Medical Advisor will deal with any issues related to appropriate receiving hospitals, bed and surge capacity, and the coordination of specialised medical resources to the incident as well as monitoring the outstanding normal patient workload of the ambulance service.

### Gold Staff

This is a senior operational officer nominated to assist the Strategic Commander throughout the incident.

### Gold Command Suite

Gold Command Suite is the location from which the Gold Commander and the Gold Team will manage the Trust during a major incident. There are enhanced communication facilities provided so that the Gold Commander can maintain an overview of the Service. The Gold Command Suite should be opened by an EPRO/EOC Officer.

### Gold Group

The gold group is made up from representatives across the trust department/directorates;

| | | | | | |
|---|---|---|---|---|---|
| IM&T | Patient Transport | Finance | Control Services | Operations | Legal Services |
| Human Resource | Resourcing | Fleet/Logistic/VRC | Communications | Education & Development | SOR Liaison |
| | Business Continuity | EPRR | Medical Directorate | Voluntary Agencies | |

Their role is to provide the Strategic Commander with information, support and ensure their respective departments continue to function or to assist with staff redeployment to support other essential areas of the organisation. They should support the recovery phase following the incident and assist with the planning for protracted incident to ensure resilience for key functions. Legal Services support and guidance should be engaged early pending any public enquiry which is likely to follow this type of incident

**Strategic (Gold) co-ordinating meetings**

The Strategic group will meet at a location detached from the scene with suitable communications and meeting facilities. In general, the nature and difficulties of the incident will govern the frequency of Gold meetings.

The Strategic co-ordinating group meetings will follow the standard template which is provided in the Gold Command Suite. The group will determine the strategic issues relevant to the incident. In addition, the group may provide liaison with central government and other bodies and ensure that sufficient support and resources are available to the incident. Strategic group members will execute actions from the action cards provided.

Strategic meetings will also take place on a multi-agency basis. A Gold representative, with the delegated authority to commit LAS resources on behalf of Gold Medic will attend and report back to Trusts' Gold Medic.

### 4.4.3 Tactical Command

**Ambulance Incident Commander (AIC/Silver Medic)**

The AIC is responsible for coordinating and directing the work of the Service during a significant or major incident and will normally be located in the Special Operations Centre, they will direct the overall management of the incident(s).

The AIC will appoint an operational commander to each incident. They will be directly accountable to the AIC for on-scene management and arrangements. The AIC may if required use Motorcycle Response Units (MRU) or Cycle Response Units (CRU) to convey messages if the event that radios/mobile telephones become ineffective.

**Ambulance Tactical Advisor**

An Emergency Planning and Resilience Officer will tactically advise the AIC of any specialist personnel or equipment that may be necessary to assist in the management of a major incident and provide advice and support on matters relating to emergency planning and other ambulance service or NHS requirements. They are also available to offer advice regarding the assistance of outside agencies e.g. Local Authority, Military Aid and site-specific information.

**Specialist Pre-hospital Medical Support**

The LAS operates an on call pool of specialist trauma doctors and paramedics to provide Pre-Hospital Medical Support for a Mass Casualty Incident in the following roles:

- Strategic Medical Advisor – provided by the on call Gold Doctor from the Medical Directorate

- Scene Medical Advisor – provided by a LAS on call specialist doctor to respond to scene to and work alongside the Ambulance Scene Commander.
- Casualty Clearing Station Medical Lead – provided by a LAS on call specialist doctor to respond to scene and work within the Casualty Clearing Station (CCS).
- Enhanced Care Teams (also known as Medical Emergency Response Incident Teams (MERIT) – provided by either London's Air Ambulance or an on call pool of Emeritus Doctors, BASICS Doctors and Emeritus Paramedics. These Doctor/Paramedic teams are activated to scene when required at the request of the Strategic Medical Advisor.

**Loggist**

Both Gold and Silver commanders should have a loggist with them at all times. The loggist role is to keep a log of all decisions made by their Gold or Silver commander. The log should be an accurate record of all information, decisions, reasoning, facts, tasks and actions that take place from the beginning to the end of a major incident. It is vital that the loggist is used solely for the logging of the incident and is not used as an assistant to Gold/Silver commanders. Due to the critical role of the loggist, it is essential that staff are trained for this task and a list of the trust's trained loggists is held by the Emergency Planning and Resilience Team.

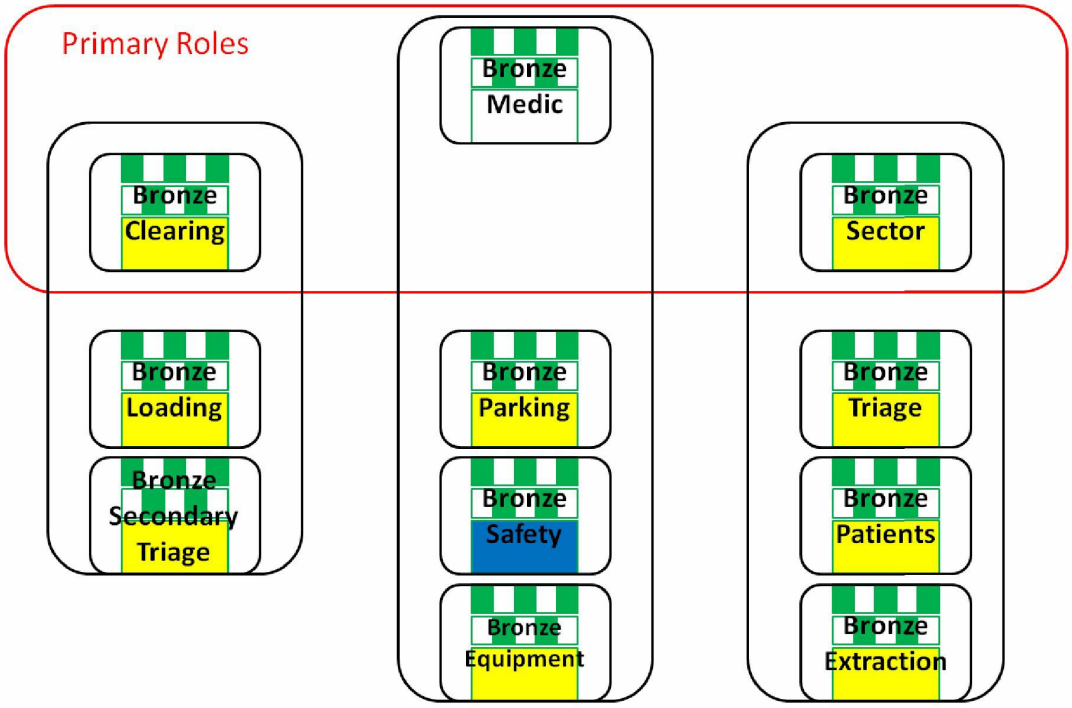
### 4.4.4 Operational Command

**Operational Command Structure**

The Operational Command Structure is designed as a scalable and flexible response to enable the appropriate provision of command support to any incident.

Using the model ensures that all functions are carried out across the incident and can be implemented by one operational commander.

It complements the initial actions of the 1st, 2nd and 3rd Ambulance staff to arrive on scene.




**Primary Operational Roles:**

**Bronze Medic**

Is the representative of LAS Silver Medic on scene, they are responsible for implementing the actions of all other Bronze Roles until those posts have been filled with other staff (if required)

During a Significant Incident or the initial stages of a Major Incident Bronze Medic will be responsible for implementing the actions of Bronze Parking, Bronze Safety and Bronze Equipment until those posts have been filled with other staff.

**Bronze Sector**

Is responsible for a designated area of the incident. The incident site may be split into multiple areas with a Bronze Sector appointed for each.

During a Significant Incident or the initial stages of a Major Incident Bronze Sector will be responsible for implementing the actions of Bronze Triage, Bronze Patients and Bronze Extraction until those posts have been filled with other staff.

**Bronze Clearing**

Will oversee operations in the Casualty Clearing Station.

If necessary more than one Casualty Clearing Station may be established with a Bronze Clearing appointed for each.

During a Significant Incident or the initial stages of a Major Incident Bronze Clearing will be responsible for implementing the actions of Bronze Secondary Triage and Bronze Loading until those posts have been filled with other staff.

**Individual Command Functions**

**Ambulance Scene Commander(s) – (Bronze Medic)**

He/she will manage all Ambulance Service and medical operations on the scene under the direction of the AIC. He/she will be responsible for ensuring that objectives set by the Tactical commander are carried out. To achieve this the operational commander will need to nominate a number of different operational roles, these are traditionally officer roles but can be performed others. The on scene commander will be located at the Forward Command Point through which personnel, technical and material support will be requested as required. He/she with partners from other services/agencies will form the Joint Emergency Services Command & Control Centre (JSECC) and will attend the multi-agency meetings to ensure that liaison is on-going with other agencies at the scene and aid prompt resolutions to any challenges as they arise.

The Command Support Vehicle will act as a conference facility for the operational Commander and the Command Support Team (CST) from EOC. They will act as radio operator, telephonist and loggist. They will keep a log of all communications and actions. If there is no CST the on scene commander is expected to keep their own log of communications and decisions. The vehicle is not designed for controlling the incident.

**Ambulance Parking Officer – (Bronze Parking)**

The Ambulance Parking Officer will be responsible for ensuring that LAS resources are correctly parked and ready to proceed to the Loading Point as directed. The duties of the Ambulance Parking Officer include:

- Ensuring attending crews are wearing PPE.
- Maintenance of records of staff and vehicles attending.
- Ensuring liaison with the loading officer is commenced and is ongoing.
- Management of keys and call signs of vehicles attending.
- Instructing crew staff what equipment to take to the scene (e.g. triage cards etc.).
- Briefing crews on the nature of the incident.

**Ambulance Safety Officer(s) – (Bronze Safety)**

The Ambulance Safety Officer will be responsible for the overall safety of all Ambulance and

NHS staff at the scene and must ensure that the environment and working practices at the scene do not place any staff at undue risk. Other duties of the Ambulance Safety Officer include:

- Identification of specific hazards.
- Liaison with the multi-agency safety officers.
- Ensuring that the correct PPE is worn.
- Identification of stress/fatigue in staff.
- Monitoring rest and refreshment periods.

**Ambulance Equipment Officer – (Bronze Equipment)**

The Ambulance Equipment Officer will be responsible for the issue and recovery of all Service equipment at the scene. Other duties of the Ambulance Equipment Officer include:

- Liaison with the Hospital Ambulance Liaison Officer (HALO) to arrange for specialist hospital equipment to be brought to the scene as required through SOC.
- Arranging for refreshment points to be set up at the scene for LAS staff.
- Consideration of the need for requesting the attendance of the Mass Casualty Equipment Vehicle (MCEV).
- Accessing major incident dressings packs provided at all major transport hubs.

**Sector Commander(s) – Bronze Sector**

He/she will be responsible for ensuring that the scene commander's instructions are delivered in a given area of the incident and for ensuring the functions of bronze Triage, Bronze Patients and Bronze Extraction are carried out. They should liaise with counterparts from other services present to promote robust communications and collaborative working.

**Primary Triage Officer – (Bronze Triage)**

The Primary Triage Officer will co-ordinate the triage sieve of casualties at the incident site. Other duties of the Primary Triage Officer include:

- Ensuring that triage sieve is carried out in pairs where resources allow.
- Ensuring all casualties are sieved.
- Ensuring only basic airway management is performed.
- Ensuring all casualties are correctly labelled.
- Any patient with a reduced level of consciousness is placed in the recovery position.
- Ensuring staff look for signs of life during the triage sieve process.
- As ambulance teams go forward, they take primary response bags and oxygen with them.

**Patient Liaison Officer – (Bronze Patients)**

- The Patient Liaison Officer will be responsible for communicating with patients and keeping them informed of what has occurred and how the LAS intends to deal with it. This is an on-going task for the duration of the incident.
- This role should be set up as soon as possible so that patients are aware of what is happening and are able to assist and cooperate.
- A loud hailer is carried on Officer vehicles, Command Vehicles and Equipment Vehicles for the purpose of communicating with large numbers.
- The police hold responsibility for communication with uninjured people at the scene.

**Extraction Officer – (Bronze Extraction)**

The Extraction Officer will be responsible for ensuring all patients are removed in priority order from the scene, they will work closely with the Bronze triage officer and multi-agency partners to ensure all patients removed appropriately. The duties of the Extraction Officer include.

- Log the number and location of casualties that require recovery to the Casualty Clearing Station (CCS)
- Request teams from the operational commander stating if any special skill mix is required for example an entrapment may require a Doctor, Paramedic and two additional personnel to carry the patient.
- Log Extrication teams as they enter and leave the incident site.
- Monitor the welfare of teams closely.

Extraction Teams can be multi agency and the number and skill mix within each team will depend on the incident and available resources. A dynamic assessment should be made by the extrication officer on what those teams need to look like.

**Casualty Clearing Officer – (Bronze Clearing)**

The Casualty Clearing Officer will co-ordinate the treatment and evacuation of casualties to the receiving hospitals through the sieve and sort process. Other duties of the Casualty Clearing Officer include:

- Arranging the siting and setting up of a casualty clearing station.
- Ensuring that casualties held at the casualty clearing station are triaged by a Secondary Triage Officer.
- Ensuring that patient documentation has commenced.
- Handing over patients to Bronze Loading.

**Ambulance Loading Officer – (Bronze Loading)**

The Ambulance Loading Officer will organise the ambulance loading point(s) which should be located near to the CCS. They are responsible to the AIC. The duties of the Ambulance Loading Officer include:

- Liaison with the police to ensure access and egress routes exist.
- Ensuring liaison with the Parking Officer is commenced and is on-going.
- Ensuring that all casualties have been triaged and are labelled prior to transportation to hospital.
- Instructing crew staff to contact Red Base for information on which hospitals to convey their patients to.
- EOC will provide a CST where possible; If there is no CST the Ambulance Loading Officer is expected to keep their own log of communications and decisions.

**Secondary Triage Officer – (Bronze Secondary Triage)**

The Secondary Triage Officer will carry out the triage sort of casualties at the Casualty Clearing Station. Other duties of the Secondary Triage Officer include:

- Ensuring all casualties are continually sorted.
- Ensuring all casualties are correctly labelled.

**Casualty Clearing Station Medical Lead**

The role of the Casualty Clearing Station Medical Lead is to provide oversight, support and advice to ambulance clinicians providing medical care to casualties within the CCS. The aim of the Casualty Clearing Station Medical Lead is to maximise clinical care for all patients, this will encompass both those with potentially life threatening injuries (P1 and P2) as well as the management of those with minor injuries (P3) some of whom can be assessed and referred or discharged directly from scene.

**Enhanced Care Teams (MERIT)**

An Enhanced Care Team comprises of an experienced pre-hospital care trauma doctor and paramedic. Teams can be provided by either London's Air Ambulance or an on call pool of Emeritus Doctors, BASICS Doctors and Emeritus Paramedics.

The first Enhanced Care Team on scene will be provided by the on duty London's Air Ambulance crew, should this team be unavailable or additional teams be required the Strategic Medical Advisor and/or the Scene Medical Advisor will request further resources.

The roles of the Enhanced Care Team is to provide specialist medical care above that of the current levels of ambulance practice; to assist within the CCS with the treatment and stabilization of patients prior to transportation to definitive care and to support ambulance

crews with patients who are trapped or in extremis. Doctors should not perform advanced procedures within casualty clearing unless the staffing and casualty flow allows & after consultation with the Medical Advisor.

**Scene Medical Advisor (SMA)**

The role of the Scene Medical Advisor is to support the Ambulance Scene Commander providing medical advice, ensuring that appropriate clinical care is provided at the scene, requesting the activation of specialist resources and coordinating all non LAS medical personnel. The Scene Medical Advisor can also request the invocation of the P4 category in conjunction with the Ambulance Scene Commander and Strategic Medical Advisor.

**Hospital Ambulance Liaison Officer (HALO) – (Bronze suffix name of the receiving hospitals)**

Each hospital that has been placed on major incident alert will have an HALO appointed to it. This will normally be the local Sector Training Officer. The HALO's prime responsibility is for ambulance crew welfare and collation of patient numbers. Other main tasks and duties include:

- Providing equipment & consumables to restock vehicles.
- Ensuring crew staff update their status with EOC.
- Ensuring that triage tags are used.
- Facilitating the quick turnaround of ambulances.
- Ensuring that staff welfare issues are considered for crew staff.
- Maintaining a log of vehicle details and patients arriving.

**Non Emergency Transport Service Liaison – (Bronze PTS)**

The primary function of the NETS Liaison Officer will be to facilitate and co-ordinate the removal of uninjured and priority three patients from the scene. They will be responsible to the AIC and will provide an on scene link with the NETS Strategic Officer. Their duties will include:

- Arranging for appropriate resources to transport Priority 3 patients.
- Arranging for appropriate resources to convey uninjured persons where necessary.
- Co-ordinating request for related hospital transfers resulting from the incident.

**Additional command roles for Hazardous Materials/CBRN(E) Incidents**

When an incident involves hazardous materials, the following additional roles are required to support the command function:

**Decontamination Officer – (Bronze Decon)**

The Bronze Decontamination Officer is located in the clean area and reports to the AIC. Duties include:

- Liaison with the appropriate Bronze Sector (hazard area) and the HAZMAT Advisor.
- Ensuring that sufficient resources have been mobilised and arrangements made for their reception.
- Inspection of all Decontamination operators who are to enter the warm zone to ensure that the CPPE is donned correctly
- Ensure appropriate comms/radios are available for all Ambulance Decontamination team operators.
- Ensuring the health and safety of all Ambulance staff in the Warm Zone.

**HAZMAT Advisor**

The primary function of the HAZMAT Advisor is to advise the AIC on decontamination capability, capacity and on issues directly relating to the specialist CBRN/HART response to the incident, including the effects of the hazardous materials on exposed persons. The HAZMAT Advisor will be decontamination trained and will have experience in managing decontamination incidents at this level. The On-call HAZMAT Advisor will respond to the Incident Control Room to support the AIC.

Other functions include:

- Liaison with the Public Health England regarding the immediate health effects of the hazardous material.
- Liaison with the Environment Agency regarding waste management.
- Liaison with the Government Decontamination Service representative regarding the scene clean up.
- In conjunction with Bronze Decon/Bronze HART forecast any specialist equipment requirements.
- Liaison with specialist responders from other agencies to determine the hazardous material involved.
- Assist with the technical input into the Dynamic Risk Assessment for the hazard area.
- Complete an Exposure Log detailing potential exposure to hazardous materials of all staff involved in the incident.
- Advice to the AIC/Bronze Medic at conventional incidents where HART have committed to the scene in Personal Protective Equipment (including Urban Search and Rescue, Working at Height or Working on Water incidents.

**Radiological Protection Supervisor (RPS)**

The primary function of the RPS is to advise the AIC/Bronze Medic with regards to the health effects and potential risks to staff and patients at an incident involving ionising radiation. This advice will be based on the type of radiation, the amount of energy emitted by source, the time exposed and any shielding between the source and the staff/patient.

The RPS is available 24/7 and forms part of the national mutual aid arrangements.

Support is available to the RPS from the Public Health England on call Radiological Protection Advisor.

**HART Team Leader**

The HART team leader will be responsible for ensuring HART is ready to respond to patients within the hazard area and the appropriate Personal Protective Equipment is available to the Team as required under the direction of the Ambulance Incident Commander.

- Agree the plan for the scene assessment with Bronze Medic.
- Manage the Health and Safety of HART staff.
- Agree a safety plan with the LFB Sector Officer if appropriate.
- Record the Dynamic Risk Assessment for the hazard area.
- Agree a plan with the AIC regarding Casualty Collection Points.
- Agree a plan with the AIC regarding deploying HART inside the inner cordon.
- Support the incidents command and control structure as required by the AIC.
- Liaise with the Hazmat Advisor regarding CBRN/HAZMAT implications to Health, Staff, Patients and the Organisation.

### 4.4.5 Multi agency co-ordinating meetings

The multi-agency co-ordinating group will consist of all the partner agencies attending the incident and will meet close to the scene.

The Scene Commanders will call an initial meeting of the multi-agency co-ordinating group at the earliest reasonable opportunity. The agenda should be based around the following:

- Safety.
- Situation reports.
- Priorities.
- Future developments.

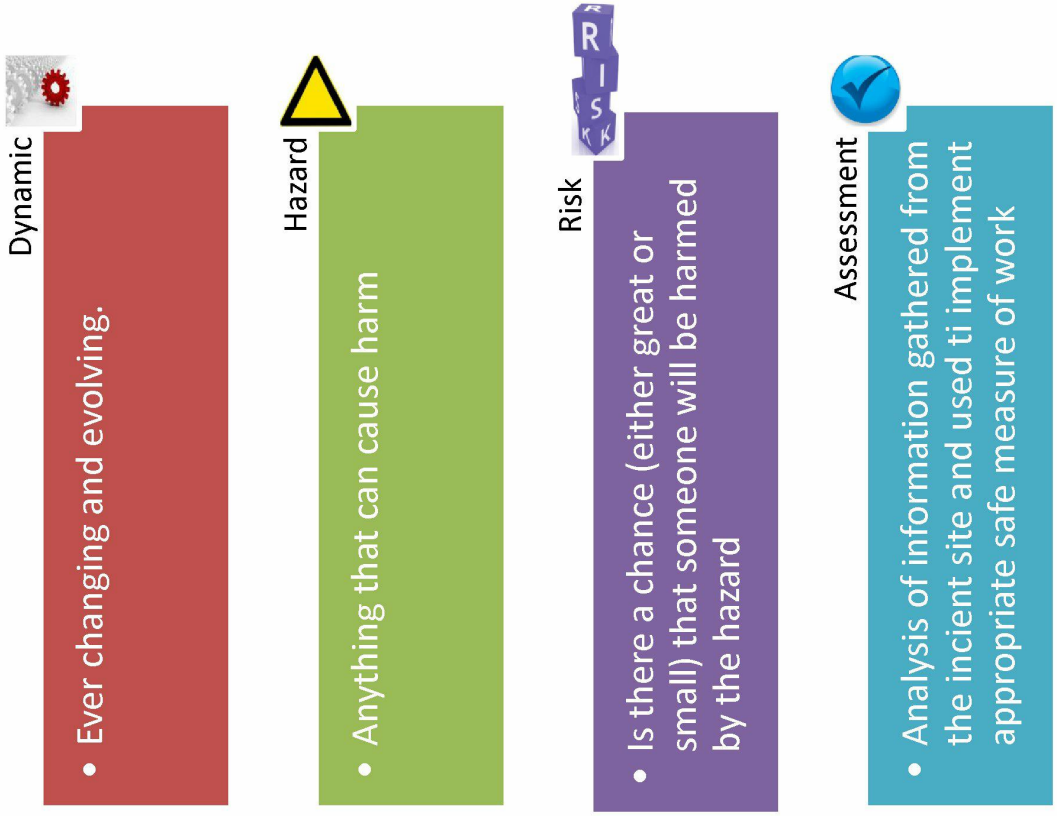
The LAS should briefly describe the situation as it affects its own operations and mention those matters for which it requires the assistance or co-operation of others.

## 4.5 Safety

### 4.5.1 Dynamic Risk Assessment Process

It is important to work closely with other responding agencies to obtain a joint understanding of risks involved in the incident.

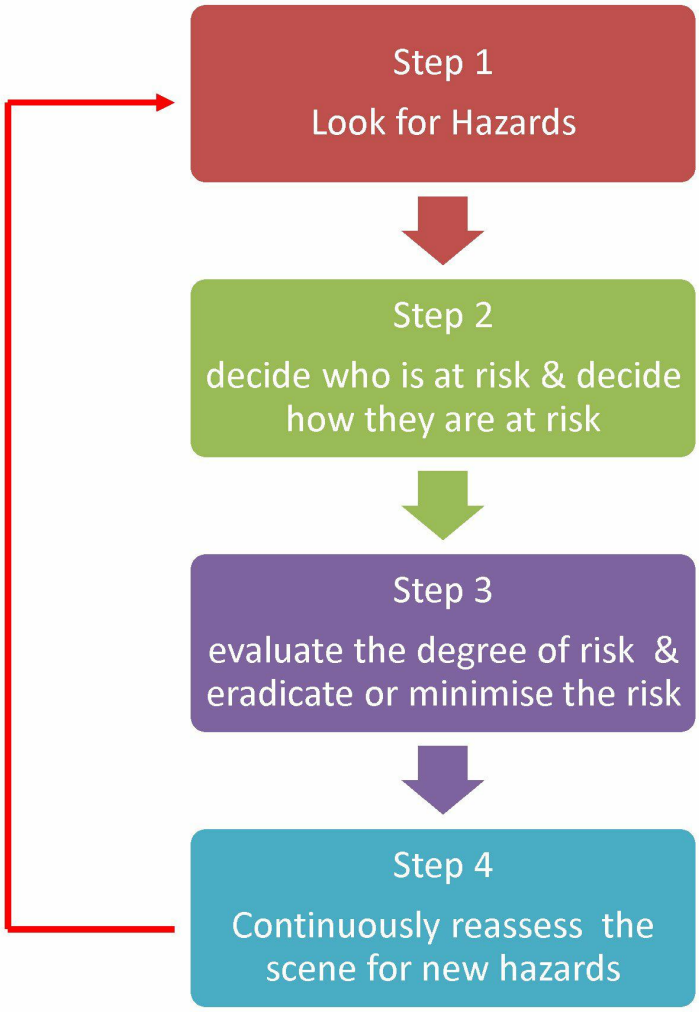
The dynamic risk assessment process should be adopted by all staff when attend an incident, this will assist in ensuring the provision of a safe working environment for all staff, patients and the wider [redacted].




**Remember P.E.M.E**

- People
- Materials
- Equipment
- Environment

### 4.5.2 Dynamic Risk Assessment Cycle



### 4.5.3 Personal Protective Equipment (PPE)

| DESCRIPTION | IMAGE | IMAGE | DESCRIPTION |
|---|---|---|---|
| Standard Operational PPE |  |  | HART Incident Ground PPE |
| HART Safe Woking At Height PPE |  |  | HART Inland Water Operations PPE |
| Cat 4 Infectious Disease PPE | CAT 4<br><br>INSERT IMAGE |  | CBRN Powered Respiratory Protection System PPE |
| HART Civil Responder 1 PPE |  |  | HART Gas Tight Suit PPE |
| Public Order PPE |  |  | Fire Arms Incident PPE |

| | | | |
|---|---|---|---|
| Cat 4 Infectious Disease PPE | IMAGE TO BE ADDED | | |

## 4.6 Communication

### Introduction

Control Services is an integral part of any Major Incident management system. The initial call will be received by Control Services which will dispatch appropriate LAS resources. The early identification of significant incidents or potential major incidents is of paramount importance.

### 4.6.1 Specialist Operations Centre (SOC)

The SOC is the dedicated management suite within the control suite which supports and manages the tactical command function during incidents and other operations. The SOC is responsible for:

- Providing a central coordination of incident activity
- Providing a liaison function for the Tactical Commander & Tactical Advisor
- Deployment of resources to the incident
- Nomination and declaration of receiving hospitals
- Allocating ambulances their destination hospital ensuring even distribution
- Communication with hospitals and external organisations
- Primary logging duties
- Paging instruction procedures
- Management of airwave talk groups and communication
- Facilitating requests of additional resources, equipment and personnel to scene

The EOC Watch Manager or nominated deputy has the responsibility to ensure that SOC is opened at the earliest opportunity once a significant or major incident has been identified.

The SOC should be staffed with sufficient number of staff with dispatch experience to manage the incident. The call sign for SOC is 'Red Base'.

If necessary normal operations in EOC should be temporarily re-arranged to relocate sufficient staff to SOC to manage the incident

**SOC Waterloo**

The SOC Waterloo is located on the ground floor adjacent to the Emergency Operations Centre. It is designed to manage spontaneous incidents or events, with a capacity to handle four 'Sector' desks or two 'Incident Islands', with 14 positions.

**SOC Bow**

The SOC Bow is located on the 2nd floor. It is designed to manage pre-planned events, with a capacity to handle the control of our large annual events or 5 smaller events simultaneously, with 35 positions. Adjacent to the SOC suite is a dedicated event Commander facility for the coordination and command of events.

If the need arises, during multiple or protracted incidents, or due to the location of the incident, SOC Bow may be used to control incidents. The call sign for SOC Bow during an Incident is Red Base and during a pre-planned event is 'Event Control'.

The following SOC roles should be fulfilled during a Significant incident:

| SOC STAFFING | LEVEL 1 – SIGNIFICANT INCIDENT |
|---|---|
| SOC Manager | During a Significant Incident can be fulfilled by an Area Controller or Watch Manager. Is responsible for coordinating SOC actions. |
| Radio Operator | Should be fulfilled by an EMD3 or above.<br>Monitor and communicate with all resources via an open TG. |
| Telecoms Dispatcher | Should be fulfilled by an EMD2 or above.<br>Receive and makes phone calls with other agencies. |

The following SOC roles should be fulfilled during a Major Incident:

| SOC STAFFING | LEVEL 2 – MAJOR INCIDENT |
|---|---|
| Silver Medic | Ambulance Incident Commander. Overall responsible for ensuring the management of the incident |
| Incident Control Room Manager | Fulfilled by an Watch Manager. Will report and liaise directly with Silver Medic to assist in managing Incidents |
| Command Radio Operator | Monitor the Officer communications on the Command Channel via an open TG |
| Resource Radio Operator | Monitor the resource communications on the resource Channel via open TG |
| Incident Allocator | Ensure the allocation of all resources including officers ensuring the PDA is fulfilled. When the PDA is met assists with telecoms |
| Status Board Operator | Is responsible for collating the roles fulfilled on scene and tracking patient movement to hospitals |
| Critical Loggist | Log critical issues & manage status of managers, carry out paging protocols as directed and answer incoming calls if required |
| Telecoms Dispatcher | Handles all incoming & outgoing telecoms, alerting other agencies, hospitals and EBS to the incident, gaining bed status and informing of incoming patients |
| Tactical Advisor | Tactical Advisor |
| CSV Driver | Must be CSV Driver trained. Consider CO or CTA staff |
| Command Support Team (CST) | CST to attend scene and pass information from scene to SOC & Silver. Used as an information gathering tool |
| MPS Special Operation Room | Process Police generated calls and act as communications link between control rooms |

### 4.6.2 Initial Actions of Control Services

The EOC Watch Manager or nominated deputy will assume overall responsibility for the EOC response to a significant or major incident and ensure that the following initial actions have been undertaken, not necessarily in the sequence detailed. Some of these actions may take place in EOC prior to the opening of the Special Operations Centre (SOC), although SOC opening must not be delayed:

- Dispatch the pre-determined attendance (PDA) of ambulances and commanders, Emergency Planning & Resilience Officer (EPRO), Equipment Support Vehicle (ESV), Mass Casualty Equipment Vehicle (MCEV) & Command Support Vehicle (CSV)
- Utilise a working CAD to dispatch all resources. Ensure that this is also used to log of all messages and actions.
- Commence paging instruction for appropriate managers.
- Inform the on call LAS Communications Officer & Tactical Advisor.
- Inform the Police Service and Fire Brigade.
- Dispatch a Command Support Team (CST) with command support vehicle to the incident.
- Ensure that a S/METHANE report has been requested and received from the first resource on scene and that the crew are told to carry out the procedure listed on their Major Incident Action Cards.
- Check existence of relevant locality information and contingency plans for further information.

The following actions are best executed from SOC although if the opening of SOC is delayed they must be instigated in EOC:

- Move into the Specialist Operations Centre (SOC) as soon as possible, ensuring the team are briefed and roles are allocated
- Allocate the predetermined airwave talk groups. Ensure that all resources are informed by MDT, airwave and text message, as well as general broadcast message. All resources should provide a radio check once they have changed talk group.
- Check existence of relevant locality information and contingency plans for further information.
- Ensure the appropriate officer(s) proceed to the scene(s) to act as the operational commander(s). Ensure that SOC and the Ambulance Incident Commander know which officers are fulfilling these roles.
- In consultation with the Ambulance Incident Commander dispatch or alert specialist resources.
- Commence recording details on the incident status board.
- Nominate and Notify appropriate hospital(s). Ensure operational managers are aware which hospitals are to receive patients.

- Nominate a Medical Advisor and instruct him/her to report to the AIC. If a Medical Emergency Response Incident Team (MERIT) is required by the AIC contact the Medical Advisor.
- Inform EBS, giving names of the receiving hospital(s).
- Inform NHS London (NHS01)

### 4.6.3 Pre-determined attendance (PDA)

The purpose of the pre-determined attendance is to ensure appropriate resources are mobilised in the early stages of an incident when identified as either Significant or Major. The Emergency Operations Centre uses PDAs during various types of incidents and those for Significant and Major Incidents are described below;

- Significant Incident, event type "SIGNIF":

The Pre-determined attendance for a Significant Incident is;

- 4 x Ambulances,
- 2 x Incident Response Officers
- 2 x Operational Commanders (Could include additional IRO's)

Consideration must be given to deploying specialist assets such as Tactical Advisor, HART, Central Operations, Command Support Team and Equipment Support Vehicle to assist in the management of the scene.

- Major Incident, event type "MAJORA and MAJORB":

The pre-determined attendance for a declared major incident or each site of a multi-sited incident consists of:

- 20 x Ambulances,
- 8 x Officers (3 x Incident Response Officers and 5 x Operational Commanders)
- Tactical Advisor
- Command Support Vehicle with a Command Support Team
- Medical Emergency Response Incident Team (MERIT) if required
- Ambulance liaison officers and hospital liaison officers should also be deployed to the appropriate hospitals
- HART and Central Operations
- Equipment Support Vehicles (ESV) – as listed in the table below:

| | | |
|---|---|---|
| 1st Scene | 2x ESV's,1x DH Mass Casualty Vehicle (MCV) | Consider additional ESV and MCV if required and low likelihood of further scenes |
| 2nd Scene | 2x ESV's, 1x MCV | Request mutual aid MCV's |
| 3rd Scene | 1x ESV and 1x MCV | |
| 4th Scene | 1x ESV and mutual aid MCV's | |

### 4.6.4 On-going actions of Emergency Operations Centre

- Update the Police, as appropriate, giving the names of receiving hospital(s).
- Ensure that any information received relating to safety of responders is distributed in a timely manner between all organisations involved.
- Dispatch officers, if necessary, to fulfil all the key roles at the scene and at the receiving hospital(s).
- Mobilise the required resources for the incident.
- Maintain liaison with Gold Command Suite.
- Update receiving hospitals and EBS of relevant scene reports, obtaining revised patient intake numbers.
- Give regular comprehensive briefings to the Gold meetings.
- Ensure all communication and actions are logged, recording patient movements.
- Update the nominated hospitals with incoming patients, advising of the call sign, number and priority of patients, and an ETA. A 'blue call' should not be taken.

### 4.6.5 Closure actions of Emergency Operations Centre

- Give "scene evacuation complete" messages at the appropriate time to all participating hospitals. These messages should include known/expected number of patients still en route
- A scene evacuation does not mean a hospital can stand down from a major incident. This must be decided by the hospital management.
- Inform other agencies of London Ambulance Service "scene evacuation complete".
- Ensure that all EOC staff involved are available for an EOC "hot debrief" immediately after the incident.
- Re-stock SOC and grab packs to ensure room is in a state of readiness.
- Collate all documentation and incident logs.
- Prepare a report for the Head of Resilience & Special Operations.

### 4.6.6 Airwave Communication

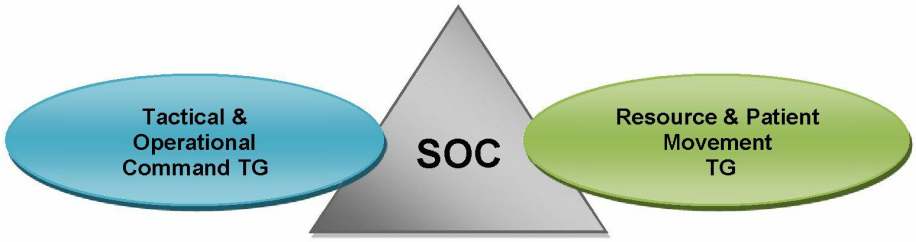
In the early stages of any incident where a number of resources are attending it may be prudent to nominate a single talk group for all resources to communicate on, even if the incident has not been declared significant or major and SOC is not opened. During a declared or potential significant or major incident, the following communications plan must be adopted to ensure effective command of the incident. SOC will seek acknowledgement of any information/action messages passed. All incidents will see the talk group operated in group mode broadcasting to all users, with all request to speak dismissed.

**Significant Incident**

During a Significant Incident there may only be a single talk group identified, controlling all resources and managers. Should the need arise, a second talk group can be opened allowing the management of communication with managers and resources separately.

**Single Major Incident**

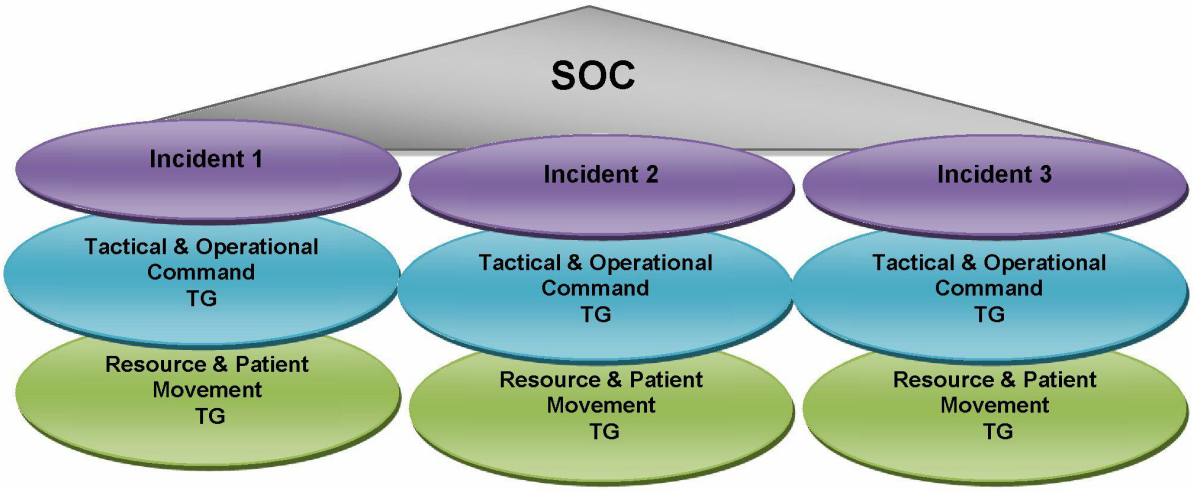
Ensure allocation of at least two talk groups (TG) to be used by the (1) command team, (2) ambulance resources and those officers involved in resource/ patient movement (Parking, Loading, Hospital Liaison Officers). Instruct all resources deployed to the incident to switch their radios to the designated talk group.



The following table identifies the groups of staff that should be allocated to each talk group:

| Command TG | Resource & Patient Movement TG |
|---|---|
| • Tactical & Operational officers (with the exception of those listed on the other TG) | • Ambulance & clinical resources<br>• Loading Officer<br>• Hospital and Ambulance Liaison Officers<br>• Parking Officer<br>• Marshalling Officer |

Each incident has a predetermined set of talk groups to be used. These are available in EOC and should be nominated by the Watch Manager.




Multiple Incidents / Multi-sited Major Incident;

N.B. this can be replicated for up to 9 separate incidents

Each incident must have its own Command TG but resource & patient movement talk groups can be combined across different sites if required.

**Use of airwave during an incident:**

Control Services must ensure that all resources deployed to an incident are informed of the correct talk groups to use. They must ensure that all updates are given to resources verbally, as well as electronically via MDT / airwave messages. This is to ensure that all responders are kept informed of the progress. Regular general broadcasts can be given with the current situation.

The following should be considered:

- Resources to continue to request to speak (RTS) to inform EOC/SOC of those waiting to communicate

- EOC/SOC during an incident must return the RTS in group (selected) mode, dismissing the RTS. This allows all resources to hear the information, understand how the incident is progressing and ensures all are aware of any safety issues
- All talk groups being used must be monitored on an ICCS to enable the recording of the communication. Only in extreme circumstances should handsets or desktop fixed mobiles be used within EOC/SOC
- The on call Tactical Advisor and radio engineer must be informed when major incident talk groups are in use
- Any safety information must be broadcast across all talk groups being used at the relevant incident

### 4.6.7 Communications Failures

In the event of a communications failure scene commanders should plan to communicate by other means. Motorcycle Response Units and Cycle Response Units should be utilised to pass messages. These facilities should be prepared as a matter of course.

**Airwave contingencies:**

In the event of an airwave failure the following must be considered;

- Ensure a major incident talk group is being used. These have a higher priority than primary dispatch talk groups
- If having communication difficulties from within a building consider using a gateway from a vehicle main set on scene
- Is the failure localised to a specific geographical area? If so consider using MRU and CRU to liaise and pass messages from outside the "black spot"
- In the event of a airwave failure, consider using airwave in direct mode operation (DMO) for on scene command communications
- Deploy a command support team with command support vehicle to manage the DMO talk group and assist with communications
- Seek advice from the on call EPRO and airwave team

### 4.6.8 Command Support Team

The London Ambulance Service has a fleet of Command Support Vehicles (CSV), deployable with a Command Support Team (CST), which may be activated to support the command functions on scene during an incident.


The role of the Command Support Vehicle & Team is to:

- Log communications from the Scene Commander at the site of the incident.
- Assist in gathering information and collecting data to provide a picture of the scene for SOC and Ambulance Incident Commander
- Form a Joint Emergency Services Command & Control Centre (JESCC) with the other services on scene.
- Act as a focal point for ambulance and medical staff and other emergency services at the scene.
- Ensure that all officers have the appropriate tabard and airwave handset. A stock of TETRA radios are kept on the vehicles if required.

All Airwave enabled resources will be controlled from the SOC.

All messages should follow the appropriate chain of command, ensuring that control is maintained, i.e. any messages for ALO/HLOs at hospitals from Bronze officers at scene will pass through SOC via a designated open talk group.

The Command Support Vehicle is to act as a conference and briefing facility for the operational team and is not designed for controlling the incident.

### 4.6.9 Paging

On receipt of a Significant or Major incident declaration, Control Services must ensure that the paging instructions has been instigated and followed.

Each pager message will have one of three colour coded prefixes:

| | |
|---|---|
| **GREEN**: | ALL ROUTINE/INFORMATION ONLY MESSAGES. |
| **AMBER**: | PREPARE A STATE OF READINESS/INCIDENT MESSAGES. |
| **RED:** | INCIDENT, ACTIVATION REQUIRED. |

The paging action cards and guidelines available in EOC and SOC must be followed. A pager message must include:

- Red / Amber / Green prefix
- Location of the incident including any RVP
- Nature of the incident
- Talk group being utilised
- CAD number
- Senders initials and control room being managed from

Update pager messages must be sent with the following information:

- Change of nominated talk groups
- When SOC is open including nominated landline phone number
- Updates with RVPs, locations or incident details
- Nominated receiving hospitals
- Other related incidents
- Stand down/ Scene Evacuation Complete

Further information is contained with the EOC paging guidelines and quick reference guide.

### 4.6.10 Call signs

The following call signs will be used at significant and major incidents.

| Role | Call sign |
|---|---|
| SOC / EOC | Red Base |
| Ambulance Incident Commander | Silver Medic (Tactical Commander) |
| Ambulance Tactical Advisor (Emergency Planning & Resilience Officer ) | Echo Papa (number) |
| Ambulance Medical Advisor | Mike Delta (number) |
| Ambulance Strategic Advisor | Echo Papa (number) |
| Ambulance Scene Commander | Bronze Medic |
| Ambulance Sector Commander | Bronze Sector (number or geographic) |
| Ambulance Inter Agency Liaison Officer | Echo Papa (number) |
| Ambulance Parking Officer | Bronze Parking |
| Ambulance Casualty Clearing Station Officer | Bronze Clearing |
| Ambulance Extraction Officer | Bronze Extraction |
| Ambulance Loading Point Officer | Bronze Loading |
| Ambulance Safety Officer | Bronze Safety |
| Ambulance Primary Triage Officer | Bronze Triage |
| Ambulance Secondary Triage Officer | Bronze Secondary Triage |
| Ambulance Equipment Officer | Bronze Equipment |
| Ambulance Hospital Liaison Control Officer (HALCO) | Via HALO |
| Hospital Ambulance Liaison Officer (HALO) | Bronze suffixed with Hospital name |

| | |
|---|---|
| Ambulance Command Support Vehicles (CSV) | YC31, YC32, YC33, YC34<br>Team to adopt officer call sign on scene |
| Ambulance Patient Liaison Officer | Bronze Patients |
| Non-Emergency Transport Service Liaison Officer | Bronze Transport |
| MERIT | Delta Mike (number) |
| Ambulance Airwave Tactical Advisor | TBC |

| CBRN / Hazardous Environment | Call Sign |
|---|---|
| Ambulance Decontamination Officer | Bronze Decon |
| Ambulance Entry Control Officer | Entry Control |
| HART Supervisor | Bronze Sector (HART) |

If the incident covers a large area it can be divided into sectors. Each sector can be identified either by a number or a point of the compass. The Officer appointed to take charge of a sector will take the Call Sign, “Bronze” suffixed with the number or point of compass/landmark (e.g. "Bronze Parking North" or “Bronze Parking Horse guards”).

If more than one major incident is being dealt with all call signs will include a suffix indicating the location of the incident, e.g. Bronze Medic Westminster. The important point is that all are aware of the method to be used.

### 4.6.11 Inter service Communications

Robust communication links must be established as soon as possible. There are several technological solutions available for this, but these are no substitute for frequent Multi-agency meetings along with well-established working practices.

Interoperability talk groups are available through the TETRA system. This facility should be requested via EOC who in consultation with the ambulance radio project (ARP) and Emergency Planning & Resilience Officer designate appropriate talk groups.

NHS England (London) on-call EPRR team will be informed that the LAS has declared a Major Incident, they will then disseminate the message to the wider health community.

### 4.6.12 Incidents on the London Underground Network

If the incident is on the underground network then consideration should be given to dispatching resources to the next stations either side of the incident where casualties may evacuate from.

If provided by LUL or LFB, all underground incidents will be responded to using the LUL identification codes to ensure the correct entrance is attended.

Each emergency service using airwave on the underground network are restricted to a single

talk group due to capacity issues. Officers deployed to sub-surface sections of the underground network must be instructed to use the same talk group. This should be designated by EOC/SOC. There is no restriction to the number of talk groups that can be used above ground at street level, outside of the station.

Control Services must inform all staff attending an incident on the transport network to follow the POWER procedures.

London Underground Limited (LUL) has procedures in place during an incident to halt trains on a specific line or the entire network. This is known as "Code Amber" or "Code Red".

- Code **Amber** is where trains are instructed not to go further than the next station and then stop.
- Code **Red** is where trains are instructed to stop at their current location. This could be inside a tunnel.

For further information see the site specific contingency plan. EOC must inform the on call Tactical Advisor of either a code Amber or Red.

## 4.7 Assessment

| | |
|---|---|
| S/M | **Significant Incident / Major Incident**<br>Or omit if not. |
| E | **Exact location of the Incident** |
| T | **Type of Incident**<br>Include descriptions of numbers and types of buildings / vehicles involved. |
| H | **Hazards present and potential** |
| A | **Access**<br>Provide details of the best access and egress routes. |
| N | **Number (Approximate) and type of casualties**<br>P3-Injured Walking P1/P2-Injured Not Walking.<br>And Dead. |
| E | **Emergency Services**<br>Who is on scene, who is required.<br>Share your report with other agency commanders. |

In liaison with the other Emergency Services identify and establish:

- Access and egress routes to and from the incident site
- Ambulance casualty reception and casualty clearing station
- Ambulance control point
- Ambulance parking point
- Ambulance loading point(s)

**Consider potential hazards when designating the above.**

***The first crew on scene should not attempt to rescue or treat casualties until relieved of their initial "First on Scene" roles by Ambulance Officers***

### 4.7.1 Other Considerations

Staff should be aware that there are ***site specific contingency action cards*** for specific sites throughout London. In addition, all staff are issued with incident action cards to remind them of their role on arrival. Staff should make themselves familiar with their contents.

In order to provide sufficient initial equipment for the treatment of patients prior to the arrival of Equipment Support Vehicle (ESV) and Mass Casualty Equipment Vehicles (MCEV) it may be appropriate for crews to strip the first and second ambulances of their equipment. These vehicles should be moved to prevent them from being used to transport casualties to hospital. As staff go forward to the incident scene they should take items of equipment with them such as primary response bags, oxygen, and other equipment as appropriate, this should be left near to the forward incident area and triage should then commence. The purpose of the equipment is to provide an initial forward equipment stock.

Any ambulance crew that conveys a patient MUST advise Red Base (and the Ambulance Loading officer if in position) of the following information:

- casualty numbers
- patient classification: Priority 1 with Major Trauma, Priority 1, Priority 2, Priority 3
- approximate age

Red Base will designate the receiving hospital for each casualty.

It should be noted that during a Major Incident there is no requirement for blue calls – the use of priority 1, male/female, adult/child will suffice.

Within the assessment for required resources at the scene of the incident it may be appropriate to commandeer a coach or single deck bus. Where possible staff should request buses/coaches via EOC.

## 4.8 Triage

### 4.8.1 Principles of triage

The main objective of the LAS at any multiple casualty incident is to produce the largest number of survivors. In order to do that, the LAS uses a tried and tested system called triage, which classifies patients according to their physiological needs.

During an incident the LAS will use two levels of triage – these are referred as "triage sieve" and "triage sort". Both levels use the casualties clinical observations to determine which priority group they fall into. The priority groups are as follows:

| Priority | Description | Extraction | Colour |
|---|---|---|---|
| 1 | Immediate | Treatment within 1 hour | RED |
| 2 | Urgent | Treatment with in 4hrs | YELLOW |
| 3 | Delayed | Treatment can be up to 4hrs and above | GREEN |
| 4 | Expectant | | RED with BLUE Corner |

The LAS uses SMART Triage tags to identify the triage priority of each casualty.

### 4.8.2 Triage sieve

The first ambulance crew or responder on scene of a multiple casualty incident must ensure that the role of "Primary Triage Officer" is allocated. Ideally this will be the second ambulance crew or responder on scene. This bronze role has the responsibility to ensure that a triage sieve is commenced as soon as possible. As a bronze role, they must further ensure that patient numbers and movements are tracked at all times.

Triage sieve quickly sorts out casualties into priority groups. Each LAS Ambulance has a triage pack consisting of 40 triage cards along with Major Haemorrhage dressings and Oro-pharyngeal airways.

Using the algorithm card attached to the pack the staff undertaking triage sieve must systematically work through the patients, triaging and labelling them.

For best effect, triage sieve should be carried out by staff in pairs, rather than staff on their own. One of the staff should carry out the triage process, whilst the other maintains an overview of the situational awareness.

The triage sieve process includes the following lifesaving interventions:

- Checking for any signs of life
- Basic airway manoeuvres, and airway adjuncts (such as Naso or Oro-pharyngeal airways)
- Control of catastrophic haemorrhage
- Casualties with reduced level of consciousness should be placed in the recovery position

### 4.8.3 Triage sort

On the arrival of further resources, patients are moved to a place of safety, usually the casualty clearing station. At this location they can be re-triaged using triage sort, which in essence is the Triage Revised Trauma Score (TRTS). This system is based on three parameters: respiratory rate, systolic blood pressure and the Glasgow Coma Scale.

The Secondary Triage Officer must ensure that triage sort is carried out correctly. This should be done by clinical staff allocated to the CCS carrying out a triage sort on a patient, using the triage card that has been attached to the patient during a triage sieve. They should then note the findings of the TRTS on the card and update the triage category by refolding the card as necessary.

A separate area should be identified for P3 patients to undergo a triage sort prior to leaving for hospital on buses. A crew must be identified to travel with the P3s.

### 4.8.4 Not Injured

People that have been involved in an incident and do not require medical intervention are categorised as "Not Injured".

Once these people have been removed from any hazards and processed through a triage sieve by the LAS they must be handed over to the Police for collation of details and witness statements. Often these people will be housed at a "survivor reception centre". Consideration must be given to providing a bronze officer and a clinical resource at the Survivor Reception Centre to ensure rapid patient care should anyone become unwell later into the incident. The Bronze officer will take the role of a Sector Bronze.

During some incidents it may not be possible to separate all injured and non-injured persons, this could include relatives, carers or dependants of casualties. To identify them a separate Not Injured triage tag is carried on the Equipment Support Vehicles

### 4.8.5 Expectant category

The expectant category is only used following the authority of Gold Medic. This situation arises when there are such large numbers of patients, the ability of the LAS to respond to the clinical needs of every individual is compromised. Patients with potentially un-survivable injuries will not be treated.

Expectant patients must be triage labelled as "immediate priority 1" which is red in colour but with a blue flash corner folded so that it is visible. This function will normally be carried out by the MERIT/HEMS/BASICS Doctors attending the incident following direction/guidance of the Strategic Medical Advisor (Gold Doctor).

### 4.8.6 Covering of the Deceased

To ensure patient dignity, operational need, scene clearance and scenes of crime management in relation to the preservation of evidence the LAS will carry out the following;

- Where a deceased person is identified at the scene of an incident and **is not** in public view or that of the media, the body will be assessed for signs of life, appropriately triage tagged (marked) with time & Initials and left uncovered.
- Where a deceased person is identified at the scene of a major incident and **is** in public view or that of the media, the body will be assessed for signs of life, appropriately triage tagged (marked) with time & Initials in order to allow due attention for forensic processes and covered, with the triage tag visible.
- In the event a body at the scene of a major incident being covered and not having a visible triage tag or marking, identifying the fact that a clinical assessment has taken place, such an assessment will take place immediately.

## 4.9 Treatment

### 4.9.1 Casualty clearing station and ambulance loading point

The casualty clearing station is a place of relative safety to which casualties are evacuated from the incident site. Triage sort, assessment, treatment and stabilisation are carried out by LAS clinicians and Enhanced Care Teams (MERIT). The casualty clearing station is co-ordinated by the LAS Bronze Clearing officer supported by the Casualty Clearing Station Medical Lead.

A suitable area or building between the inner and outer cordons near to the site should be identified for use as the casualty clearing station. The LAS have a number of temporary structures held on the Equipment Support Vehicles (ESV) which can be used for this purpose.

Casualty Management Vehicles carry additional trolley beds and patient handling equipment to assist in the movement of casualties at the incident site.

It is vital that patient documentation starts within the casualty clearing station and should be documented on a PRF.

### 4.9.2 Blue calls and status reporting

All staff that convey patients to a hospital have a responsibility to ensure that SOC have been advised of the patient's triage priority, gender, and age. There is no requirement to provide blue calls due to the hospital's readiness to receive multiple casualties, however staff should complete the normal PRF/HRF as required for each patient.

### 4.9.3 Children in Major Incidents

If adults and children are seriously injured, they may need to be taken to separate facilities, but a balance needs to be struck between the benefits to children being kept close to their

parents and their distress at seeing severely injured parents.

If adults are seriously injured but the children have minor injuries or are uninjured – Then the family should be taken to major trauma centre/trauma unit, where arrangements for the care of the children should be made.

If the children are seriously injured and the adults are uninjured or have only minor injuries, the family should be taken to the designated children's major trauma centre/trauma unit.

## 4.10 Transport

### 4.10.1 Arrival at hospital

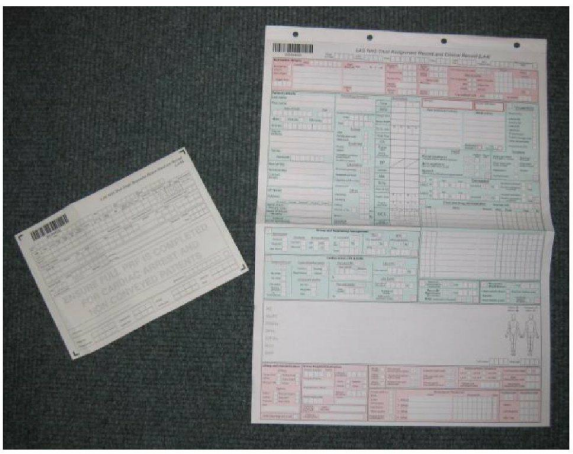
Once the patient arrives at the hospital the patient will be re-triaged by hospital staff. The ambulance crew must ensure that they report their arrival with both SOC and the HALO at the hospital.

Where possible equipment should be retrieved and returned to the incident site. Crews may replenish some equipment through the HALO.

The HALO has a responsibility to retrieve every patient's LAS triage card. Where cards cannot be retrieved, photocopies should be made and returned to EPRR.

### 4.10.2 Labelling and documentation

Documentation of patients must start as soon as possible. Triage labels must be attached to patients in the initial stages of the incident even if there is no opportunity to collect personal details. Details of each patient should be collected as soon as they enter the casualty clearing station/area.



It may not always be possible for ambulance crews to record the usual details of patients carried on the Patient Report Forms (PRFs). In this event records should be made by description, e.g. "elderly man", "teenage girl" etc. Ambulances should not be delayed at the scene in order to obtain personal details of individual casualties however a HRF or PRF **must** be completed for every patient transported. In all circumstances the triage label must be completed. It is particularly important that those patients who have received drugs can be readily identified on admission to hospital. Further patient details will be obtained by the police at the receiving hospitals.

Every effort should be made by all staff to accurately record a description of patients injuries and where an injured patient was found, this should also include any distinguishing features.

### 4.10.3 Use of buses and coaches

Within the assessment for required resources at the scene of the incident it may be appropriate to commandeer a coach or single decker bus. Where possible staff will request provision of buses or coaches via SOC. Casualties should be accompanied on the bus to hospital by LAS staff in case of deterioration. Police should also accompany the staff on the bus.

### 4.10.4 Clinical Telephone Advice – CHUB

Clinical Advice will be available via the CHUB, staff may be utilised ringing back callers and advising that the LAS is dealing with a large incident and that they may need to make other arrangements.

### 4.10.5 Non-Emergency Transport Service (NETS)

**Overview**

The use of LAS NETS vehicles and resources should be considered at the earliest opportunity and a request made through the on call NETS senior officer. Initially NETS will provide a nominated senior manager either to LAS HQ (or other nominated location) and/or to the incident scene.

NETS operate a fleet of double and single manned vehicles including some with stretcher capability, covering a number of hospital sites across London. All of these vehicles have multi-occupancy capacity and a number also have blue light capability.

NETS will provide proportionate, scaled support to the incident as requested by the Service, this can include all or some of the following;

**Command**

- NETS Strategic Officer – The on call Senior NETS manager who will be an integral part of the LAS Gold Co-ordinating Group within LAS HQ.
- NETS Liaison Officer – A NETS Manager who will attend the scene and act as the focal point for NETS resources, this manager can be utilised on scene to support the incident command team as required.
- NETS Operational Officer – A NETS Manager who will be designated by the PTS Strategic Officer on notification of the incident. They will coordinate NETS resources in support of the incident and maintain other NETS commitments.

- Hospital Liaison Officer – A NETS manager who can attend nominated hospitals and fulfil the Bronze HALO role.
- NETS Support Officer – A nominated NETS manager, who will coordinate support activities such as requests for staff or equipment movements and other requests not directly involved with the incident.

**Control**

NETS operate two principle Transport Operations Centres (TOCs), both of which are operational during normal working hours. Pan London resources and out of hours operations (where applicable) will be controlled via the NETS Central Desk.

Requests for NETS assistance should be directed to the on call NETS Manager via the NETS Central Desk (where operational) who will co-ordinate the NETS response

NETS maintain a number of further predefined form-up and co-ordination points where support functions can be located, these are at Greenwich, Pinner and Camden stations.

**Transportation**

Initial deployment – NETS can deploy a number of initial vehicles directly to the incident RVP, or alternative identified location, to assist with the rapid removal of Priority 3 patients. Out of hours the on- call Senior NETS Manager should be contacted.

Further resources – For larger scale incidents NETS can supply additional vehicles. These would be deployed in cells of up to five vehicles. The cells would be assembled at a nominated NETS location prior to deployment to the RVP or alternative agreed location.

### 4.10.6 Displaced People

Some emergencies may require the evacuation of a large surrounding area because of the danger to life from environmental or structural hazards. The local authority have pre identified suitable facilities available and will use local authority staff and voluntary agencies to staff these centres. The purpose is to provide security, welfare, communication, catering.

### 4.10.7 Rest Centre

Is a facility where persons displaced by a major incident of any size can find shelter, support and sustenance as appropriate. Personnel from the local authority and voluntary agencies will staff rest centres as appropriate. In addition to providing facilitation for documentation teams, the centre will provide shelter, first aid treatment, welfare support and communications. The voluntary aid societies may also be present to supply comfort and counselling.

### 4.10.8 Survivor Reception Centre

Those who have been involved in the incident may be able to provide important information/evidence in relation to the event. Where practicable survivors and witnesses should be directed to the Survivor Reception Centre. Here investigations can begin to interview witnesses and forensic managers can assist with the collection of evidence. Police will supply a documentation team, who will pass on details to the casualty bureau.

A police security team will also be deployed at the centre. Consideration must be given to providing a clinical resource at the Survivor Reception Centre in the early stages. It has been recognised that often following an incident once in a calm environment people can develop post incident symptoms. Sign posting to mental health and counselling services.

### 4.10.9 Vulnerable People

LAS may become involved in the evacuation of vulnerable persons and supporting the local authority. It should be noted that information surrounding vulnerable persons is accessed via the Local authorities and CCGs. NHS England can also assist with contacting primary and specialised commissioning teams.

### 4.10.10 Friends and Relatives Reception Centre

When demand warrants it, consideration should be given to establishing a secure, comfortable area where friends and relatives of casualties and missing persons can be directed for information. The size and scale of the incident, numbers of fatalities and possibly the area of destruction will affect any decisions made.

### 4.10.11 Humanitarian Assistance Centre (HAC)

A sophisticated facility where bereaved families, survivors and anyone else directly affected by an incident can receive information and appropriate support from all the relevant agencies, without the need for immediate referral elsewhere.

It is the responsibility of the Local Authority to set-up the HAC with support from the police and other agencies, following a request from the Gold co-ordinating group. Sites for the HAC have been identified across London, there are site specific plans produced for these sites

The LAS does not have a specific role at the HAC and would only attend if specifically requested to do so or upon receipt of an emergency call to the location.

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## 5.1 Logging

Maintaining records of activity and decisions is an essential part of any incident response.

Record keeping is an integral part of healthcare work and staff are well versed in creating patient report forms.

The Trust was criticised after the 2005 London bombings for a lack of records;

> "Unfortunately, it is not possible to examine in detail the London Ambulance Service's response to the Edgware Road explosion … because records of the response were not maintained. The timeline provided to us by the London Ambulance Service contains no entries beyond 9.21 am... This failure to maintain records is not unique to the Ambulance Service; the London Fire Brigade has also commented … on the failure to record information about its response and the need to do so in future."
>
> London Assembly
> Report of the 7 July Review Committee
> 6 June 2006
> §3.37 page 52

Following this the Trust has moved to a new control room computer system, introduced loggist training and developed new log books.

### 5.1.1 Logging in Control Rooms

Within EOC the Command Point computer Aided despatch system allows operators to rapidly log information relating to incidents.

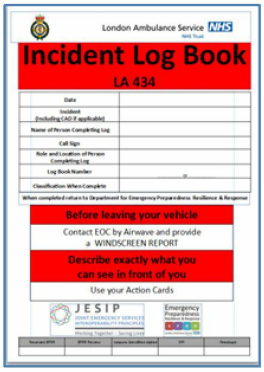
Information can be shared between individual calls and sent electronically to Mobile Data Terminals and Airwave Handsets.

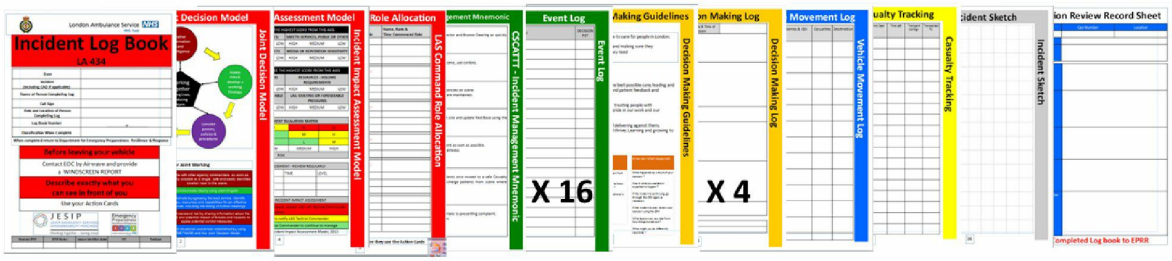
In the event of a system failure paper based logs are maintained.

### 5.1.2 Logging On Scene

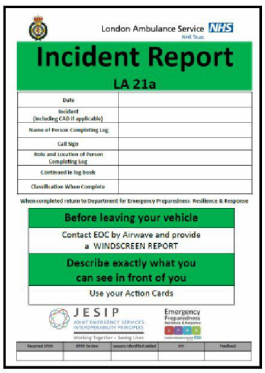
To ensure consistency and promote familiarity the Trust standard Log Book (LA434) is used for all pre-planned events and incidents.

The Log books are produced in an A5 format which can easily be carried in the pockets of the Incident Comm and Tabards.

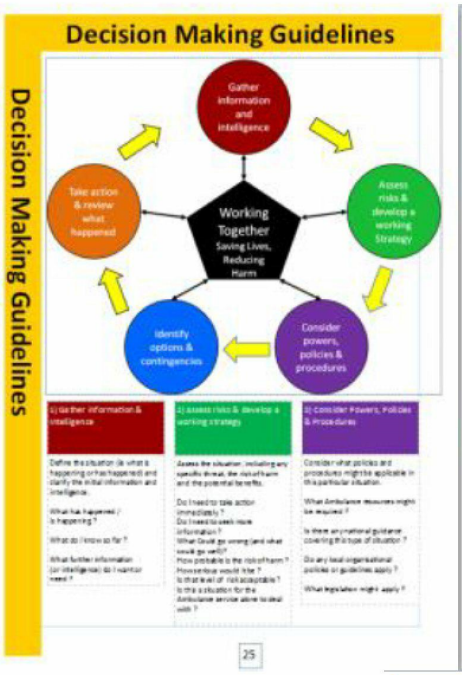


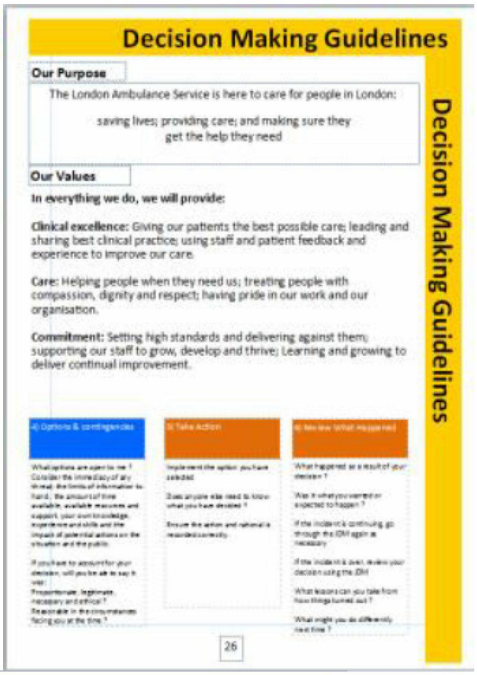



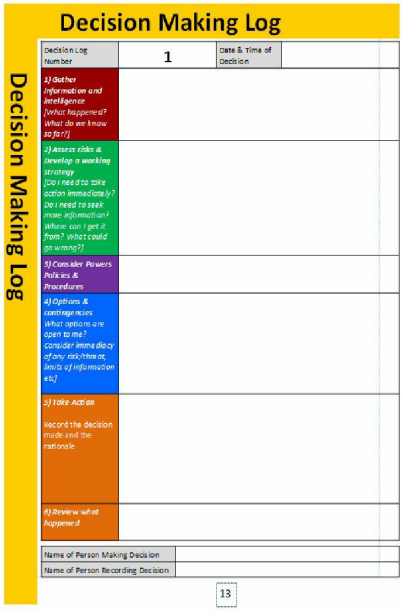

A shortened version of the Log Book adhering to the same format is used by Operational Commanders to record smaller incidents (LA21a)




### 5.1.3 Decision Logs




### 5.1.4 Record Keeping

Completed log books are returned to EPRR where they are reviewed and stored for future reference.

Completed log books are reviewed by and EPRO where appropriate feedback is given to the person completing the log and as identified lessons and notable practice is fed into the Trust lessons process.

Completed log books must be kept for a period of time in line with the Trust and legislative arrangements following an incident.

## 5.2 Post Incident Procedures

### 5.2.1 Operational activities

Following any incident the Service has a responsibility to ensure that staff have access to appropriate support and welfare services. The Trust has a duty to ensure that operational procedures are carried out to restock and maintain the fleet. Debriefing is a very important process in order for the Trust to further develop services from lessons identified, make recommendations for change to our partners and adapt service protocols if needed. It is therefore the Resilience Department who have the responsibility on behalf of Gold to organise, chair and administer incident debriefs – monitoring the progress of actions as necessary.

Post-incident the Trust has a responsibility to ensure that the following procedural and administrative activities are carried out:

- A "hot debrief" immediately after the incident chaired by the Ambulance Incident Officer and to include the circulation of welfare information.
- The re-stock of Trust resources including control rooms and equipment vehicles
- "Stand down" time for all staff involved.
- Feeding of staff where necessary.
- The collation of all paperwork and voice recordings to form a primary transcript record
- All members of staff receive a debrief pro-forma.
- All operational and EOC command officers to submit a report to the Resilience Team.
- An internal Trust SOC debrief.
- An internal Trust Major Incident debrief.
- Lessons learnt and debrief actions to be allocated.

### 5.2.2 Debriefing

The LAS internal debriefing process should be followed at an early opportunity by a joint medical services debrief involving representatives from all the medical organisations involved in the incident. The joint medical service debrief should be organised by the ambulance service who should also supply the Chair and secretarial support.
Information gathered from these debriefings can then be presented, where appropriate, to the Joint Services debriefing, usually organised by the Police Service. This will review the

response overall, identify any lessons learnt and any revision required to the existing plans. It must be remembered that the notes taken at debriefs are subject to legal rules on disclosure and may form the basis of evidence before an inquiry.

**The London Ambulance Service has an obligation under the Controls Assurance process and the Civil Contingencies Act 2004 to assess their compliance with emergency planning requirements and must review, improve and test this plan on a regular basis. Lessons learnt are the basis of this process.**

### 5.2.3 Reporting Procedures

The Department for Emergency Preparedness Resilience & Response will collate all incident reports from managers undertaking principal roles and prepare an overall report. This report will include outcomes and actions required from all debriefing sessions.

### 5.2.4 Records and Public Inquiries

In the immediate aftermath of a major incident, the emergency services are likely to receive praise for the way in which the incident was handled. However it is important to remember that at a later date there may be calls for a public inquiry. It is vital that possible evidence for these inquiries is not destroyed or lost. This evidence may not only be the notes and records taken at the time of the incident, but may be documents created before the incident occurs. It is good practice to appoint an inquiry officer within the first few hours of the initial response to preserve and protect clinical records and logs of why, when and who took decisions.

Records must be clear, concise and accurate. It is unlikely that details will be remembered after the event however the trust must be able to demonstrate that, with supporting evidence, everything reasonable and practical was done.

### 5.2.5 Staff Support after a Major Incident

In order to respond to the potential needs of staff involved in a Major Incident the LAS uses the TRiM System, which adheres to NICE best practice guidelines. TRiM Consultations are delivered by Senior LINC Workers who have been trained as TRiM Practitioners and are also trained how and when to liaise with managers and staff support staff. The TRiM training equips Practitioners to assess the possible psychological aspects of traumatic incidents via conducting a structured risk assessment Consultation and through the delivery of basic psycho-educational briefings, if appropriate.

TRiM Consultations aim to:

- Identify trauma risk factors and trauma risk levels
- Normalise stress reactions
- Reinforce coping strategies
- Raise awareness of Support Services available

- Facilitate early referral to specialist help if required

A traumatic event, by definition is physically and emotionally overwhelming (e.g. where emotion overwhelms rational or logical thought processes). This disrupts the basic personal belief systems of the survivor – including trust, security, predictability and controllability. People may experience a range of differing reactions to traumatic events including: shock, fear, anger, helplessness, sadness and shame. These are all completely normal reactions to an event that may be considered extraordinary. Other effects may include chronic anxiety, sleep disturbances, intrusive memories and feelings, numbing, irritability, depression, social withdrawal, and physical sensations.

Usually these reactions are only experienced for a few weeks, and by accessing the appropriate support services staff affected can learn to better manage and understand traumatic stress and also learn to enhance personal resilience. According to statistics used by NICE, immediately after a traumatic event some 60% of people experience a similar set of symptoms. Within 4-6 weeks, however, that figure falls to about 10%. Most people get better without any intervention. The TRiM strategy reinforces people's natural tendency towards wellness and resilience and it also provides a structure of support and guidance on how staff can learn to look after both themselves and each other.

**Understanding that most people will cope with even the most serious events is important. It is the minority who are likely to require extensive support, assistance and perhaps even referral to specialist services.**

Managers are given support and advice on how to best manage individuals who may be struggling. (See Managers' Guide to Traumatic Stress which can be accessed on The Pulse in the Appendix of The Stress Management Policy).

**Crucially, it is important not to send staff home but instead staff should be encouraged to remain at work within a familiar environment and with colleagues who have undergone the same experience – this is an important part of the healing process.**

Sending staff home during these traumatic events is rarely the best option as an individual often goes home to an empty house or to a house where family or partner are there and a staff member will aim to protect these close relationships. Whereas, staying within the workplace with the individuals, who also managed/witnessed the incident, and delegating/carrying out appropriate manageable tasks, will prevent isolation, reinforce psychological containment and encourage the re-building of self-confidence and resilience, it is also a proactive attempt to normalise the situation within a familiar working environment, which is part of the healing process. In such situations a manager will monitor the staff member give him or her the opportunity to discuss the problem with a LINC Worker, ensure that the staff member is involved in group activities and gives information about the effects of traumatic stress and self-help measures following Traumatic incidents (relevant information is contained in the abovementioned Managers' Guide to Traumatic Stress).

**Research has shown that appropriate information given before and reinforced after Traumatic incidents can help to decrease levels of distress and build resilience against having to manage future Traumatic Incidents.**

### 5.2.6 Staff Support Management Strategy after a Major Incident

**The Planning Meeting**

Careful planning is required for any effective intervention. Within 48 hours after an incident, a meeting is arranged to engage the organisational management structure and to examine who was involved. The support of line managers is instrumental in ensuring that the strategy is implemented. Traumatic events vary and it is essential that a flexible approach to planning should be taken.

**Analysing Traumatic Events and Allocation of Staff**

At a planning meeting, it is important that a decision is made as to whether any action (and what level of action and implementation) is required. Preliminary research has shown that certain events are more likely to cause psychological distress, including:

- Experiencing or witnessing serious injury to others, particularly colleagues and vulnerable groups such as women, children and the elderly.
- Complex or prolonged trauma.
- 'Near miss' events which could have resulted in serious consequences.
- If staff experience immediate overwhelming distress.

After deciding whether or not to intervene and then filtering, it is necessary to decide between carrying out individual or small group interviews. Prior to conducting risk assessments, the 10 risk factors are discussed within the confines of the planning meeting and some preliminary information obtained, especially that relating to exposure to previous traumatic events and previous psychological problems.

**Risk-Assessment Interview Structure**

A structured interview model, referred to as the BDA (before, during and after) model, is used to conduct risk-assessment interviews with both groups and individuals. **Its purpose is not to eliminate or reduce post-traumatic reactions, but to allow the Practitioner to identify those who may be at risk of developing psychological problems.**

Information disclosed during the interview is considered to be confidential; the only caveat to this (as explained to the interviewees) concerns information that causes a serious concern for the safety of the interviewees, others or the organisation. TRiM Practitioners are advised to seek assistance if they are unclear as to how to proceed.

**The One Month Follow-Up Assessment**

The importance of the 1-month follow-up assessment is threefold. **First**, some exposed staff may develop psychological problems after a delay and a stand-alone interview will not detect these. **Secondly**, some individuals continue to experience psychological distress following the initial interview and are at risk of developing long-term psychological problems. **Lastly**, an individual's adjustment to the traumatic event can be gauged by comparing their initial psychological and behavioural state (and risk-assessment score) with that assessed at the 1-month follow-up.

**Staff Management and referral**

After the initial risk-assessment meeting, managers are informed about the degree of psychological stress that exposed staff members have endured. After the 1 month follow-up interview, staff are encouraged to seek help if their distress is not settling (as indicated by persistently raised scores or scores which have increased).

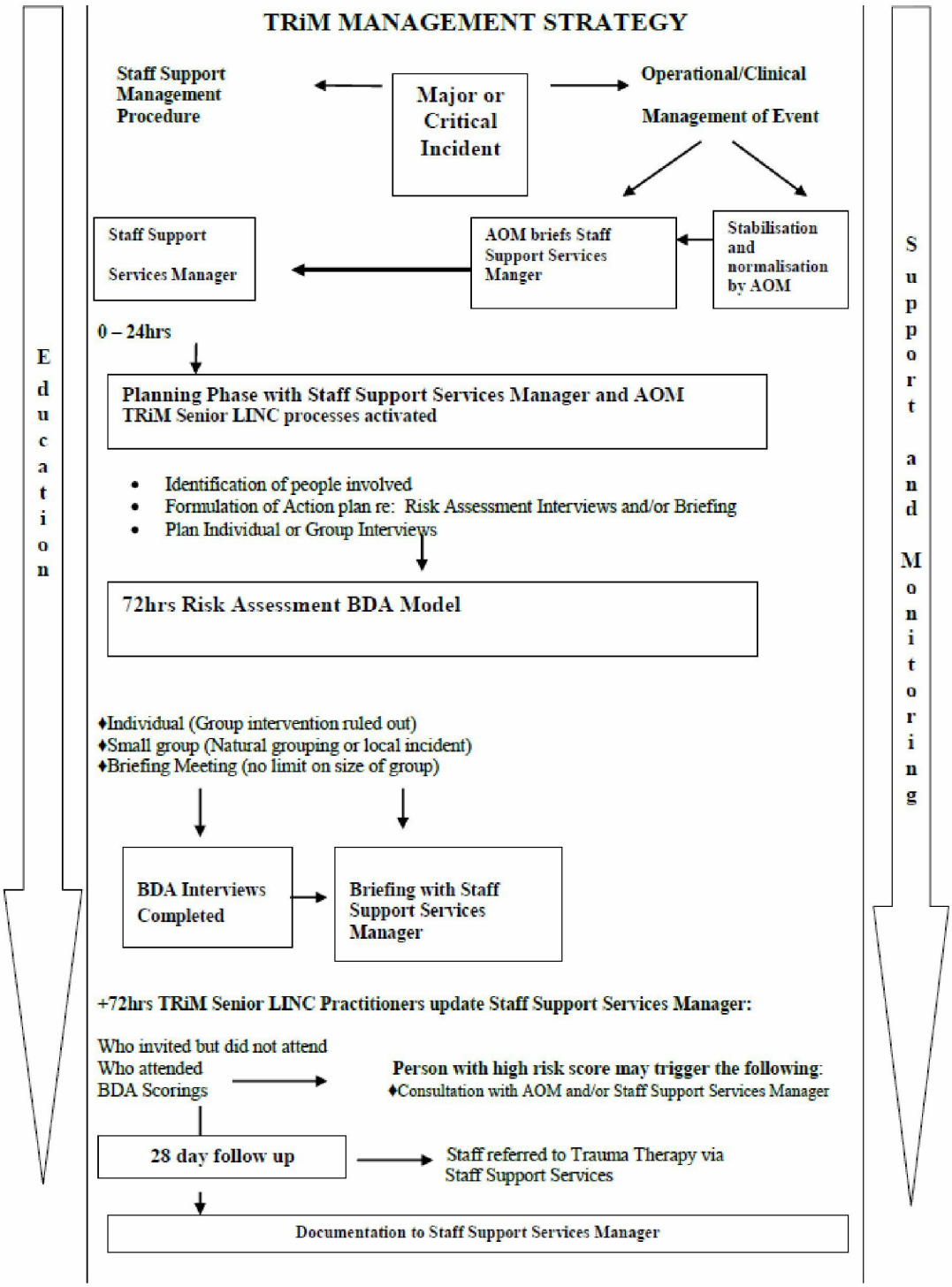
**Documentation**

Information from the initial assessment is securely stored and used when conducting the follow-up interviews. After completion of the 28-day follow-up, only a simple record is kept in the form of a diary entry of who was assessed, their scores and a brief management plan. This information is kept separately from other staff and health records. From a legal perspective, it is important to record the names of those who were offered the procedure, but declined to take part.

**It must be stressed that the TRiM Consultations are separate to any investigation that might look into why the incident occurred in the first place.**

**(see the Traumatic Incident Flowchart below)**

London Ambulance Service NHS
NHS Trust



### 5.2.7 Staff Support Services Contact Details

**LINC** – The LINC Network is part of Staff Support Services. Individuals can self-refer and contact a LINC worker informally either face to face or by telephone. A complete list of LINC workers and contact numbers can be found on the Pulse under 'About me', clicking on 'My Support' and following the links or phone **Senior LINC 24-hour Confidential Line on** [redacted]

### 5.2.8 Staff Counselling

Confidential counselling is available through our Bespoke Staff Counselling Service which consists of 8 members of staff: two internal staff: Staff Support Services Manager (Psychodynamic Psychotherapist and specialist in Trauma) and the Person-Centred Senior Counsellor, and six external counsellors with extensive experience with both trauma and/or Emergency Service work environments, who have diverse psychotherapy modalities. Individuals can self-refer or be referred by their manager. Appointments can be made by telephoning the **Senior Counsellor on** [redacted].

### 5.2.9 Employee Assistance Programme (EAP)

The EAP is a 24hour Confidential Helpline offering telephone advice and support on a range of personal and work issues and can be contacted on [redacted]

**For further information please contact:**

**Staff Support, Counselling and Occupational Health Services Manager**

**Tel:** [redacted]

**Mobile:** [redacted]

| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Incident Response Plan | 6 – Communication | Official Sensitive |

## 6.1 Communications Introduction

In the event of a major incident in London, the Service can expect significant interest from regional, national and international media.

It is important from the outset that the Service provides timely, accurate information about its response to the incident. This is key to managing the organisation's reputation and reassuring the public. The media can also be used as a mechanism for providing advice to Londoners about how they should use the 999 service whilst it is under pressure.

Contact should be maintained at all times with other London agencies to ensure consistency of approach and messages.

Members of the Communications Department should refer to the department's crisis manual in the event of such an incident, which is available through the Communication Team and on-call arrangements.

## 6.2 Communications Initial actions

The on-call press officer will be notified by pager about a significant or major incident. They should obtain basic details about the incident from the Emergency Operations Centre at this stage:

- Nature and location of incident.
- Time of first call and source.
- Resources sent to scene – number of staff, number and type of vehicles.
- Known/expected casualty numbers.
- Hospitals receiving casualties.
- Name of Silver and Gold medics.

The on-call press officer should then inform senior managers in the team who will arrange for team members to make their way to Headquarters.

Contact should be made with communication professionals from NHS England (London) region direct to the NHSE London Comm's Team/On-call arrangements and the other London agencies as soon as possible, through the established first alert system.

A holding statement outlining the Service's initial response should be issued to the media at the earliest opportunity.

## 6.3 Media handling at Headquarters

Roles should be delegated as detailed in the Communications Department's crisis manual to ensure:

- Overall management of the team.
- An established link with the Information Officer in the Specialist Operations Centre (SOC) and regular updates are obtained from them.
- Strategic communication advice is provided at Gold meetings.
- A dedicated media spokesperson is identified.
- Joint agency liaison takes place.
- Information from different sources is collated.
- Statements are written, issued and radio interviews are given.
- Incoming calls are taken and responded to.
- Internal communication takes place.
- The external website and the intranet are updated.
- Media coverage is monitored.

## 6.4 Media handling at the Scene

A lead press officer and supporting press officer should attend the scene based on the findings of a risk assessment. Attendance at scene may also be dependent on whether there are one or more incident scenes. These officers should ensure:

- Contact is made as soon as possible with the Service's dedicated spokesperson.
- Contact is made with other agency press officers.
- Information is fed back regularly to Headquarters' office.
- Interviews are given at scene by the media spokesperson where appropriate.

## 6.5 Communications Joint agency working

A member of staff from the Communications Department will be responsible for liaison with other agencies. Their role will involve:

- Triggering the first alert system if a major incident is declared.
- Contributing to teleconference calls and joint Gold communication meetings.
- Working from established media centres.
- Supporting and briefing the Service's spokesperson at joint news conferences.
- Making contact with receiving hospitals and ensuring they receive statements.

## 6.6 Communicating Casualty figures

The ambulance service collates the casualty figures, but they should not be released before being shared and agreed with Police Gold.

## 6.7 Communications Post incident

There can be sustained media interest in the days, weeks and even months that follow a major incident. The role of the Communications Department will involve:

- Handling media requests including input to documentaries.
- Coordinating visits and making arrangements for tributes.
- Managing awards for staff.
- Evaluating media coverage.
- On-going internal communication.

## 6.8 Media spokesperson

A senior operational officer will be identified in the early stages of a major incident to act as the Service's dedicated media spokesperson. Working with a member of the Communications Department, their role will involve:

- Giving interviews to the media about the Service's response to the incident. Interviews may take place at a scene, Headquarters or a joint media centre.
- Representing the Service on the panel at joint agency news conferences.

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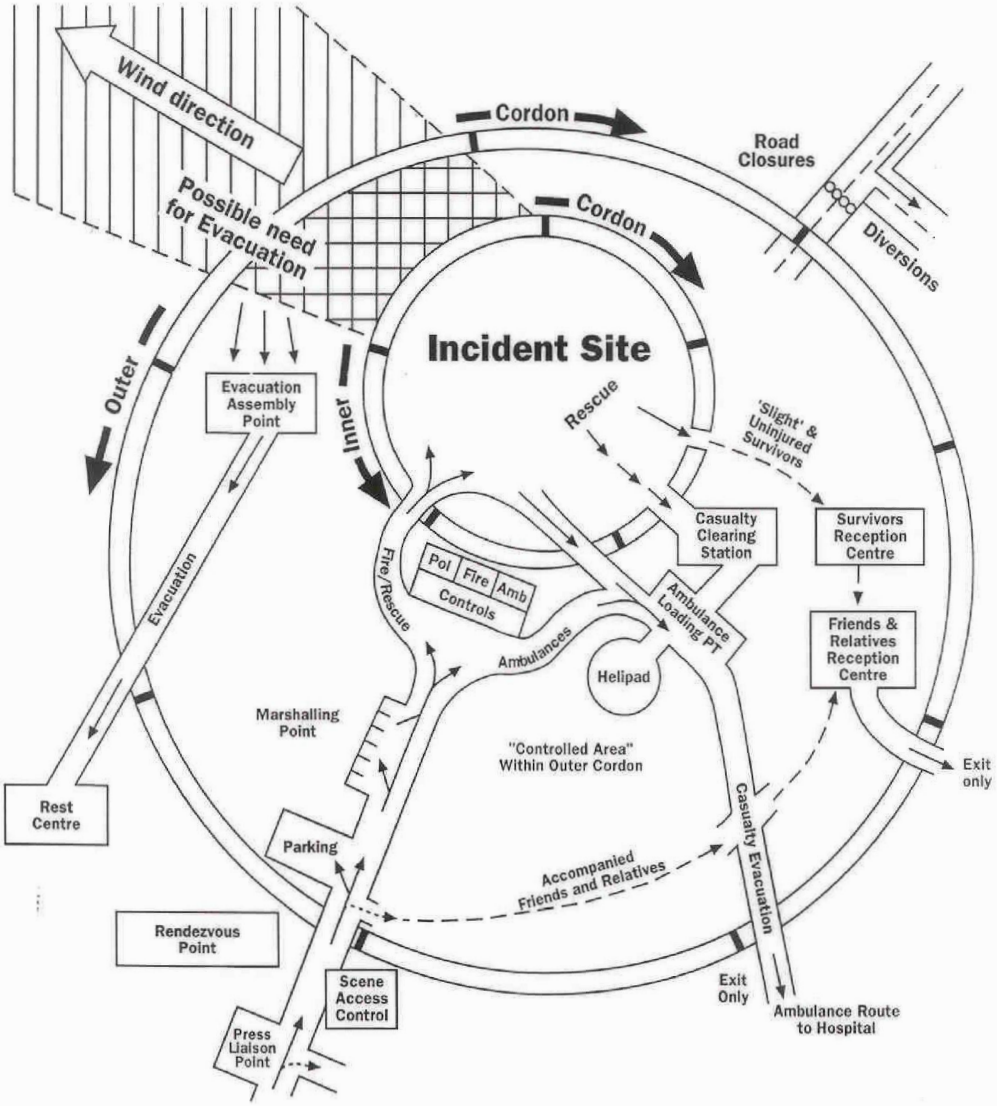
| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 - Appendix 1 | **Incident Site Diagram** | **Official Sensitive** |



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| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 - Appendix 2 | **Command Responsibility** | **Official Sensitive** |

## Appendix 2 – Bronze and Silver responsibility sectors

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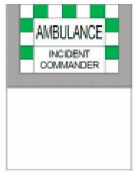
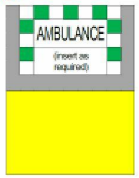
| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Appendix 3 | **Incident Command Tabard Colours** | **Official Sensitive** |

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




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




**Strategic Advisor, Tactical Advisor or ILO** Green lower half with green & white checked shoulders.


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

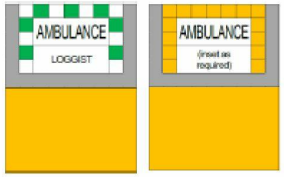

**Decontamination Officer**
Purple lower half and green & white checked shoulders.


**AMBULANCE ENTRY CONTROL OFFICER (ECO)**
Green and Yellow all over check.


**Command Support or Airwave Tactical Advisor**
Green and White Check


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


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



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| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Appendix 4 | **Command Role Descriptors** | **Official Sensitive** |

- AMBULANCE INCIDENT COMMANDER
- AMBULANCE SCENE COMMANDER
- AMBULANCE MEDICAL ADVISOR
- AMBULANCE STRATEGIC ADVISOR
- AMBULANCE TACTICAL ADVISOR
- AMBULANCE INTER AGENCY LIAISON OFFICER
- AMBULANCE SECTOR COMMANDER
- AMBULANCE PATIENT LIAISON OFFICER
- AMBULANCE COMMAND SUPPORT TEAM
- AMBULANCE PARKING OFFICER
- AMBULANCE CASUALTY CLEARING OFFICER
- AMBULANCE LOADING OFFICER
- AMBULANCE SAFETY OFFICER
- AMBULANCE PRIMARY TRIAGE OFFICER
- AMBULANCE EXTRACTION OFFICER
- AMBULANCE SECONDARY TRIAGE OFFICER
- AMBULANCE EQUIPMENT OFFICER
- AMBULANCE LOGGIST
- AMBULANCE HOSPITAL LIAISON OFFICER
- AMBULANCE DECONTAMINATION OFFICER
- AMBULANCE PRESS OFFICER
- AMBULANCE COMMAND SUPPORT
- AMBULANCE ENTRY CONTROL OFFICER
- AMBULANCE AIRWAVE TACTICAL ADVISOR

**Example of badges**

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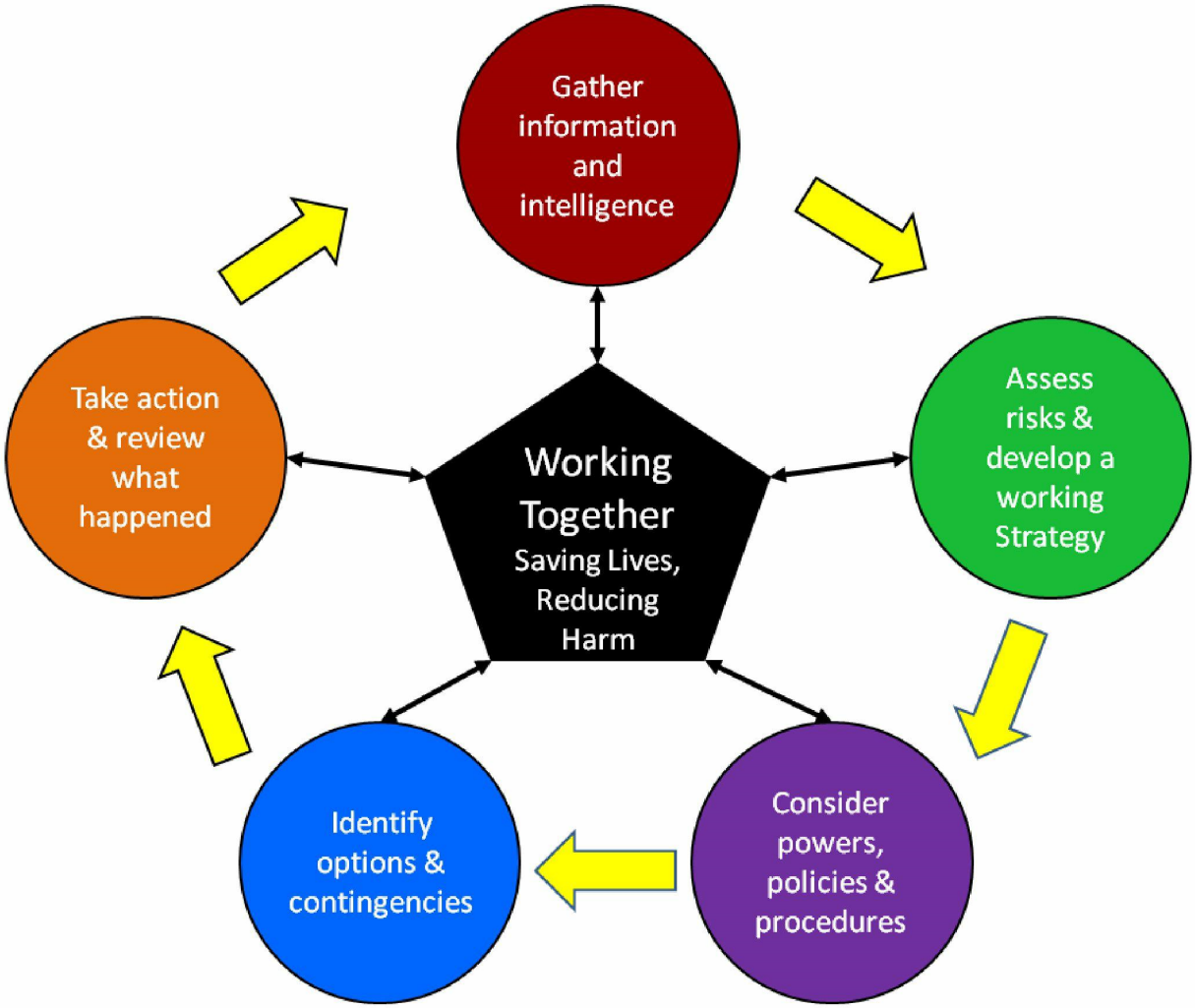
| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Appendix 5 | **Joint Decision Model** | **Official Sensitive** |



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| Section | Sub Section | Protective Marking |
|---|---|---|
| Appendix 6 | **Joint Decision Model** | **Official Sensitive** |

| Stage | Actions |
|---|---|
| 1 | Gather information and intelligence. Ask yourself:<br>What is happening (or what has happened) ?<br>What do I know so far ? |
| 2 | Assess Risks and develop a working strategy. Ask yourself:<br>Do I need to take action immediately ?<br>What do I know so far ?<br>Do I need to seek more information?<br>What could go wrong ?<br>How probable is the risk of harm and how serious would it be ?<br>How can multi agencies work together to resolve this ?<br>Am I trained to deal with this ? |
| 3 | Consider powers, policies and procedures. Ask yourself:<br>What legal powers do I have or need to make this decision ?<br>Is there a formal policy to follow in this instance, can I use my discretion ?<br>What other obligations might be applicable (eg multi agency protocols) ? |
| 4 | Identify options and contingencies. Ask yourself:<br>What are we trying to achieve ?<br>What options are open to me ? |
| 5 | Take action and review what happened. Ask yourself:<br>What happened as a result of my decision ?<br>Did it achieve the desired outcome ?<br>Is there anything more I need to consider ?<br>What lessons can be taken from how things turned out ? |
| Working Together<br><br>Saving Lives, Reducing Harm | |

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| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Appendix 7 | **Police CBRN Tabards** | **Official Sensitive** |

Police National CBRN Centre

Intelligent preparation for CBRN terrorism

## Appendix 7a – Police CBRN Bronze Command Structure Tabards

The CBRN Bronze Commander will, on successful completion of the CBRN Bronze Commander Course at the Police National CBRN Centre, be issued with a full set of command structure tabards.

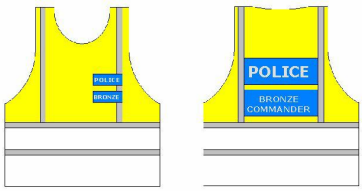
The CBRN Bronze will be responsible for the tabards and will maintain control of them prior to any incidents.

Once the CBRN Bronze is deployed to an incident they will; issue the tabards to the supervisors in conjunction with the "Role /function action cards" in section 2 of the "CBRN Bronze Commanders and CBRN Supervisors Operational Handbook".

The tabards have been designed to integrate as far as practicable, with the Fire and Rescue Service (FRS) and Ambulance Service tabards.

## Appendix 7b – CBRN Bronze Command Structure Tabards

**Bronze Commander**

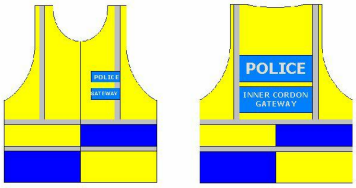



Colour Yellow/White

**Inner Cordon Supervisor**

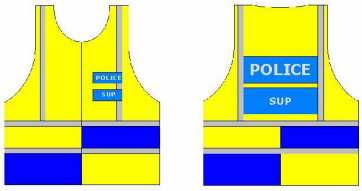

Colour Yellow/blue

**Inner Cordon Gateway Supervisor**




Colour Yellow/blue

**SUP Supervisor**

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**Scene/Hazard Assessment Supervisor**


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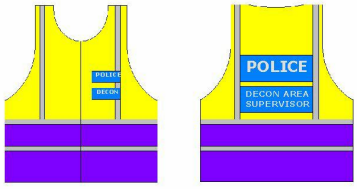
**Decontamination Supervisor**

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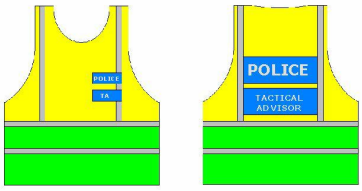
## CBRN Bronze Command Support Tabards

**Tactical Advisor**

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**PNCBRNC Military Liaison**


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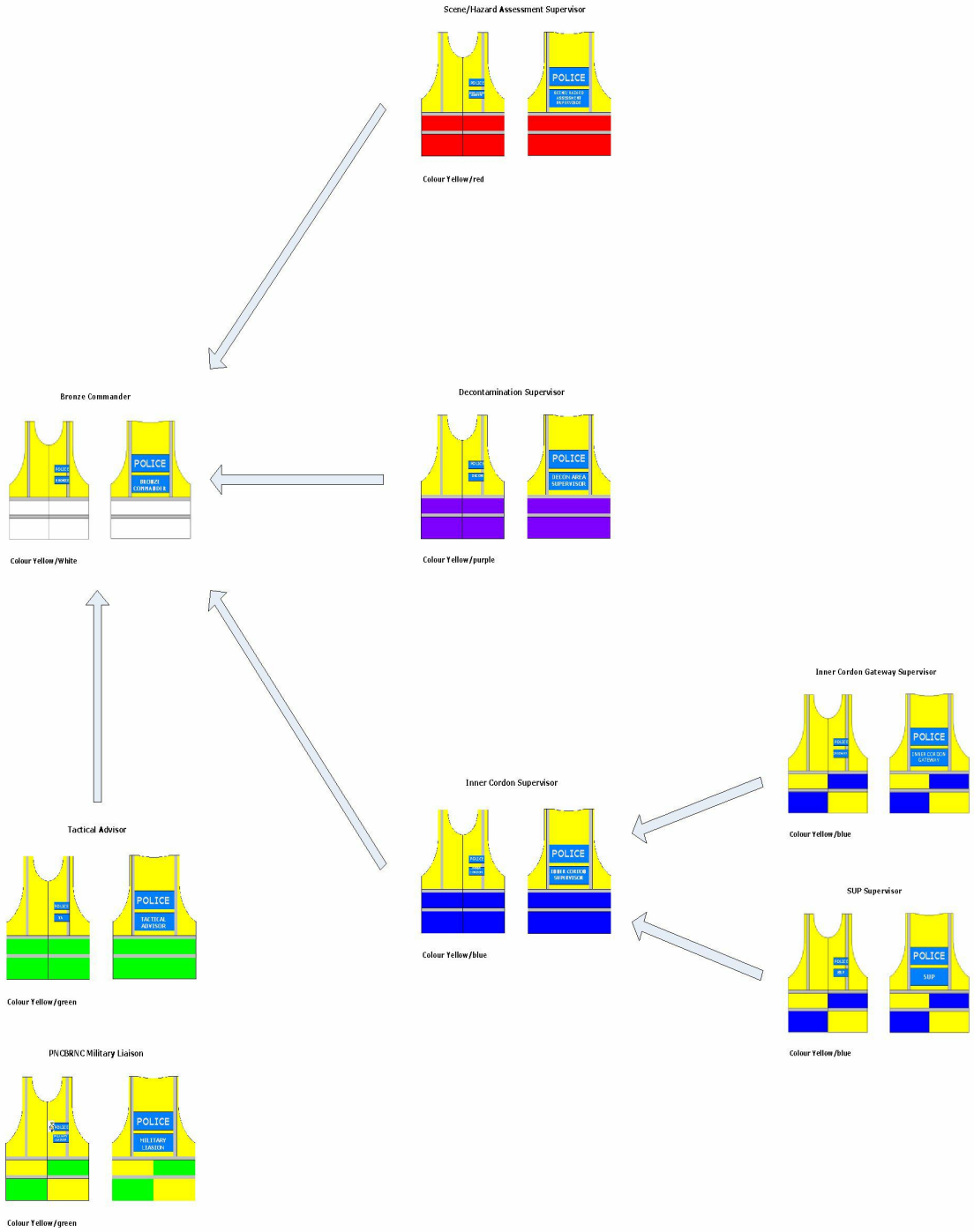
## Appendix 7c – CBRN Bronze Command Structure Tabards



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| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Appendix 8 | **Quick Reference Paging Guide** | **Official Sensitive** |

| | INCIDENT TYPES | "Routine Incident" ^ | Significant Incident Declared * | Major Incident Declared * | Aircraft Full Emergency / AGI / AGG | Aircraft Accidents | CBRN / HAZMAT Incident | Public Order Incident | MTFA / ACTSHO | Other Police Operations |
|---|---|---|---|---|---|---|---|---|---|---|
| ON CALL | Incident Delivery Manager | | | | | | | | | |
| | EPRR SPOC Tactical Advisor (EPRO) | | | | | | | | | |
| | On Call Tactical Commander (Silver) | | | | | | | | | |
| | On Call Communications Officer | Consider | | | | | | | | Consider |
| | Strategic Commander (Gold Medic) | | | | | | | | | |
| | Strategic Medical Advisor (Gold Doctor) | | | | | | | | | |
| | Senior Clinical On Call | | | | | | | | | |
| PAGING GROUPS | Significant / Major Incident Group | | | | | | | | | |
| | Silver & Bronze Groups | | | | | | | | | |
| | Relevant Airport Group | | If at Airport | If at airport | | | | | | |
| | MERIT Paramedic & Doctor Groups | | | Silver to Authorise | | | | | | |
| | Major Incident Support Group | | | | | | | | | |
| | Directors Group (Executive Management) | | | | | | | | | |
| | St John Ambulance | | | Gold to Authorise | | | | | | |
| | British Red Cross | | | Gold to Authorise | | | | | | |
| | Public Order Silver Cadre Group | | | | | | | | | |
| | Operation Plato / Active Shooter Group | | | | | | | | | |

This document is intended as a guide to cover the initial paging steps of an incident. It does not cover every scenario, for full details see OP/003 Paging Procedure, paging action cards, contingency plans and major incident plan.

***Significant Incidents include (with patients):**

- Fire calls, 6 pumps or more attending
- Explosions
- Single location incident with ≥ 6 patients
- Train Stuck in Tunnel / Railway Incidents
- Public order incidents
- Incidents at high profile locations
- COMAH Site Incidents – Off site plan activations
- Marine / Waterways / River Accidents
- Acts of Aggression / IED / Bomb Warnings
- Declared major incidents by another London emergency service
- Declared major incident by neighbouring ambulance service

| KEY | |
|---|---|
| | Amber message required |
| | Red message required |

**^ See over for incident types that the Incident Delivery Manager & EPRR SPOC must be informed of.**

***A significant / major incident must have been declared for these columns to be used.**

**Updated November 2015– v1.0**

Department for Emergency Preparedness, Resilience & Response

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| Section | Sub Section | Protective Marking |
|---|---|---|
| 1 – Appendix 9 | **Mass Prophylaxis** | **Official Sensitive** |

In the event of a major incident, in particular one involving a need for mass prophylaxis or treatment of a large number of people, the London Ambulance Service NHS Trust (LAS) has the ability to put in place mechanisms that allow staff to administer medicines to patients, the wider public, or to protect staff. These mechanisms would be activated on the request or advice of the Department of Health (DoH), NHS England (NHSE), Public Health England (PHE), or any other statutory or advisory bodies. If asked by these agencies, the LAS will also provide staff to assist in mitigating the impacts of the on-going emergency.

The Human Medicines Regulations (2012) is the legislation enacted by the LAS to allow staff to administer various medications. Schedule 17 (Part 3) allows registered paramedics to administer a range of prescription only-medications, with the provision that the administration is only for the immediate, necessary treatment of sick or injured patients. Schedule 19 of the same legislation provides for the administration of a small number of medicines (including nerve agent counter measures) by any person trained to do so.

The LAS also routinely uses Patient Group Directives (PGDs) in the administration of a number of specific medications. They are defined by the National Institute of Health and Care Excellence (MPG2, 2013) as:

*'Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor (or dentist). However, supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for patient care, without compromising patient safety'.*

Arrangements for the development of a PGD by the Medical Directorate are detailed in Part C of Trust Policy and Procedure for the Use of Medicines (TP008); a PGD could be developed at short notice by the LAS if requested to by one of the aforementioned agencies or a developing situation required it.

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LONDON AMBULANCE SERVICE NHS TRUST
OPERATIONAL ARRANGEMENTS

SECTION 2

London Ambulance Service NHS
NHS Trust

# Special Contingencies

OFFICIAL SENSITIVE

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| Date of Issue: September 2016 | To be reviewed at least annually by the Department for Emergency Preparedness, Resilience and Response. |
| Authorised by: Chief Executive | |
| Page **127** of **196** | |

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| Section | Sub Section | Protective Marking |
|---|---|---|
| 2 – Special Contingencies | **Contents** | **Official Sensitive** |

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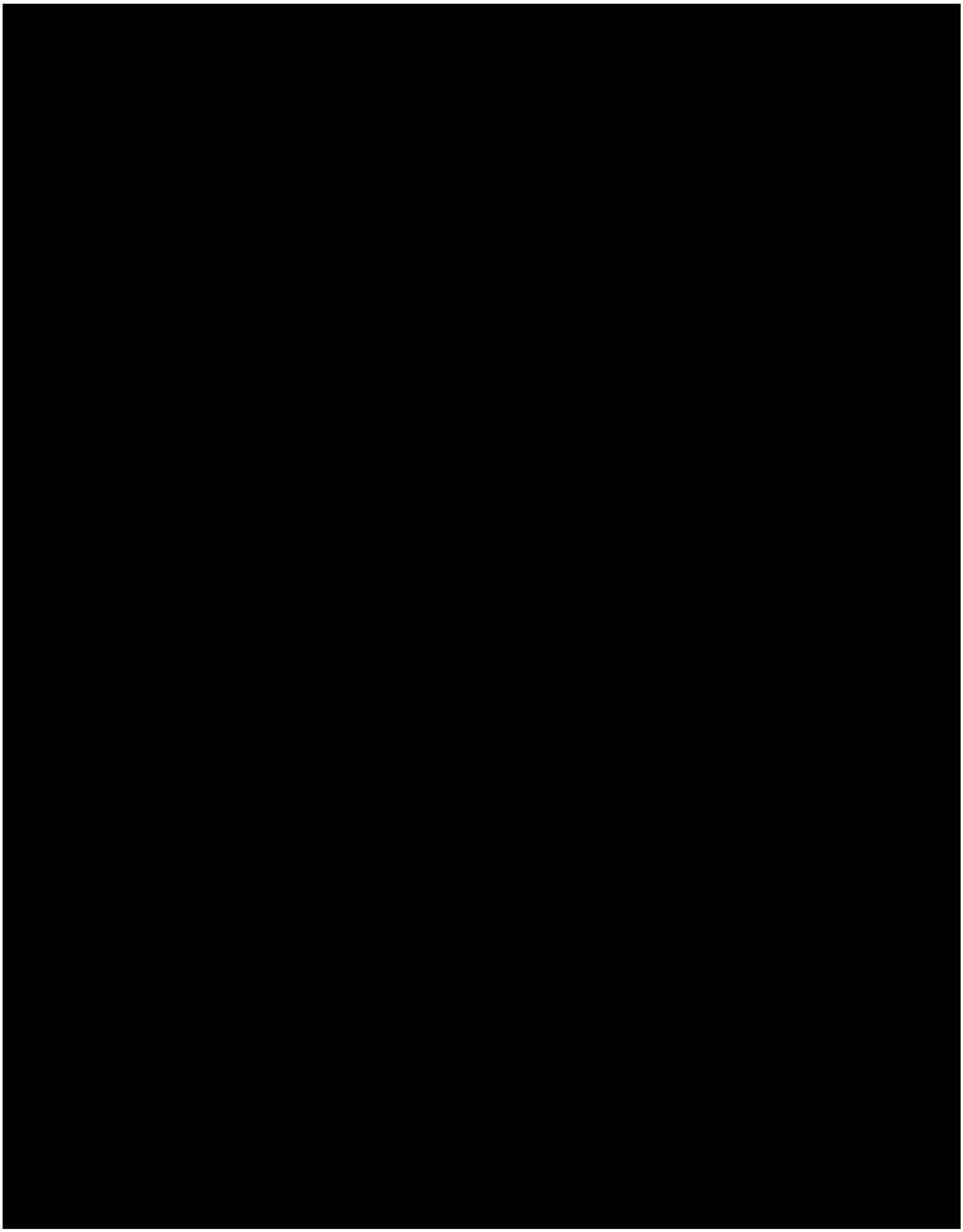
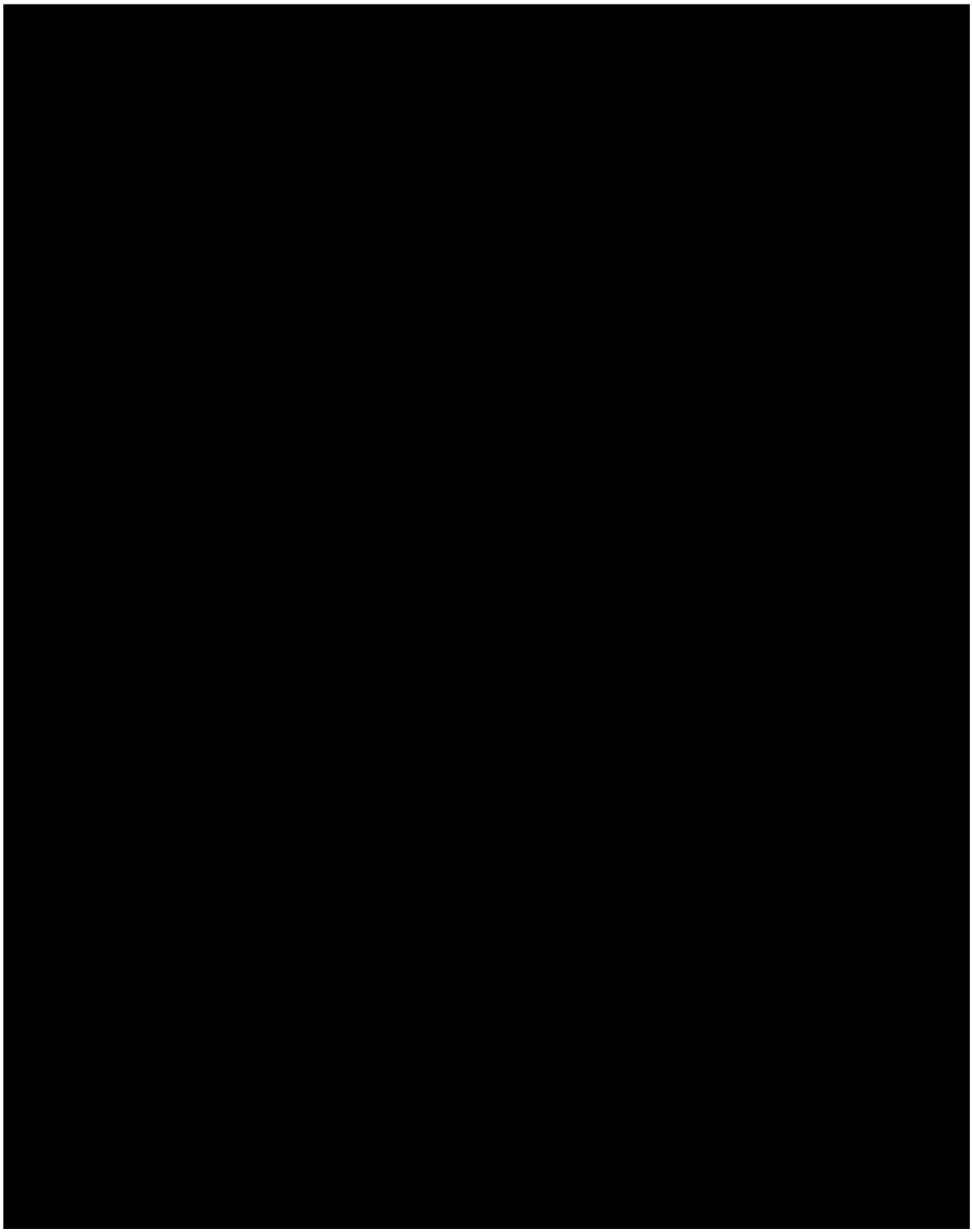
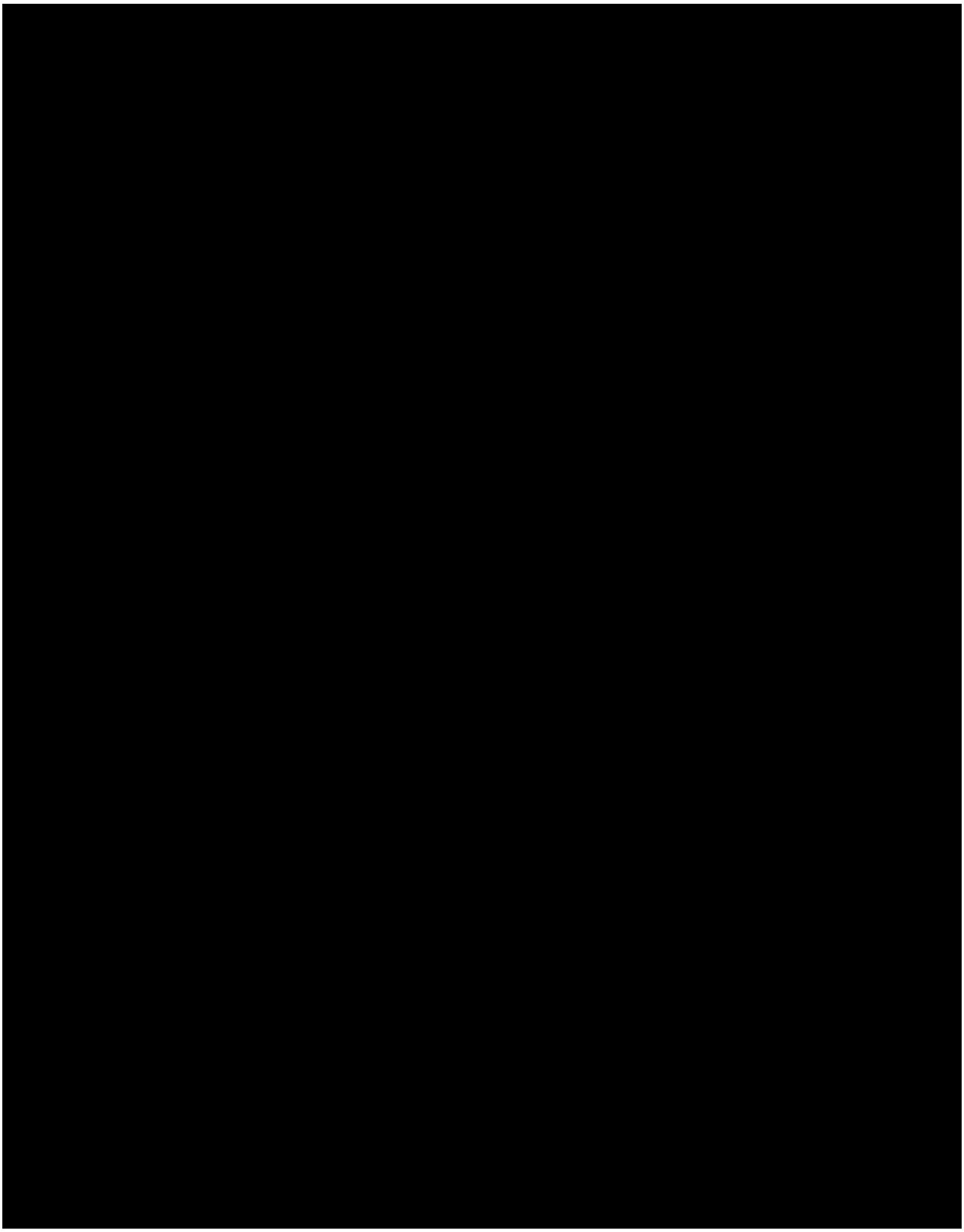
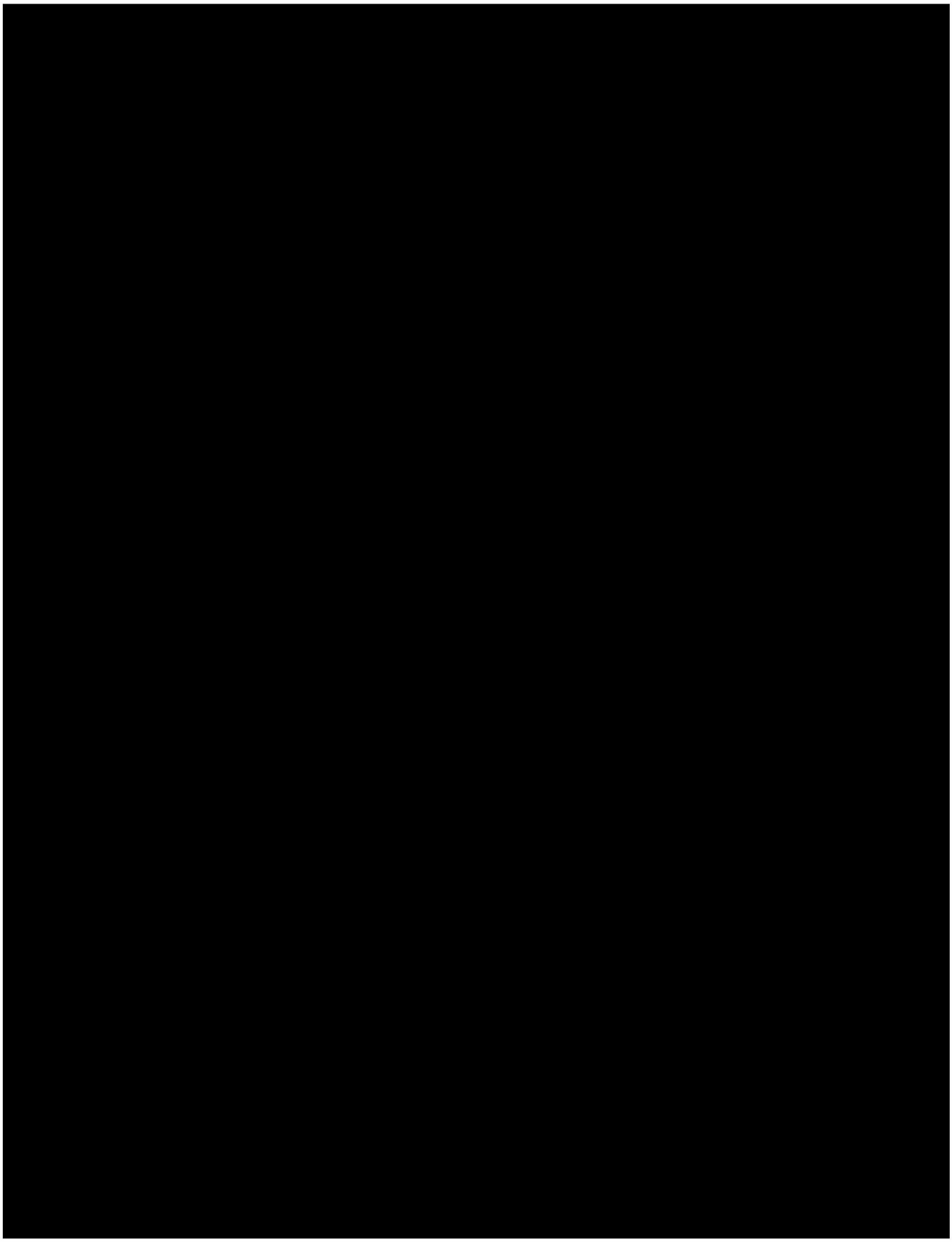
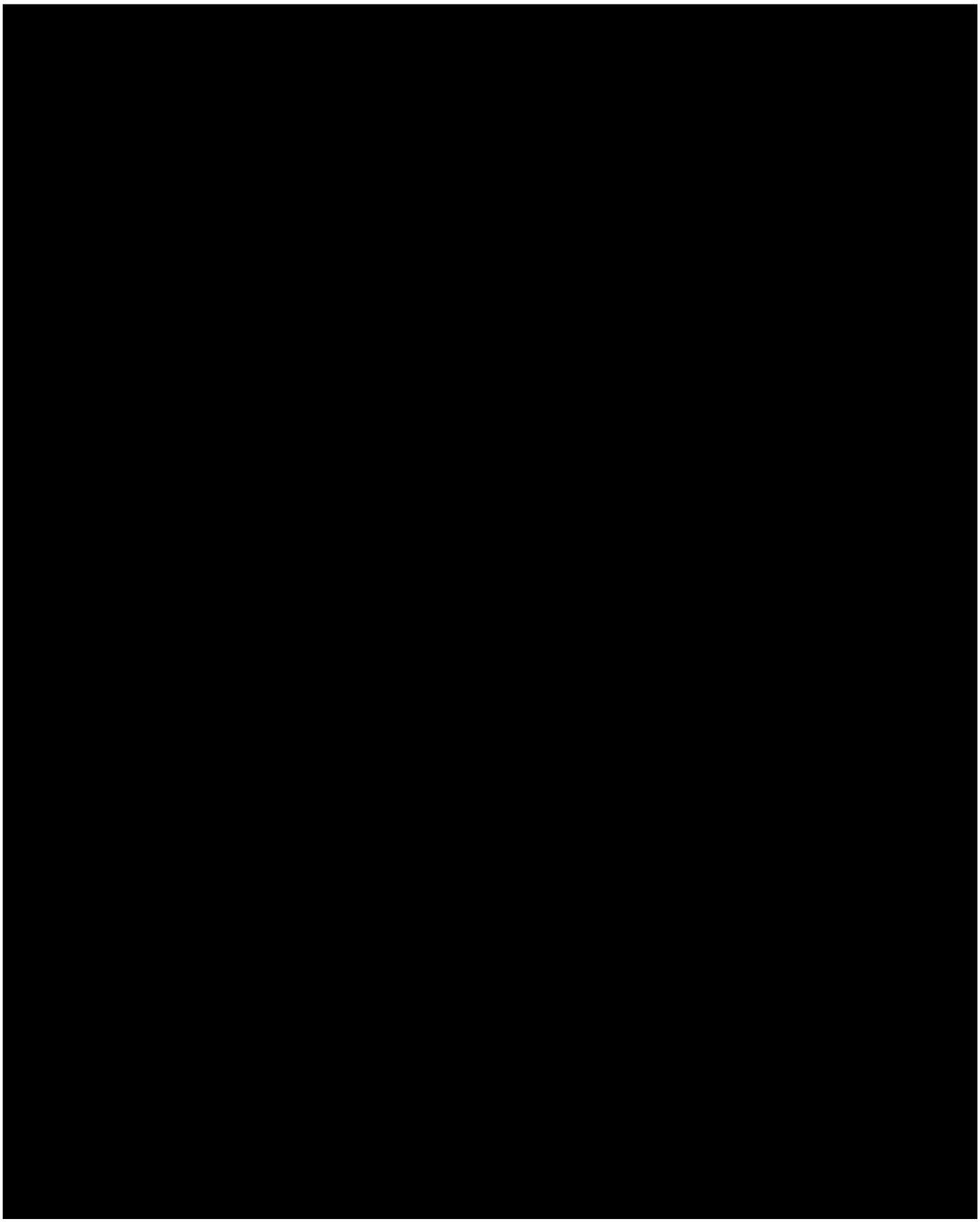
6.3
6.4
6.5
7 –
7.1
7.2
8 –
8.1











| Section | Sub Section | Protective Marking |
|---|---|---|
| 2 – Special Contingencies | **3 – Public Order** | **Official Sensitive** |

## 3.0 Introduction

"Public Order" is a term used to describe a number of violent occurrences ranging, in order of seriousness, from simple assault to riot. Large scale violence can erupt spontaneously e.g. as a result of a disturbance at a nightclub or as part of a carefully orchestrated plan e.g. during a protest march or demonstration. The principles of commanding either a planned or spontaneous disorder remain the same. There is a specific contingency plan for spontaneous public order incidents listing attendance and actions of LAS staff that should be referred to in addition to this section.

## 3.2 Pre-planning

Under normal circumstances, organisers, police and ambulance services prepare joint plans for large crowd events e.g. football matches and pop concerts, and these include arrangements for responding to a public order incident.

The Metropolitan Police have a responsibility to ensure that all agencies are included with the planning of a known demonstration that may lead to a potential disorder. In turn the LAS EPU will carry out a risk assessment using the information provided to determine what the LAS response should be. The areas that will be considered include the threat level, types of rival factions involved, previous history, time of year, LAS resources and PPE required, the use of the Voluntary Aid Societies and the nomination of hospitals.

## 3.3 Training

The LAS maintain a cadre of staff trained to respond to Public Order Incidents. The staff consist of Clinical staff and Bronze Officers to form Incident Response Teams, Tactical Advisors, Tactical Commanders and Strategic Commanders.

All of the staff undergo training with the Metropolitan Police and are required to re-qualify each year.

## 3.4 General Guidelines

Effective control, command and leadership during a public order incident is vitally important to ensure staff safety. EOC must ensure that staff are not deployed into an area of disorder. Bronze and Silver Officers must ensure that they provide effective briefings prior to any deployment.

On identification of a potential Public Order Incident, EOC must undertake the actions as detailed in the EOC action card for public order incidents.

Where possible, LAS staff must work behind police lines, police medics will extricate casualties from threatened area to the LAS staff at the forward casualty collection point. Patient treatment on the street should be avoided where possible. Patients should be moved to a Casualty Reception Point as quickly as possible. Patients requiring transportation should be conveyed by a support Ambulance. Where possible, LAS Ambulances should reverse towards any incident and keep the engine running and cab doors locked – this should allow for an easy escape if necessary.

All LAS staff must ensure that they maintain a neutral position while attending any potential disorder. Even though we work for the health service, staff in a uniform may be seen as authority figures by some factions, therefore neutrality is important for the safety of yourself and others.

The maintenance by all Officers of an ongoing dynamic risk assessment and log of decisions is of paramount importance.

## 3.5 LAS resources

The LAS will deploy a structured response to public order incidents whether planned or spontaneous. The structured response emphasises the importance of staff safety through teamwork, effective deployment and leadership. There are several elements that can be instigated during a response that include the following:

- LAS Public Order Tactical Commanders and Tactical Advisors.
- Casualty Reception Point that comprises of 2 x AEU Ambulances with 2 x staff on each vehicle, and 2 x Officers.
- Incident Response Team consisting of 6 x LAS Medical Response Team (MRT) crew staff and 1x Officer in a personnel carrier vehicle, with dedicated driver.
- LAS liaison officer to the MPS Special Operations Room or the local police control room as required.

The Resilience Team has the responsibility to advise on the most appropriate response for any public order incident. Conducting dynamic risk assessments is vital, and options and decisions should be recorded by Bronze and Silver Officers.

Three person crews should not usually be required during a public order incident. In the event that an ambulance crew has to convey a violent member of the public, the assistance of a police escort should be sought.

## 3.6 Response – Casualty Reception Point

The purpose of each Casualty Reception Point (CRP) is to provide a focal point for any casualties to be directed to, thus reducing the need for LAS staff to deploy into the area of disorder.

Once established, the location of the CRP(s) should be passed to the relevant Police control. Police should be encouraged to bring casualties to the CRP.

Each CRP will include 1 x Ambulance for use as a minor treatment area and 1x Ambulance ready for immediate transport of more serious injuries.

The Officers will take on the roles of Ambulance Forward Incident Commander and Bronze Clearing.

The CRP must be positioned with consideration for good egress should the need arise.

## 3.7 Response – Incident Response Team

An Incident Response Team (IRT) comprises of 6 x LAS MRT PO trained staff and dedicated driver under the command of an LAS MRT PO Bronze Officer. If required, the IRT can be supported by a dedicated driver who will remain inside the minibus and not need to be dressed in POPPE.

During a pre-planned event, they can be deployed in standard operational uniform with MRT Bergens to attend calls in crowded places.

During a Public Order incident, they can be deployed in Public Order Personal Protective Equipment (POPPE). Carrying basic life saving equipment they can be deployed to calls as appropriate.

## 3.8 Response – Support Ambulance

A support ambulance is an AEU ambulance with two crew deployed to support the CRP in conveying casualties to hospital. This allows the ambulance CRP to remain as one unit. On occasions, support ambulances may be required to be deployed to another location to collect casualties from an IRT.

## 3.9 Public Order Personal Protective Equipment (POPPE)

The authority to deploy staff in POPPE rests with LAS Gold in consultation with the Public Order Silver and Tactical Advisor.

POPPE is maintained by the Resilience Team with sufficient for 14 staff available for immediate deployment.

Incident Response Team staff can be issued with POPPE. It is not normally necessary for other staff to receive POPPE.

POPPE should be seen as protection for LAS staff and the decision to wear such equipment should be made as early as possible rather than as a result of provocation.

The equipment is clearly marked "Ambulance" and includes a helmet, flame retardant coverall, flame retardant base layer, limb armour and gloves. During a spontaneous incident, it is important to make an early decision to use the POPPE as it will take some time to bring together the staff and equipment.

Once in position, it will take 45mins for staff to dress in POPPE.


### Criteria for deployment of MRTPO Staff in POPPE

The following three criteria's must be met to gain authority from LAS Gold to allow the deployment of MRT PO staff in POPPE:

- Police Officers deployed in POPPE.
- Disorder or potential disorder, large enough by virtue of geographic area or numbers of persons involved, to prevent casualties being removed directly to casualty reception points by police officers.
- Potential for casualties directly or indirectly involved in the incident with requirement for LAS attendance

With at least 1 of the following affecting LAS staff:

- Risk of thrown missiles that have the potential to cause injury.
- Risk of exposure to flame with intention to cause injury.
- Increased risk of blunt trauma injury.
- Risk of injury from ground debris.

It is vital that consideration is given to adequate rest and refreshment for staff deployed in POPPE.

## 3.10 Hospitals

During a planned public order event the Resilience Team have the responsibility to nominate and advise a number of hospitals. During a spontaneous public order situation EOC have the responsibility to ensure that hospitals have been nominated and advised using the "Major Incident Standby" phraseology as soon as possible.

Patients will be conveyed to the most appropriate receiving hospital, but minor injuries from rival factions should be sent to different hospitals.

It may be necessary to discount hospitals that are in a threatened area or in close proximity to the disorder or due to self referrals. However, during these circumstances a patient(s) with life threatening condition(s) should still be conveyed to the nearest hospital.

## 3.11 Voluntary Aid Societies

The Voluntary Aid Societies will not be used in the response to any Public Order Incident, but may be already involved if the incident is centred around a stadia or public event.

The LAS PO Tactical Commander will provide guidance on how and where the VAS resources should be utilised.

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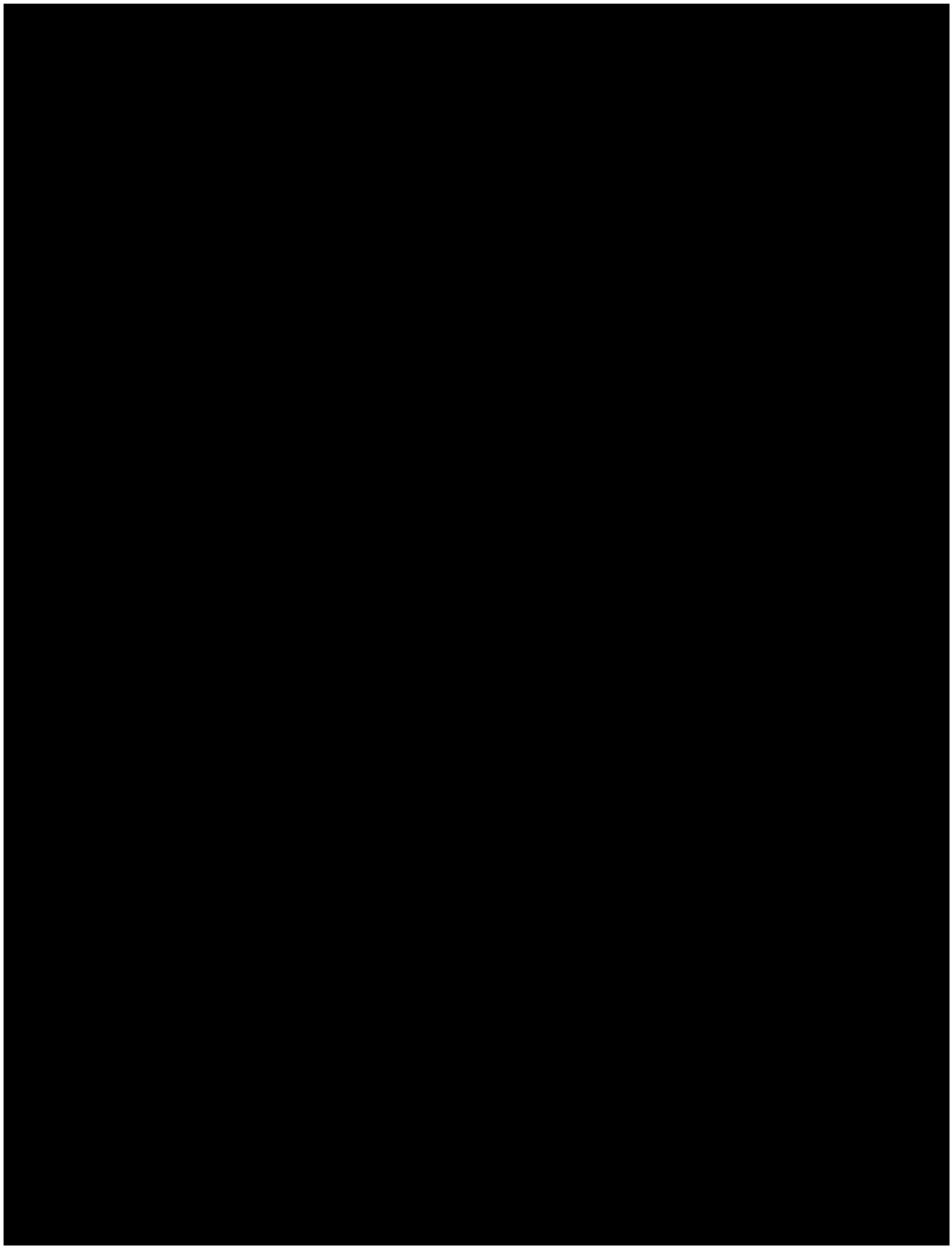

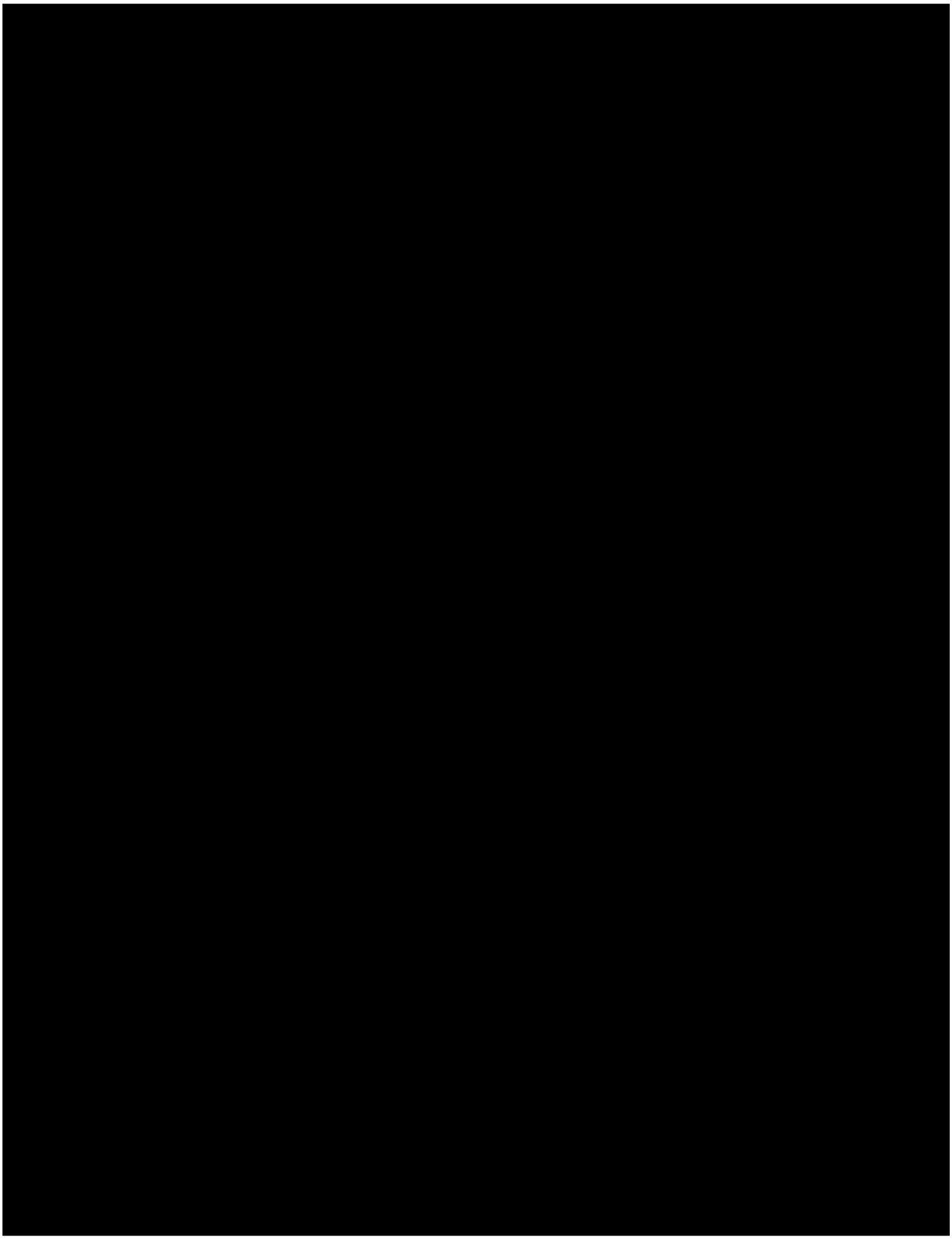

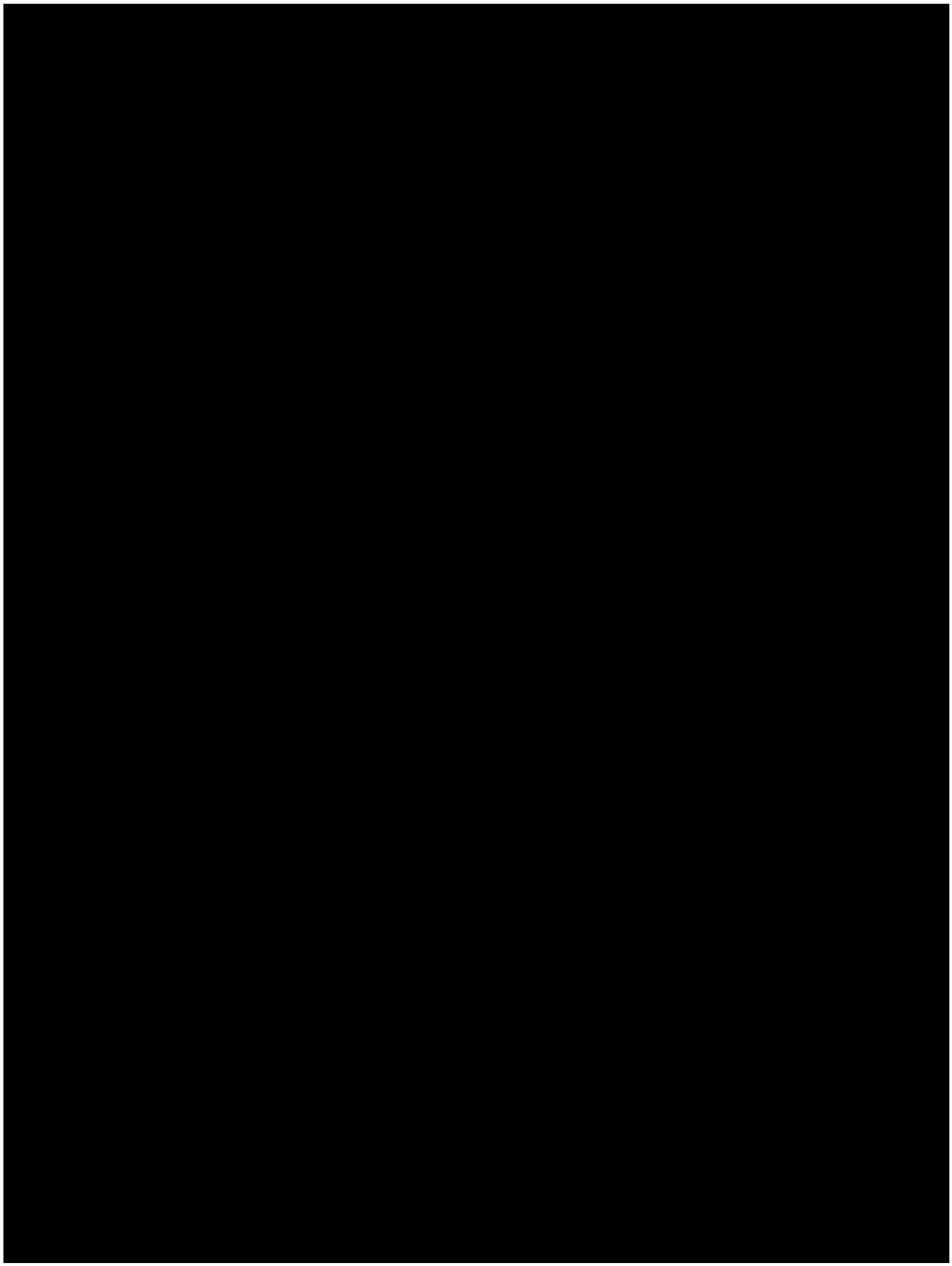

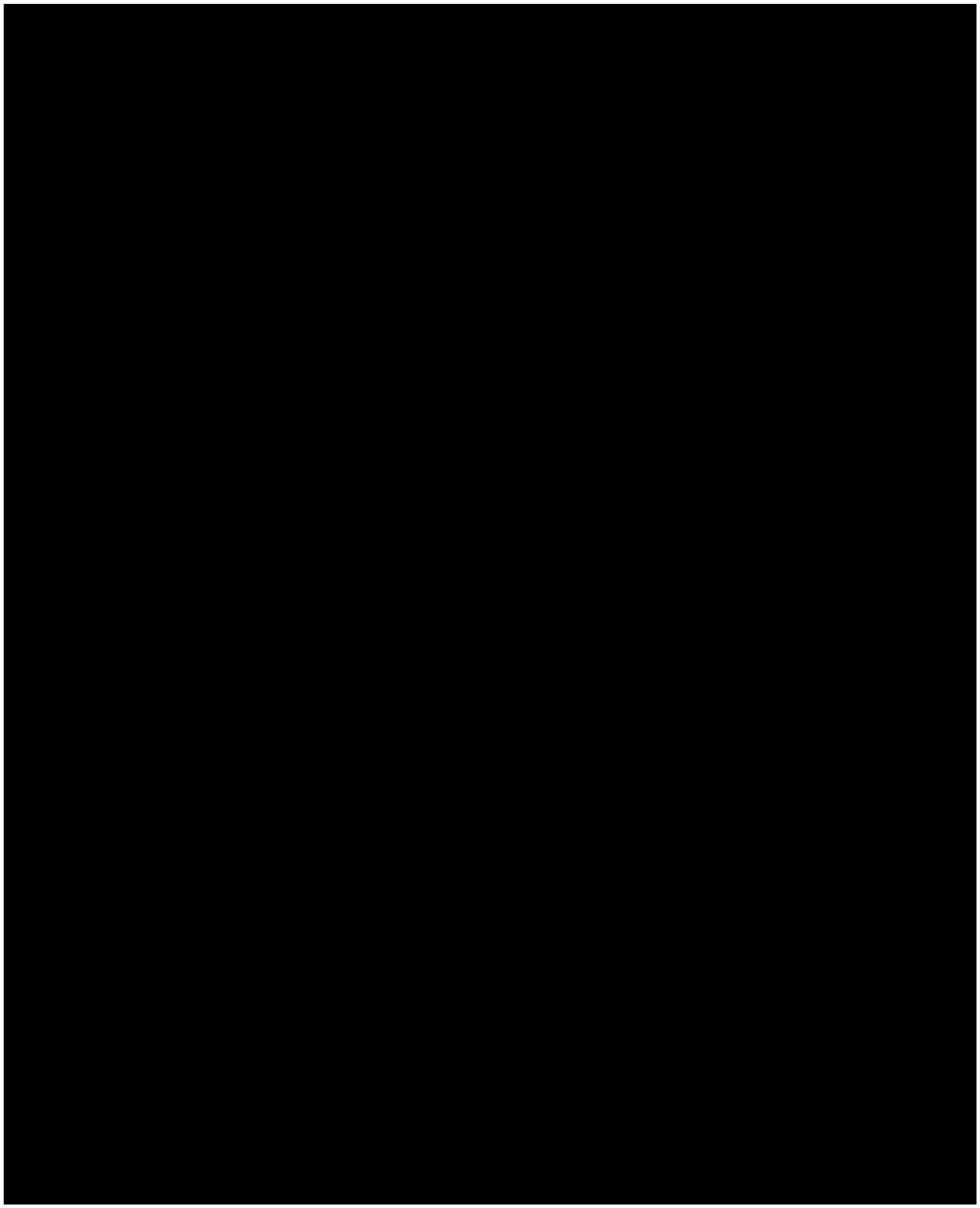

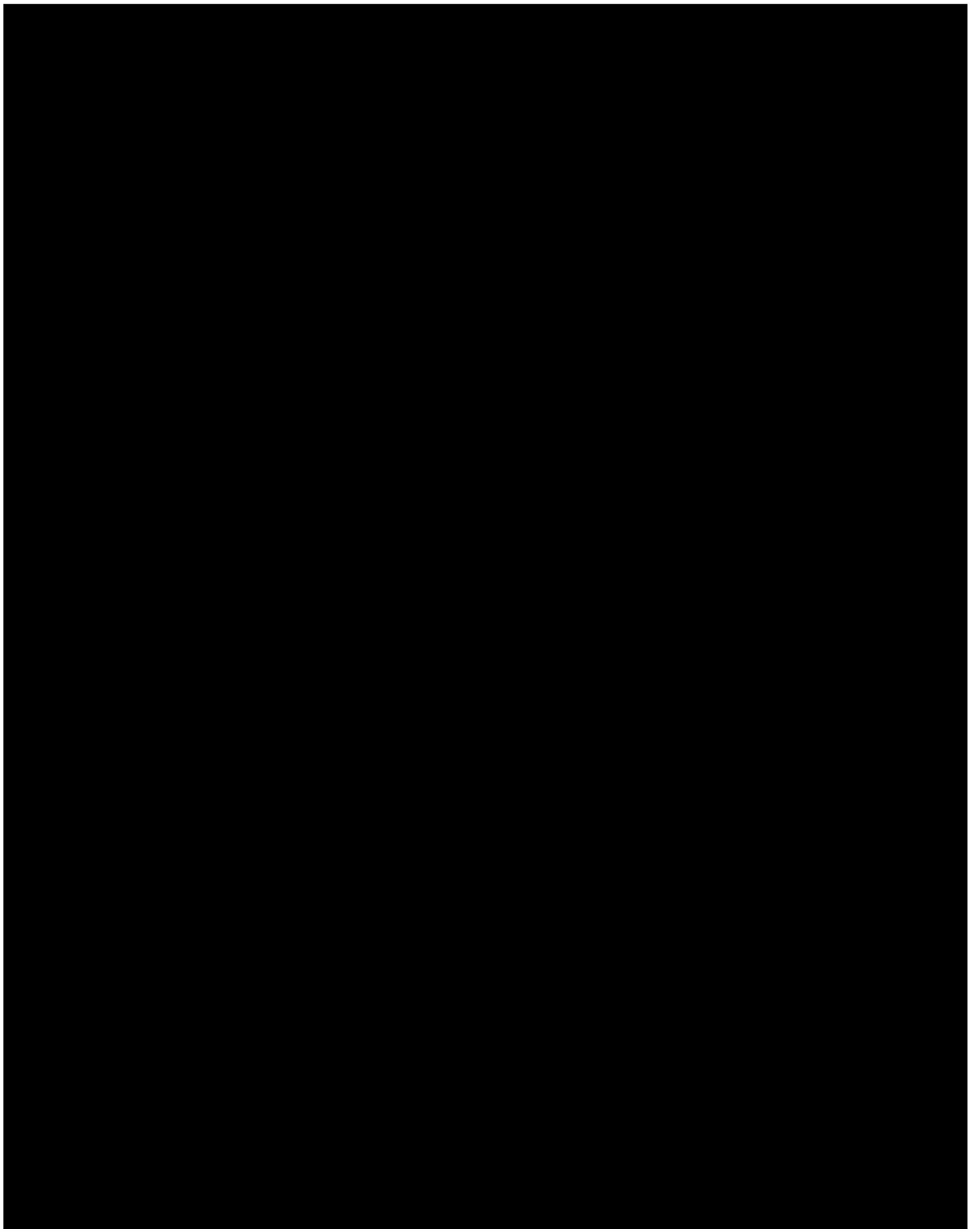

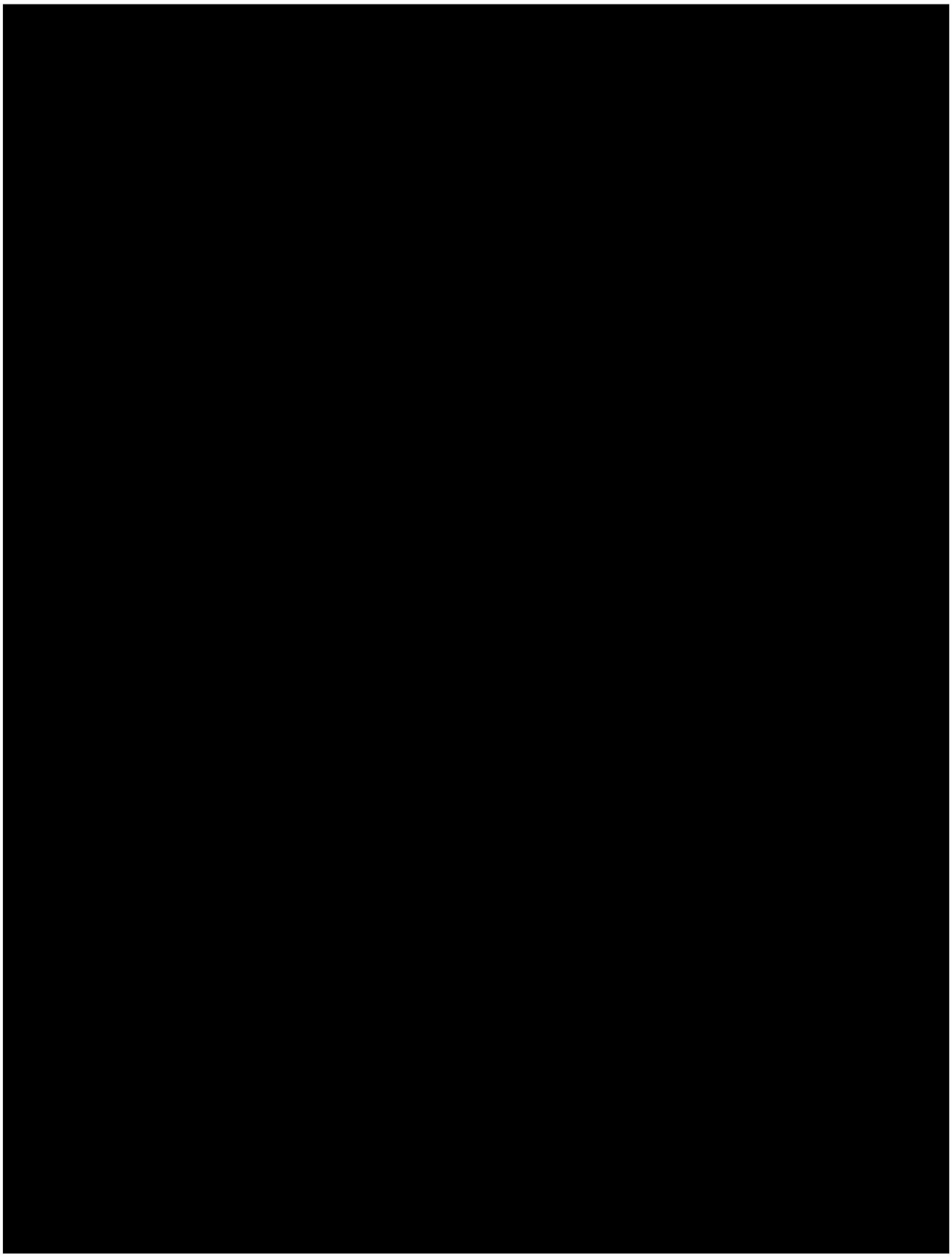

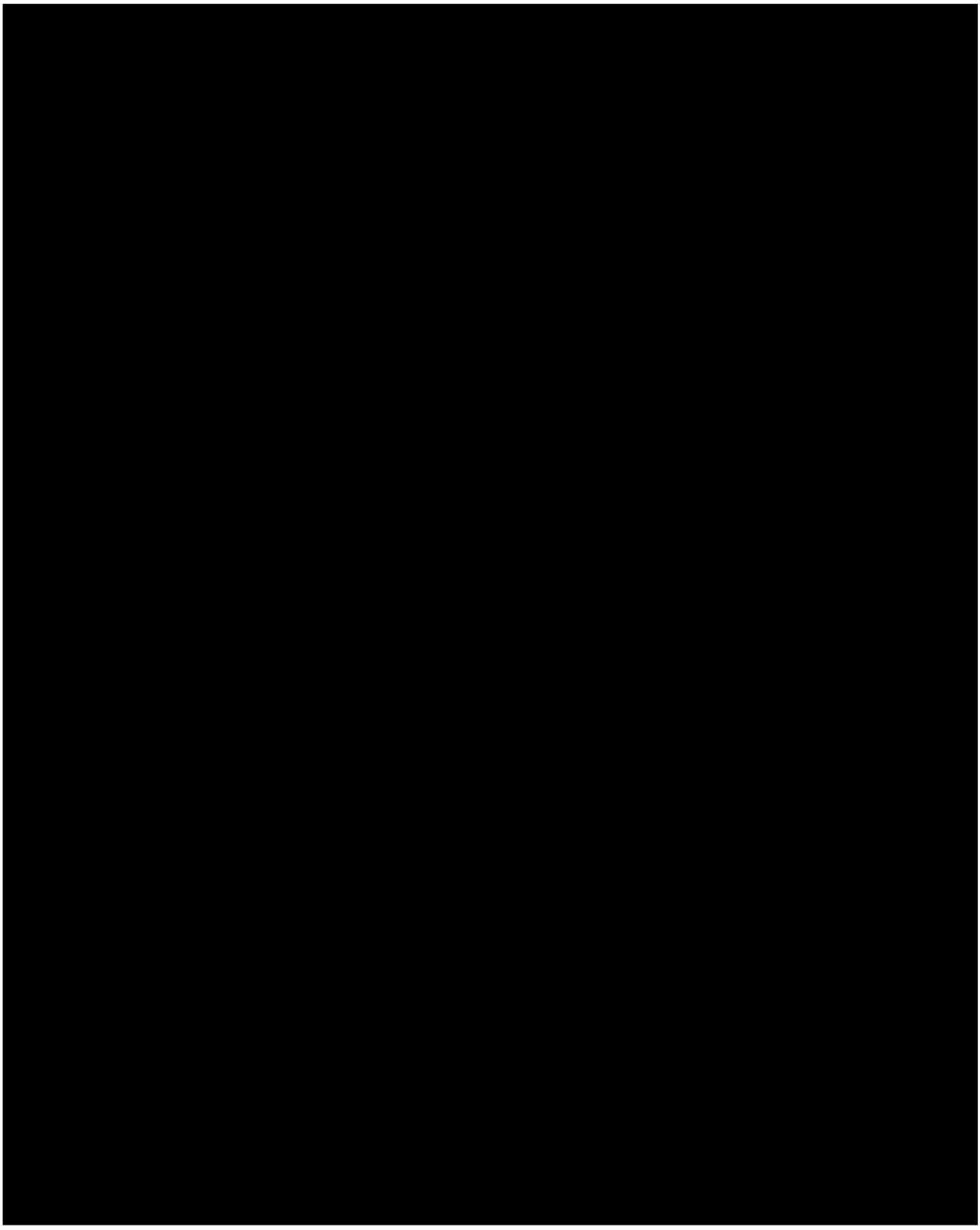

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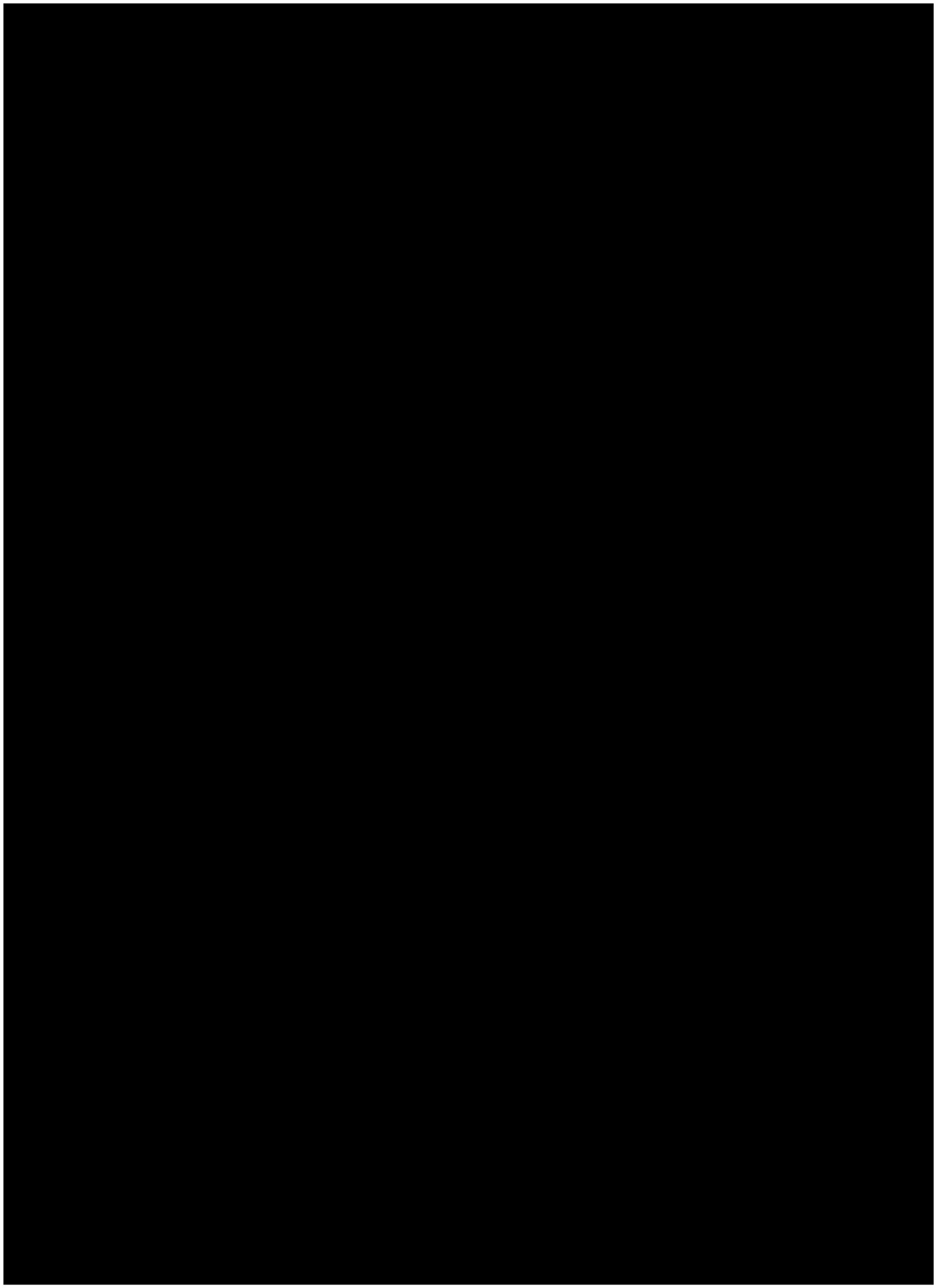

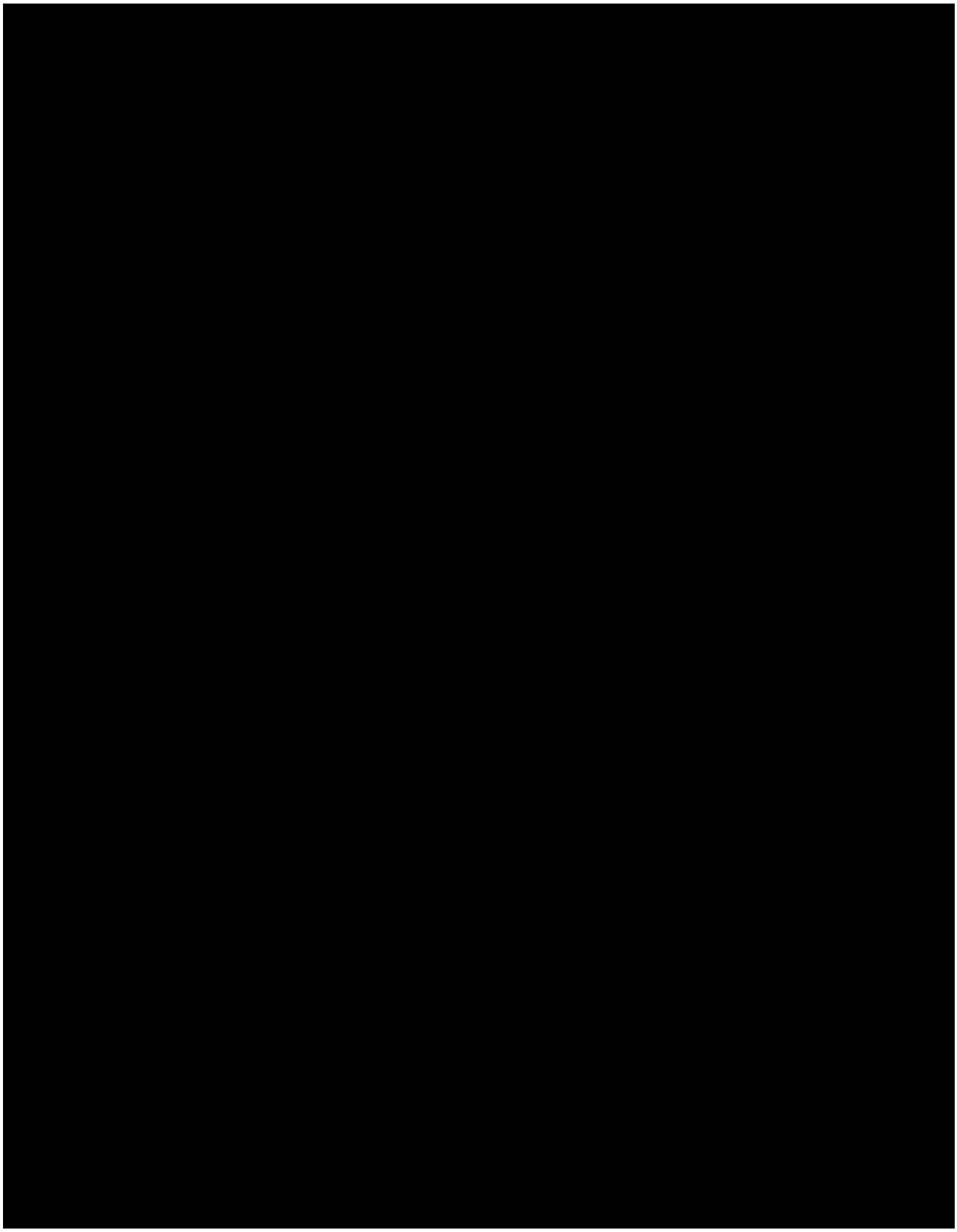

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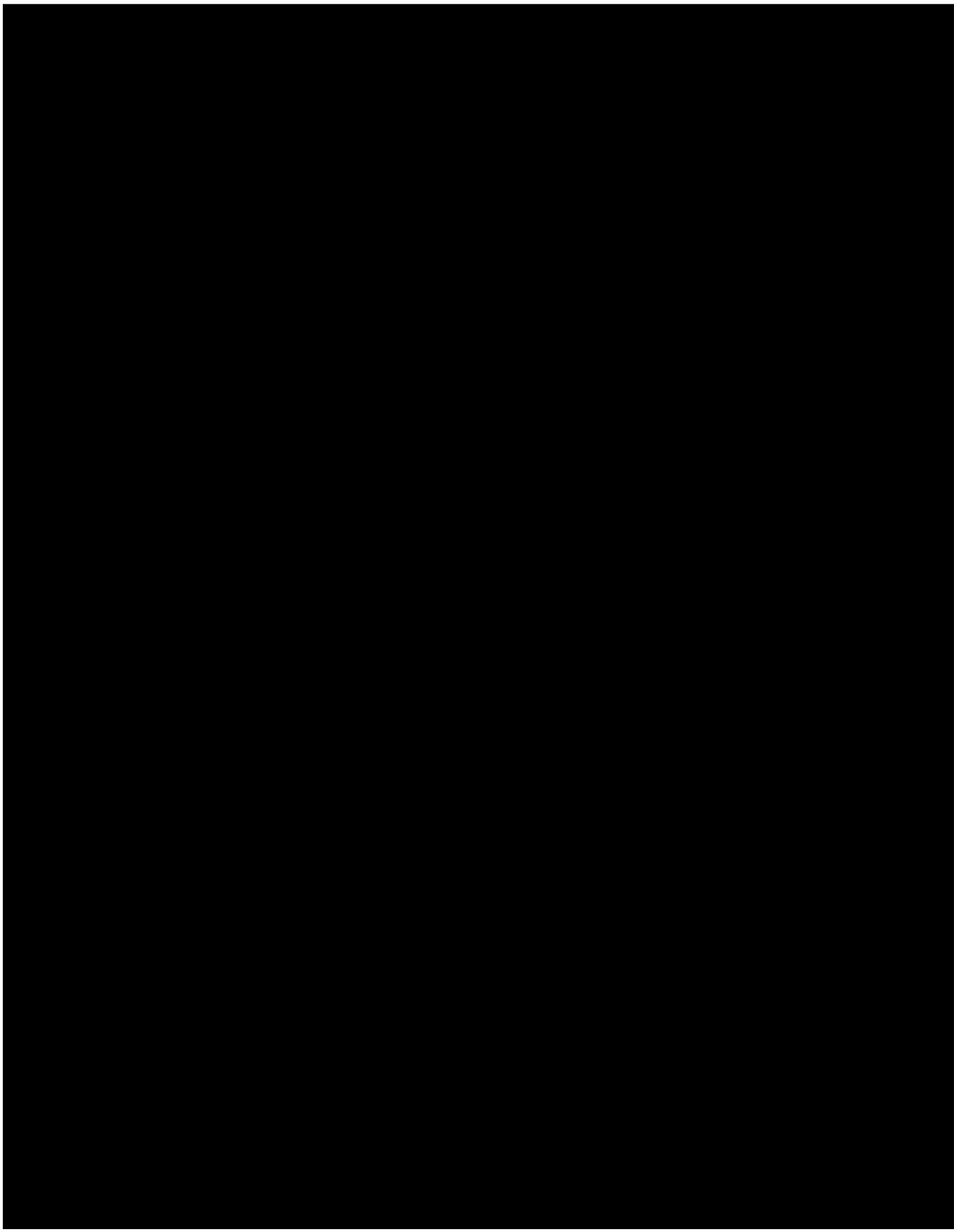

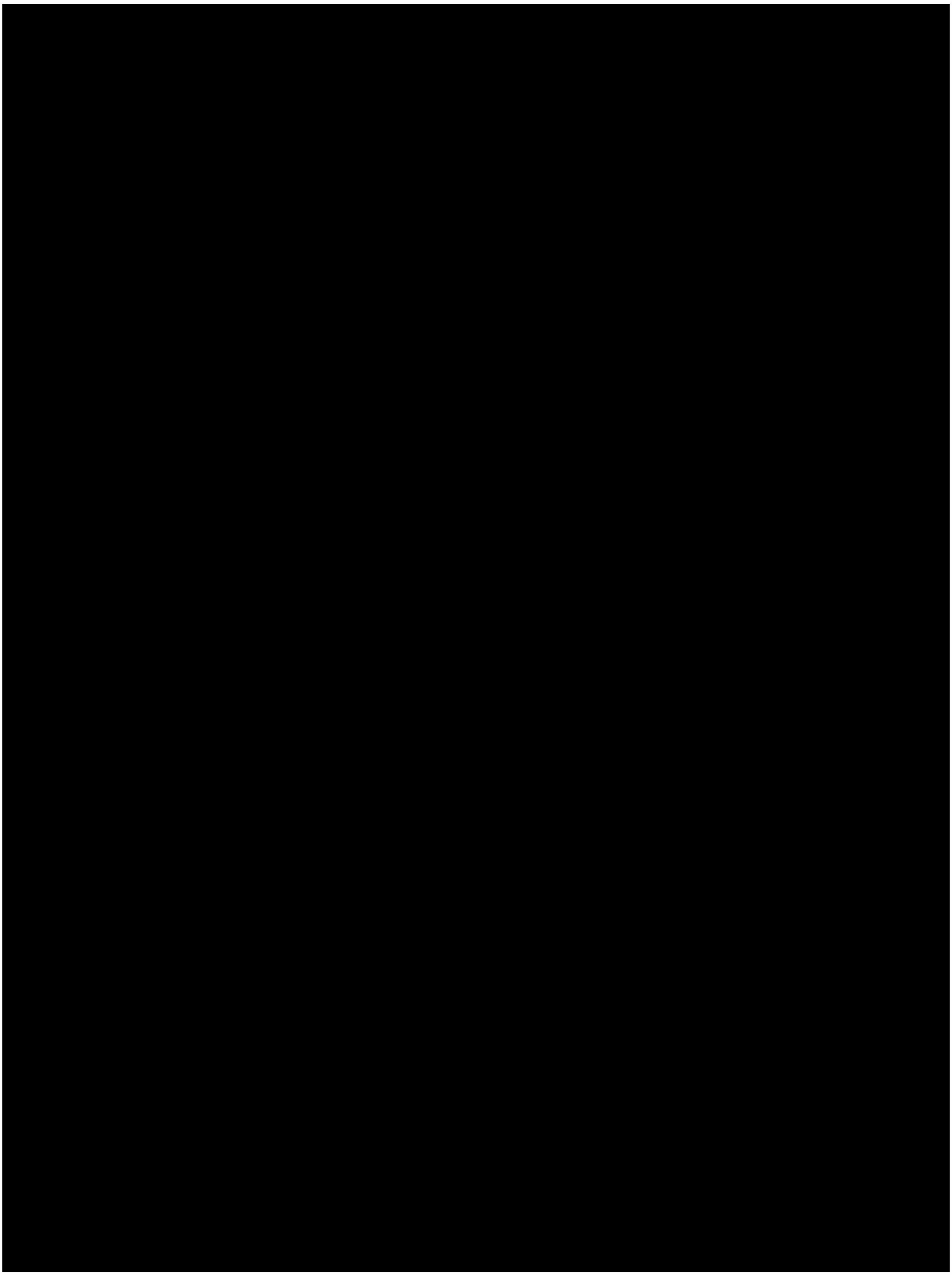

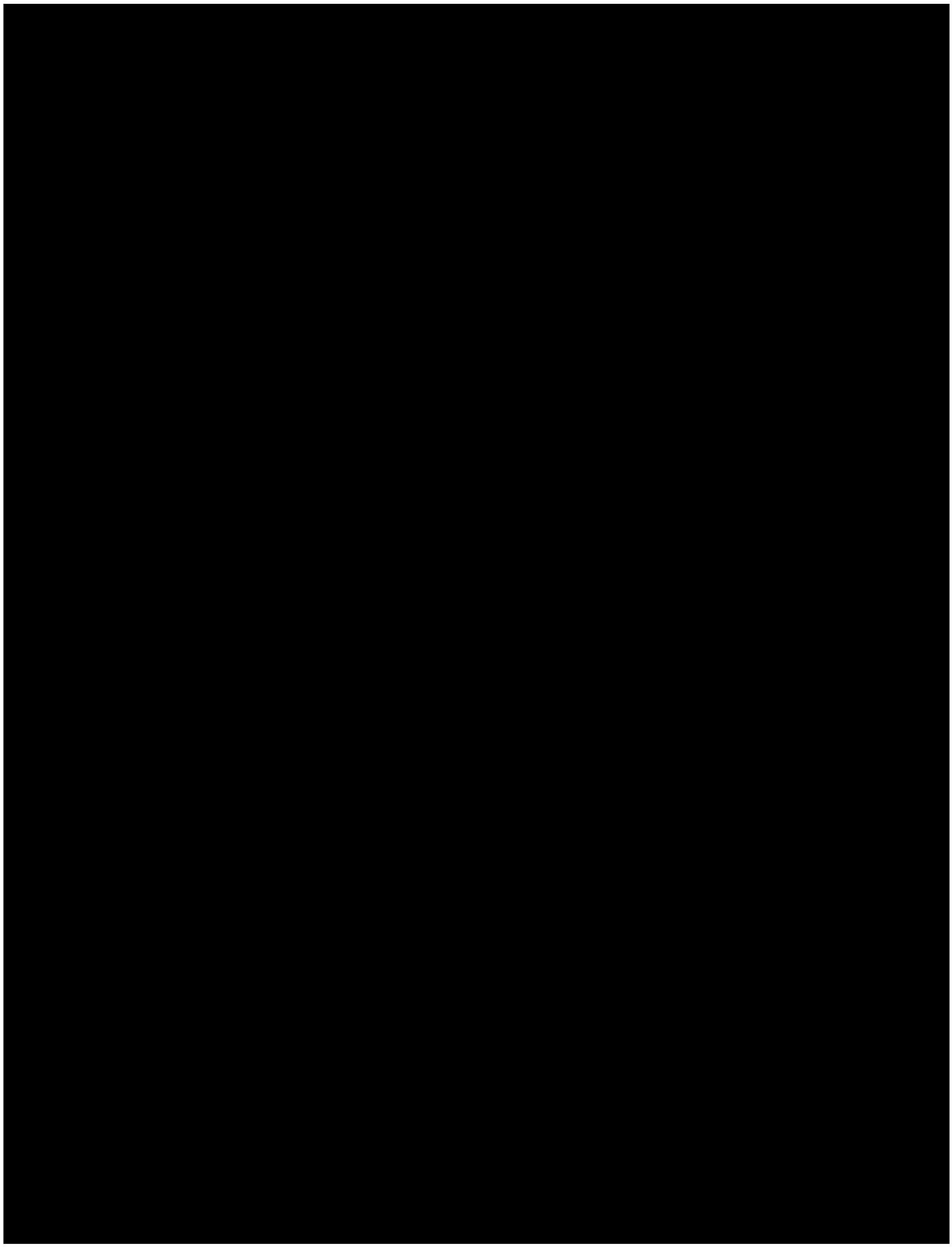

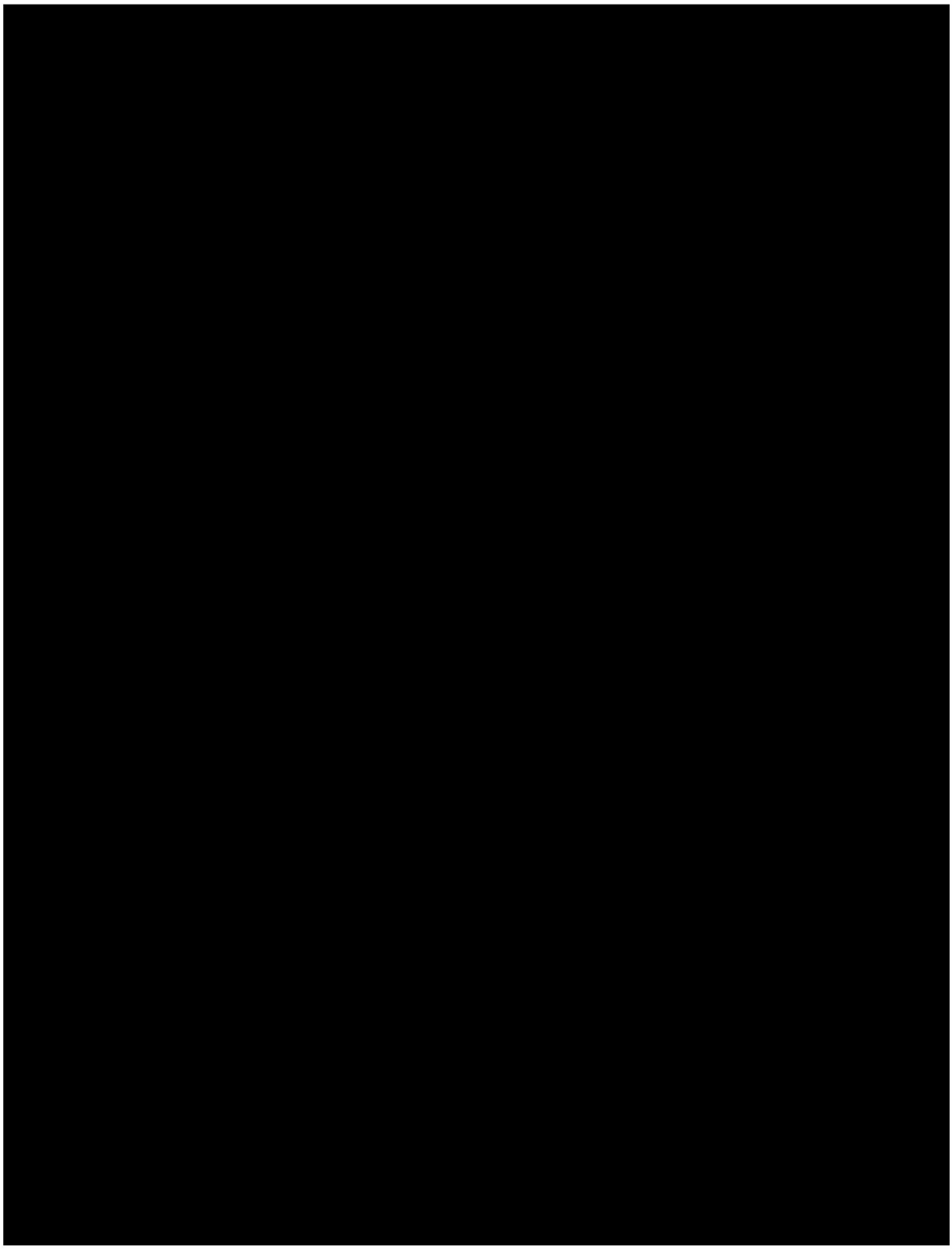

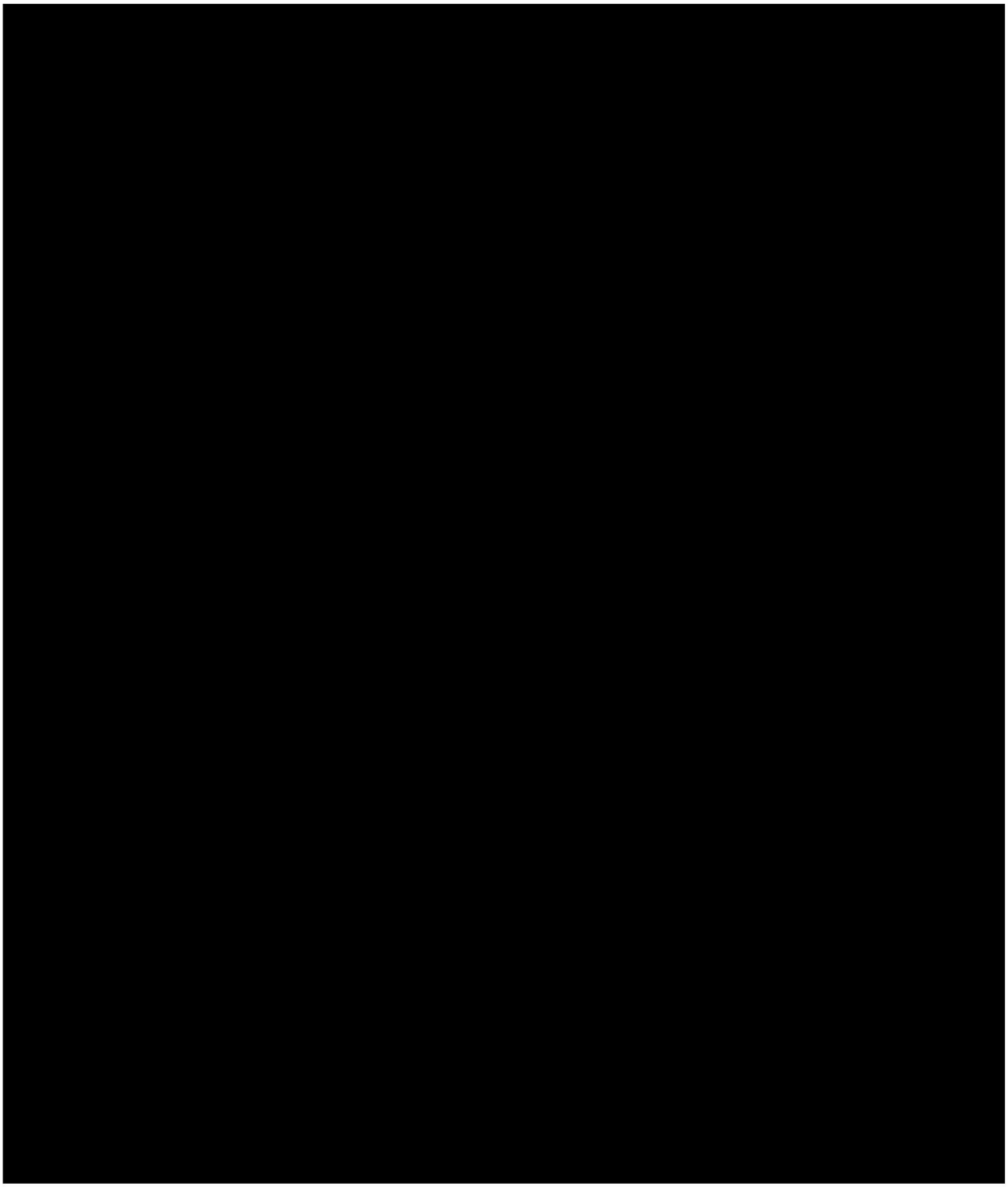

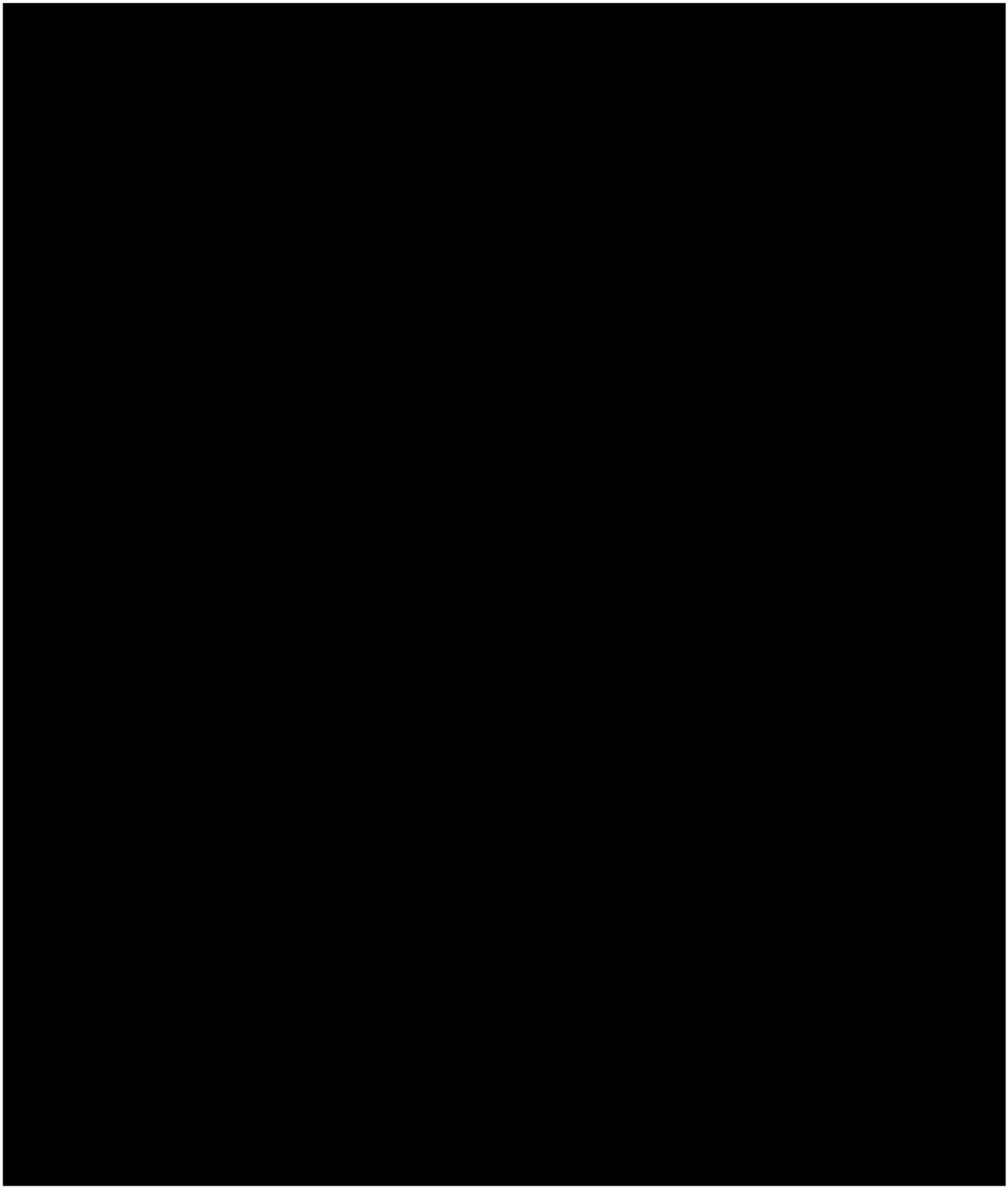

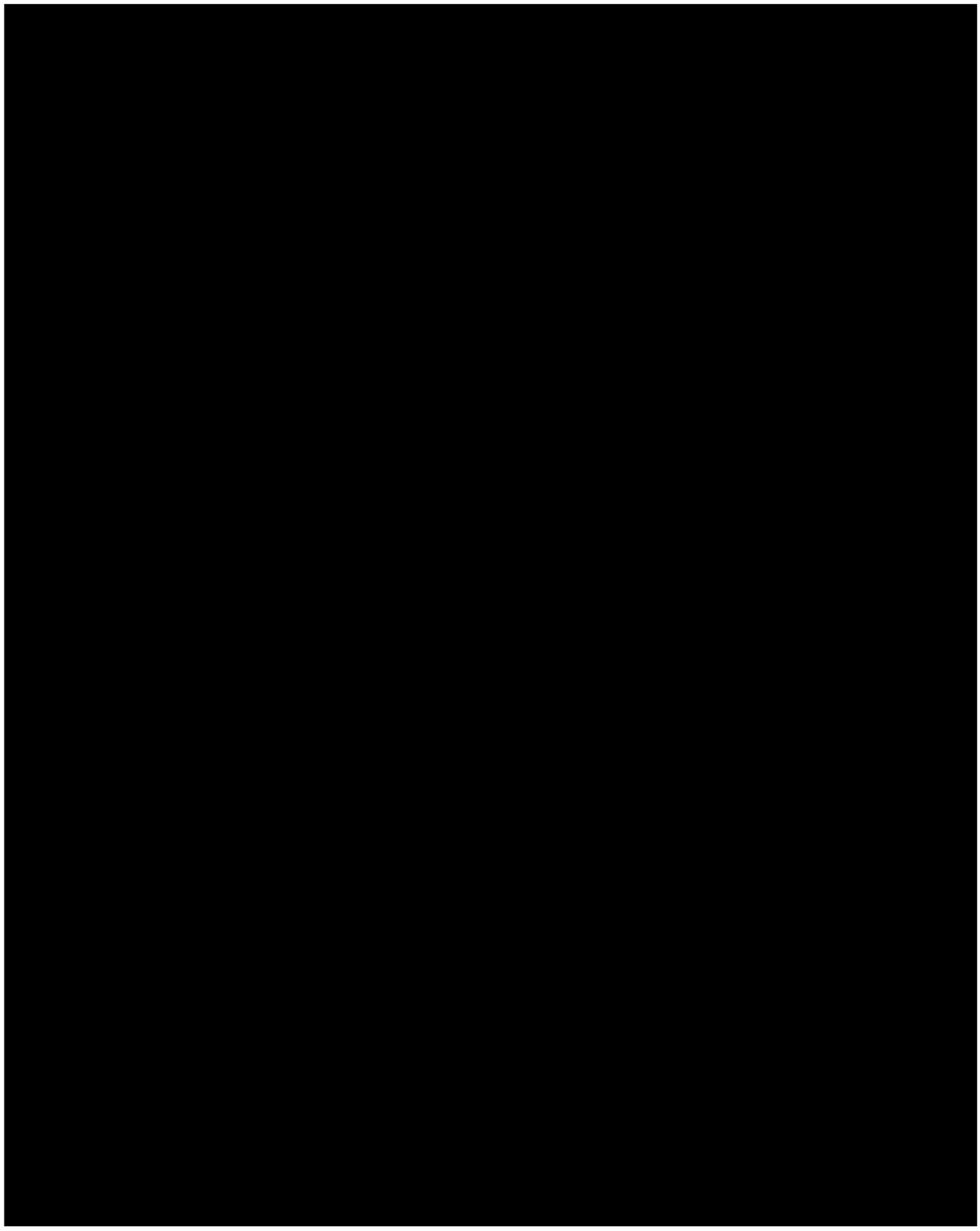

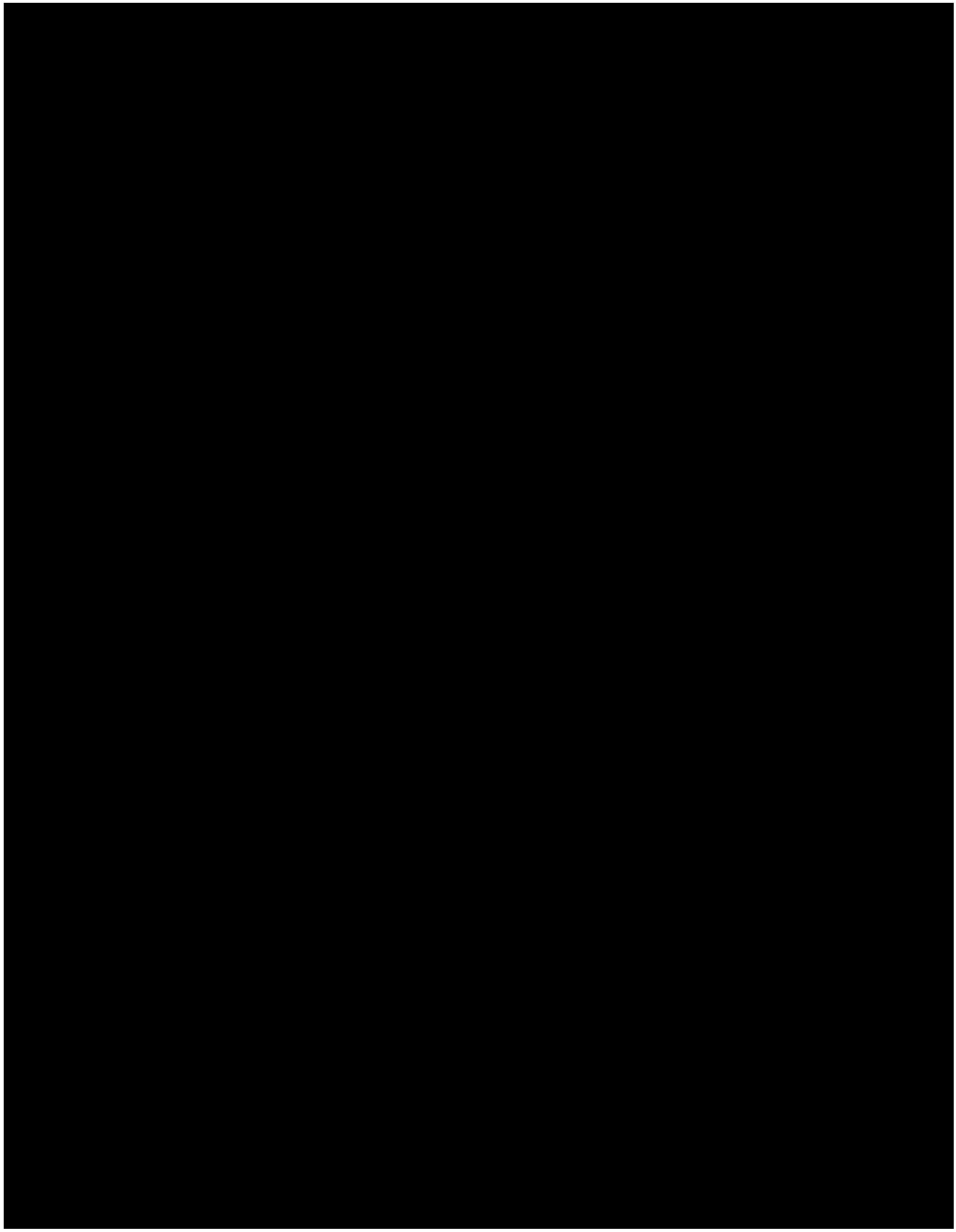

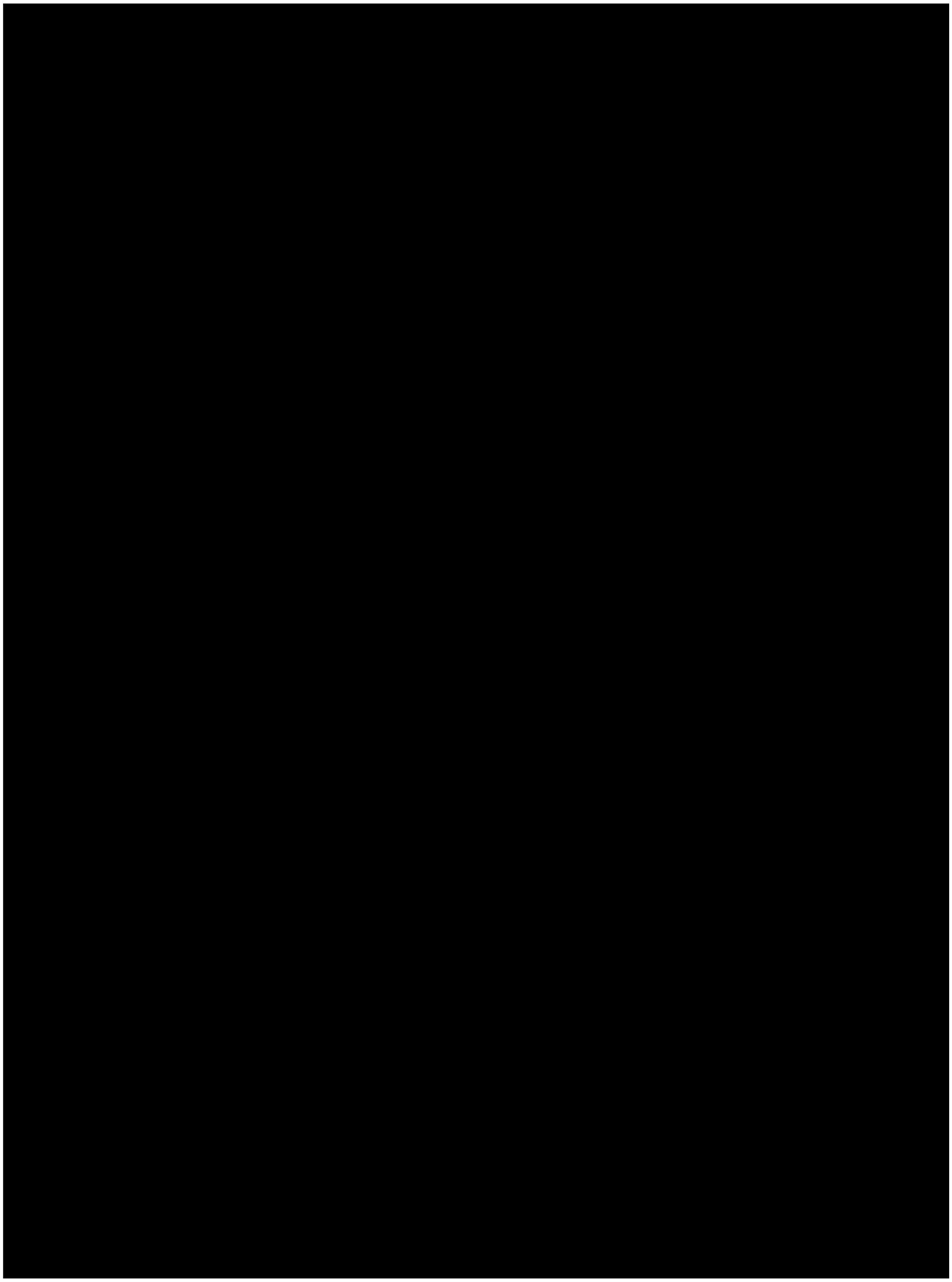

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LONDON AMBULANCE SERVICE NHS TRUST
OPERATIONAL ARRANGEMENTS

SECTION 3

London Ambulance Service NHS
NHS Trust

# Internal Major Incident

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## 1.1 Internal Major Incident

The NHS Act 2006 (as amended) requires NHS England to ensure that the NHS is properly prepared to deal with an emergency. CCGs, as local system leaders, should assure themselves that their commissioned providers are compliant with relevant guidance and standards and they are ready to assist NHS England in coordinating the NHS response.

The key elements are contained in Section 252A of the NHS act 2006 (as amended) and are:

a) NHS England and each CCG must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency.

b) NHS England must take steps as it considers appropriate for securing that each CCG and each relevant service provider is properly prepared for dealing with a relevant emergency.

c) The steps taken by NHS England must include monitoring compliance by each CCG and service provider; and

d) NHS England must take such steps as it considers appropriate for facilitating a coordinated response to an emergency by the CCGs and relevant service providers for which it is a relevant emergency.

A "relevant emergency" is defined as:

- In relation to NHS England or a CCG: any emergency which might affect NHS England or the CCG (whether by increasing the need for the services that it may arrange or in any other way);

- In relation to a relevant service provider: any emergency which might affect the provider (whether by increasing the need for the services that it may provide or in any other way).

## 1.2 Internal Major Incident Definition

An internal major incident for the NHS includes any disruption to the service such as fire, breakdown of utilities, major equipment failure, unplanned significant increase in call rate, severe adverse weather, and violent crime or staff shortages. Whilst the Major Incident plan offers a generic response structure for incident management, internal Major Incidents offer a different set of challenges (more often closely aligned to Business Continuity challenges) and require special measures to be implemented.

Internal Major Incidents present a serious clinical safety and reputational risk to the Trust and may present ongoing issues for the London Ambulance Service, rather than just the spontaneity of a "Big Bang" major incident. An internal Major Incident is likely to present similar challenges to the Trust in regards to our ability to maintain services during the period of the incident as those associated with a traditional Major Incident in the external environment except an internal Major Incident is unlikely to have an obvious incident scene to visualise the response against.

During an internal Major Incident it is likely that some emergency calls will not receive a response and/or may be directed to other providers including 111 and others will experience significant delays, as collectively the demand for individual calls may outstrip the availability of ambulances resources. **It is important to note, that the risk to patient care, as well as to the Trust, is the same as that experienced during a conventional major incident.**

This section of the plan should be read in conjunction with the Business Continuity Plan which offers the guidance on what to do once an Internal Major Incident has been declared and its should be maintained in line with the Business Continuity arrangements of the Trust.

## 1.3 Triggers for Internal Major Incidents

It is difficult to ascribe a full set of triggers for an internal Major Incident however the following is provided as guidance for the strategic group for consideration.

| TRIGGERS FOR AN INTERNAL Major Incident | |
|---|---|
| Issue | Indicative metric or threshold |
| Calls being held | >200 of any category |
| Control Services abstractions | >15% or more over seasonal levels |
| Operational staffing abstractions | >20% or more over seasonal levels |
| Catastrophic loss of EOC | Inability to receive and dispatch emergency calls |
| Heatwave | >35celcius leading to activity surge of >20% |
| Adverse weather (winter) | <-5celcius leading to activity surge of >20% or significant snow fall |

These are also a set of generic questions which may be used to inform the decision making process for triggering the Internal Major Incident Plan; however the list is not exhaustive and will require strategic consultation.

- Is the circumstance likely to result in a dramatic decline in the ability of the London Ambulance Service to respond to critically ill patients for an extended period of time?

- Is the circumstance likely to interfere with the supplies of vital London Ambulance Service equipment for an extended period of time?

- Will the circumstance deny access to London Ambulance Service Critical Infrastructure for an extended period of time?

- Will the circumstance have a detrimental effect on London Ambulance Service staff? (i.e. morale, safety).

- Will the circumstance have a negative impact on the reputation of the London Ambulance Service?

If the answer to any of the above questions is yes, then immediate consideration should be given to declaring an Internal Major Incident.

## 1.4 Implementation of the Internal Major Incident Plan

Upon receiving information that there may be a problem which will necessitate the invocation of the Internal Major Incident plan, the Duty Incident Delivery Manager (or other suitable senior on duty manager for example the Duty Watch Manager) should arrange a strategic meeting, either by teleconference or at HQ in the Gold Command Suite.

Early activation of the Internal Major Incident plan is essential to maintain patient safety, and as such the on call Strategic Commander, on call Strategic Medical Advisor, and on call Single Point of Contact for EPRR should be notified for discussion and decision, which includes the On Duty Incident Delivery Manager an on Duty Watch Manager (as current arrangements for Surge Management calls.)

**The strategic decision to declare an Internal Major incident remains the responsibility of the On-Call Strategic Commander for the Trust (Gold Medic).** The decision should be recorded in a LA434 Major Incident log, along with the rationale and circumstances that have preceded the decision. If a Control Services Incident Management Log is used in the preceding period, the Incident Management Log number should be referenced in the LA434. An incident cad should also be set-up in CommandPoint.

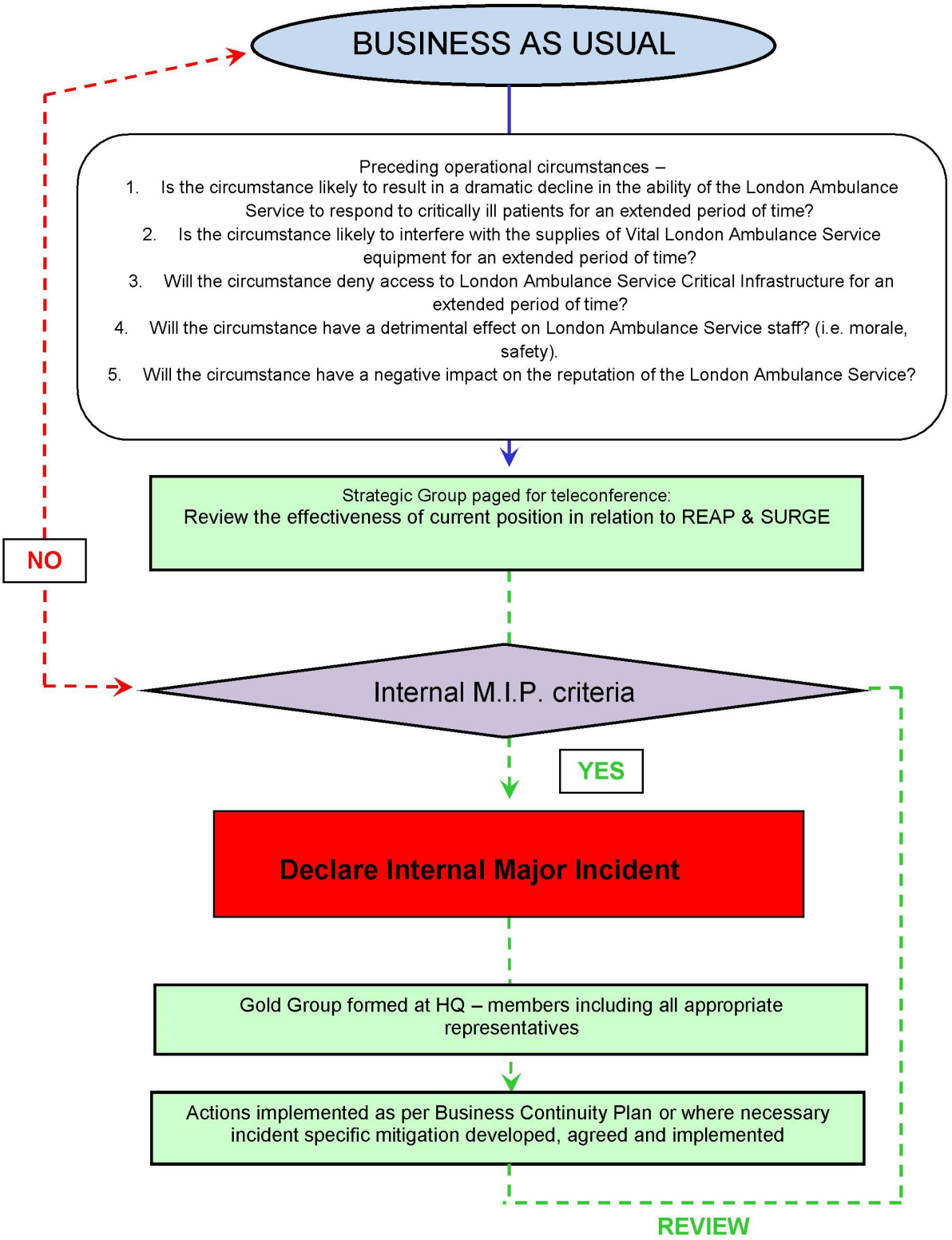
Once the decision has been taken to declare an Internal Major Incident, pager messages should be sent notifying the appropriate managers of the declaration. Depending on the situation that has necessitated the declaration; the pager message should also tell managers what is required of them. The strategic group should then make their way to headquarters, where a Strategic Command cell will form in Gold Command Suite.

Staff should also be notified as soon as possible of the declaration of an internal Major Incident, either through the text messaging system or via Airwave/MDT General Broadcast. The Strategic Commander should contact NHS England, London Region, and in discussion with the Chief Executive Officer and Director of Operations notify the London Resilience

Team Duty Officer (Via EPRR SPOC), the Association of Ambulance Chief Executives and National Directors of Operations Group.

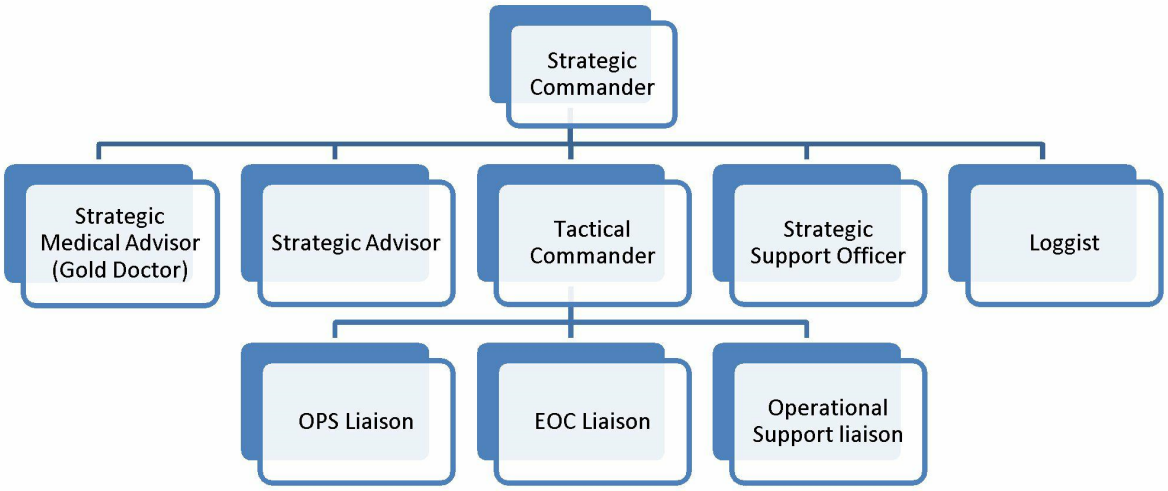
Internal Major Incidents may be preceded by indicators that lead to the belief that the Trust may face challenges in the coming hours or days, however the Surge Management Plan and Resource Escalatory Action Plan (REAP) should always be considered as mitigation of the escalation towards an Internal Major Incident. ***See Figure 1.1***

**Figure 1.1 Implementation Flowchart for London Ambulance Service Internal Major Incident Plan**



## 1.5 Command Structure for Internal Major Incident

Due to the specialised requirements of internal Major Incidents there is a dedicated command structure which should be implemented for such events. This command structure should be implemented once the Major Incident has been declared.




Additional roles should be added as required, but every effort should be made to minimize the size of the group. Lessons identified from past incidents have shown that as the group grows in size, decisions become more diluted and harder to manage.

The Strategic Commander role for the Trust must be filled by Gold Medic or their nominated delegate. From a governance perspective, ultimate responsibility for decisions taken during the Internal Major Incident rests with the Strategic Commander. They should provide a strategy for the Trust to follow, providing a framework for the tactical commander to work within. Each decision that is taken should be justified and recorded on the appropriate paperwork.

The Tactical Commander may be either the Duty Incident & Delivery Manager or On-call Tactical Commander if the incident is affecting service delivery or the wider NHS or Operations. The Tactical Commander is responsible for delivering the actions required to achieve a strategy for the incident. It is important to ensure that there is a distinction between strategy and the tactics required to achieve the strategy as set by Gold.

The tactical commander will receive information from the liaison officers, and collate this for the strategic meetings. This information will include the current operational situation,

the current EOC situation and any support issues that are currently interfering with core service delivery.

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LONDON AMBULANCE SERVICE NHS TRUST
OPERATIONAL ARRANGEMENTS

SECTION 4

London Ambulance Service NHS Trust

# Site Specific Contingency Plans

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OPERATIONAL ARRANGEMENTS

SECTION 5

London Ambulance Service NHS
NHS Trust

# Action Cards
# Operational and Control Services

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LONDON AMBULANCE SERVICE NHS TRUST
OPERATIONAL ARRANGEMENTS

SECTION 6

London Ambulance Service NHS
NHS Trust

# Business Continuity Framework

OFFICIAL SENSITIVE

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|---|---|
| Date of Issue: September 2016 | To be reviewed at least annually by the Department for Emergency Preparedness, Resilience and Response. |
| Authorised by: Chief Executive | |
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## Recovery from Major Incident (Business Continuity)

During any major incident it is essential that a recovery cell is established to support the trust Strategic Commander. The recovery cell is made up of members of the Business Continuity Working Group. The role and function of this cell is to ensure that the trust is working to resume the 'new normality' as quickly and as safely as possible after a disruptive event.

The following points should be considered

- Service Business Continuity Plan to be viewed in relation to return to normality through the whole of the LAS.
- Consider early release of operational staff and vehicles from scene if near to "scene evacuation complete" declaration.
- Amalgamate resources if multi-site incident is near to closure for the LAS on scene.
- Resource centres to view in collaboration with Gold, rota changes due to core cover Vs incident cover.
- Welfare aspects of all staff to be viewed in regard to what action to take over the following days/weeks.
- Hot de-brief actions to be implemented.
- Service de-brief dates to be viewed in collaboration with other supporting agencies and LESLP partners.
- During the incident a nominated talking head supported by the communications Department will provide reassurance messages to the public of London, this will also be supported by updates to the media from the Communications Team in the way of press statements to re-enforce any messages.

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# GLOSSARY OF TERMS

***AMBULANCE FORWARD COMMAND POINT:***
A point at which a specially equipped vehicle (CSV) is sited, at the scene of a Major Incident, to operate as an Ambulance command Point. It provides a reporting, co-ordinating and communications centre for ambulance, medical, nursing and voluntary aid personnel. This point will be established in close proximity to the Police and Fire Service Command vehicles.

***AMBULANCE EQUIPMENT OFFICER:***
An Officer responsible for the mustering, issue and collection of all patient care equipment on site. He/she will maintain control of the Equipment Support Vehicle's equipment and will replenish on site stocks as necessary. He/she will direct, in liaison with the AIO, the on site distribution of stretcher bearers assembled at this point.

***AMBULANCE INCIDENT COMMANDER: (INCLUDE TACTICAL COMMANDER):***
The Officer in overall control of Ambulance operations for the incident including the scene, hospitals, marshalling areas, evacuation areas

***AMBULANCE SCENE COMMANDER: (Operational Commander)***
An Officer who, under the direction of the AIO, co-ordinates health care resources at the incident scene.

***AMBULANCE LIAISON OFFICER (ALO):***
An Officer responsible for providing liaison with ambulance crews and hospital receiving staff from an Incident. The officer is based at the hospital.

***AMBULANCE LOADING OFFICER:***
An Officer responsible for the management of the Ambulance Loading Point. He/she will ensure that casualties are documented and evacuated in priority order. He/she will maintain control over vehicle access/egress and personnel operating within this area.

***AMBULANCE LOADING POINT:***
An area, preferably on hard standing and in close proximity to the Casualty Clearing Station, from where casualties are evacuated in order of priority.

***AMBULANCE PARKING OFFICER:***
An Officer responsible for the management of the Ambulance Parking point. He/she will direct vehicles and staff forward to the Ambulance Loading Point as required.

***AMBULANCE PARKING POINT(S):***
Point(s) designated at the scene of an Incident where incoming Ambulance resources report and are held in readiness for forward deployment, thus avoiding congestion at the entrance to the site or at the Ambulance Loading Point.

***AMBULANCE SAFETY OFFICER:***
An officer appointed to ensure the safety of all LAS & medical staff working within the incident boundary and that they are correctly dressed in PPE.

***AMBULANCE TACTICAL ADVISOR:***
An Emergency Planning Advisor appointed to assist and advise the Trust on Incident Response procedures.

***CASUALTY BUREAU:***
Central information point for all records and data on casualties. Maintained by Police service.

***CASUALTY CLEARING OFFICER:***
An Ambulance Officer who, in liaison with the Casualty Clearing Station Medical Lead, supervises assessment/labelling of casualties for evacuation in accordance with triage priorities.

***CASUALTY CLEARING STATION:***
An area set up at an Incident by the Ambulance Service to assess, treat and triage casualties and direct their evacuation.

***CASUALTY EVACUATION COMPLETE:***
Term used to indicate that treatment and removal of casualties from the scene is complete.

***COMAH:***
Control of Major Accident Hazards Regulations.

***CO-ORDINATING GROUP:***
The Gold/Silver Commanders of the emergency services who convene to consider/review strategy/tactics relating to the co-ordination of activity at a Major Incident.

***COMMAND SUPPORT VEHICLE (CSV):***
Specially equipped communications vehicle sited at the scene of a Major Incident to operate as the Ambulance Forward Command Point.

***EMERGENCY OPERATIONS CENTRE:***
Permanent Operations Room which receives, collates and co-ordinates all demands for the A&E service in the geographical area covered by the London Ambulance Service and allocates resources accordingly.

***EQUIPMENT SUPPORT VEHICLE (ESV):***
Vehicle equipped with specialist patient care equipment, Major Incident stocks of stretchers, blankets, patient care backpacks, inflatable tents, emergency lighting etc.

***EQUIPMENT/STRETCHER BEARER POINT:***
Point where bulk supplies for First Aid equipment, blankets and stretchers are available. Point where able-bodied persons are assembled to assist with the on site transfer of casualties by stretcher, to the Casualty Clearing Station or the Ambulance Loading Point.

***FORWARD AMBULANCE CONTROL POINT/AMBULANCE FORWARD COMMAND POINT:***
A selected point, near or at the scene, where the Forward Incident Officer can direct the operation. There may be a requirement for more than one Forward Command Point. Forward Command(s) will maintain a communications link with the SOC.

***COMMAND SUPPORT OPPERATIVE:***
A radio operator trained member of EOC staff who assists the command team with radio communications and records the Operational Commanders log.

***HOSPITAL LIAISON OFFICER (HLO):***
An officer responsible for providing liaison with the hospital control team staff during a Major incident. The officer is based at the hospital.

***INNER CORDON:***
Surrounds the immediate scene and provides security for it. Often denotes an area where hazards exist.

***JOINT EMERGENCY SERVICES CONTROL CENTRE (JESCC):***
The point from which the management of the incident is controlled and co-ordinated. All Emergency Services are represented at this location.

***Joint Emergency Services Interoperability Principals (JESIP)***
Principals which set out how emergency responders will work together to save life and reduce harm.

***LESLP:***
London Emergency Services Liaison Panel

***LINC WORKER:***
Listening, Informal, Non-judgemental, Confidential peer support

***LOCAL AUTHORITY EMERGENCY PLANNING OFFICER:***
Co-ordinator of a local authority's response to Major Incidents etc.

***MACC:***
Military Aid to the Civil Community.

***MAJOR INCIDENT CANCELLED:***
The term used to cancel a Major Incident Alert.

***MAJOR INCIDENT DECLARED – ACTIVATE PLAN:***
The term used to prefix messages to confirm a Major Incident.

***MAJOR INCIDENT STANDBY:***
The term used to prefix messages indicating that an incident may have or has occurred which could result in a large number of casualties.

***MARSHALLING AREA:***
Area to which resources and personnel not immediately required at the scene, or being held for further use, can be directed to stand by.

***MASS CASUALTY EQUIPMENT VEHICLE:***
National capability vehicles which carry a range of advanced life support equipment, dressings, mass casualty oxygen systems and large quantities of drugs.

***MEDIA CENTRE:***
Central contact point for media enquires, providing communication and conference facilities and staffed by spokespersons from all agencies involved.

***MEDIA LIAISON OFFICER:***
Officer responsible for the initial release of information from the scene of the incident and liaison with other Services at the Medical Centre.

***MEDIA LIAISON POINT:***
Rendezvous and initial holding area, at or near the scene, designated for use by accredited media representatives prior to establishment of a media centre.

***MEDICAL ADVISOR:***
The medical officer with overall responsibility, in close liaison with the AIO, for the management of the medical resources at the scene of the Major Incident.

***MEDICAL EMERGENCY RESPONSE INCIDENT TEAM (MERIT):***
A medical team who will attend the incident site to assist the triage and treatment of casualties. The ambulance service will alert and organise transportation for the team to the incident site.

***OUTER CORDON:***
Seals off an extensive area to which unauthorised persons are not allowed access.

***POST TRAUMATIC STRESS DISORDER (PTSD):***
Stress caused as a direct result of a traumatic event causing both physical and psychological symptoms.

***PRIMARY TRIAGE OFFICER:***
Officer responsible for the co-ordination of the triage sieve of casualties at the incident site.

***RECEIVING HOSPITAL:***
Any hospital listed as having facilities to receive and treat patients who are seriously injured or critically ill resulting from a Major Incident, on a 24 hour basis. Should have facilities for provision of MIO and MERIT at request of ambulance service.

***RENDEZVOUS POINT(S):***
A point usually nominated by the Police, as a safe area to which all vehicles and personnel must report before proceeding to the incident site or parking points. A Rendezvous Point (RVP) will generally be identified at any high risk location for the initial mustering of Emergency Service Vehicles (Airport, COMAH site, etc.).

***SECONDARY TRIAGE OFFICER):***
Officer responsible for the triage sort of casualties at the Casualty Clearing Station.

***SENIOR CO-ORDINATING GROUP – See Co-ordinating Group***

***SENIOR INVESTIGATING OFFICER (SIO):***
The Senior Detective appointed to assume responsibility for all aspects of the Police Investigation.

***SURVIVORS RECEPTION CENTRE (SRC):***
Secure premises to which those who have been directly involved in the incident and are uninjured can be taken.

***TRIAGE:***
The prioritising of casualties in respect of their injuries. On this basis an effective casualty evacuation plan will be implemented.

***TRIM:***
Trauma Risk Management Scheme offered to staff via the LINC worker scheme

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## References and other documents

- Civil Contingencies Act 2004
- Emergency Preparedness Guidance on Part 1 of the Civil Contingencies Act 2004, its associated Regulations and non-statutory arrangements
- Emergency Response and Recover, non-statutory guidance to complement Emergency Preparedness
- Business Continuity Arrangements
- Public Health Core standards
- Department of Health – Handling Major incidents: An Operational Doctrine, 2005
- London Emergency Service Liaison Panel Major Incident Procedure Manual 8th edition
- Joint Emergency Services Interoperability Project Doctrine
- London Resilience Mass Casualties Framework
- National Ambulance Service Command and Control guidance 2012
- JRCALC Guidelines ASA Operational Arrangements for Civil Emergencies
- Guide to Safety at Sports Grounds
- The Event Safety Guide
- NHS Commissioning Board Emergency Preparedness Framework 2013
- London trauma Network plan
- National Burns Plan
- Health & Social Care Act 2014
- Francis Report

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