



NWAS

Incident Response Plan

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Further information on this document and the procedures contained therein can be sourced by contacting the NWS Resilience Team at resilience.team@nwas.nhs.uk

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1. Introduction

The aim of this document is to ensure that it provides the detail required to deal with a response for a major incident or major incident standby, but also generic enough to deal with critical incidents that fall below the threshold of major incidents, thereby ensuring the response by North West Ambulance Service (NWAS) NHS Trust is patient focussed, clinically led and effectively managed, and is in compliance with the Civil Contingencies Act 2004 (CCA), The NHS Act 2006, ((HM Government, 2006), Health and Care Act 2022 (HM Government, 2022) NHS England Emergency Preparedness, Resilience and Response Framework (EPRR) 2022 (NHS England , 2022) and associated guidance and regulations. This will enable all staff to become more familiar with the content and utilise its contents more frequently leading to a reduction in skill fade.

1.1. Objectives

The objectives of this plan are to ensure that during a major incident, NWAS will:

- Ensure an effective and coordinated response to the incident, which can be flexible and scalable and adapted to work in a wide range of specific scenarios
- Follow the Joint Emergency Services Interoperability Principles (JESIP) aim of working together, saving lives, reducing harm
- Establish an effective Strategic, Tactical and Operational command structure
- Coordinate and manage the on-site NHS response
- Work with other responders and NHS partners to effectively resolve the incident
- Provide an opportunity to learn from Incidents and Debriefs.

To effectively meet these objectives this plan will:

- Be compatible with Local Resilience Forum (LRF), Integrated Care Boards (ICB) & multi-agency plans
- Offer guidance, direction, and information to NWAS staff and other NHS personnel
- Provide a source of reference that will assist in the integration of plans with NHS partners, other emergency services and other external agencies, i.e., LRFs
- Be generic for it to be utilised for other incidents not defined as Major. To allow Trust personnel the opportunity, to make best use of the associated Incident Action Cards in day-to-day incidents that they are required to attend.

1.2. Protective Marking

Due to the nature of some of the information contained within this document it is classified as OFFICIAL and should not be shared without the permission of North West Ambulance Service NHS Trust.

1.3. Plan Updates

The Incident Response Plan and associated Action Cards will be subject to an annual interim review to consider lessons identified from major (and other) incidents, events, or exercises and to comply with new guidance or

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legislation. The review will determine if an interim reissue of the plan is necessary, but the plan will be fully revised and reissued every three years.

1.4. Major Incident Training and Exercising

The Trust is committed to providing training on current threats and hazards to the Trust and to the region. Regular training sessions take place both internally and externally with multi-agency partners. These sessions include new skills and processes identified using lessons learnt from previous incidents and exercises.

NHS England Minimal Occupational Standards (MOS) Emergency Preparedness Framework (NHS England, 2022) states that 'Training should be focused on the specific roles and requirements assigned to an individual, aligned to a training needs analysis. In addition to covering all aspects of the response role, training should also highlight wider organisational and multi-agency response structures.' On call Commanders and Trust staff with particular roles in a major incident (e.g. Special Operations Response Team (SORT)) are required to undertake appropriate training. Courses both internal and external are linked to the Ambulance Commander National Occupational Standards (Skills for Health 2012) and MOS EPRR 2022.

The Trust will ensure that the appropriate competencies of its on-call managers are developed and maintained in line with the Skills for Justice, National Occupational Standards (NOS) for Ambulance Commanders as defined in Schedule 3 of the Standards for NHS Ambulance Service Command & Control 2018, and in line with National Command and Control Guidance. Commanders' compliance (NARU, 2019) with the NOS will be assessed via periodic scrutiny of Continual Professional Development (CPD) portfolios.

To ensure Commanders are trained and competent they are required to fulfil the following criteria as outlined in Schedules 2, 3 and 4 of the Standards for NHS Ambulance Service Command & Control;

- Completion of national agreed entry level course for Command level
- Completion of continuity courses/participation in exercises every 18 months in accordance with the National Ambulance Resilience Unit (NARU) Standards for NHS Ambulance Service Command and Control.
- Maintenance of CPD via the National Occupational Standards (NOS).

The Incident Response Plan will be subject to both internal and multi-agency exercises which may take the form of:

- Communication Exercise – every 6 months (minimum)
- Table Top Exercise – every 12 months (minimum)
- Command Post Exercise – every 3 years (minimum)
- Live Exercise – every 3 years (minimum) (NHS England Emergency Preparedness Resilience & Response Framework v3 2022, will be known in this document as EPRR Framework 2022)

The Plan may be exercised alongside site specific plans (e.g. stadia), emergency plans of other organisations (e.g. LRF plans) and others (e.g. those under the Control of Major Accident Hazards Regulations 2015 (COMAH Plans) or Radiation (Emergency Preparedness Public Information) Regulations 2019 (REPPIR)).

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The Resilience Team maintain a record of all commanders training completed, including requalification dates, expiry dates and staff involvement within exercises.

1.5. Specific risks within the NWAS operation area

- 66 upper tier COMAH sites as defined under the Control of Major Accident Hazards (COMAH) Regulations 2015
- 74 lower tier COMAH sites as defined under the Control of Major Accident Hazards (COMAH) Regulations 2015
- 5 licensed nuclear sites covered under the Radiation (Emergency Preparedness and Public Information) Regulations 2019.
- Extensive Major Accident Hazard Pipeline networks
- Extensive road and rail transport infrastructure
- Two international airports
- Major population centres
- Numerous high-profile sports venues and events

1.5.1. Site Specific Quick Reference Sheets (SSQRS)

All upper tier COMAH sites as well as a number of high-profile venues, including public sites, such as sporting stadia and prisons have had a Site Specific Quick Reference Sheet (SSQRS) produced. These sheets are designed to give EOC and first on scene responders, as well as commanders critical information about the site which will assist in their planning and decision making for the response to an incident. The following details will be included:

- Specific location by Grid Square, post code and what3words
- Any useful telephone numbers
- Any codewords used specifically for the site
- Other proximity sites that are of interest
- Overview of site activity, hazards and risks
- Access routes and points, as well as marshalling areas, Rendezvous Points (RVPs) and Forward Command Points (if allocated)
- Details on Command & Control, including incident control rooms, FCP at scene as well as off sites command details for TCG & SCG if called

These plans are held on Resilience Direct under NWAS Area Contingency Plans, with a link provided to all 5 Local Resilience Forums (LRFs) to allow them to be viewed and reviewed with every Category 1 responder and appropriate working groups to assist with the development of multi agency plans. Hard copies will also be held in each EOC, so that information can be passed to responders if required. All SSQRS's are classified as Official Sensitive, so care must be taken in terms of how they are secured and disposed of after the incident.

The SSQRS will be reviewed annually or as and when changes occur (COMAH sites are normally reviewed every 3 years), with the updated changes announced on Resilience Direct and at the subsequent appropriate forum to ensure all stakeholders are sighted to the most up to date version.

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2. Joint Emergency Services Interoperability Principles (JESIP)

2.1. Joint Doctrine

Public inquiries and inquests from numerous major incidents have identified that emergency services should have worked better together and displayed greater co-operation and coordination, i.e., better interoperability. Launched in 2013, the Joint Emergency Services Interoperability Programme (JESIP), (now referred to as Joint Doctrine: The Interoperability Framework) established principles for joint working which were recently updated in Edition 3 (October 2021).

The purpose of the Joint Doctrine is to provide a framework of common models and principles, which when applied consistently will improve interoperability between organisations across all levels of command. (JESIP 2021). The guidance builds upon and compliments the Civil Contingencies Act (2004) and associated guidance: Emergency Preparedness (HM Government , 2012) and Emergency Response and Recovery (HM Government , 2013).

To introduce the Doctrine and principles to emergency organisations an extensive programme of training for commanders from the three emergency services has been delivered, supplemented by training resources for Control Room Staff and partner agencies. The Trust, along with other UK Ambulance Trusts, Police and Fire and Rescue Services, has been involved in delivering and receiving this training and is committed to embedding its principles in the way we respond to emergencies.

2.2. Principles for Joint Working

The core principles under JESIP for joint working are:

2.2.1. Co-location

To effectively perform the functions of command, control and coordination, commanders must be co-located as quickly as reasonably practicable at a safe and easily identified location, to assist responders in jointly agreeing objectives. For operational commanders this location would be the Forward Command Point (FCP) where the joint response to the incident is managed.

2.2.2. Communication

Effective communication is essential to joint working; in a response to an incident this begins in Control Rooms and continues throughout the response between commanders, utilising multi-agency talkgroups in order to exchange reliable and accurate information. To obtain shared situational awareness the information exchanged must be clear, free from technical jargon and abbreviations, unambiguous and timely.

2.2.3. Coordination

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

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potential conflicts, preventing duplication of effort and minimising risk. Usually, the police will act in a 'lead' capacity by chairing meetings to promote an effective response.

2.2.4. Joint Understanding of Risk

Jointly understand risk by sharing information about the likelihood and potential impact of threats and hazards, to agree appropriate control measures. By jointly understanding risks and the associated mitigating actions, organisations can promote the safety of responders and reduce the impact that risks may have on members of the public, infrastructure and the environment.

2.2.5. Shared Situational Awareness

This is defined as a common understanding of the circumstances, immediate consequences, and implications of the emergency, along with an appreciation of the available capabilities and the priorities of the responder organisations. Achieving shared situational awareness is essential for effective interoperability. Establishing shared situational awareness is important for developing a Common Operating Picture (COP) at all levels of command, between incident commanders and between control rooms. Use of the M/ETHANE (Section 7.1) situation reporting method and The Joint Decision Model Section (Section 4.9.1) has been agreed between the emergency services as the ways in which information can be shared and acted upon and how decisions will be made.

2.2.6. JESIP APP

All staff are encouraged to download the latest version of the JESIP App onto their work phones. This will provide them with useful hint, tips, and guides across a number of subjects that are of benefit in a deployment.

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Figure 1 - Diagram showing the principles for joint working JESIP Edition 3 (October 2021)



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3. Incident Plan Activation

Any member of staff may declare a Major Incident, Major Incident Standby, or Critical Incident. It is however the responsibility of the Emergency Operations Centre (EOC) Duty Manager to ratify the decision and implement the Trust Incident Response Plan.

3.1. Definition of a Major Incident

The term 'major incident' as defined by the Cabinet Office & JESIP in NHS EPRR Framework 2022 is;

'An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.'

The definition is accompanied by the following explanatory notes.

- a) 'Emergency responder agencies' describes all Category one and two responders as defined in the Civil Contingencies Act (2004) and associated guidance.
- b) a major incident may involve a single-agency response, although it is more likely to require a multi-agency response, which may be in the form of multi-agency support to a lead responder.
- c) the severity of consequences associated with a major incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a major incident is unlikely to affect all responders equally.
- d) the decision to declare a major incident will always be a judgement made in a specific local and operational context, and there are no precise and universal thresholds or triggers. Where LRFs and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

3.2. Definition of an Incident within the National Health Service

For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

3.2.1. Business Continuity Incident

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure. (EPRR Framework 2022)

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Within NWAS an online/Business Continuity Management System (BCMS) planning tool kit is available for Directorate and Department Leads to support BC management. This system is also available to Commanders so that plans are accessible out of hours in the event of a disruptive challenge and can be accessed through the Shared Drive, Service Delivery File.

3.2.2. Critical Incident

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services. (EPRR Framework 2022)

These types of incidents will often be managed through the control measures identified in the National Resource Escalation Action Plan (REAP) REAP Plan (NWAS, 2021)

3.2.3. Major Incident

For the NHS, a major incident is defined as:

Any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties as to require specialist arrangements to be implemented.'
(NHS England EPRR Framework 2022)

Within the NHS this will include any event defined as an emergency under section 8.1.4 of the above framework

3.3. Standard Messages used by the NHS Organisations

NWAS employs the standard messages used by NHS organisations NHS England EPRR 2022 when communicating information regarding major incidents (text in green boxes). These are as follows:

- Major Incident – Standby
- Major Incident – Declared
- Major Incident – Cancelled
- Major Incident – Stand Down

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3.4. Major Incident – Standby

Major Incident – Standby

This alerts the NHS that a major incident may need to be declared.

Major incident Standby is likely to involve the participating NHS organisations in making preparatory arrangements appropriate to the incident, whether it is a 'rapid onset', a 'rising tide' or a pre-planned event.

As soon as reports indicate that a major incident *may* have occurred, the Incident Response Plan may be initiated through a 'Standby' message cascade as detailed within the EOC Duty Manager Action Card 21.

NWAS resources should be identified and 'held' awaiting further information, A Major Incident Standby Pre-Determined Attendance (PDA) is available to allow the EOC to start identifying assets that may be required. EOC will effectively activate the Incident Response Plan and processes required to prepare the service for a Major Incident - Declared response. Resources can easily be cancelled later if not required. Under the Interoperability Framework, Major Incident Standby is no longer included as a standard message but will continue to be utilised by the NHS. (JESIP 2021 & NHS England, EPRR 2022).

Remember, it is easier to 'stand down' from a potential major incident than it is to escalate when it is too late - it is better to bring the plan into operation early, rather than to delay doing so with a consequent risk to casualties

3.5. Major Incident – Declared

Major Incident Declared – Activate Plan

This alerts NHS organisations that they need to activate their plan and mobilise additional resources

Should the EOC consider that a major incident *has* occurred from initial call(s) they should not hesitate to declare a 'Major Incident'.

When a major incident is declared, the EOC Duty Manager will ensure that the words '**Major Incident - Declared**' are contained in all initial mobilisation messages. A Major Incident PDA is available to the EOC Manager to start prioritising assets for the incident.

Remember – if in doubt declare a Major Incident.

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3.6. Major Incident – Cancelled

Major Incident – Cancelled

This message cancels either of the first two messages at any time and may only be used by the declaring organisation

'Major Incident – Cancelled' terminates either the 'Major Incident – Declared' or 'Major Incident – Standby' messages where it is determined that the ambulance service is not required. The appropriate cascade of this information must be actioned.

If a major incident declaration or standby message has been initiated, it can only be cancelled on the authorisation of the Strategic or Tactical Commander following liaison with the EOC Duty Manager.

3.7. Major Incident – Stand Down

Major Incident - Stand Down

The phrase 'Major Incident – Scene Clear' is used to inform the NWAS command team and all receiving hospitals that all live casualties have been removed from the site. Where possible, the Ambulance Tactical Commander will make it clear whether any casualties are still en-route to hospital.

It should be noted that the major incident status can endure for a period of time after the scene is clear of casualties. NWAS Command and Control structures may remain in place to support the wider management of the incident

While ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each NHS organisation to assess when it is appropriate for them to stand down

If a major incident declaration or standby message has been initiated, it can only be stood down on the authorisation of the Strategic or Tactical Commander following liaison with the EOC Duty Manager taking into account current pressure of work.

3.8. Major Incident Declared by another agency

When an external agency informs NWAS that they have declared a major incident the NWAS on call Tactical Commander will be informed and an appropriate response should be made to the incident based on the information and intelligence available and what impact it may have on NWAS. Where deemed appropriate, partner organisations (e.g. UKHSA and NHS on call staff) should be informed to allow them to assess the impact on their own organisation.

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It must be noted that a major incident for another agency may not necessarily be a major incident for NWAS; however, NWAS does have a responsibility to support other responders under the CCA 2004. It should also be noted that whilst NWAS will adhere to the standard major incident terminology used by NHS organisations, other agencies and LRF areas may use different terms. However, the Major Incident – Declared terminology is recognised across all LRF areas.

3.9. Mass Casualty Incidents

The NHS England Concept of Operations for Managing Mass Casualties (NHS England , 2017) defines a Mass Casualty Incident for the health services as:

“An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services’ ability to manage.”

A Mass Casualty Incident may involve hundreds or thousands of casualties with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures to cope and require further measures to appropriately deal with the casualty numbers.

Mass Casualty Incidents are usually caused by sudden onset events and exclude casualties as a result of infectious diseases such as pandemic influenza. However, several smaller incidents may combine to become a larger response, or be geographically diverse but require a mass casualty response to be enacted due to the large number of simultaneous casualties.

Examples of complex incidents which could produce numbers on a scale that could be described as Mass Casualty Incidents include the following:

Incident	Fatalities	Injured
Terrorist attack on the World Trade Centre, New York, USA 2001	2,993	8,700
Bomb in a nightclub, Bali, Indonesia 2002	202	300
Multiple bombing attacks to a transport system, Madrid, Spain 2004	191	1,900
Tsunami, Asia, 2004	200,000+	Unknown
Multiple bombing attacks to a transport system, London, UK 2005	52	650
Marauding terrorists with firearms, Mumbai, India 2008	166	293
Marauding terrorist with firearms and bombing, Oslo, Norway 2011	85	176
Earthquake and Tsunami, Japan 2011	15,853	6,023
Marauding terrorists with firearms and bombings, Paris, France 2015	130	368
Terrorist with firearms, Orlando, USA 2016	49	53
Vehicle borne terrorist with firearm, Nice, France 2016	84	308

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Bombing and fire, Bagdad, Iraq 2016	326	246
Mass shooting, Las Vegas, USA 2017	58	851
Terrorist with bomb, Manchester, UK 2017	22	139
Westminster Bridge, London, UK 2017	6	50

For NWS, the decision on whether an incident should be described as 'mass casualty' will predominantly be based on an overwhelming number of casualties requiring treatment at the scene(s), necessitating a request for extensive mutual aid. For other NHS organisations the trigger levels for activation of their mass casualty arrangements may be much lower due to the limited availability of specialist resources for incident response.

There is no specific standard message for the declaration of a Mass Casualty Incident. However, EOC must make it clear to partners that the Trust is dealing with a suspected or confirmed Mass Casualty Incident as part of the major incident cascade.

The NWS Combined Mass Casualty Distribution Plan (NWS, 2020) can be found in the Green Room and in the Tactical Commanders file of the Electronic Battlebox on the NWS S Drive. This combined regional document will help to inform NWS commanders and MERIT doctors on the most suitable route and location for the distribution of casualties from a major incident in the first 2 hours, see Para 10.2.

3.10. Marauding Terrorist Attacks (MTA)

A marauding terrorist attack may take many forms and may include a wide range or combination of methodologies, from lower sophistication to higher complexity attacks, including:

- Bladed weapon
- Vehicle as a weapon
- Fire as a weapon
- Improvised Explosive Devices (IEDs)/grenades
- Firearms
- Siege (including the taking of hostages to prolong an attack or impede rescue operations)
- Chemicals (e.g. acid or alkali).

A marauding terrorist attack may be single or multi-sited, can include single or multiple attackers and may be fast moving with casualties spread over a wide range of locations. There may also be gaps in time and / or proximity between attacks, so commanders and responders should maintain an awareness of potentially linked incidents. Crowded spaces and places, including iconic sites, remain a target for attackers.

The 'marauding' element may involve an attacker moving between or within structures or other populated areas searching for victims. It may also include a small number of circumstances where an attacker seeks out new victims with little or no need for such movement; for example, an attacker discharging a firearm from a vantage point into a crowded area.

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The overarching aim of the emergency services is to provide a coordinated response to an attack which will save life by neutralising the threat, delivering emergency medical care, rescuing or removing casualties and survivors and managing a return to normality as soon as practicable (MTA JOPS Dec 20). (Joint Working Group, 2020)

The Trust's response to MTA incidents is based on two sets of guidance:

- Responding to a Marauding Terrorist Attack: Joint Operating Principles for the Emergency Services (MTA JOPs) - this document details the multi-agency principles behind the response and is designed to be flexible in order to enable commanders to adapt the guidance to any situation. The document was completely reviewed in 2019, and subsequently updated in Dec 2020 as Edition 2 (Joint Working Group, 2020) drawing on experience and learning from attacks in London and Manchester.
- The National Ambulance Resilience Unit (NARU) National Standard Operating Procedures – these procedures provide the basis for the ambulance service response to an MTA incident. (NARU Command & Control Guidance July 2019).

In order to provide an effective response to an MTA incident, the Trust utilises the following specialist resources.

3.10.1. Hazardous Area Response Team

The Hazardous Area Response Team (HART) would likely form the initial Ambulance response to an MTA. Located in the cities of Liverpool and Manchester they would each immediately provide 6 staff, trained and equipped to respond to such an incident. This team will be commanded by a HART Team Leader. Action Card 33 provides details of what the Team Leaders role and responsibilities are at scene.

3.10.2. Special Operations Response Team

In the event of an MTA, the Special Operations Response Team (SORT) would support HART in their response. Deployed on Ambulances and RRVS undertaking routine Ambulance work they can be redeployed to an MTA as required. Operational across the North West region there are circa 290 staff dual trained in the disciplines of MTA and CBRNe and would aim to deliver a total capability of 35 staff to the incident.

3.10.3. Ambulance Intervention Team Commander (AITC) (Action card 32)

The Ambulance Intervention Team Commander is a substantive Trust commander or NILO with specific training to manage the effective forward deployment of staff into the warm zone at an incident. Depending on the attack methodology, it may not always be necessary to deploy an AITC to the scene. Operational and Tactical Commanders have received training to command an MTA; However, an AITC will always be deployed where the attack methodology involves firearms and can be considered for those incidents involving bladed weapons.

3.10.4. National Inter-agency Liaison officer (NILO) (Action card 14)

The NILO is a trained and vetted ambulance officer who can provide advice and support to Trust incident commanders as well as partner agencies. The NILO will work alongside the Trust command structure to support

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decision making and multi-agency liaison at the scene and / or at a designated command location. Within NWS the NILO is a dual role with the Tactical Advisor, and all are trained in both disciplines.

3.11. Major Incident Management - (C.S.C.A.T.T.T.)

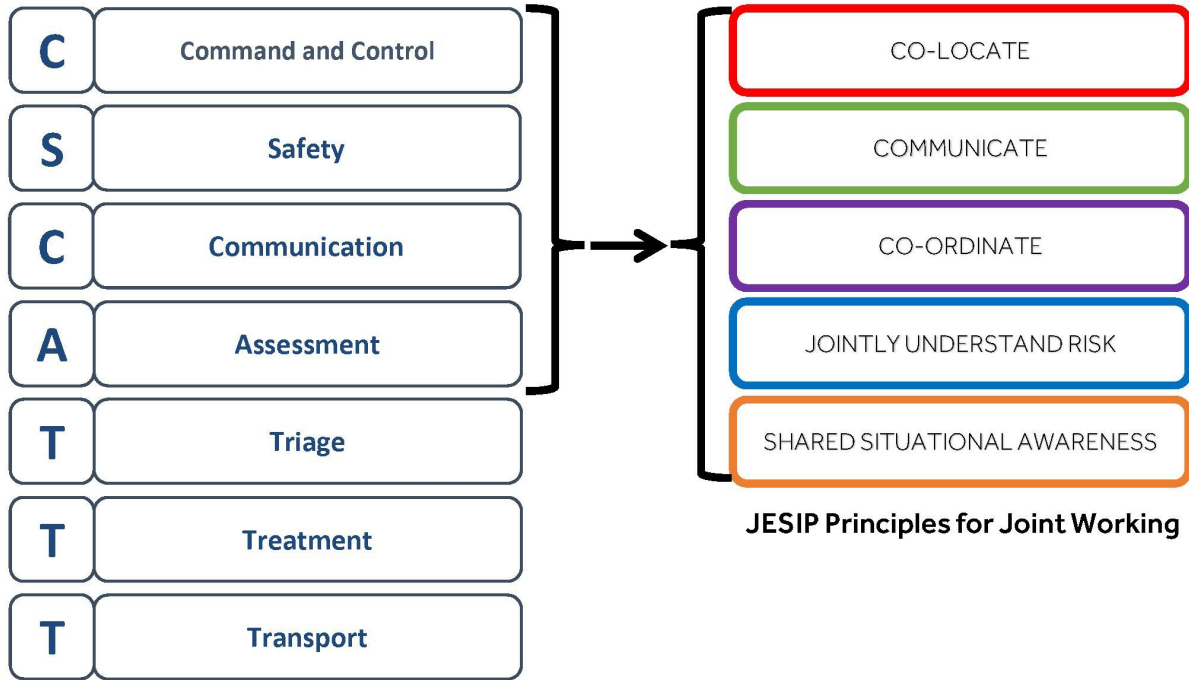


Figure 2- CSCATTT Model and JESIP Principles

The CSCATTT model is the mainstay of the NHS Ambulance response to major incident Management and provides a structured approach to ensure NWS and the NHS maintain an effective coordinated response. JESIP Principles for Joint Working must be reinforced throughout the Command and Control process.

3.12. The role and responsibilities of North West Ambulance Service

The North West Ambulance Service forms part of the National Health Service response to a major/critical incident. It is principally geared to the immediate clinical needs of those directly or indirectly associated with the incident and their subsequent transportation to established treatment centres. The NWS strategic goal is to deliver the right care, at the right time, in the right place, every time. This goal does not change during a major incident.

The Ambulance Service works to ensure that it is capable of responding to major incidents of any scale in a way that delivers optimum care and assistance to the casualties, which minimises the consequential disruption to healthcare services, and which brings about a speedy return to normal service provision. This is done by ensuring the Ambulance Service works as part of a multi-agency response across organisational boundaries.

The key responsibilities of the North West Ambulance Service include:

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- The saving of life, in conjunction with the other emergency services.
- To instigate an effective command and control structure, including the provision of medical advice to commanders, at Strategic, Tactical and Operational levels, as well as identifying and deploying functional roles as and when required.
- To protect the health, safety and welfare of all health service personnel on site.
- To carry out a health service assessment for the incident, alerting receiving hospitals and notifying wider health partners.
- To co-ordinate and manage the on-site NHS response, including the provision of communications.
- To instigate a triage process utilising Sieve and Sort when required.
- To provide treatment to casualties, including proportionate clinical care within the hot or warm zone of an incident when required.
- To arrange and maintain the most appropriate means of transporting the injured to appropriate facilities.
- To provide clinical decontamination of casualties and to support mass decontamination.
- To mobilise the UK national capabilities stock.
- To maintain adequate emergency cover for ongoing core business, minimising disruption to normal workload.
- To alert and co-ordinate the work of the Voluntary Aid Societies enabling them to provide services appropriate to the incident or in support of core business.
- To have the facility to deploy and provide sufficient bulk equipment to meet the requirements at the site.
- Have the facility to call on an ambulance tactical advisor/NILO who has expertise to provide advice on matters relating to the major incident plan and the required response of the trust if appropriate.
- Provide post incident welfare and initial debriefing followed by a formal debrief for all of its staff involved in the incident, which will allow lessons to be learnt and incorporated into policies and procedures, as well as training, testing, and exercising going forward.

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4. Command

This section gives an overview of NWS Command and Control arrangements in a major incident – these arrangements are based on best practice taken from the National Ambulance Service Command and Control Guidance (2019) published by the National Ambulance Resilience Unit (NARU), and the Joint Doctrine: The Interoperability Framework, Edition 3 October 2021 published by Joint Emergency Services Interoperability Programme (JESIP).

Commanders at all three levels as well as the Tactical Advisor/NILOs are to become familiar with the sites within their geographical area, that are utilised to host an SCG or TCG and what facilities are available to them.

4.1. NWS Command and Control

NWS employs a 3-tier command system comprising of Strategic, Tactical, and Operational Commanders – ‘a hierarchical system whereby individuals are empowered through their role within the structure, providing them with specific authority over others for the duration of the incident or event. This is regardless of an individual’s rank in the organisation’s day to day structure. During an incident where the command structure is activated, the day-to-day rank of the individual changes into that person’s role within the incident.’ (NARU, 2019)

If an individual is suitably qualified (having attended the nationally recognised course and conducted NOS in line with the NHS Ambulance Command & Control standards), experienced and empowered by the Trust to undertake the role, then they should not be replaced by a more senior officer, unless there are exceptional circumstances, that must be formally logged, with the decision making and reasons stated (section 4.2.6).

The nature of the incident will determine whether all levels of command are required. Most large or major incidents will require a multi-agency approach to command and control.

**Remember: The ‘role’ has authority.
The individual must have completed both external and internal NWS Annual Command Training particular to the role allocated to them.**

4.2. Command Roles

4.2.1. Strategic Commander

NWS Incident Response Action Card 22 outlines the Strategic Commander’s key responsibilities and provides a generic strategy based on the NARU template (NARU Command & Control Guidance 2019). (NARU, 2019) The action card **must** be referenced during the management of an incident.

The Strategic Commander has overall responsibility for the command, response and recovery for any major incident for their organisation. They will set the Trust’s strategic aims for the incident – i.e., develop a Strategic Plan. This provides a framework for the Tactical Commander(s) to work within. This should be tailored or edited by the

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Strategic Commander as necessary to meet the requirements of the incident response or nature of the occurrence. The Executive on call (see action card 30) may wish to offer support in the development of overall strategy but the responsibility for this continues to rest with the Strategic Commander.

The Strategic Commander is required to communicate the NWS strategy to the Tactical Commander and ensure that it is effectively converted into a functional and achievable Tactical Plan. Regular dialogue between the Strategic and Tactical Commanders is necessary to ensure that the tactics being employed remain effective in the management of the incident. If the dynamics of the incident have resulted in the formulation of a tactical plan before the Strategic Commander is in place, then this plan should be reviewed in line with the emerging strategy. The frequency of communication between the Strategic and Tactical Commanders will be determined by the type of incident, the complexity of the situation or resource requirements, the need for support to be sourced from external partners (in line with overall strategy) and the stage of the response in terms of time elapsed.

There will be one NWS Strategic Commander per incident

The NWS command structure has three Strategic Commanders on call at any time due to the extensive geographical footprint of the Trust. The span of command/control of these on call Commanders is that of the NWS functional area in which they are based; Cheshire and Merseyside, Cumbria and Lancashire and Greater Manchester. This may seem at odds with the agreed principles that there will be one Strategic Commander for each incident, but it is necessary to have additional capacity available for multi seated incidents or wide area challenges. As multi agency Civil Contingencies structures are based around County boundaries (which are contiguous with Police Force and local Resilience Forum boundaries) this arrangement is necessary to allow adequate representation of NWS at major incidents declared in each County.

To ensure multi-agency communication and coordination during a major incident or event, the Strategic Commander will attend and effect command from the multi-agency Strategic Coordinating Group (SCG), if formed. However, where an incident only affects the health service and no SCG is sitting then the Strategic Commander may decide to manage the incident from a Trust location such as the Regional Operating Coordination Centre (ROCC), or EOC. The Strategic Commander must set out in their incident decision log the rationale on where to be based during an incident.

It should be remembered that although the Police Strategic Commander will generally lead on coordination of an incident during the response phase, a Strategic Commander from any organisation may request that an SCG is established. The Chair of the SCG is likely to be a very senior Police Officer but this may vary by Local Resilience Forum (LRF) and type of incident and may even change by rotation for protracted incidents.

For incidents such as severe weather or wide area flooding when each county in the North West may have established an SCG, then additional Strategic Commanders can be called to attend, or a suitably authorised officer could be sent as a liaison between the NWS area Strategic Commander and an SCG. Command resilience will always be a consideration should incidents become protracted, and rotas of all command levels will be drawn up to ensure that cover is maintained and to augment the formal on call rota.

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The Strategic Commander should consider the arrangements contained with the Resource Escalation Action Plan (REAP) and Patient Safety Plan (PSP) which can be accessed via the green room. The internal departmental Business Continuity arrangements that will also be of benefit are located on the Shared Drive.

It is vital that the Strategic Commander maintains discipline in the chain of command and does not attempt to contact those not directly under her/his command or outside the span of control, unless a sound rationale or necessity exists. Such actions should be carefully logged with a detailed description of the background to this decision.

For Incidents that affect more than one NWAS functional area or involve the whole region, such as the COVID pandemic, the Trust now employs an overall Strategic lead, who will direct what resources and assets are to be employed and to what location. The list of Strategic leads is held by the ROCC.

The Strategic Commander should be able to contact the following as key communications lines or partners in order to effect command:

- Strategic level representatives of multi-agency partners e.g. Police, Fire and Rescue Service, Military, Health such as ICB, national and local government
- NWAS Tactical Commander
- NWAS Regional Operational Coordinating Centre (ROCC)
- NWAS Regional Health Control Desk (RHCD)
- NWAS Emergency Operations Centre
- NWAS Executive On Call
- NWAS Press On Call
- NWAS Loggist
- NWAS Strategic Medical Advisor
- National Ambulance Resilience Unit (NARU) on call officer
- Scientific & Technical Advisory Cell
- NWAS Tactical Advisor/NILO
- PTS Manager

Whilst it is not the responsibility of the Strategic Commander to make tactical decisions, they still have responsibility for ensuring the tactics which are being employed are effective.

4.2.2. Tactical Commander

NWAS Incident Response Action Card 13 outlines the Tactical Commander key responsibilities. The action card **must** be referenced during the management of an incident.

The Tactical Commander works at the tactical level and has responsibility for developing the Tactical Plan for the use of resources at the incident. The Tactical Plan will be developed within the framework of the Major Incident Strategy and any available intelligence and associated risks. A generic Tactical Plan taken from the NARU template (NARU Command & Control Guidance 2019) (NARU, 2019) can be found on the back of the Tactical Commanders Action Card. This should be adapted by the Tactical Commander as necessary.

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

The Tactical Plan provides a framework for the Operational Commander to operate within. The Tactical Commander supports the Operational Commander to achieve their objectives and to manage the incident effectively. The Tactical Commander should not get involved in the direct operational management of the incident (NARU Command & Control Guidance 2019).

The NWS Tactical Commander should locate alongside the Police Tactical Commander in order to ensure a multi-agency approach to the resolution of the incident. (NARU Command & Control Guidance 2019)

The location of the Tactical Commander will be determined by the location of the Tactical Coordinating Group (TCG). This will usually be held at a local police station or headquarters, or near the incident scene.

In order to assist in the decision-making process or tactical plan development, the Tactical Commander may request the assistance of a Tactical Advisor/NILO to provide advice with regards to those options and specialist resources that may be available and appropriate to the management of the incident.

The key communication lines and partnerships for the Tactical Commander are:

- Tactical level representatives of multi-agency partners e.g. Police, Fire and Rescue, Military, Health, national and local government
- NWS Strategic Commander
- NWS Tactical Advisor/NILO
- NWS Operational Commander
- NWS Medical Advisor
- NWS Major Incident Suite
- NWS Emergency Operations Centre
- NWS Trauma Cell
- NWS Press On Call
- NWS Loggist
- NWS PTS Control

There will be one NWS Tactical Commander per incident

On rare occasions it may be necessary to increase the number of Tactical Commanders in response to multi-sited incidents.

4.2.3. Operational Commander

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NWAS Incident Response Action Card 4 outlines the Operational Commander’s key responsibilities. The action card **must** be referenced during the management of an incident.

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

The Operational Commander ensures that the Tactical Plan is carried out, and that they understand the Major Incident Strategy. Importantly they must understand and be able to discharge their responsibilities within these. As the Operational Commander they will provide leadership and management to the other NWAS functional role officers and any other direct reports. (NARU, 2019)

The key communication lines and partnerships for the Operational Commander are:

- Operational Commanders from multi-agency partners e.g. Police, Fire and Rescue (Tactical), Military, local authorities
- NWAS Tactical Commander
- NWAS Casualty Clearing Officer
- NWAS Casualty Clearing Station Medical Lead
- NWAS Primary Triage Officer
- NWAS Secondary Triage Officer
- NWAS Parking Officer
- NWAS Loading Officer
- NWAS Safety Officer
- HART Team Leader
- NWAS Decontamination Officer
- NWAS Equipment Officer
- Forward Doctor
- NWAS Tactical Advisor/NILO

For complex incidents (e.g. rail crash) or multi-sited incidents (e.g. terrorist attack) the incident may be divided into sectors. This will require a separate Commander for each sector. These Commanders, e.g. Sector Commander 1, 2, etc. would be subordinate to the Operational Commander managing the incident scene, with Action Card 29 providing details of their roles and responsibilities at the incident. Ultimately the Tactical Commander will ratify the operational management structure dependent upon the scale or nature of the incident.

4.2.4. Command Structure Discipline

In the event of Major Incident - Standby or Declared messages being given, experience has shown that managers not directly involved in the initial response will offer their services via the EOC. Though there are benefits to this, it is essential that the Trust follows the identified Incident Response Plan and the set Command and Control procedures in the initial stages (see section 4.6).

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In addition, managers not directly involved in the initial response may contribute to the longer-term management of the incident through relieving those managers who may have formed the initial response to the incident or by coordinating the securing of additional staff. These managers may also be utilised as part of the longer term recovery phases. The Tactical Commander in consultation with the Strategic Commander should consider the appropriate use of these resources and skills.

It is essential that managers do not self-deploy and become involved in the response phase without the direction of the Strategic or Tactical Commander

4.2.5. Handover / Relieving of Command

There may be circumstances where those in a command or functional role may be required to handover and/or be relieved to/by another Commander. This could include a protracted incident where a routine handover of command is required or, in exceptional circumstances, where it is felt the individual Commander is either not performing their role adequately or may be unable to do so for a variety of reasons. Relieving a Commander of duty due to either not performing their role adequately or where it is felt they are unable to do so, for Operational Commanders, can only be authorised by the Tactical or Strategic Commander for the incident. A Tactical Commander can only be relieved of Command by a Strategic Commander. The Strategic Commander can only be relieved of Command by the Executive on Call, or the Accountable Emergency Officer (AEO). The Joint Decision Model (JDM) must be used to aid in the decision making and attempts made to verify the efficacy of the current NWS response to the incident. All NWS staff can raise concerns to the chain of Command as part of standard working practice.

Individual Commanders are to be informed personally through mobile phone or face to face, including when they are going to handover / be relieved and if known at that stage by whom. This will allow the outgoing Commander to prepare any handover notes, update personnel in support functions and partner agencies who are part of the JESIP process. Wherever possible, the outgoing Commander should adequately brief and prepare the relieving Commander for their role face to face.

The EOC are to be made aware of the change in command and it is to be logged appropriately including the background to the decision making. The remainder of the chain of Command are to be informed of the change via an airwave radio message or other communication means for situational awareness.

The following must be included in any formal handover of command:

- Obtain sufficient information to determine the current status of the response, this is to include details of the most recent METHANE report, the status of the multi-agency risk assessment and be in the IIMARCH format.
- Timing and location of the next multi-agency meeting and where possible an introduction to other agency Commanders.
- Any significant concerns around the welfare of NWS staff deployed.
- A formal handover time is to be agreed and reported back to the EOC for logging, confirming who has been relieved and who has assumed the command appointment.

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- The chain of Command is to be informed via an airwave radio message or other communication means for situational awareness.
- The handover proforma on the back of the Commanders' Action Cards (Action Cards 4a, 13a, 22a) are to be used to confirm the process, to include the named outgoing and incoming commanders.

This process is to be included as part of commander training and set as a standard objective for both Major Incident and non Major Incident Exercises to enable embedding as business as usual.

4.2.6. Operational Discretion

Historical incidents and learning has shown that there may be exceptional circumstances where those in a Command role may be faced with a situation that is highly unusual where policies and procedures in place at the time are unable to offer adequate options to save life, work together and reduce harm in line with NWS strategic intentions. Where this is the case, the Commander wherever possible and where time allows should;

- Seek immediate advice from the most appropriate and suitable role e.g. Tactical Advisor / NILO, Medical Advisor (not exhaustive list)
- Operational and Tactical Commanders should share their understanding of the situation with the Command role in the more senior role to theirs (Operational to Tactical, Tactical to Strategic)
- Discuss with appropriate multi agency Commanders or Managers.

If an appropriate policy or procedure cannot be found to deal with the situation, the JDM should be used to develop the most suitable plan that takes into account the need to save life, work together and reduce harm together with any other strategic intentions set by NWS. This may require approval by the Strategic Commander and should be logged appropriately including the background to the decision making and communicated to those within the chain of Command. However, in a time critical dynamic situation with immediate life risk this should not delay action being taken. As soon as possible, the Commander should aim to return NWS working practice to that within a recognised policy or procedure. When this is achieved, this should also be logged appropriately and communicated to those in the chain of Command.

4.3. Command Support

4.3.1. NWS Tactical Advisor/NILO

The NWS Tactical Advisor/NILO (Action Card 14) provides advice with regards to options and specialist resources that may be available and appropriate to the management of a major incident that may help the Tactical Commander and other key roles in their decision-making process.

The Tactical Advisor/NILO also acts as the NWS National Inter-agency Liaison Officer (NILO) able to communicate with multi-agency partners to gather sensitive information.

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This role has been developed to ensure expertise is also available to advise and support all levels of command during large complex events, including CBRNE - terrorism, HAZMAT, Urban Search and Rescue (USAR), firearms and police-led overt / covert operations.

4.3.2. Ambulance Loggist (Action Card 19)

NWAS has a number of trained Loggists across the Trust who are able to maintain accurate log books and records in accordance with legal standards and best practice.

Located alongside either the Strategic or Tactical Commander when requested, the Loggist will record information, decisions, the Commander’s rationale and actions taken during the incident.

4.3.3. NWAS Press Office / Ambulance Press Officer (Action Card 23)

The Trust has in place an established Media Plan which provides a 24hour capability and which encompasses actions in the event of a major incident. The NWAS Press Office will handle media enquiries as well as provide advice to the Strategic Commander and if appropriate, in liaison with NHS agencies (wider NHS).

The police will generally lead the media response to major incidents with partner agencies feeding into any established Media Cell. The NWAS Press Officer will feed into the multi-agency response after consultation with the NWAS Strategic Commander.

The Trust Press Officer will coordinate corporate communications in relation to any incident both externally and internally, liaising with all other agencies to ensure joint agency communications as well as supporting the NWAS Commanders on all media enquiries; providing briefing and updates to the media when required; setting up press conferences; and contributing to joint press statements.

The press office will aim to issue a holding statement in fifteen minutes of a major incident being declared and will aim to update the statement at least every forty-five minutes.

During the early stages of a major incident there is the potential for media and the public to be present at the incident scene. Crews must be mindful of this and act accordingly.

4.4. Control Centres

4.4.1. NWAS Emergency Operations Centre (EOC) and EOC Duty Manager

The overarching aim when supervising a control room is to ensure that rapid and effective actions are implemented to save lives, reduce harm and lessen the effects of the incident. Control room supervisors and managers have a responsibility to ensure they are prepared to carry out their role; this includes keeping up to date with policies and

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processes that are used for major incidents. The main responsibilities of the EOC Duty Manager relate to ensuring appropriate levels of resources are deployed to the incident in line with the information received.

Where the incident relates to a fixed site e.g. COMAH, REPPiR, Sports Ground, Airport or other site where a response plan exists, the agreed pre-determined attendance (PDA) should be mobilised and site specific arrangements activated in accordance with that plan or SSQRS. A general PDA is provided to assist the Duty Manager for Major Incident Standby and Declared incidents, to allow assets and personnel to be identified to support the incident commander (see section 7.2).

The EOC Duty Manager will ensure that the designated actions and procedures are followed in line with Action Card 21 and its subsets, plus Appendix A of the Interoperability Framework (JESIP Oct 2021). The EOC Duty Manager will assume the role of 'EOC Operational Commander' as defined in the NARU Command and Control Guidance. The EOC Escalation On-Call Manager will assume the role of 'EOC Tactical Commander' as defined in the NARU Command and Control Guidance.

Through maintaining an overview, the EOC Duty Manager will provide support to the Strategic and Tactical Commander, highlighting any possible problem areas and taking in account of the implications to NWS core business. The EOC will be the main conduit to ensure up to date information and intelligence is disseminated throughout the chain of command.

To assist with maintaining shared situational awareness the EOC Duty Manager should inform other emergency services' control rooms following declaration of a major incident/standby. A dedicated Emergency Services Inter-Control (ESICTRL) Talkgroup exists that is monitored 24/7 by all control rooms within the North West Region from all emergency services. This talkgroup should be the primary method of initial notification to Emergency Services partners control rooms, of a major Incident and/or critical incidents and for sharing situational updates in the M/ETHANE format, in order to deliver a coordinated response. (JESIP Emergency Services Inter Control Talkgroup July 2020). (Policing, 2020)

4.4.2. Dynamically Controlled Access Zone (DCAZ)

The Computer Aided Dispatch (CAD) System utilised by NWS is called C3. This system contains a dynamic tool that can assist NWS in the management of potential or actual major incidents.

C3 has the capacity to allow the EOC team to apply a controlled dispatch zone to an incident or incidents that then enables an overarching and dedicated ability to manage incidents or pre-planned events more effectively and safely. DCAZ are designed to be applied rapidly by an EOC Manager – it is not an IM&T function but is controlled by user access privileges.

DCAZ key points:

- Allows the creation of a customised control zone for a specific incident, especially those that involve ongoing risk to responders.
- DCAZ areas will help manage both spontaneous incidents and pre-planned events.

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- When created, ALL waiting and active incidents that are within the DCAZ are removed from the normal geographic zone. A nominated person must always monitor the DCAZ zone to ensure no incidents are missed.
- The DCAZ will suspend the automatic notification of any NWS Community First Responders within the DCAZ area.
- The DCAZ will notify the dispatcher of any NWS resource entering the DCAZ or routed to do so.
- Allows the EOC Dispatch Desks to focus on incidents that are not associated with the DCAZ incident/event.
- DCAZ Zones must be deactivated upon the conclusion of the incident/event to ensure that no incidents are routed to a dispatch zone that is no longer monitored.

The DCAZ functionality within C3 should be considered by the EOC Duty Manager. It is important to remember that the use of DCAZ is only authorised by the Strategic Commander.

4.4.3. Major Incident Suites

NWS has three Major Incident Suites available to provide support to a major incident. These centres are located alongside the area EOCs and will be activated by the EOC Duty Manager should an incident occur within their geographic area. As a minimum the functionality of the equipment held in the Major Incident Suites is to be tested every 3 months.

The Strategic Commander, if not attending a multi-agency Strategic Coordinating Group, will be based in the appropriate area Major Incident Suite or EOC.

A Support Team drawn from NWS directorate leads (e.g. Fleet Care, Supplies, and IM&T) may be required to support this function, for example:

- The acquisition of ambulance aid, medical equipment, supplies and medical gases.
- 'Staff recall' of additional staff including making arrangements for the relief of staff engaged on the major incident, which may be supported by local rostering departments.
- The provision of all non-patient transport in support of the incident.
- Arrangement for refreshments and food for staff involved in the incident.
- Arrangements for obtaining fuel for vehicles.
- Arrangements for dealing with vehicle breakdowns.

The following are suggested roles that may be present at the Major Incident Suite when convened:

- Risk and Safety
- NWS Press Office
- Information Management, and Technology (IM&T)
- Patient Transport Services (PTS)
- Fleet Care
- Loggist
- Resilience Team representative

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The Major Incident Suite will support large-scale / major incidents within their operating area.

4.4.4. Regional Operational Coordinating Centre (ROCC)

The role of the Regional Operational Coordinating Centre (ROCC) is to provide a regional overview of capacity and resource issues across the Trust (and if applicable national issues). They also provide a liaison role both locally and nationally and can link with a Strategic Coordinating Group (SCG) and Tactical Coordinating Group (TCG) if required by the Strategic Commander.

Primacy over command and control decisions remains with the Strategic Commander for the incident. The ROCC provides support to the Strategic Commander's decisions and requirements. The ROCC is not part of the chain of command but provides a command support function through the ROCC Tactical Commander, in line with the priorities and direction provided by the Strategic Commander. Action Card 25 details the role of the ROCC.

Where a number of separate incidents are on-going and the support of the incidents is within the capacity of the Major Incident Suite, the ROCC will maintain a watching brief and continue to provide strategic support to the Major Incident Suite as required.

NHS strategic resources will be made available to support the NWS Command and Control structures in the event of a major incident being declared. They may be located in the Major Incident Suite or ROCC facilities, but are most likely going to be coordinated through the National Ambulance Coordination Centre (NACC).

4.4.5. Regional Health Control Desk (RHCD)

Upon notification of a major incident, whether Stand-by or declared, the RHCD has the immediate role of following the actions as detailed on the Regional Health Control Desk Action Card (Action Card 24). These include the dissemination of the information to the wider NHS and other designated organisations followed by further actions in line with its normal function of liaison and supporting the patient flow.

One of the routine functions of the RHCD is to regularly monitor hospital capacities. This function will be maintained during a major incident liaising with the NHS command team to enable the transportation of the casualties to the appropriate treatment centre. The information collated should be available on request and regularly updated.

Alerted hospitals should be re-contacted at regular intervals to provide situation updates, irrespective of whether new information is available.

4.4.6. NWS Trauma Cell

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The Trauma Cell offers access to senior clinical advice for Major Trauma incidents to assist pre-hospital clinical decision making where senior clinicians are not already on scene. The Trauma Cell will also support EOC/MERIT by arranging the necessary emergency transport for MERIT Doctors during a Major Incident. It should be noted that during a Major Incident, MERIT should be the primary source of medical advice for commander decision making including utilisation of the Regional Mass Casualty Distribution Plan and selection of appropriate destinations for patients.

4.5. National Coordination

4.5.1. NHS England

NHS England's general EPRR role and responsibilities are to:

- Set a risk based EPRR strategy for the NHS
- Ensure there is a comprehensive NHS EPRR system and assure themselves and DHSC that the system is fit for purpose
- Lead the mobilisation of the NHS in the event of an emergency, in line with the NHS incident response levels (see figure 3)
- Work with UKHSA and DHSC, where appropriate, to develop joint response arrangements
- Undertake its responsibilities as a Category 1 responder under the CCA 2004.

At a regional level NHS England will:

- Provide director level representation at the LHRP
- Ensure that each LHRP is suitably co-chaired by the ICB 26
- As a category 1 responder, ensure suitable representation at the LRF(s)
- Ensure integration of plans across the region to deliver a unified NHS response to incidents, including the provision of surge capacity
- Maintain capacity and capability to coordinate the regional NHS response to an incident 24/7 through effective surge and escalation planning at ICB level
- Work with relevant partners through the LHRP and LRF structures
- Seek assurance through the local LHRP and commissioners that the Core Standards are met and that each ICS can effectively respond to and recover from incidents
- Coordinate and locally endorse any requests from NHS organisations for military assistance
- Provide support to the ICB, as required, to ensure any response to a Major Incident is effective
- Discharge the local NHS England statutory EPRR duties as a Category 1 responder under the CCA 2004 (delegated function).

Please note that the levels described in Figure 3 below should not be confused with those detailed in the NARU Resource Escalation Action Plan.

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Incident response level	
Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

Figure 3 - NHS Incident response levels EPRR 2022

4.5.2. National Ambulance Coordination Centre (NACC)

The Ambulance Service in England has a National Ambulance Coordination Centre (NACC), currently based at West Midlands Ambulance Service HQ, Brierley Hill, West Midlands.

The NACC coordinates the ambulance service response to incidents, events or pre-arranged triggers that have an impact across more than one Trust. The centre's main function is intelligence gathering and production of a 'national picture' within Ambulance Trusts which can be shared between Ambulance Trusts and the DH, NHS England and government departments. The NACC will facilitate mutual aid arrangements between trusts and making sure necessary arrangements to ensure receiving trusts get the appropriate assistance in a timely manner. The NACC will also feedback factors affecting ambulance trusts regarding national policy decisions. For detailed information on the NACC see the NARU NACC Plan 2021.

All requests to activate the NACC must be made by the NWS Strategic Commander by informing both the West Midlands Ambulance Service on call Strategic Commander and the NARU on call officer.

4.6. NWS Major Incident Functional Roles

Should a member of staff be given a role to undertake during a major incident they must follow the relevant action card for that role. Tabards and sliders are available on every frontline DCA and RRV as well as the Incident Support Units and must be worn. Additional information on each role can be found in the NARU National Ambulance Command and Control Guidance (2019). In order to prepare staff for these functions, any exercises and formal training should consider including those roles that will be used in Major and critical incidents. Staff are encouraged to use the Incident Action Cards to enhance their understanding of the roles at day-to-day incidents where

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appropriate. This will reduce skill fade and give crews more confidence at performing their assigned roles during difficult and prolonged incidents.

4.6.1. First Resource on Scene – (Action Card 1)

In the early stages of an incident, the first resources at scene are likely to be in the best position to assess the scale of an incident and the potential need for a wider response. Each NWS DCA and RRV has had a windscreen report placed in the cab to assist the crew with its initial report and remind them of the IOR REMOVE, REMOVE, REMOVE process if it is relevant at the incident.

The first resource on scene, when they have achieved situational awareness of the incident, should assume the role of acting Operational Commander and should wear the appropriate tabard. When they have achieved situational awareness, they should update EOC with a M/ETHANE (see section 7.1) situation report. The acting Operational Commander will stay in position till relieved by a substantiated Operational Commander and will follow the instructions on the First Resource on Scene Action Card. Where there are two NWS staff members on the first resource, the more senior crew member should take on the acting Operational Commander role with the second assisting in the communication link to EOC and meeting further arriving NWS resources.

The acting Operational Commander must not become involved in treating patients but concentrate on establishing initial command and control of the incident. It is important that all individuals who could be first on scene of an incident, are empowered to declare a major incident for their organisation and understand the implications of declaring or not declaring one. (JESIP October 2021)

It is imperative that the acting Operational Commander establishes key functional roles early in the Command and Control of a major incident, such as Parking Officer, Casualty Clearing Officer, etc.

As soon as possible, the Acting Operational Commander should co-locate with commanders from other responding organisations.

4.6.2. Second Resource on Scene – (Action Card 2)

The second resource on scene will be given the function roles of Parking Officer and Casualty Clearing Officer and should switch from action card 2 to action cards 7 and 8 (Parking Officer and Casualty Clearing Officer) as soon as they are briefed. It is vital that an appropriate space is provided for incoming vehicles and equipment is established and an appropriate area sourced for the Casualty Clearing Station.

Where the second resource on scene is a solo responder, they should be given the role of Parking Officer (action card 7) with the next arriving NWS staff member being the role of Casualty Clearing Officer (action card 8).

4.6.3. Subsequent Ambulance Resources – (Action Card 3)

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Staff on subsequent resources on scene will adopt functional roles at the incident if necessary. If other NWS staff are also on scene, for example a Senior Paramedic Team Leader in an RRV, it may be appropriate for them to take on one of the above roles.

All subsequent crews arriving at the scene will report to the Ambulance Parking Point prior to undertaking a role within the incident. These crews will only adopt a casualty triage or treatment role once the Tactical Commander is satisfied that an appropriate level of scene command and control has been established and that it is safe to do so. (Ambulance blue lights switched off except on a 'live' motorway).

It is imperative that the first three vehicles or first six staff on scene establish Command and Control of the incident. They will not become involved in patient triage or treatment until appropriate command and control has been established for the scene.

4.6.4. Primary Triage Officer (Action Card 5)

The Ambulance Primary Triage Officer is responsible for the coordination of triage by all resources including the Hazardous Area Response Team (HART). They will ensure teams of suitably qualified staff will perform a triage sieve of all casualties at the scene of the incident. The Primary Triage Officer will report to the NWS Operational Commander with the number and status of casualties so that appropriate arrangements can be implemented to enable their effective treatment.

Dependent upon the nature of the incident and the area the incident covers, there may be the requirement to have multiple Triage Officers, for example when an incident scene is 'sectorised'. Where this is implemented, the call sign will have numerical suffixes (Triage 1, Triage 2 and so on).

4.6.5. Casualty Clearing Officer (Action Card 8)

The primary responsibility of the Casualty Clearing Officer is the management of all activities within the Casualty Clearing Station (CCS); to include the triage and treatment of casualties in liaison with the Casualty Clearing Station Medical Lead (CCSML) and NWS Loading Officer to ensure that casualties are despatched to hospital appropriate to their priority. The Casualty Clearing Officer will establish an appropriate safe location for the CCS and Casualty Loading Point as the two locations must work in conjunction. The infrastructure for the establishment of the CCS (if there isn't a suitable building which can be utilised) will come from the incident support fleet. If these vehicles have not already been mobilised to scene, then the Casualty Clearing Officer can request their attendance so that their tentage, lighting and heating can be deployed.

The Casualty Clearing Officer will provide regular updates to the NWS Operational Commander with regards to the numbers and status of casualties within the Casualty Clearing Station and the number of casualties despatched from the incident site to a receiving hospital. The Casualty Clearing Officer is responsible for completing correct documentation of patients moved from the CCS. This is done using the tear-off strip from the SMART Triage cards.

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In a dynamic multiple casualty incident, it may only be possible to maintain accurate details on the numbers and status of casualties who have undergone treatment and have left scene for hospital. A 'best estimate' may therefore be necessary for those casualties still within the Casualty Clearing Station.

In order to ensure that casualty data is shared effectively, particularly for the purpose of the Police Casualty Bureau, it may be advantageous for a Police Officer to be co-located alongside the Casualty Clearing Officer or Loading Officer.

The Casualty Clearing Officer should take responsibility for liaison with the CCSML, Loading Officer and the NWS Trauma Cell to ensure the correct distribution of casualties to the most appropriate specialist units. The NWS Combined Regional Mass Casualty Distribution Plan, developed in conjunction with NHS England and the Regional Trauma Network, will help to inform NWS commanders and MERIT doctors on the most suitable route and location for the distribution of casualties from a major incident (NWS, 2020).

4.6.6. Secondary Triage Officer (Action Card 6)

The NWS Secondary Triage Officer is responsible for the coordination of triage of casualties (Triage Sort) within the Casualty Clearing Station and /or other suitable holding area for casualties that have been evacuated from the immediate incident scene.

The Secondary Triage Officer *will not* routinely become actively involved with the clinical treatment of casualties but will concentrate on the continued triage sort of casualties thereby ensuring the most appropriate casualty is transported from the incident at the most appropriate time.

4.6.7. Parking Officer (Action Card 7)

The NWS Parking Officer is responsible for the establishment and management of a suitable and safe parking area for ambulance service vehicles arriving at the scene or Rendezvous Point (RVP). The Parking Officer will brief staff on the key locations and any hazards prior to mobilising vehicles from the RVP to the Loading Point when required.

4.6.8. Loading Officer (Action Card 16)

In liaison with the Casualty Clearing Officer, the Loading Officer is responsible for ensuring the appropriate and effective loading of casualties from Casualty Clearing Station (CCS) on to the next available appropriate vehicle.

The Loading Officer will advise on the suitability of the Casualty Loading Point at the CCS and will work closely with EOC and the Parking Officer to maintain an adequate throughput of ambulances (and/or equipment) to the CCS. This role will also have responsibility for the identification of patients suitable for air evacuation following discussions with the CCS Medical Lead.

The Loading Officer will ensure that all patients leaving scene have a triage tag attached and that a record is maintained of all patient movements on the Casualty Loading Point Log.

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4.6.9. Equipment Officer (Action Card 9)

The deployment of an Equipment Officer should be considered for protracted incidents that will require an uplift or resupply of equipment, as well as critical and Major Incidents that include the deployment of national assets or Major Incident Support Units. Through liaison with NWAS Operational Commander, the Equipment Officer is responsible for the distribution of ambulance equipment at the scene and arranging for any resupply throughout the incident. The Equipment Officer is also responsible for the recovery of ambulance equipment from the scene and designated receiving hospitals (in conjunction with the Hospital Ambulance Liaison Officer).

Equipment can be sourced from ambulance vehicles already on scene (if not immediately required as conveying vehicles), the Incident Support Fleet and National Capabilities Mass Casualty Vehicles (NCMCV), HART fleet, Rapid Response Vehicles, and bulk stores requested from ambulance stations or central stores.

Movements and issue of equipment should be recorded as far as possible on the Equipment Log (provided on Action Card 9A) to aid retrieval or restocking later. This role can request the mobilisation of ISUs if not already dispatched to scene and has the responsibility for ensuring that all equipment (and clinical waste) is removed from the scene after the incident has been stood down.

4.6.10. Safety Officer (Action Card 10)

In liaison with the Operational Commander, the Safety Officer is responsible for ensuring that the environment and working practices of all ambulance and medical personnel involved with the incident are not placed at undue risk. Once it is deemed appropriate to deploy a Safety Officer, the EOC will identify a trained individual through the use of the NWAS Computer Aided Dispatch (CAD) who will be deployed to the incident.

The Safety Officer will also monitor the welfare of all ambulance and medical personnel throughout the incident, observing staff for signs of stress and/or fatigue and by ensuring that appropriate levels of Personal Protective Equipment (PPE) are always worn.

The Safety Officer will liaise directly with the HART Team Leader and Safety Officers of other emergency services to ensure that ambulance or medical personnel do not enter hazardous areas which exceed their level of training or PPE.

Although all ambulance responders at the scene are required to assess their own safety constantly (using DORA/ERICPD tools) the Safety Officer will maintain a wider view and work with other services to maintain a shared understanding of risk and work with the Operational Commander, Parking Officer and Tactical Advisor/NILO to maintain a safe working environment as far as practically possible given the type of incident being dealt with.

The Safety Officer will brief the Parking Officer at the Parking Point and monitor the welfare of all staff (looking for injuries and signs of fatigue, heat or cold exposure or psychological reactions) as far as possible. Any concerns or unsafe practices should be notified to the Operational Commander who can include these in their decision making and risk mitigation.

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4.6.11. Hazardous Area Response Team Leader (HART) (Action Card 33)

In liaison with the Operational Commander, the Hazardous Area Response Team (HART) team leader is responsible for ensuring that the full capabilities of the HART response are known and factored into operational plans. As such and where appropriate, they should join the Operational Commander at multi-agency meetings and may be required to liaise directly with the Tactical Advisor / NILO around other capabilities on scene.

The HART team leader will monitor the welfare of all ambulance and medical personnel within the inner cordon throughout the incident, observing staff for signs of stress and/or fatigue and by ensuring that appropriate levels of Personal Protective Equipment (PPE) are always worn. They may establish an inner cordon safety log and will ensure HART and SORT staff deployed into a hazardous environment receive an IIMARCH briefing including Actions On and Generic Rescue Plans.

Where necessary consideration should be given to the use of the HART command structure from the 2nd HART team, training team or mutual aid for neighbouring Trusts. Additionally, an exit plan should be discussed with the Operational Commander for incidents that are not HART specific or reduce in risk to no longer requiring HART attendance.

4.6.12. Hospital Ambulance Liaison Officer (HALO) (Action Card 15)

A Hospital Ambulance Liaison Officer (HALO) will be deployed by the RHCD and will attend each designated receiving hospital and will become the conduit between an incident site and the hospital emergency department. The HALO will establish links with a number of personnel in different locations which may include the following:

- The Hospital Emergency Department Officer (or similar role)
- The Hospital Command Team (likely to be located in the Incident Co-ordination Centre ICC)
- The Police Casualty Bureau Officer (if present).

They will ensure that relevant information is passed to the EOC, the Tactical Commander and the Police (Casualty Bureau). Where resources allow, the HALOs will be managed on a separate talkgroup within EOC.

The HALO will not become involved in the treatment of casualties arriving at the emergency departments but will maintain a log of patients arriving at the hospital and ensure a quick turn round of vehicles. The HALO will also ensure that the welfare requirements of staff are met prior to returning to the scene.

This role will also perform a vital role in liaising with clinical staff at the hospital should a request for specialist medical resources (e.g. surgeons, anaesthetists) or bulk medical supplies be received from the scene. The need for this role may persist after a 'scene clear' message is received as there may be a number of secondary (inter-hospital) transfers to arrange and the presence of a HALO will prove beneficial in these circumstances and also to maintain a watch on ambulance staff welfare.

4.6.13. Patient Transport Services First on Scene (Action Card 27)

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It is unlikely that a PTS crew will be the first resource on scene, however in the rare case that it does occur, all PTS crews must be trained to be able to assess the scale of the incident and the potential need for further assets to be deployed. Action Card 27 is designed to assist any PTS crews that find themselves dealing with an incident of such complexity that they require further advice from PTS Control. The passing of an initial 'ETHANE' report which removes the need for any consideration of declaration of a major incident is essential so that PTS Control can relay to the appropriate EOC to allow additional deployment or declaration decisions to be made. A handover to the first Paramedic Emergency Services (PES) crew or ambulance officer should be given upon their arrival. Patient Transport Service resources can be called upon (subject to contractual restrictions as a commissioned service) to provide additional, non-emergency patient or logistics transport. PES crews need to be aware that PTS crews are not normally issued with Airwave handsets, but these can be requested through the Broughton EOC Duty Manager, where the Trust retain 20 terminals in line with national policy for use in Major Incidents. EOC procedure (NWAS EOC Airwave Procedure EOC-ARP-0010, 2020) Terminals Management will provide the relevant details including the issue and release process.

4.6.14. Patient Transport Service (PTS) Managers

In the event of a major or critical incident occurring at a time when the Trust's PTS Managers are on duty, consideration should be given by the Tactical Commander in consultation with EOC Duty Manager and if appropriate, the Strategic Commander, to utilise the skills and qualities of these managers, specifically in key roles such as the HALO role at a receiving hospital familiar to that manager. These managers are familiar with the movement of large numbers of patients and with the assistance of the HALO action card will be effective in this role.

The logistical movement of 'after treatment' casualties (those who have been involved in the incident, have received treatment at the hospital and require further medical assistance to return to home or to a further treatment centre) may be achieved in consultation with the PTS Managers at the hospital. This may involve the re-allocation or cancelling of planned journeys and transfers, to accommodate the demands of the consequences of the major or critical incident.

The Tactical Commander in consultation with the EOC manager should consider the need for PTS resources during the response and recovery stages of a major/critical incident, including personnel and vehicles. The final authorisation for using PTS resources will be the responsibility of the Strategic Commander

In addition, PTS staff may be utilised to provide transportation of 'ambulant cases' from the incident, using PTS vehicles with a larger capacity than PES vehicles, subject to availability.

4.7. Medical Support

4.7.1. Medical Emergency Response Incident Team (MERIT)

MERIT Doctors are a critical command support function that work directly alongside the Tactical Advisor/NILO cadre. The primary role of MERIT is to provide the NWAS on-call command structure with medico-legal advice during major, critical, or complex incidents.

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MERIT Doctors have received additional specialist training to undertake the roles of:

- Strategic Medical Advisor (Strategic)
- Medical Advisor (Tactical)
- Forward Doctor (Operational)
- Casualty Clearing Station Medical Lead (Operational)

MERIT Doctors are notified of an incident by the EOC Duty Manager (Action Card 21) /Critical Incident Manager (Action card 21a) under procedure EOC0069. MERIT Doctor 1 determines if an additional Doctor is needed (MERIT Doctor 2), and what medical role they will undertake. MERIT is predominantly a remote medico-legal advice role, however, if mobilisation is requested, deployment is arranged by the Trauma Cell Advanced Paramedic under procedure EOC0069.

4.7.2. Strategic Medical Advisor (SMA) (Action Card 28)

Strategic Medical Advisor is a command support role that is principally responsible for providing medico-legal advice to NWS Strategic Command. The role of the Strategic Medical Advisor is undertaken by the trust Medical Director or an Associate Medical Director and is co-located with the NWS Strategic Commander.

The Strategic Medical Advisor primary responsibilities are to:

- Provide medico-legal advice to the Strategic Commander in the event of a major, critical or complex incident
- Ensure that the Medical Advisor (Tactical) has access to the required medical resources, and monitors overall hospital capacity
- Provide a medical liaison function for national strategic partners
- Support the Strategic Commander in the event of national medical mutual aid requests from other sectors of the NHS.

The Strategic Medical Advisor can be used for situations such as saturation of the NWS combined Mass Casualty Distribution Plan. Strategic Medical Advisor support can be requested by the NWS Strategic Commander or Medical Advisor (Tactical). The Strategic Medical Advisor will be notified by the Emergency Operations Room (EOC) Duty Manager, or as part of the NWS Pre-Determined Attendance (PDA) framework.

4.7.3. Medical Advisor (Tactical) (Action Card 17)

Medical Advisor (Tactical) is a command support role that is co-located with the NWS Tactical Commander and National Interagency Liaison Officer Tactical Advisor/NILO. It is the responsibility of the EOC Duty Manager / Critical Incident Manager to notify MERIT Doctor 1 for major, critical and complex incidents, or alternatively, at the request of the NWS Tactical Commander, or as determined by the NWS PDA framework.

NWS MERIT provides a Medical Advisor (Tactical) and Forward Doctor/Casualty Clearing Station Medical Lead (CCSML) (Operational) which are additional to the Strategic Medical Advisor. MERIT Doctor 1 determines who will

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undertake the role of Medical Advisor, Forward Doctor, or CCSML. Role allocation will be determined by each Doctors proximity to the incident and the location of the Ambulance Tactical Commander.

The Medical Advisor's primary responsibilities are to:

- Provide medico-legal advice to the NWS Tactical Commander on the use of specialist medical assets.
- Ensure the Forward Doctor/CCSML (Operational) has the medical assets required for the duration of the incident
- Assume overall responsibility for casualty distribution once a full handover has been received from the Casualty Clearing Officer.
- Provide the Forward Doctor/CCSML and Casualty Clearing Officer with advice in the form of a 'critical friend' in order to support clinical decision making.
- Be the responsible officer for casualty distribution, with the Casualty Clearing Officer, to appropriate medical facilities from the incident using the NWS combined Mass Casualty Distribution Plan.
- Achieve open dialogue with the receiving hospital(s)
- Ensure the Tactical Commander is appraised of casualty distribution decisions
- Establish communication and be the lead Medic where multiple Doctors (both internal and external) are deployed to an incident
- Liaise with Police and multiagency partners to support Disaster Victim Identification (DVI) processes.

4.7.4. Forward Doctor (Operational)(Action card 18)

The Forward Doctor (Operational) is a command support role, co-locating with, and providing medico-legal advice to the Operational Commander and National Interagency Liaison Officer Tactical Advisor/NILO.

The Forward Doctor will be notified for major, critical and complex incidents by the Medical Advisor (Tactical). They can also be contacted at the request the Operational Commander, or as determined by the NWS PDA framework.

The Forward Doctor's primary responsibilities are to:

- Coordinate and direct clinical care in order to support the Casualty Clearing Officer
- Be the on-scene single point of contact where multiple Doctors are deployed at an incident
- Communicate directly with the Medical Advisor (Tactical) to advise upon the condition of individual casualties to order to inform the Medical Advisors rational for casualty distribution.
- Request specialist medical teams or equipment if required
- Identify to the Medical Advisor when relief of medical teams might be indicated.
- Ensure that casualties have been effectively triaged and are receiving an appropriate treatment regime.
- Ensure all clinical records are completed
- Source medical advice from the Medical Advisor in the form of a 'critical friend' in order to support clinical decision making.
- Support decisions regarding Recognition of Life Extinct (ROLE)

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4.7.5. Casualty Clearing Station Medical Lead (CCSML) (Operational) (Action card 26)

The Casualty Clearing Station Medical Lead (CCSML) (Operational) is a functional role and works directly alongside the Casualty Clearing Officer at a Casualty Clearing Station. The role of the CCSML can be undertaken by the Forward Doctor, or allocated to an additional MERIT Doctor if deemed necessary by the Medical Advisor (Tactical). A CCSML can be requested by the Medical Advisor (Tactical) or Operations Commander via the Complex Incident Manager and deployed using procedure EOC0069.

The CCSML primary responsibilities are to:

- Ensure casualties have been effectively triaged and are receiving an appropriate treatment regime.
- Coordinate, support and advise Paramedics and medical staff in the Casualty Clearing Station, to maximise the clinical care of all patients attending the CCS and appropriate onward journey to specialist receiving hospitals.
- Coordinate and direct clinical care at the CCS in order to support the Casualty Clearing Officer
- Be the on-scene single point of contact where multiple Doctors are deployed at an incident
- Communicate directly with the Medical Advisor (Tactical) to advise upon the condition of individual casualties in order to inform the Medical Advisors rational for casualty distribution.
- Request specialist medical teams or equipment if required
- Identify to the Medical Advisor (Tactical) when relief of medical teams might be indicated.
- Ensure that casualties have been effectively triaged and are receiving an appropriate treatment regime.
- Ensure all clinical records are completed
- Source medical advice from the Medical Advisor in the form of a 'critical friend' in order to support clinical decision making.
- Support decisions regarding Recognition of Life Extinct (ROLE)

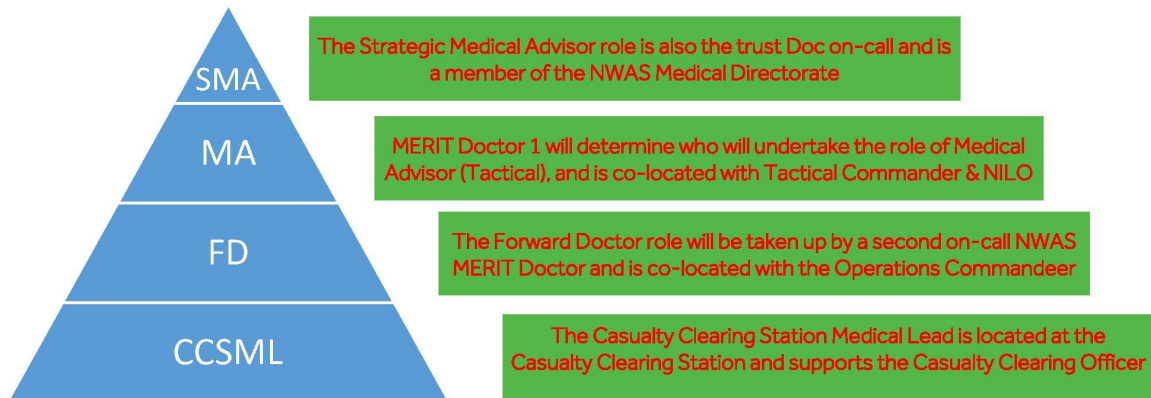


Figure 4 - Medical Team Command Schematic

The above medical roles of Strategic Medical Advisor, Medical Advisor, Forward Doctor and Casualty Clearing Station Medical Lead (CCSML) have been structured using the following schematic.

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4.7.6. Incident Command Tabards

In order to ensure that appropriate roles are easily identifiable to NWS staff and commanders from other services arriving at the scene of an incident, NWS utilise the Incident Command tabards shown in Figure 5 overleaf. The wearing of tabards should be considered for any incident where it is necessary for the commander to be identifiable.

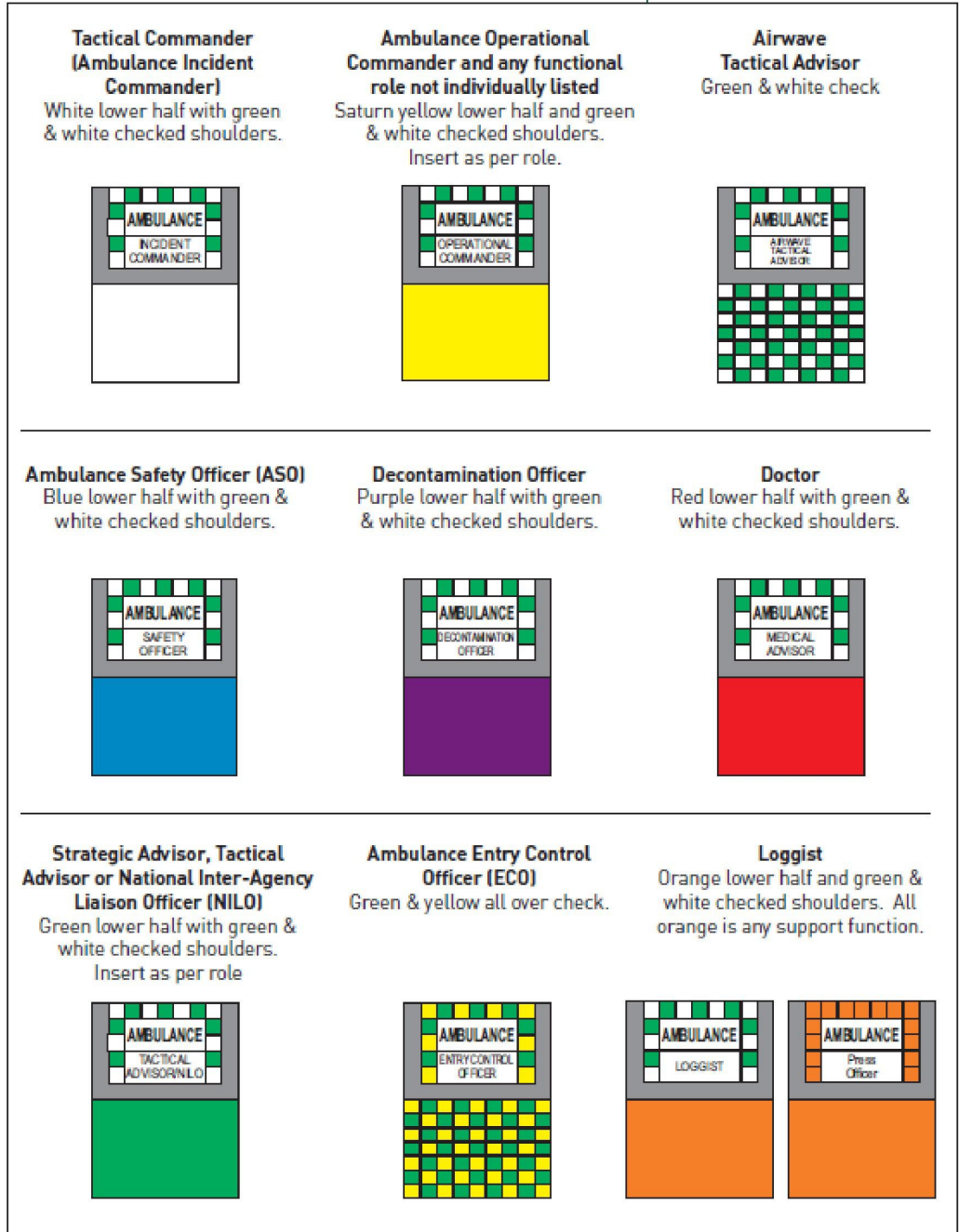


Figure 5 - Incident Command Tabards (NARU, 2019)

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4.8. Department Responses

4.8.1. Information Management & Technology

The ICT department will support the trust response to an incident either in hours via ICT SMT lead or out of hours through ICT SMT escalation on call. Support of the event will be from one of the HQ sites or from a remote location with appropriate system connectivity. ICT role will be directed for both the incident and the delivery of normal 999/111/PTS service through the ICT SMT lead.

4.8.2. Fleet Department

Fleet Department will be available to provide mechanics and technicians to maintain vehicles and generators during the response phase of a major incident and following the stand down to maximise vehicle availability.

4.8.3. Risk & Assurance and Health, Safety & Security Teams

The Risk and Assurance Team may provide additional incident management support including:

Operational and strategic risk management, including risks identified on the Corporate and Commercially Sensitive Risk Register

- Risk assurance
- Assurance reporting

The Health, Safety & Security team have provided further publications within the Health and Safety Toolkit, which can be accessed through the Green room, that can provide support to commanders. This includes guidance on dealing with suspicious packages and bomb threat procedures.

4.8.4. Medical Directorate

The Medical Directorate may provide additional incident management support including:

- Advice on clinical protocols, capacity and consent and management of deaths.
- Medicine management issues including sourcing of additional supplies etc.
- Patient Safety Management including infection prevention and control and child protection (may be of significant relevance in situations involving 'vulnerable' groups)

The Medical Directorate can be contacted via the "Doc on-call" system.

Consideration should be given by the Strategic Commander for the most appropriate use of resources that may be available at the times of response and recovery stages.

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4.9. Decision Making and Logging

Commanders are responsible for the recording of all decisions that they make in relation to an incident in their decision log. Comprehensive logging should be made of all events, decisions, rationale, and actions taken. Logging is essential to facilitate operational debriefing, and to provide evidence for inquiries and identify lessons for the future.

NWAS operates an on call Loggist structure with additional Loggist support available across departments through a cadre of staff trained to national standards. All commanders are also issued with Pocket Books, Incident Decision Logs and Dictaphones.

To facilitate decision making at all command levels, NWAS commanders will utilise The Joint Decision Model (JDM).

4.9.1. The Joint Decision Model (JDM)

JESIP has identified that a wide range of decision-making models exist, including specific models used by the individual emergency services. Such models exist to practically support decision makers working under difficult circumstances and a guiding principle is that they should not be over complicated. One of the difficulties facing commanders from different organisations in a joint emergency response is how to bring together the available information, reconcile objectives and then make effective decisions together. This in turn will help establish shared situational awareness, thereby allowing a Common Operating Picture (COP) to be developed. The JDM, shown at Figure 6, has been developed to enable this to happen and JESIP recommends that during an incident the multi-agency commanders utilise it to assist with decision-making.

In common with most decision models, the JDM is organised around three primary considerations:

Situation: what is happening, what are the impacts, what are the risks, what might happen and what is being done about it? Situational awareness is having an appropriate knowledge of these factors.

Direction: what end state is desired, what are the aims and objectives of the emergency response and what overarching values, and priorities will inform and guide this?

Action: what needs to be decided and what needs to be done to resolve the situation and achieve the desired end state?

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Figure 6 - The Joint Decision Model (JESIP Joint doctrine Edition 3 2021)

All NWS on call commanders have undertaken the appropriate JESIP Command Course and will be subject to regular ongoing refresher training.

Further detailed information on the Joint Decision Model can be found within the Joint Doctrine: The Interoperability Framework available at <http://www.jesip.org.uk/>

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5. Safety

5.1. Incident Health and Safety

The Ambulance Service has overall responsibility for all healthcare personnel at the scene of a major or critical incident (including any voluntary aid staff working under NWAS direction). The Operational Commander must appoint an appropriate person who ideally has the necessary training, experience and knowledge as the Ambulance Safety Officer early in the Command and Control set up to ensure that health, safety and welfare of all medical personnel are observed.

The Ambulance Safety Officer should be aware of the potential hazards at scene, ensuring that appropriate equipment is available, monitoring environmental conditions, record any actions taken and ensure all personnel are wearing the appropriate PPE.

The Safety Officer, assisted by the Parking Officer, will ensure that before deployment to the incident scene, all responders are given a safety briefing. Where possible, the Ambulance Safety Officer should work alongside the Safety Officers from other agencies.

5.2. STEP 1-2-3

Whilst all responders will have been given an initial safety briefing prior to deployment at a major incident, ambulance staff must still be aware of other potential hazards on their approach to the incident scene. Staff should employ the STEP 1-2-3 (Safety Triggers for Emergency Personnel).

This protocol relates to multiple casualties resulting from an unknown cause. STEP 1-2-3 should also be used by the first resource deployed to the scene of any incident as part of their Dynamic Risk Assessment (DRA).

5.2.1. STEP 1-2-3

Step 1 – One casualty: Approach using caution.

Step 2 – Two casualties: Approach with caution, consider all options, do not discount anything, report on arrival and update control.

Step 3 – Three casualties or more with no logical explanation or cause: DO NOT approach the scene: withdraw, contain, report, and isolate yourself, SEND FOR SPECIALIST HELP.

5.2.2. STEP 1-2-3-Plus

It should be noted that there are additional actions (STEP 1-2-3 PLUS) for the Initial Operational Response to a CBRN/HAZMAT Incident (IOR). The refreshed Initial Operational Response (IOR) messaging 'REMOVE, REMOVE, REMOVE' provides emergency services personnel with essential safety and first aid advice. (Cabinet Office July 2015). It can be used to support control rooms, planners and first responders on early self-help actions for:

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- Suspected deliberate or accidental exposure to a hazardous substance (vapour, powder, or liquid)
- An acid attack.

All NWS Paramedic Emergency Service staff have received IOR training as part of the NWS Mandatory Training Programme. A windscreen report highlighting the initial IOR process has been placed in each NWS Ambulance cab to assist the crews.

5.3. Dynamic Risk Assessment (DRA) / Hierarchy of Control Measures

A Dynamic Risk Assessment (DRA) is a process for assessing risk; it is a continuous thought process as shown in Figure 7. When selecting a safe system of work utilise the control in a hierarchical order to control risks present at an incident:

- Eliminate
- Reduce
- Isolate
- Control
- PPE
- Discipline

It can be remembered using the mnemonic **ERICPD**. Those undertaking a DRA should ensure that its detail is logged.

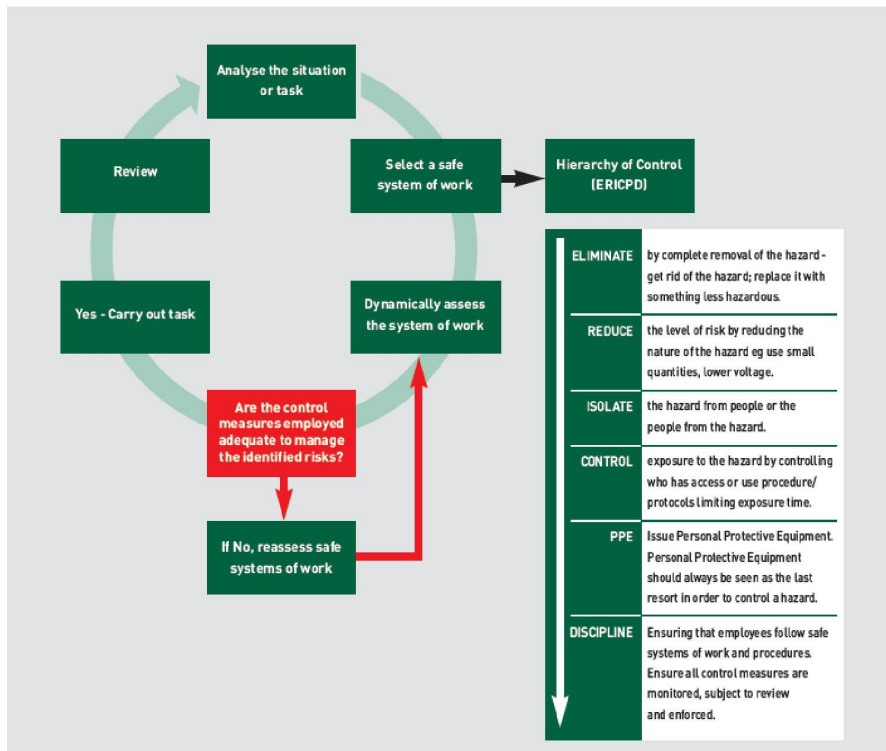


Figure 7 – Assessment/Hierarchy of Control (NARU Command and Control Guidance 2019, Version 3.0)

Dynamic Risk

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5.4. Personal Protective Equipment (PPE)

Safety helmets and high visibility jackets must be worn correctly to ensure they provide suitable and sufficient reflective and protective qualities. In addition, service issue footwear must be worn at the incident site. Specific incidents may require specialist PPE and only individuals trained in its use should employ such measures. Ear pieces must be available to assist crews in busy and noisy environments and to ensure no sensitive information can be overheard by non-authorized individuals.

All staff attending the incident scene or command location should be in possession of an official NWS identity card. Failure to provide proof of ID may result in denial of access through the outer cordon or to an official building.

Any ambulance or medical personnel, regardless of status, who arrive at the incident site, will only be allowed to work in an area to which they have the appropriate level of PPE.

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6. Communications

6.1. Communication Discipline

It is imperative that for an incident to run as smoothly as possible, all Commanders and officers show discipline to keep communications within the appropriate line of command. For example, the Strategic Commander should not contact the Operational Commander directly, nor should any of the functional role officers contact the Tactical Commander.

Correct use of communications etiquette will ensure messages are passed effectively and efficiently. Communications should adhere to the ABCD model:

- A – Accuracy messages detail must be accurate
- B – Brevity messages should be kept as brief as possible
- C – Clarity messages should be clear with no ambiguous terms or complex jargon
- D – Discipline users should always maintain discipline and professionalism during communication.

6.2. Incident Communications

The NWS EOC will designate an appropriate Airwave Talkgroup for use in the initial stages of the incident as well as a telephone number for inbound calls into the EOC (as per Action Card 21).

The pre-designated Major Incident Talkgroups for each Area are:

Cheshire & Merseyside	Quick Dial	I&S
Cumbria & Lancashire	Quick Dial	
Greater Manchester	Quick Dial	

These talkgroups will be operated 'open channel' i.e. both point-to-point and airwave telephony must be avoided to ensure shared situational awareness and reduced impact on airwave network capacity.

6.3. Communication with other emergency responders

It must be remembered that incident command does not begin when the first staff or commanders arrive on scene; it begins when the first call is received into the Emergency Operations Centre. Communication with other emergency responders in the early stages is vital to help embed the JESIP principles of communication, co-ordination, joint understanding of risk and, ultimately, shared situational awareness into any incident from the outset.

Information must be shared with partner agencies by EOC using the M/ETHANE format as soon as possible and ensure that any updates are also shared as the incident progresses.

The EOC Duty Manager must ensure that Major Incident declarations and M/ETHANE reports/updates are shared with partners via the Emergency Services Inter-Control (ESICTRL) Airwave Talkgroup. This is a designated

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talkgroup for use between all control centres from all emergency services. It is monitored 24/7 by all control rooms including all 3 NWS EOCs and is tested daily with all partners.

6.4. Airwave capacity management in major incidents

All emergency services utilise the same Airwave network and therefore capacity on that network is shared by all partner agencies – NWS EOC and Commanders must be cognisant of our impact on that capacity and ensure we minimise that impact as much as possible.

NWS EOCs should nominate a major incident talkgroup for the incident. All responding vehicles should switch to this talkgroup upon mobilisation (no other talkgroups should be monitored by the responding vehicles) and the Operational Commander should liaise with EOC to agree a communications plan. If necessary, EOC may utilise 'TMO push' to switch responding vehicles to the appropriate talkgroup (although this function only works on one radio at a time so wherever possible resources should be encouraged to change their own talkgroup – exceptions would include solo responders and commanders who cannot change talkgroup whilst driving).

Point-to-point and telephony functions should be avoided wherever possible and incident talkgroups used 'open channel'. This increases shared situational awareness with other users on the same talkgroup as well as reducing capacity usage on the network.

Commanders should consider the use of 'DMO' (Direct Mode Operation) to enable resources to communicate with each other at scene 'back-to-back' – this may be useful when signal is poor; capacity is reached or there is a network fault which means a 'normal' talkgroup cannot be used.

Commanders and EOC should consider activating a Communications Tactical Advisor (CTA) who can advise and support with advice on talkgroup usage and capacity management as well as liaise with their counterpart CTAs in partner agencies. CTAs can also liaise with the Airwave National Monitoring Centre (NMC) for information gathering and issue resolution.

In order to safeguard the Airwave cell capacity, staff not involved in the response to the incident should not monitor talkgroups in use at the incident.

The decision for the use of the NWS Airwave radios sets designated for use by other NHS staff and supporting medical agencies such as the Voluntary Aid Societies in a major incident scenario lies with the Tactical Commander. These are located on Incident Support Units.

Airwave maintain a national stock of terminals that are available should the need arise in major incidents and can be released following communications with the Airwave National Management Centre (NMC). This authorisation should be instigated through the NWS Support Centre, and the handsets are located within the server room at Broughton EOC. (NWS EOC Airwave Procedure EOC-ARP-0010, 2020) provides the detail regarding issue and authority.

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Dependent on the incident location the Police Service may have the ability to monitor the on-going usage of the airwave cells through Airwave Insite software.

6.5. Airwave Multi-agency Interoperability

Multi-agency interoperability allows the Tactical/Operational Commanders and control rooms to communicate with counterparts from other emergency services.

Airwave is an effective tool (where face to face is not practical) as a means of interoperable communications. Identification of an appropriate interoperability talk-group should be an early consideration for Operational and Tactical Commanders.

Multi-agency interoperability should be initiated by EOC as soon as possible via the Emergency Services Inter-Control (ESICTRL) talkgroup.

Standard Operating Procedures have been agreed by all five LRF groups within the North West in relation to Airwave Interoperability which pre-designates the activation process and talk-groups to be utilised. Any organisation can request this facility via the police.

In addition, regular testing of the interoperability talk-groups takes place between the region's blue light services and involves both EOC and on call commanders.

The pre-identified interoperability talkgroups for the North West Region are:

- IC1 = Multi Agency Interoperability Talkgroup for Tactical Commanders
- ES1, ES2, ES3 = Multi Agency Interoperability Talkgroups for Operational Commanders

Cheshire & Merseyside			Cumbria & Lancashire			Manchester		
TGRP	Quick Dial*		TGRP	Quick Dial*		TGRP	Quick Dial*	
	MER	CHE		LANC	CUMB			
IC1	I&S		IC1	I&S		IC1	I&S	
ES1								
ES2								
ES3								

Figure 8 - North West Interoperability Talkgroups

*It should be noted that the 'quick dial' numbers are specific to NWS and will not be the same for other agencies.

Should commanders be required to monitor both an NWS incident talkgroup and an interoperability talkgroup then they should give due consideration to their capacity and consider requesting support from a second person to co-locate with them and monitor the second talkgroup (e.g. another commander or an ambulance crew member at scene).

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6.6. Mobile Phones

Although mobile phones aid NWS in daily operations, their use in major incidents must be limited to communications between the Strategic and Tactical Commanders unless an emergency arises. Any communication done this way must be logged as mobile phone conversations will not be recorded.

Only the Tactical Commander or Operational Commander should have direct contact with EOC during an incident. All other managers not involved in the incident must refrain from contacting EOC or the Tactical / Operational Commanders. Deviating from this procedure may seriously compromise the effective management of the incident.

6.7. CASCADE and Staff Recall to Duty

Experience from previous large-scale incidents has demonstrated the willingness of off-duty staff from across all Trust departments to return to work in support of the NWS response. Whilst it may sometimes be necessary to recall staff to duty either in support of the incident response or to support the ongoing day to day workload, it is essential that this is carried out in a coordinated manner.

The CASCADE system is a platform that allows for messages to be sent to large groups of staff simultaneously as well as recording offers of assistance from off-duty staff. CASCADE has two key elements: Recall to Duty and Incident Notifications.

Recall to duty will be coordinated by the Regional Operations Coordination Centre (ROCC) under the instruction of the Strategic Commander. Not all CASCADEs will involve large numbers of staff and there will be occasions where commanders use CASCADE to communicate with specific staff groups/roles and then manage the offers of help either locally or through the ROCC without activating the full 111 team.

When activated, CASCADE notifications will go out simultaneously via SMS text message, pager message and email. If the Strategic Commander authorises a CASCADE for a recall to duty, then 111 personnel will staff a dedicated 'CASCADE Line' for offers of support from off duty staff with a fixed number:

DPA

The 111 staff will record all offers of support within the CASCADE system and this will present to the commanders via a dashboard from which they can then coordinate which offers of support they require and then provide the staff with further information/instructions.

Incident Notifications will be coordinated by Emergency Operations Centre (EOC). EOC can utilise the CASCADE system to send a notification message of a declared major incident to the wider-area command teams via a simultaneous SMS text, pager message and email.

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It is essential that staff do not self-deploy to an incident

General points for consideration by all staff when volunteering to return to work include:

- Overriding principle of 'do not self-deploy'. You may not be required immediately or where you think you should go to. RVPs may be established for safety or wider holding areas. Self-deployments create a staff welfare issue in that NWS may not know of your intentions, location, status, and this increases personal risk. You may inadvertently cross a cordon or into an unsafe area. This may also create liability and insurance issues for the Trust.
- Commanders must not go straight to scene unless directed to do so – monitor your normal Airwave talkgroup for instructions or wait call from EOC
- Do not overwhelm EOC with calls asking what to do – they will be inundated with other contacts
- Do watch/listen to the broadcast media news feeds and check official NWS Social Media feeds and website for specific instructions on how to volunteer and who to call for information
- Do not take an NWS vehicle without being directed to do so by EOC/NWS Commander
- If on duty on a vehicle await deployment instructions and watch out for bulletin board messages
- Consider that you may be required to support a longer-term response to a protracted incident so standing by or getting some rest can be essential preparation to be called the next or subsequent days
- Do not take a PTS vehicle without being told to and if such a resource is used officially, ensure it is returned to its home station in a fuelled, stocked and cleaned condition ready for its next period of duty
- Do not volunteer for duty if you are due on shift in the next 12 hours or have finished your previous shift within the last 12 hours for PES staff
- If already on duty, EOC will monitor any extensions to shift but note that staying on duty over normal shift changeover may deprive a 'fresh crew' of a vehicle if a replacement is not readily available
- If you are deployed to scene, you should be told where the RVP is or who/where you should report to. Don't forget appropriate PPE, Action Cards, tabards, and any specialist equipment that is requested (Triage Packs or NAAK pouches). Service identification must also be carried at all times.
- Volunteers should be prepared to conduct routine/domestic work to maintain core business which is just as helpful as assisting at the scene.

All information regarding available staff will be made available to the Tactical Commander who in conjunction with EOC / Major Incident Suite will determine the best use of the resources obtained through this process; this may include a gradual introduction of resources over a period of time to assist in a prolonged incident and the recovery stages.

Care must be taken not to utilise staff/managers whose normal shift may be affected by them assisting in this incident.

6.8. Resilience Direct

Resilience Direct is a secure web-based system that is owned and managed by the Civil Contingencies Secretariat. As a web-based system it can be accessed by any device connected to the internet.

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It has been designed for the resilience community to share information amongst all Category 1 and 2 emergency responders and their partner agencies across geographical and organisational boundaries – during the preparation, response and recovery phases of an event or emergency.

Resilience Direct provides emergency responders with situational awareness, clear communications and informed decision making. The platform enables organisations to fulfil these duties by supporting the adoption of multi-agency working practices and ensuring that key information is readily and consistently available to users.

Resilience Direct helps to facilitate multi-agency collaboration in many ways, which include:

- sharing emergency plans
- maintaining awareness of plans, exercising those plans, and responding, followed by a recovery phase and lessons learnt
- real-time information sharing, supported by data visualisation.

It allows NWS to store both internal and external multi-agency plans in secure folders allowing accredited staff (NWS on call commanders, Resilience Team, ROCC and EOC Managers) to access information on plans and incidents from any location where a standard internet connection exists.

6.9. Catastrophic Communications Failure

In the event of a catastrophic communications failure which affects NWS and partner agencies, each LRF has a Resilient Telecommunications Plan / Guidance Document on what options are available to responders. The NWS Tactical Advisor/NILO will advise on the location and content of the plans, which are available to accredited staff on Resilience Direct. For Internal communication failures, the EOC will initiate process EOC0016 for telephony with Business Continuity Plans providing further details.

6.10. Using 'Runners'

During a communications failure 'staff runners' may be utilised to take messages to and from key commanders. In the event of this system being adopted, it is essential to ensure the following:

- Consideration of using appropriate levels of personnel to undertake this role
- The 'runner' is adequately briefed on the task and its requirements
- All messages are recorded and documented

6.11. Dictaphones

Dictaphones are issued to all commanders and are an effective means of capturing decision making and the working conditions of the incident. Commanders should consider having their dictaphones turned on for the duration of the deployment and utilise the content in their incident log.

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7. Assessment

Assessment is the process of gathering information at scene; it should be undertaken by the First Resource on Scene and relayed to the EOC. Crews have access to windscreen reports, as well as Action Cards and the JESIP App which will assist with the initial reporting. Initial assessment should be to estimate the number and severity of injured as well as hazards present to determine the NHS response. This is provided in the first and subsequent M/ETHANE reports.

Subsequent reports will then be given by the NWAS Operational Commander to EOC / Tactical Commander – aiming to provide regular updates. Commanders should assess information for the following:

- Relevance: In the current situation, how well does the information meet the needs of the end user?
- Accuracy: How well does the information reflect the underlying reality?
- Timeliness: How current is the information?
- Source reliability: Does previous experience of this source indicate the likely quality of the information?
- Credibility: Is the information supported or contradicted by other information?

It is critical, particularly in the initial phases of a Major Incident, that updates are provided by the Commander on scene as regularly as is possible to enable the early mobilisation of resources. This will help build shared situational awareness, assist with joint decision making and build a Common Operating Picture (COP).

7.1. Windscreen Report

To assist with the initial response and provide a guide to support those resources arriving first on scene at an incident, a windscreen report has been developed, a copy of which is stuck in the cab of every frontline DCA and RRV. The windscreen report reminds staff of immediate and subsequent actions, asking them to describe to EOC exactly what they can see as they arrive before they leave the vehicle. It then includes a reminder of the M/ETHANE format, Incident Action Cards, use of ear pieces, how to change airwave talkgroup, the donning of PPE/tabards and the IOR Remove Remove Remove for hazardous substances.

7.2. M/ETHANE Report

Information should be given to the EOC using the M/ETHANE acronym. The M/ETHANE model is an established reporting framework which provides a common structure for responders and their control rooms to share major incident information. (JESIP 2021)

Each responder agency should send a M/ETHANE message to their control room as soon as possible. The information received through multiple M/ETHANE messages will gradually build to support shared situational awareness in those responding to the incident and between control rooms. (JESIP 2021). M/ETHANE reports received should be shared with other emergency services control rooms and wider health organisations as soon as possible.

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For incidents which fall outside of the standard Major Incident Standby/Declared definitions the acronym 'ETHANE' should be used to pass and share information between control rooms and responders.

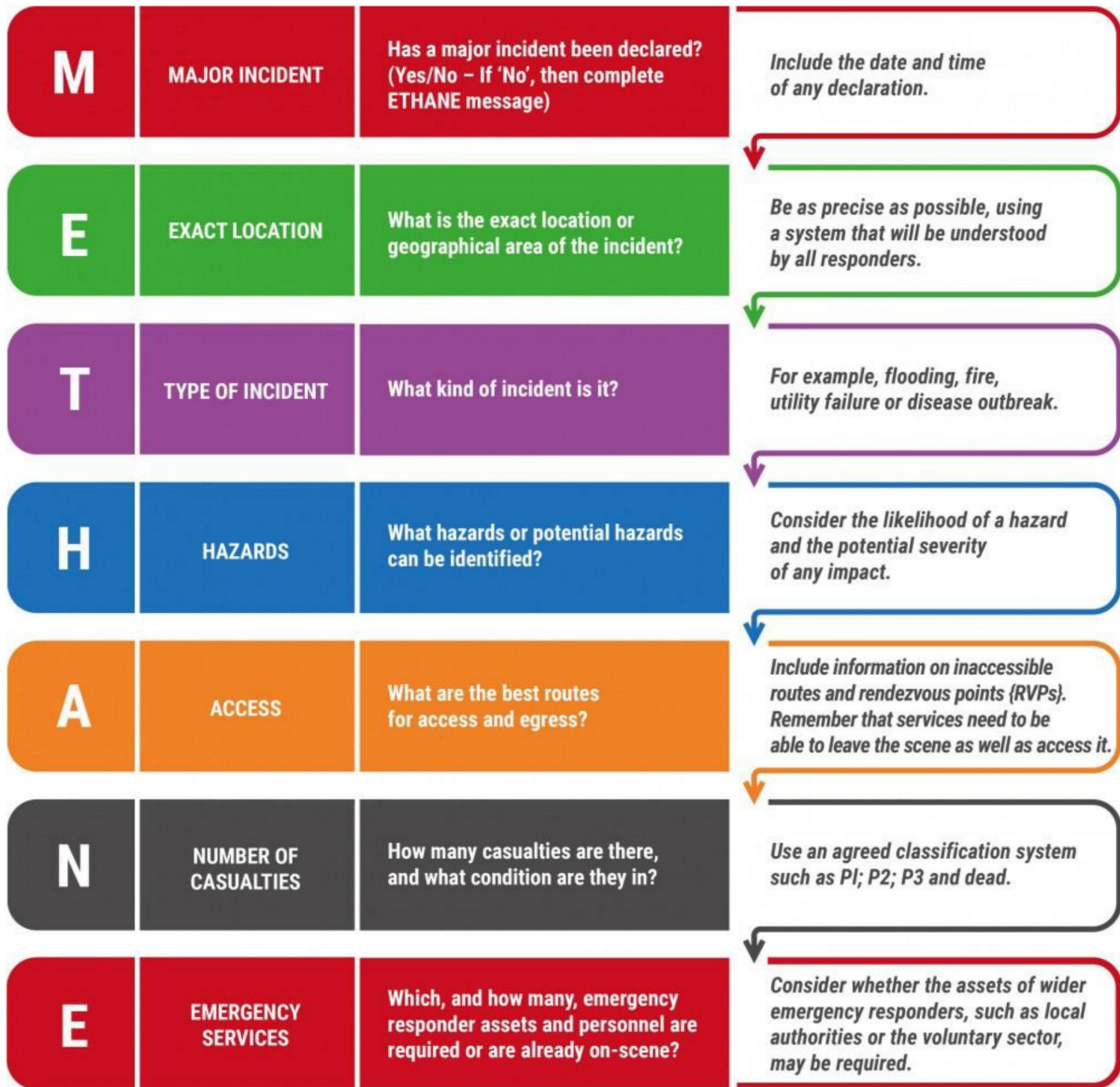


Figure 9 – M/ETHANE Sitrep (JESIP, 2021)

7.3. Continuing Assessment

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The Tactical Commander and NWS EOC will require continuing updates from the scene relating to casualty details, hazards on scene and the suitability of resources to ensure the right care is provided, given as an updated M/ETHANE message.

An assessment of the risk (DRA) to medical responders and the implications to core business within the locality should be carried out.

Continual assessment of the scene (using the JDM) should be carried out to ensure that ever changing challenges and priorities are identified and subsequently dealt with.

7.4. Pre-Determined Attendance (PDA)

To assist the EOC duty manager as well as the commanders deploying to the incident, the Trust has produced a Pre-Determined Attendance (PDA), that provides a realistic and effective minimum response that NWS could implement for a MI Standby or MI Declared. This can be amended once the commander has sufficient situational awareness to decide on the resources required

This allows concurrent activity to be conducted by the EOC thereby helping to reduce deployment timings for crews and other assets to arrive at scene. The following figure provides the details for the PDA for Standby and Declared. This detail is also available in the Green Room.

Pre-Determined Attendance (PDA) for Major Incidents	
Standby	Declared
5 X DCA	10 x DCA
1 x Urgent Care Ambulance (if available)	2 x Urgent Care Ambulances (if available)
1 x PTS Ambulance (if available)	2 x PTS Ambulances (if available)
1 x RRV	2 x RRV's
1 x Advanced Paramedic	2 x Advanced Paramedics
2 x Operational Commanders	3 x Operational Commanders
2 x SPTLs	3 x SPTLs
1 x HART Team	1 x HART Team
SORT roll call and drivers deployed	SORT fully deployed (Minimum 10)
2 x Tactical Advisors/NILO (Scene and TCG)	2 x Tactical Advisors/NILO (Scene and TCG)
2 x MERIT (Fwd Dr, Med Advisor)	3 x MERIT (Fwd Dr, Med Advisor, SMA)
Consider Enhanced Pre-hospital Care Team/s (must be co-ordinated via MERIT Fwd Dr e.g. NWAA / GNAA / BASICS)	Consider Enhanced Pre-hospital Care Team/s (must be co-ordinated via MERIT Fwd Dr e.g. NWAA / GNAA / BASICS)
2 x Loggists (Tactical & Strategic)	2 x Loggists (Tactical & Strategic) a staff member at scene can be used as the operational loggist if trained appropriately.

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1 x National Capabilities Mass Casualty Vehicle (NCMCV – Driver to standby in vehicle)	1 or 2 x National Capabilities Mass Casualty Vehicle (NCMCV – mobilise)
1 x Incident Support Unit (ISU) – Casualty Clearing (Driver to standby in vehicle)	1 or 2 x Incident Support Unit (ISU) – Casualty Clearing (mobilise)
1 x Incident Support Unit (ISU) – Decon (Driver to standby in vehicle) – incident dependent Tac Advisor guidance	1 or 2 x Incident Support Unit (ISU) – Decon – incident dependent Tac Advisor guidance
1 x Public Support Unit (PSU) (Driver to standby in vehicle)	1 or 2 x Public Support Unit (PSU) - mobilise
1 x Tactical Commander (TCG or AOCC)	1 x Tactical Commander (TCG or AOCC)
1 x Strategic Commander (made aware)	1 x Strategic Commander (SCG or AOCC)
Consider 1 x Safety Officer	Consider 1 x Safety Officer

Figure 10- Pre-Determined Attendance for Major Incidents

7.4.1. EOC Resourcing for Major Incident

The Primary EOC for a Major Incident both for Standby and Declared, should provide additional resourcing to focus on supporting the Chain of Command, until they have been stood down by the Tactical or Strategic Commander:

Primary EOC	
Standby	Declared
1 x Critical incident Manager (CIM)	1 x Critical incident Manager (CIM)
1 x Dispatcher	1 x Communications Officer (Dispatcher)
1 x Loggist	1 x Dispatcher
	1 x Emergency Medical Advisor
	1 x Loggist

Figure 11- EOC Pre-Determined Attendance for Major Incidents.

7.5. Briefing format

Commanders must follow a systematic method when conducting briefings or handing over / being relieved of duty. When constrained by time the headings of the Joint Decision Model (JDM) are an acceptable format to be used. The default template to be used by the Trust is IIMARCH (see figure 11 below). This will assist when communicating operational orders, or tactical plans between the chain of command and personnel. (NARU Comd & Control Guidance 2019).

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Element	Key questions and considerations
I	<p>Information What, where, when, how, how many, so what, what might? Timeline and history (if applicable), key facts reported using M/ETHANE</p>
I	<p>Intent Why are we here, what are we trying to achieve? Strategic aim and objectives, joint working strategy</p>
M	<p>Method How are we going to do it? Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency plans</p>
A	<p>Administration What is required for effective, efficient and safe implementation? Identification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics</p>
R	<p>Risk assessment What are the relevant risks, and what measures are required to mitigate them? Risk assessments (dynamic and analytical) should be shared to establish a joint understanding of risk.</p>
C	<p>Communications How are we going to initiate and maintain communications with all partners and interested parties? Radio call signs, other means of communication, understanding of inter-agency communications, information assessment, media handling and joint media strategy</p>
H	<p>Humanitarian issues What humanitarian assistance and human rights issues arise or may arise from this event and the response to it? Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights</p>

Figure 12- IIMARCH adapted from JESIP Joint Doctrine Ed 3, 2021

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8. Triage

The aim of triage is to provide treatment to the right patient, at the right place, at the right time. Triage principles should be applied when the number of casualties exceeds the number of clinicians available. Triage is a dynamic and continuous process and will be repeated many times during the care of the casualty. A reassessment of priority is necessary whenever a casualty's condition is noted to have changed. NWS uses the SMART® Incident Command System on each of its frontline vehicles and Incident Support Units.

There are four main types of triage – Sieve, (Adult and Paediatric), Sort, modified triage and toxic triage. Further training on the SMART® Triage system is available for all staff on the NWS Resilience Team intranet page.

Further information on triage can be found in the (NWS, NWS Triage v1.3, 2022)

8.1. Triage Sieve

Triage Sieve is undertaken at the first point of contact with the casualty and is a rapid assessment of the patient. When carrying out triage sieve it is not necessary to undertake a full head to toe assessment of individual casualties or to complete the inner sections of the SMART® Triage Tag as this will hinder the rapid assessment of all casualties at the scene.

Those undertaking primary triage should carry with them, dressings, haemostatic agents, and tourniquets to allow for the arrest of severe haemorrhage. The diagram overleaf (Figure 12) shows the triage sieve process.

Triage is best performed in pairs. It is best practice for the triage process (i.e. assessing and labelling patients with triage cards) to be undertaken by a paramedic, however any clinical grade of staff may triage. In all circumstances, any grade of staff can support the triage process as one of the triage pair.

All casualties should be clearly labelled with a SMART® Triage Tag including the deceased. Any casualty that is found without a label should be triaged immediately in order to ensure and confirm that a clinical assessment has taken place. A full assessment of the casualty can be time consuming and is not necessary during triage sieve.

8.1.1. Deceased casualties

Any major incident may be considered a crime scene until discounted by the police and therefore consideration should be given to minimising disturbance of potential evidence whilst rescuing or treating patients. Separate 'Dead' labels can be found in SMART® Triage packs. NWS responders triaging a person as 'Dead' should complete the outer label, noting their PIN (clinical) number in addition to the location, date, and the time that the casualty was triaged. Any patient who is covered, should be exposed, triaged and triage tag applied. If they are found to be deceased they can be recovered in the interest of dignity, however the triage label must be clearly visible. At a later stage when resources allow the inner part of the card can be completed to formally carry out a Recognition of Life Extinct (ROLE) in addition to completing an NWS PRF (patient report form)/EPR (electronic patient record) and Diagnosis of Death form. This is best undertaken by the Forward Doctor plus a senior clinician.

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The deceased should not be moved during the triage process unless it is the only way of reaching a live casualty or if the body may become further damaged or lost.

Responders should remember that the need to preserve evidence is secondary to saving life

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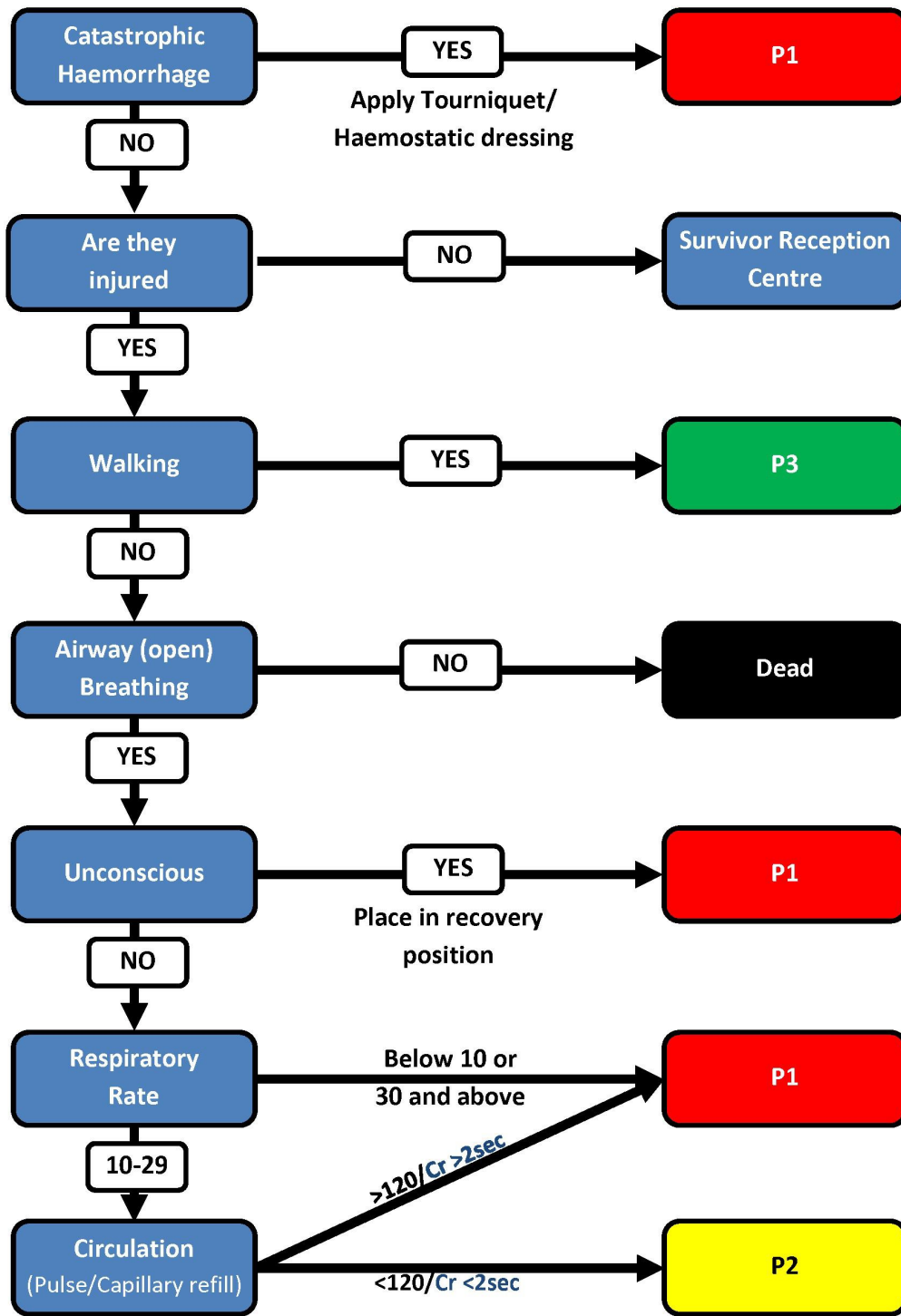


Figure 13 - Triage Sieve (NASMED July 2013)

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8.1.2. Uninjured people

Any individual found at the scene of a major incident that has been involved but not injured should be directed to a place of safety and asked to remain there until their welfare can be confirmed and their details collected by the police. Such individuals may not be physically affected, but may need other support in respect of their exposure to traumatic circumstances. They may also prove to be vital witnesses for the police in any subsequent investigation.

8.1.3. Paediatric Triage

The triage of children using the values associated to adult Triage Sieve will create 'over prioritisation' of the casualty due to age-related respiratory and cardiac rates being different from those of an adult. To address this problem, NWS employs the SMART® Triage system paediatric triage tape – available in SMART Triage packs on all frontline vehicles – to provide a capability to accurately triage children.

The SMART Paediatric Triage Tape is divided into four sections which provide the child's length and estimated age and the corresponding normal physiological ranges for these lengths and ages.

Each of these age-related sections includes the triage sieve algorithm with values for respiratory and circulatory rates relating to the age / size of the child.

Clinicians must follow the NASMeD triage sieve, however, use the physiological values corresponding with the patients' height on the triage tape.

8.1.4. Modified Triage

Modified Triage is a simplified version of Triage Sieve which has been developed by the National Ambulance Resilience Unit to enable responders to triage patients in the most challenging of circumstances.

The decision to implement Modified Triage lies with the Operational Commander and will be influenced by a number of factors, including:

- When the number of casualties is far in excess of responders
- Nature of injuries – bomb blast, gunshot, bladed weapon, vehicle borne attack
- When treat and leave is being utilised
- When PPE is required that inhibits responders from taking pulses and therefore from using Triage Sieve

The above factors are typical of a Marauding Terrorist Attack (MTA). It is therefore most likely that Modified Triage will exclusively be used for MTA incidents by specialist responders trained in its use.

When Modified Triage is implemented, it is essential that Triage Sieve is carried out at the at the earliest opportunity.

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8.2. Triage Sort

Triage Sort (Secondary Triage) normally takes place once casualties have arrived in the Casualty Clearing Station (CCS) but may be applied when large numbers of casualties require evacuation from a Casualty Collection Point (CCP) – Section 10.2. Triage Sort uses the Triage Revised Trauma Score (TRST) (Figure 10 overleaf) which is based on the three parameters of respiratory rate, systolic blood pressure and Glasgow Coma Scale (GCS). Triage Sort and details of the GCS are contained within the Smart® Triage cards. As much clinical information as possible should be recorded for each casualty.

8.3. Expectant Category

Where casualty pressures at an incident site dictate, it may be necessary to categorise casualties as P4 (Expectant – they are expected to die) either as a direct consequence of the limited nature of the medical resources available (e.g. immediate surgery is required but unavailable), or because the input required would make such demands on these sparse resources that the lives of other less seriously injured patients would be jeopardised.

Responsibility for invoking the expectant category lies with the Strategic Medical Advisor following discussion with the Medical Advisor, Strategic and Tactical Commander. The Forward Doctor is the responsible person to categorise individual patients as Expectant.

A	Glasgow Coma Score	13 - 15	4	<input type="checkbox"/>
		9 - 12	3	
		6 - 8	2	
		4 - 5	1	
		3	0	
+				
B	Respiratory Rate	10 - 29 per min	4	<input type="checkbox"/>
		>30 per min	3	
		6 - 9 per min	2	
		1 - 5 per min	1	
		None	0	
+				
C	Systolic BP	>90 mmhg	4	<input type="checkbox"/>
		76-89 mmhg	3	
		50-75 mmhg	2	
		1-49 mmhg	1	
		0 mmhg	0	
=				
A + B + C = TRAUMA SCORE			Total :	

Figure 14 - Triage Sort

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8.4. Holding and Audit Area for Deceased People

The Holding and Audit Area for Deceased People and Human Remains (commonly known as the Body Holding Area) is an area close to the scene where the deceased can be temporarily held until transfer to the emergency mortuary or mortuary (HM Government , 2013). It will generally be located near to the Casualty Clearing Station.

The responsibility for deceased casualties' rests with the Police, who will act on behalf of HM Coroner. NWS responders will not normally move deceased casualties to the Holding and Audit Area. The exception to this is when a casualty is pronounced dead whilst in the Casualty Clearing Station (CCS). In this instance, the body may be moved to provide additional capacity within the CCS. Death must be confirmed by a doctor within the CCS and the relevant NWS paperwork completed.

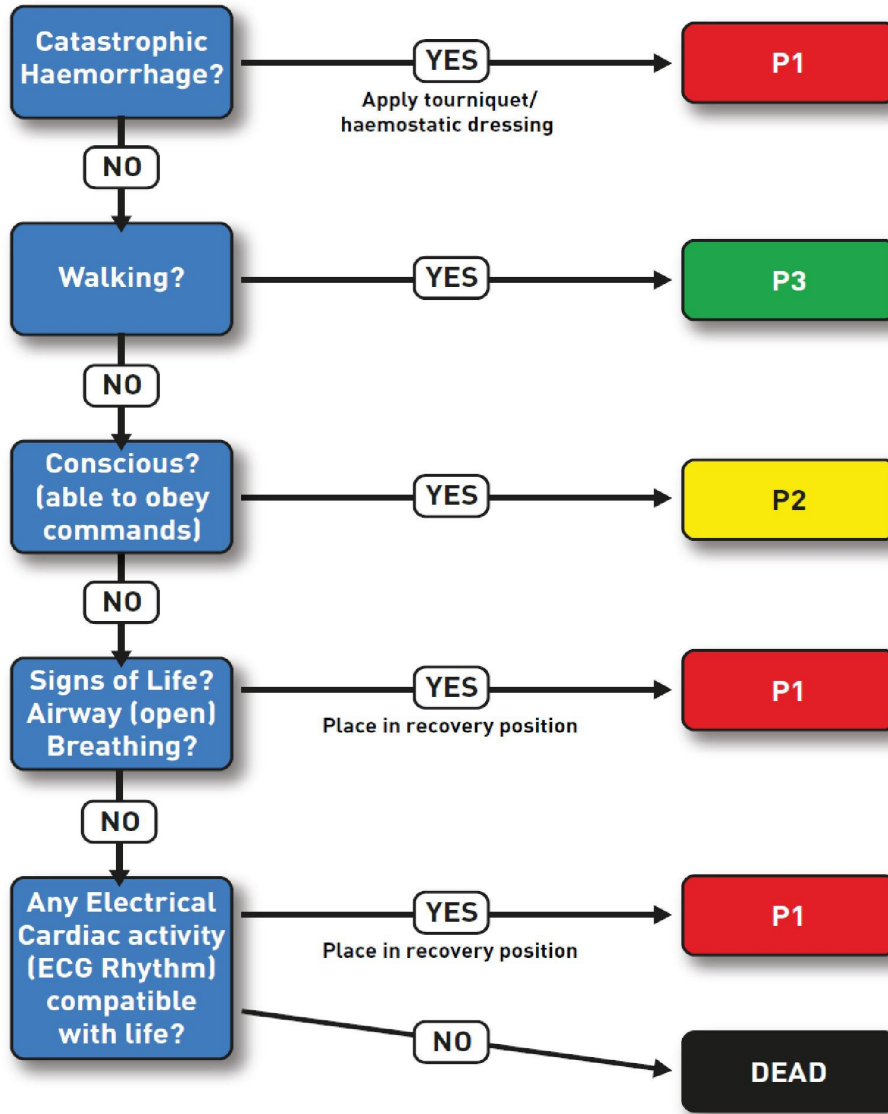
8.5. Toxic Triage

This type of triage is used in CBRN/HAZMAT Hot Zones. HART and SORT are the only NWS staff who are trained and authorised to undertake toxic triage. A patient will be re-triaged using NASMeD triage sieve/SORT at the earliest opportunity after decontamination has been undertaken.

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HART: Primary Toxic Triage

Best practice is to carry out PRIMARY TOXIC TRIAGE in pairs



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Figure 15- Primary Toxic Triage

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8.6. SMART Decontamination Cards

As the SMART PAC is supplied as a generic unit each Triage Pack also contains trifold 'CONTAMINATED' cards for use during CBRN or Hazmat incidents.

These cards are not used by NWS NHS Trust as all casualties will be decontaminated prior to leaving the scene.



Figure 16- SMART Decontamination Cards - (not used by NWS)

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9. Treatment

9.1. Treatment at the Scene

Within the inner cordon, treatment is aimed at preventing further deterioration of life-threatening injuries. The treatment schematic (Figure 15) shows the movement of casualties from the incident scene to the Casualty Collection Point (CCP) and onwards.

Specialist casualty management may be required at some incidents, such as decontamination. Detailed information can be found with the NWS CBRNE Plan. (NWS , 2021)

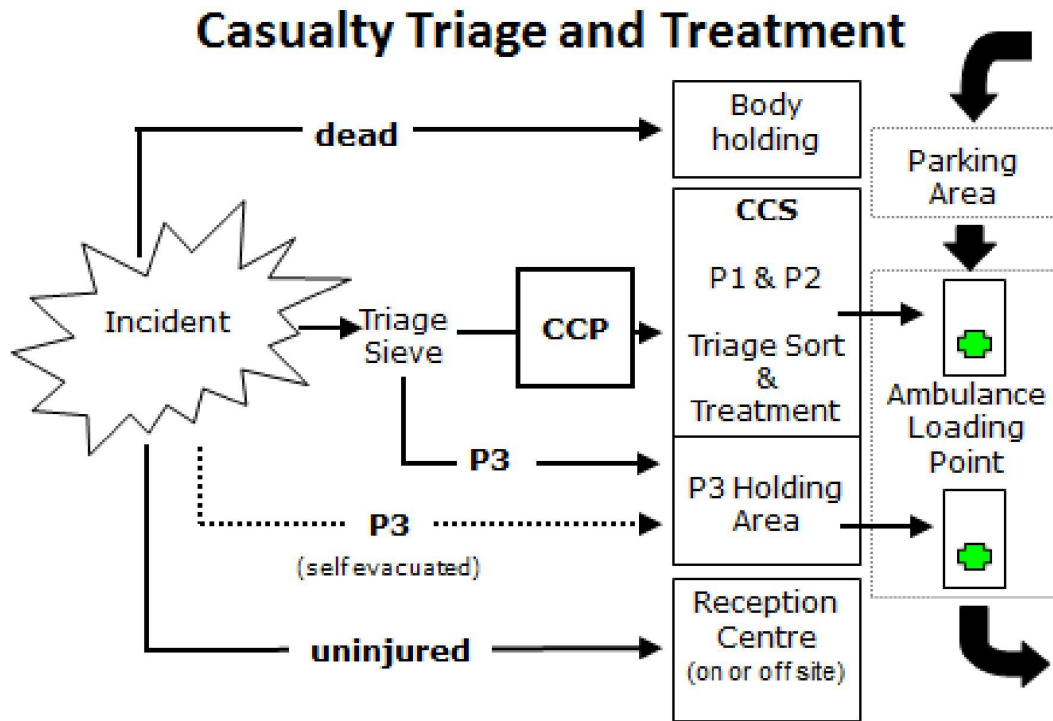


Figure 17 - Scene Layout

9.2. Casualty Collection Point (CCP)

Following Triage Sieve casualties will be evacuated in priority order to either a Casualty Collection Point (CCP) or directly to the Casualty Clearing Station (CCS) for treatment. Although the CCP process originated from the response to specialist incidents such as CBRN/Hazmat or Marauding Terrorist Attack (MTA) scenarios, its use is now commonplace for any multi-casualty incident. The CCP is designed to provide basic care for life threatening injuries prior to a casualty being moved to the CCS or direct to hospital. Equipment to establish the CCP is carried by the Hazardous Area Response Team.

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In the early stages of an incident prior to the establishment of a CCS, the Loading Officer may locate at the CCP and casualties may be transferred directly from the CCP to hospital if necessary. There is usually only one CCP, however large incidents spread across large areas or sectors may have multiple CCPs. There should, however, only be one CCS.

9.3. Casualty Clearing Station (CCS)

Once a Casualty Clearing Station has been established, all casualties **must** be directed/transferred from the site or CCP to the facility for further triage (Sort) or if appropriate to a P3 (walking wounded) holding area. Casualties will then receive treatment and subsequent transport to a location appropriate to their condition subject to availability, such as; Accident Emergency Department, Major Trauma Centre, Trauma Unit, Minor Injuries Unit, Burns, Neuro or other specialist unit. It is imperative that all casualties go through the CCS process so that accurate details can be maintained and their destinations recorded. The NWS Combined Regional Mass Casualty Distribution Plan, (NWS, 2020) developed in conjunction with NHS England and the Regional Trauma Network, will help to inform NWS commanders and MERIT doctors on the most suitable route and location for the distribution of casualties from a major incident.

Treatment within the CCS should aim to stabilise the casualty with a view to getting them to a definitive point of care as soon as practicable

The CCS will be managed by the Casualty Clearing Officer and where possible, be supported by a Casualty Clearing Station Medical Lead (CCSML). When determining a suitable location for the CCS, safety considerations such as the integrity of buildings or land, vehicular accessibility, and environmental considerations such as wind direction must be made. The Operational Commander is responsible for constructing the Casualty Clearing Station with the assistance of SORT.

To ensure that casualty data is shared effectively, particularly for the purpose of the Police Casualty Bureau, it may be advantageous for a Police Officer to be co-located alongside the Casualty Clearing Officer or Loading Officer.

9.4. Vulnerable Persons

The document Identifying People who are Vulnerable in a Crisis (HM Government , 2008) identified the statutory requirement for Category 1 responders to plan for and meet the needs of those who may be vulnerable in emergencies. Although the 'vulnerable' may vary according to the nature of the incident the definition of vulnerable people can be *'those that are less able to help themselves in the circumstances of an emergency'* Emergency Preparedness London (HM Government , 2012)

Vulnerable groups or individuals in specific scenarios and locations may be pre-identified as part of the work of the Local Resilience Forum. They may include:

- Children
- Older people
- Those with impaired mobility
- Those with impaired mental/cognitive function

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- Sensory impaired
- Individuals supported by health or local authorities i.e. people in residential/nursing homes, prisons, sheltered accommodation etc.
- Temporarily or permanently ill people
- Individuals cared for by relatives
- The homeless
- Pregnant women
- Non-English speakers including refugees and asylum seekers
- Tourists
- Travelling community

(HM Government, 2008)

NWAS responders may be called upon to assist with the evacuation or treatment of the vulnerable during a major incident and their identification should be an early consideration for the Tactical Coordinating Group.

Although LRF and Local Authority plans will identify schemes in place to assist in the management of vulnerable people, NWAS is able to utilise services such as Language Line which may be of help when assessing and treating casualties.

Social factors and personal characteristics of adults and children injured or displaced from their homes due to a major incident may lead to them being at an increased risk of harm. This risk may be further exacerbated if the individual is considered to be vulnerable. NWAS responders should be cognisant of their duties under the NWAS Safeguarding Vulnerable Persons Policy (2021) and report any concerns as soon as practicably possible.

Protracted Incidents – if an incident is going to be protracted and there are concerns about vulnerable persons, consideration should be given to the setting up of a team in line with the NWAS Policy on Safeguarding Vulnerable Persons (Sep 2021), as well as Safeguarding Vulnerable Persons Procedures (Sep 2021), both of which can be found on the Green Room.

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9.5. Specialist NWS Teams & Resources

The following specialist teams and resources are available to NWS Commanders to assist in the resolution of any Major, Critical or Complex Incident.

9.5.1. Hazardous Area Response Team (HART)

HART operations are a functional role within the NWS response. Although the HART response is supervised by the HART Team Leader, the responsibility for HART resources falls under the command of the Operational Commander.

The purpose of a HART response is to provide life-saving medical care to patients within the inner cordon at a range of emergency incidents, including those involving Chemical Biological Radiological Nuclear (CBRN) or hazardous materials (HAZMAT), those requiring an Urban Search & Rescue (USaR) capability such as accessing patients in difficult locations such as working at height, confined spaces, or rubble piles. They will also respond to patients caught up in flood environments including swift water rescue and those involved in a Marauding Terrorist Attack. Finally, they are also the Trust response to High Consequence Infectious Diseases.

Responding within the inner cordon of a major incident is by nature a hazardous environment, requiring the implementation of Safe Systems of Work (SSoW) including Standard Operating Procedures (SOPs) and appropriate Personal Protective Equipment (PPE). HART personnel are trained, have a wide range of PPE and work to national SOPs to be able to operate safely within these environments.

9.5.2. Special Operations Response Teams (SORT)

The Special Operations Response Team (SORT) staff are drawn from Service Delivery Operations. They are volunteers who are routinely deployed on Ambulances and RRVs but have been trained in a variety of extra disciplines. If required they can be deployed to CBRN, HazMat or MTA incidents as well as Major, Critical and Complex Incidents. Trained in such disciplines as clinical decontamination, triage and catastrophic haemorrhage from ballistic injuries associated with firearms / IEDs etc they can also provide support to logistical challenges that a protracted incident may cause such as:

- The erection and operation of the Trust's decontamination equipment
- The erection and maintenance of the Trust's shelters
- The operation of generators to supply the site with power
- The provision of lighting and heating
- The setting up and running of Casualty Clearing Stations
- The mobilisation of specialist Trust vehicles
- Other duties that fall within the Special Operations remit to meet the developing threats and challenges

There are circa 290 SORT staff regionally which should yield a minimum capability of 35 staff on duty 24/7. Consisting primarily of Paramedics the team also contains a number of EMTs as well as a small number of Advanced

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and Consultant Paramedics. EOC hold a record of all current NWS SORT staff on the Computer Aided Dispatch (CAD) system and can identify and deploy them to an incident as and when required.

9.5.3. National Capability Mass Casualty Vehicles (NCMCV's)

The NCMCVs are part of the National Capabilities Programme. Each vehicle contains enough medical equipment to provide emergency treatment for:

- 100 casualties either P1 or P2
- 250 P3 casualties

The equipment is based on planning assumptions of incidents that involve a ratio of 80% adults to 20% paediatric casualties. The NCMCVs also carry mass oxygen delivery systems (MODS) and a range of specialised drugs and equipment to be used by doctors if required.

NWS holds three NCMCV on behalf of NHSE and NARU. Two are in the GM Area and one in the Cheshire and Merseyside Area.

The Duty Tactical Advisor/NILO can provide advice on appropriate deployment of the NCMCVs.

9.5.4. Incident Support Units (ISUs)

NWS has 7 x ISU cells each consisting of:

- 1 x Major Incident Support Unit carrying specialist equipment for the triage and treatment of casualties involved in a variety of major incidents and the establishment of a Casualty Clearing Station (CCS).
- 1 x Decontamination Unit carrying specialist equipment for the decontamination of casualties resulting from either a HazMat or CBRN incident.

The vehicles are 7.5T but can be driven on a standard license however SORT staff should be deployed to the ISUs locations for onward deployment to the incident ground as they have received driver awareness training in the safe operation of the vehicles and the equipment contained within them.

The Tactical Advisor/ NILO can provide advice on appropriate deployment of the ISUs.

9.5.5. Public Support Unit (PSU)

The PSU is designed to transport basic first aid equipment to the scene of a major or mass casualty incident. The equipment is intended for use by the general public or on scene first aiders to care for P3 patients in the initial stages of an incident when Ambulance staff focus will primarily be on P1 and P2 patients.

There are four PSUs in service in NWS located at the following stations:

- Penrith Ambulance Station (Cumbria and Lancs Area)
- Preston Ambulance Station (Cumbria and Lancs Area)

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- Ashburton Point (Greater Manchester Area)
- Bootle, Liverpool (Cheshire and Mersey Area)

Each PSU carries the following as a minimum

- 10 x Mega Mover stretchers
- 1600 Wipes

The major incident fleet may be relocated to provide additional cover for specific risks. All vehicles are tracked and their locations can be confirmed by EOC. Advice on deployment of the fleet can be provided by the Tactical Advisor/NILO.

9.6. Medical Emergency Response Incident Team (MERIT)

MERIT Doctors are a critical command support function that work directly alongside the NILO/Tactical Advisor cadre. The primary role of MERIT is to provide the NWS on-call command structure with medico-legal advice during major, critical or complex incidents. MERIT Doctors have received additional specialist training to undertake the roles of a Medical Advisor (MA), Forward Doctor (FD) and Casualty Clearing Station Medical Lead (CCSML) as outlined in section 4.7 of this document.

9.7. Shelter Capability

In the event of there being no natural shelter available at an incident location, the Trusts' major incident casualty clearing station tents can be utilised. The tents are located on the Incident Support Units. The tents themselves, in addition to the required supporting equipment have specific manual handling arrangements. SORT should be deployed to manage the erection of these structures.

Certain locations i.e. airports etc may have their own mobile shelters or pre-determined indoor locations for use as a shelter area. In the first instance, the CCS should be stocked from the ISU; further supplies should be sourced in liaison with the Equipment Officer.

9.8. Voluntary Aid Societies (VAS)

NWAS has established links with Voluntary Aid Societies across the North West:

- St. John Ambulance
- British Red Cross
- Mountain Rescue Teams (and other search and rescue teams)
- British Association for Immediate Care (BASICS)
- Royal National Lifeboat Institution (RNLI)
- North West 4X4

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The organisations listed above have provided support to NWS during major incidents and to support business continuity arrangements during periods of high demand. These agencies have ambulance resources and medical personnel that, in addition to Major Incident response, assist with core duties such as 999 calls and other cases as directed by NWS EOC.

In addition to the on-site response to a major incident and the support of NWS core resources, there may be a requirement for the VAS to provide off site medical support to local authority reception centres, etc. during the response to a major incident to relieve the impact on NWS.

LRFs will normally have their own voluntary sector forum that can be activated during an incident, subject to appropriate approval, most likely to be at strategic command level.

The EOCs and the ROCC hold contact details for all Voluntary Aid Societies which provide support to NWS.

It must be remembered that some VAS personnel may be already supporting other Ambulance Trusts and therefore this may reduce the availability of resources to NWS.

9.9. Mutual Aid

NWS is party to the NHS Ambulance Service National Mutual Aid for Spontaneous, Protracted and Pre-Planned Incidents Memorandum of Understanding (MoU) Dec 2020. Previous versions of this MOU had traditionally been focused on mutual aid support for no notice Major Incidents often involving mass casualties. Events such as the 2018 attempt on the lives of the Skripal's and the murder of Dawn Sturges in Salisbury and Amesbury respectively, have demonstrated the need for NHS Ambulance Trusts to support each other during protracted incidents which may not be defined as a conventional response to a Major Incident, but may require a specialist response.

The MOU is intended to support and to assist NHS Ambulance Trusts by providing a framework and structure to enable the delivery of a coordinated national response to a range of major or catastrophic incidents which may be prolonged in nature or as part of a pre-planned mutual aid response, including the support to business continuity arrangements.

The Trust receiving a request for assistance will have a duty to supply mutual aid, subject to the maintenance of a safe level of service delivery within its own area.

Spontaneous mutual aid may be required when one or more Ambulance Trusts are responding to a no notice major or mass casualty incident. Such incidents may place overwhelming demands on an Ambulance Trust, particularly in situations which result in mass casualties.

Therefore, it is reasonable that a Requesting Trust may require immediate additional support from neighbouring Ambulance Trusts or other National interoperable assets, even though the information about the incident may be incomplete.

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A predetermined minimum mutual aid response is laid out in the MOU for the Strategic Commander to consider once a request is received.

The extent of assistance to be provided by the assisting Ambulance Trust will be agreed by the Strategic Commander at the time of request and may be reviewed in the light of changed circumstances at the incident or locally.

Supporting Trusts will employ practices in accordance with their own clinical governance standards. The host Trust will have primacy at the incident scene and all resources deployed through mutual aid will act under the command and control of the host Trust.

It is essential that any mutual aid requirements are identified as quickly as possible. Preparation and activation of such resources from other Trusts may take some time. It is essential that the host Trust identifies what is required and the location of the Strategic Holding Area (SHA), Tactical Holding Area (THA) or Rendezvous Point (RVP).

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10. Transport

10.1. Patient Movement

Movement of patients can be tracked using the Triage Card tear-off transport strip. This is attached to each SMART Triage Tag which once removed (when patient is loaded onto an ambulance) is retained by the Loading Point Officer for patient tracking use.

During a major incident NWS staff must ensure they notify EOC in the usual way when arriving/leaving scene and arrival at hospital so that accurate records are maintained.

The decision on the destination of patients will be made in consultation between the Tactical Commander, Medical Advisor, Casualty Clearing Officer and NHS England Tactical Commander. Consideration should be given to the following:

- Suitability of hospital / medical facility to take appropriate triage category (P1, P2 and P3)
- Location of the receiving hospital and specialisation (Trauma/Burns/Paediatrics, etc.)
- Current bed status / capacity of hospital
- Infrastructure – i.e. road network and helicopter landing sites
- Possibility of self-presenters causing congestion
- Depletion of medical resources at receiving hospital
- Hospital security

10.2. Regional Mass Casualty Distribution Plans

The NWS Combined Mass Casualty Distribution Plan (NWS, 2020) developed in conjunction with NHS England and the Regional Trauma Network, will help to inform NWS commanders and MERIT doctors on the most suitable route and location for the distribution of casualties from a major incident.

The plan details the numbers of P1 and P2 casualties which may be received by North West hospitals in the first two to three hours following an incident involving large numbers of casualties. Currently the plan covers the Greater Manchester, Cheshire & Merseyside, and Lancashire & South Cumbria areas. In addition to casualty reception numbers, the document also details the clinical specialities of each receiving hospital.

Mass Casualty Distribution Plans provide an immediate indication of a hospital's capacity to receive casualties and must be referenced during any incident involving the movement of large numbers of patients.

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10.3. Transport of Children

In an incident involving injured children, it may be necessary to transport them directly to specialist paediatric receiving hospitals or units. Wherever possible, parents should remain with their children. However, the clinical needs of both parents and children should be the primary factor in deciding where to transport casualties. It is accepted by the North West trauma networks that on rare occasions parent and child who both elicit a major trauma outcome, requiring treatment at a major trauma centre will travel together to the same hospital. This is in acknowledgment of the human factors that some parents will refuse to be separated from their children irrespective of their own injuries. In this scenario, a clinical judgement must be undertaken to convey to the most appropriate hospital based on the highest priority casualty (ie. adult or child).

Appropriate escorts may need to be sought for unaccompanied children, whether they are injured or not. The Police and Local Authority should be informed at an early stage of the presence of unaccompanied children to allow for appropriate welfare arrangements to be made.

Regardless of the incident which they are attending, NWAS staff must adhere to the Safe Transportation of Children Policy (2021) and the accompanying Procedures (2021). (North West Ambulance Service NHS Trust, 2021)

10.4. Methods of Transport Available

The transport of patients during a major incident will depend on number and severity of casualties and the available resources. Options other than NWAS resources to be considered include:

- Voluntary Agencies
- Private Ambulance Organisations
- Local Authority
- Public Transport, e.g. buses, rail, taxis
- Military assets
- Air assets e.g. Helimed, Commercial operators

The decision to utilise these resources should be made by the Tactical Commander in consultation with the relevant agency and the Strategic Commander.

10.5. Patient Transport Service

Where there are large numbers of P3 casualties to be moved, the Patient Transport Service (PTS) may be available to assist. PTS vehicles are generally designed to carry multiple patients who require minimal clinical care.

If any PTS vehicles are utilised out of hours by PES crews, then they should be returned to their base station in full readiness for duty (cleaned, fuelled and stocked) so that PTS obligations are not compromised. If for whatever reason this is not possible it is the responsibility of the PES Manager(s) to inform the relevant PTS Control and PTS managers should be notified of the fact without delay.

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In hours, routine PTS work may have to be cancelled in order to free resources to attend a major incident. Ambulance commanders should be aware of the disruption caused to both NWS and hospital business by the cancellation of PTS work. Rescheduling of patient appointments in the days and weeks following an incident may add to the pressures which the health infrastructure may already be under. Cancellation of PTS work is therefore a decision for the NWS Strategic Commander which should only be made following consultation with the NHS Strategic Commander.

10.6. Air Support

Air ambulances can provide an additional resource to the transportation of casualties or medical resources to the scene. Additional air ambulance resources can be made available from neighbouring ambulance services, coastguard, or the military. Access to these is requested via the NWS EOC.

The Tactical Commander and the Medical Advisor will identify the most appropriate use of air resource in consultation with the Police. This may include dedicated or predetermined landing sites.

If three or more helicopters from two or more agencies are tasked to deal within a defined area the Police Service in consultation with the military may instigate a Combined Tactical Air Cell (CTAC) whose role will be to ensure that a single communication platform is available for the aircraft to make effective and safe tasking of resources possible. The representation in this Cell will be from all agencies supplying resources.

Prior to the use of the air ambulance at the scene of a major incident, agreement must take place between NWS EOC and the Tactical Commander to decide whether the air support unit is required. If no hazards are present which preclude the use of air support resources, consideration should be given to:

- Visibility, weather conditions, present and potential physical hazards
- Exact location and nature of incident
- Ground to air communication procedures should be adhered to during the response

If the Air Ambulance transports any casualties, they must be logged by the Ambulance Loading Officer.

Helicopter landing sites should be agreed following consultation between the Operational Commander and aircraft pilot via the ground to air communication procedure. Interoperability talkgroup ES3 of the local police area has been designated for ground to air communications.

10.7. Arrival at Hospital

Each receiving hospital will be designated an NWS Hospital Ambulance Liaison Officer (HALO) to provide a communications link between NWS and the hospital. Ambulance staff should make contact with the HALO who will assist with the patient handover and ensure rapid turnaround of resources.

10.8. Police Casualty Bureau

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The Police Casualty Bureau will collate relevant information regarding persons involved in an incident. It is the initial single point of contact for receiving and assessing information about people who are believed to be involved in an incident (College of Policing , 2013).

The primary aims of the Casualty Bureau are to;

- Provide information for the investigation process
- Trace and identify people involved in an incident
- Reconcile missing person record cards with casualty and survivor/evacuee records

Once the Casualty Bureau has been established contact details will be publicised through the media. It is important for the Trust to co-operate with this function and assist where possible with information gathering.

The Tactical Commander should pass on information of receiving hospitals and patient distribution to the Police Incident Commander.

10.9. Survivor Reception Centre (SuRC)

Uninjured people and if necessary, casualties with minor injuries may be moved away from the immediate scene to a Survivor Reception Centre (SuRC). The SuRC provides a secure area in which survivors not requiring acute hospital treatment can be taken for short term shelter and first aid. Evidence might also be gathered here (HM Government, 2011).

The Local Authority will lead on the provision of the SuRC but it may initially need to be established by the emergency services in the early stages of an incident (HM Government , 2013). NWAS may therefore need to provide staff and resources at the SuRC until medical support is available from NHS or VAS resources.

The NWAS Tactical Commander should liaise with the NHS Tactical Commander regarding the provision of medical support to the SuRC

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11. Recovery

Once the incident response phase is over and all patients have been moved from the scene, NWAS will formally declare Major Incident Stand Down and inform all partners, in particular receiving hospitals. It should be noted that it is the responsibility of each organisation to decide when it is appropriate for them to stand down from major incident status. The NWAS stand down will be declared by the most senior NWAS commander involved in the incident, but this will be at Strategic or Tactical command level.

To return to a state of normality, NWAS will need to ensure the following;

- Assessing staff occupational health
- Ensure a post incident hot de-brief has taken place
- Re-stocking of consumables
- Cleaning and refuelling of vehicles
- Ensure that all PTS vehicles are returned to home stations, cleaned, and refuelled.

Due to the wider health implications to staff, Occupational Health should be engaged to monitor and facilitate a treatment package to staff who have been involved in a major incident.

Special consideration should be given to staff who believe they may have family or friends involved in the incident.

11.1. Recovery Phase

Business Continuity Management (BCM) has an important role to play during all phases of an incident. The Trust has in place BCM arrangements that are designed to help sustain normal core business during and after an incident. Details of these can be found in the Business Continuity Plans for each department. The actions detailed in the Resource Escalation Action Plan (REAP) may be used to increase capacity within the Trust.

An electronic software toolkit (C2 BCMS) has been developed for Commanders to access the Business Continuity Plans for each directorate.

It is vital when the Trust is challenged by a major incident that early thought is given to issues such as the management of staff recalled to duty. It is recognised that during a major incident many staff may voluntarily return to work on an ad-hoc basis. This can lead to major staffing issues during protracted incidents as the staff pool available to relieve the responders has been used up in the initial stages of the response. Rostering Team support is essential to manage a smooth transition to normal activities.

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The recovery phase should begin at the earliest opportunity and should be run in parallel with the response. It does not end until all disruption has been rectified, demands on services have returned to normal and the physical and psychosocial needs of those involved have been met.

Recovery and return to 'normality' following a major incident, may take some considerable time and effort.

11.2. Incident Debriefing

Hot debriefs should take place as soon as possible after the incident has been stood down, normally held at a suitable venue away from the scene (such as an ambulance station where there will be toilet and refreshment facilities). Staff involved in the incident may have been exposed to the elements for some period of time, in difficult and often traumatic situations, so allowing them the comfort of shelter and 'familiar' surroundings will help in the 'return to normality'. Notes should be taken to capture initial concerns both in terms of how the incident was managed, but to also identify the impact on individuals, who may have been operating under difficult and stressful circumstances. Commanders can use Dictaphones but these notes should be written down at the earliest opportunity. These contemporaneous notes may also be required for any future investigation or inquiry.

The lessons identified will enable further resilience to be applied to the emergency plans of all organisations.

Debriefs should follow the CSCATTT mnemonic to allow crews to follow a structure that is understood. Areas that are likely to come up are as follows:

- Systems and procedures – such as command and control, triage, casualty transportation
- Equipment – communication devices, PPE, resources
- Personnel – activation and mobilisation, welfare issues and numbers

All personnel who were included in the incident are to be invited to the formal debrief process that is to take place on a date agreed by the sponsoring commander. A set format has been developed for the Trust that will lead to a number of recommendations which will be owned by individuals identified by the debrief team. An Action Tracker will be produced by the Resilience Quality & Improvement Team, to ensure these actions are completed. The Trust Debrief Policy (May 2021) is available in the Green Room.

11.3. Post incident welfare

Following a difficult incident, some staff members may require further support. This may become apparent at the hot debrief; however it is not uncommon for this to manifest itself much later. Line managers must take this into consideration and consider observing for the common signs for stress. The Management of Stress Procedure (NWS May 2021) (NWS, Stress Management Procedure, 2021) provides details on a pro-active approach to support staff based on three levels of intervention. Referral to Occupational Health as well as information on counselling may have to be considered by managers. This procedure is available in the Health, Safety & Security Tool Kit in the Green Room.

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11.3.1. Trauma Risk Management (TRiM)

Trauma Risk Management (TRiM) is a trauma focused peer support system. The aim is to identify individuals who may be at risk of developing a traumatic stress related illness; these can range from 'emotional aftershocks' such as anxiety related symptoms to more extreme conditions, for e.g. Post-Traumatic Stress Disorder (PTSD). It ensures that the organisation is fulfilling its legal duty of care obligation in relation to the Health and Safety at Work Act (1974), provides economic benefits by reducing sickness absence and improves staff morale by showing that the organisation does care for their health and wellbeing.

A TRiM assessment can be requested or offered by any member of staff for any incident they attend, be that trauma or medical. In relation to a major incident TRiM should be mentioned at the closing point of the hot debrief. This should then be followed up by a formal email which will give further information about TRiM and how to access the assessment. There is no time scale for the assessment other than an assessment should not be complete until at least 24hrs following the incident. Some staff may not want to access an assessment until weeks or even months after the event which is acceptable. TRiM will be coordinated and managed in the same way regardless of the type or size of the incident. This will be led by the existing TRiM assessors, coordinators, and managers.

11.4. Log Books and Documentary Evidence

As the incident may be scrutinised in subsequent investigations, inquiries, or court proceedings, at the stand down of the incident all log books along with any additional notes, photographs, diagrams etc. should initially be submitted to the area Resilience Team area office for retention.

As a result of recent high profile major incidents, the Trust has identified the need to centralise the process and collect evidence at the earliest opportunity to preserve and ensure the integrity of legal documents prior to cases receiving scrutiny during coronial, criminal and/or litigious proceedings.

Commanders and other key staff are to have written up their notes from an incident no later than 24 hours after the incident. Any logs are then to be forwarded and submitted within 72 hours of the incident to the area Resilience Team office.

Early coordination, retention and storage of all documents created during an incident will maximise the chances of a successful outcome should an incident proceed to court. The Head of Contingency Planning will coordinate the collection and retention of all evidence with further managers designated as necessary to collect evidence specific to their area of work. The Legal Services Department should be consulted regarding this process but where this would result in a delay, evidence gathering should commence as soon as practicable following the incident stand down with consultation with the Legal Services Department taking place at the earliest available opportunity.

Examples of evidence to be collected include, but are not limited to:

- PRFs (originals) – chronological order, arrange for copies to be scanned
- Details of all operational staff deployed (including contact details)
- Details of Emergency Medical Advisors and Dispatchers in attendance

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- Command structure details
- Incident log books (commander and EOC/support centres)
- Completed action cards and logs
- Any contemporaneous notes made during the incident
- Photographs from the scene
- CCTV footage from vehicles and Trust premises
- The Sequence of Events (SoE) for the incident and all related calls
- Activity and resource information
- Demand levels
- Statements of Duty Managers – key players involved in decision making process
- Copies of policies/protocols underpinning EOC decision making process
- Notes and minutes from multi-agency meetings at all levels
- Internal bulletins
- Press releases
- External media footage
- Telephone records for all mobile phones used during the incident
- Copies of all recorded mobile phone and Airwave communications (it will be necessary to have these transcribed)
- Internal / external debrief dates and notes
- Post incident investigations
- Staff statements – chronological order
- Dictaphone logs

In the immediate aftermath of the incident, it may also be necessary to consider the retention of clinical waste, particularly if there is the potential for a crime to have been committed.

It is likely that requests for staff statements will be made by the Police Service. All external requests for staff interviews must be channelled through Legal Services prior to statements being taken.

All Log Books, written and recorded notes taken during an incident / debrief are to be completed within 24 hours and should be forwarded to the Resilience Team within 72 hours of the close of the incident

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12. List of Abbreviations

The following abbreviations refer to terms found within this document and other terminology commonly used within the Ambulance Service. The Lexicon of UK Civil Protection Terminology, produced by the Cabinet Office, contains a full set of definitions of terms which are used across responding agencies and aims to create a single point of reference for civil protection terminology as one of the underpinning elements of interoperable communications and coherent multi-agency working. The Lexicon can be found at [Emergency responder interoperability: lexicon - GOV.UK](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/671217/emergency-responder-interoperability-lexicon.pdf)

AIT(C)	Ambulance Intervention Team (Commander)
BASIC	British Association for Immediate Care
BCM	Business Continuity Management
BIA	Business Impact Analysis
BRC	British Red Cross
BTP	British Transport Police
C2	Command and Control
CCSML	Casualty Clearing Station Medical Lead
CSCATTT	Mnemonic – Command & Control, Safety, Communications, Assessment, Triage, Treatment and Transport
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosives
CCA	Civil Contingencies Act 2004
CCMA	Casualty Clearing Medical Advisor
CCG	Clinical Commissioning Group
CCP	Casualty Collection Point
CCS	Casualty Clearing Station
CLP	Casualty Loading Point
CQC	Care Quality Commission
CRR	Community Risk Register
DDMC	Dynamic Decision Making Cycle
DCAZ	Dynamically Controlled Access Zone
DMO	Direct Mode Operation
DH	Department of Health
DMP	Demand Management Plan
DRA	Dynamic Risk Assessment
ERICPD	Mnemonic – Eliminate, Reduce, Isolate, Control Measures, PPE and Discipline
EOC	Emergency Operations Centre
EP	Emergency Preparedness
EPRR	Emergency Preparedness, Resilience and Response
ESICTRL	Emergency Services Inter Control
FCP	Forward Control Point
FIM	Force Incident Manager
FD	Forward Doctor
HALO	Hospital Ambulance Liaison Officer
HART	Hazardous Area Response Team
HAZMAT	Hazardous Materials
HPA	Health Protection Agency

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IIMARCH	Mnemonic – Information, Intention, Methodology, Administration, Risk, Communication and Human Rights
IM&T	Information Management & Technology
IRU	Incident Response Unit
ISU	Incident Support Unit
JDM	Joint Decision Model
JOP	Joint Operating Procedures
LA	Local Authority
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
M/ETHANE	Mnemonic – Major Incident (Declared or Stand-by), Exact location, Type of Incident, Hazards, Access, Number of casualties and Emergency Services (required and present)
MA	Medical Advisor
MCA	Maritime & Coastguard Agency
MERIT	Medical Emergency Response Incident Teams
MICC	Major Incident Coordination Centre
MIMMS	Major Incident Medical Management and Support
MISU	Major Incident Support Unit
MoD	Ministry of Defence
MOU	Memorandum of Understanding
MRT	Mountain Rescue Team
MTA	Marauding Terrorist Attack
NACC	National Ambulance Coordination Centre
NARU	National Ambulance Resilience Unit
NHSE/I	National Health Service England & NHS Improvement
NMC	National Management Centre
NWAA	North West Air Ambulance
NWAS	North West Ambulance Service NHS Trust
PES	Paramedic Emergency Service
PPE	Personal Protection Equipment
PTS	Patient Transport Service
RD	Resilience Direct
REPPIR	Radiation Emergency Preparedness and Public Information Regulations
RHCD	Regional Health Control Desk
ROCC	Regional Operations Coordinating Centre
RRV	Rapid Response Vehicle
SCC	Strategic Coordination Centre
SCG	Strategic Coordinating Group
SHA	Strategic Holding Area
SJA	St John Ambulance
SOP	Standard Operating Procedure
SORT	Special Operations Response Teams
SMA	Strategic Medical Advisor
STAC	Science & Technical Advisory Cell
SuRC	Survivor Reception Centre
TCC	Tactical Coordination Centre
TCG	Tactical Coordinating Group

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THA	Tactical Holding Area
TMA	Tactical Medical Advisor
UKHSA	United Kingdom Health Security Agency
VAS	Voluntary Aid Societies

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14. Appendices

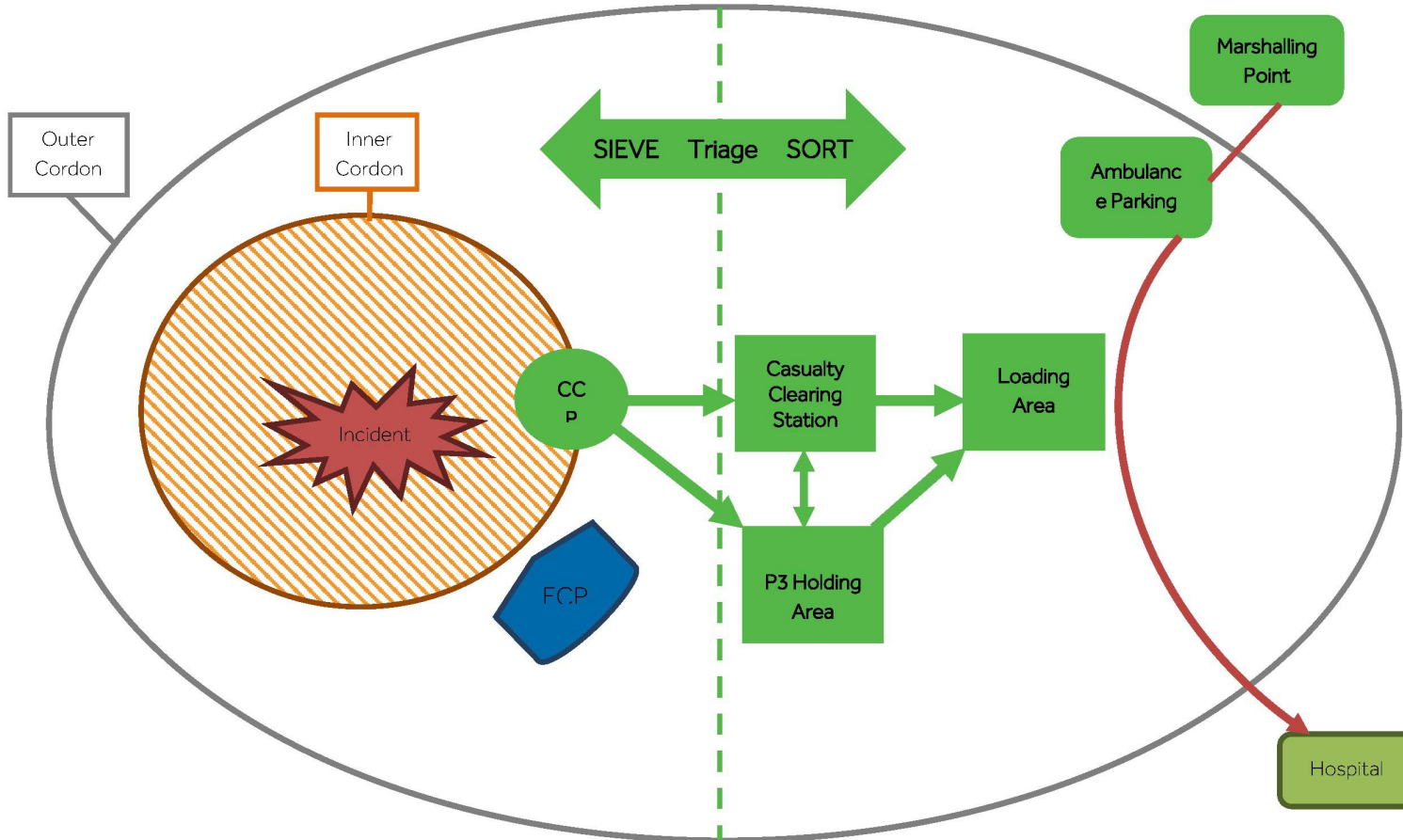
- 14.1 Appendix A - Incident Diagram
- 14.2 Appendix B - Roles and Responsibilities of other agencies

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14.1. Appendix A – Generic Incident Diagram

Reviewed by Joe Barratt, Head of Special Operations April 22



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14.2. Appendix B- Roles and Responsibilities of other Responding Agencies

The following lists are not exhaustive or comprehensive; they are to act as a guide to what each agency may offer during a response.

14.2.1. The Police

An overview of the primary areas of the police responsibility at a major incident is to:

- Manage overall coordination of the incident
- The saving and protecting of life in conjunction with other emergency services
- Coordination and communication between 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 and RV points
- Investigation of the incident and obtaining evidence
- Collation & dissemination of casualty information (persons at scene; persons at hospital; deceased at mortuaries)
- Establish a Casualty Bureau
- Media liaison
- Identification of the dead on behalf of the HM Coroner
- Prevention of crime

14.2.2. The Fire and Rescue Service

An overview of the primary areas of the Fire and Rescue Service responsibility at a major incident is to:

- Lifesaving, through urban search and rescue
- Fire-fighting and fire prevention
- Rendering humanitarian services
- Hazard Sector identification
- Meteorological information
- Work with the ambulance service to provide a mass decontamination service (Home Office, 2004, p. 16)
- Provide and / or obtain specialist advice and assistance where hazardous materials are involved
- Safety management within the inner cordon, other than during the initial stages of terrorist incidents
- Salvage and damage control; and environmental control
- The provision of specialist equipment, e.g. pumps, rescue equipment and lighting

14.2.3. Acute and Foundation Trusts

An overview of the primary areas of responsibility of acute, mental health and community NHS Trusts and foundation trust responsibility at a major incident, in accordance with their business remit is to:-

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- Provide a safe and secure environment for the assessment and treatment of casualties
- Provide a safe and secure environment for staff that will ensure suitable and sufficient health, safety and welfare
- Provide a clinical response including the provision of general support and control / specialist health care to all casualties, victims and responders
- Liaise with the Ambulance Service, NHS Area Team, local Primary Care Organisations (PCO) including GP's, out of hour's services and Minor Injuries Units (MIU's) and other health care agencies as appropriate
- Ensure where possible that there is an operational response to provide 'on scene' medical cover
- Provide appropriate support to any designated receiving hospital
- Provide limited decontamination to self-presenters at the hospital
- Maintain communications with relatives and friends
- Where applicable, deliver community services including walk in centres and domiciliary support and support to rest centres, to meet needs of people in the community affected by the incident, and to assist the hospital in identifying capacity for casualties requiring admission

14.2.4. NHS England national team

At a national level NHS England will:

- Support the NHS England AEO to discharge their 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 national incidents
- Have available specialist clinical advice to the NHS on planning for and responding to an incident. This may also include the provision of a clinical support cell during the response to an incident
- Provide assurance to HS of the NHS's ability to respond to incidents, including assurance of capacity and capability to meet wider UK resilience strategy requirements as they affect the health service
- Support DHSC in its role in the UK central government response to emergencies
- Action any requests from NHS organisations for military assistance
- Support organisations during the response and recovery phases of an incident or emergency.

14.2.5. NHS England (Region)

At a regional level NHS England will:

- Provide director level representation at the LHRP
- Ensure that each LHRP is suitably co-chaired by the ICB
- As a category 1 responder, ensure suitable representation at the LRF(s)
- Ensure integration of plans across the region to deliver a unified NHS response to incidents, including the provision of surge capacity
- Maintain capacity and capability to coordinate the regional NHS response to an incident 24/7 through effective surge and escalation planning at ICB level

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- Work with relevant partners through the LHRP and LRF structures
- Seek assurance through the local LHRP and commissioners that the Core Standards are met and that each ICS can effectively respond to and recover from incidents
- Coordinate and locally endorse any requests from NHS organisations for military assistance
- Provide support to the ICB, as required, to ensure any response to a Major Incident is effective
- Discharge the local NHS England statutory EPRR duties as a Category 1 responder under the CCA 2004 (delegated function)

14.2.6. Integrated Care Boards

The ICB's role and responsibilities are to:

- Fulfil the relevant duties under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 (HM Government, 2006) and the (HM Government, 2022).
- AEO to co-chair the LHRP and maintain the involvement and support of LHRP partners at strategic and tactical level.
- Ensure appropriate director level representation at the LRF.
- Establish a mechanism to provide NHS strategic and tactical leadership and support structures to effectively manage and coordinate the NHS response to, and recovery from, incidents and emergencies, 24/7. This will include representing the NHS at Strategic Coordinating Groups and Tactical Coordinating Groups.
- Support NHS England in discharging their EPRR functions and duties locally, including supporting ICS tactical coordination during incidents (level 2–4 incidents).
- Ensure robust escalation procedures are in place to respond to disruption to delivery of patient services.
- Provide a route of escalation for resilience planning issues to the LHRP in respect of commissioned provider EPRR preparedness.
- Develop and maintain incident response arrangements in collaboration with all NHS-funded organisations and partner organisations.
- Ensure that there is an effective process for the identification, recording, implementation and sharing of lessons identified through response to incidents and emergencies and participation in exercises and debrief events.
- Provide annual assurance against the NHS EPRR Core Standards, including by monitoring each commissioned provider's compliance with their contractual obligations in respect of EPRR and with applicable Core Standards.
- Ensure contracts with all commissioned providers (including independent and third sector) contain relevant EPRR elements, including business continuity.

Where the ICB or LRF covers more than one geographical location then agreement will be made locally in respect of representation for planning and response.

14.2.7. Local Authority

An overview of the primary areas of Local Authority responsibility at a major incident is:

- Road closures and diversions

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- Transport/ Assistance for Evacuation Arrangements
- Survivor, friends and relatives, and humanitarian assistance centres
- Plant and equipment
- Building safety inspections
- Welfare arrangements
- Maps and building plans
- Temporary accommodation
- Humanitarian assistance / support
- Translation/Interpreter Services
- Help lines
- Appeal fund arrangements
- Environmental health services
- Emergency lighting
- Clearance of debris and restoration of highways (except of the Motorway Network).
- Provision of accommodation for temporary mortuaries
- Information bureau

14.2.8. United Kingdom Health Security Agency (UKHSA)

- UKHSA provides an integrated approach to protecting UK public health through the provision of public health support and advice to the NHS, local authorities, emergency services, other arms-length bodies, the Department of Health and Devolved Administrations. Specialist advice areas include infectious diseases, outbreak surveillance, chemical, biological and radiation hazards.
- UKHSA is responsible for providing public health Emergency Preparedness Resilience and Response leadership and scientific and technical advice at all organisational levels, working in partnership with other organisations to protect the public.
- In fulfilling these responsibilities UKHSA will:
- Provide national leadership and coordination for the public health elements of the emergency preparedness, resilience and response system.
- Provide health protection services, expertise and advice and co-ordinate the UKHSA response to major incidents;
- Provide risk analysis and assessment of emerging diseases, natural extreme events, chemical, radiological and Chemical Biological Radiological Nuclear and Explosive (CBRNE) threats to inform the Department of Health and other government departments and agencies, health and multi-agency EPRR;
- Ensure provision of high quality and timely public health data to the Secretary of State and NHS CB, local authorities and across Government, in preparedness and response;
- Communicate with Devolved Administrations to coordinate investigation and management of cross-border public health incidents;
- Provide guidance to professionals in health and local government and other sectors.
- Communicate with the public by providing information and advice relevant to UKHSA responsibilities.
- Details on how to contact UKHSA regional and local centres can be found on the GOV.UK UKHSA home page.

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14.2.9. Maritime and Coastguard Agency

An overview of the MCA's responsibility at a major incident is:

- Coordination of civil maritime search and rescue both off shore and around the coastline
- Alerting rescue craft – RNLI, RAF, naval support and other vessels
- Liaison with shore based emergency services

14.2.10. Other Category 1 Responders Under CCA include:

- British Transport Police (BTP)
- Port Health Authorities (Airports, Ports)
- Environment Agency (EA)

(HM Government , 2005)

14.2.11. Category 2 Responders under the CCA include:

- Utilities (water, sewerage, gas, electricity)
- Telecommunications service providers
- Railway operators
- Airport operators
- Strategic Health Authority
- Harbour authorities
- Highways Agency
- Health and Safety Executive

(HM Government , 2005)

14.2.12. Voluntary Agencies

Voluntary Aid Societies (VAS) may also be utilised during a response to a major incident. Please see section 9.8 for further details.

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