London Ambulance Service NHS Trust

Emergency Operations Centre (EOC) Management of Complex Incidents Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To describe the processes undertaken by EOC when managing and dispatching resources to complex incidents with pre-determined attendance/specific considerations and specialist response types

Sponsor Department: Operations - Control Services

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Links to Related documents or references providing additional information		
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OP010	Procedure for the Maintenance of the High Risk Address Register, Notification of High Risk Addresses and Verbal Abuse Reporting	2.3
OP014	Managing the Conveyance of Patients	1.1
OP023	Dispatch of Resources by the Emergency Operations Centre (EOC)	1.1
OP060	Control Services – Call Taking Procedures	0.9
OP066	Control Services – Use of Paper Operations	1.3

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Contents

1. Introduction

The London Ambulance Service (LAS) currently operates its Control Services function from the Emergency Operations Centre (EOC) at Trust Headquarters (HQ) Waterloo Road and the EOC at the Bow Annex, Devon's Road. Both sites act as one virtual control room with normal working or business as usual, which sees all of the day to day control services functions operate in HQ & Bow using CommandPoint™ computer-aided call taking and dispatch; for the purposes of this document it will be referred to as CPCAD.

Each Control Room has call-taking and dispatching which allows the transfer of any sections of the operation to either site depending on the needs of the Service.

Dispatch of a resource in response to any category of call received, is dependent upon a number of processes and actions by EOC staff, CPCAD, operational staff and staff of other emergency services / agencies.

This procedure describes how the varying complexities of calls received within EOC may require different responses and considerations. It also indicates how CPCAD provides a pre-planned structure for deployment of resources to larger or more complex incidents to support dynamic decisions which may also be required from on duty EOC staff.

The last two pages of the document (page 27 and page 28) provide a quick guide for EOC staff (split down into Call Handling and Dispatch) for easy reference on a day to day basis but should only be used once staff have familiarised themselves with the full content of the procedure.

2. Scope

This document is limited to the detail of actions carried out by the human element of the Dispatch process and information presented by CPCAD to EOC users; it is not intended to explain the technical algorithms or processes in place which influence the outcomes of software such as CPCAD, PSiam or MPDS all of which are involved in the triage and/or Dispatch process.

It does not extend to include decisions or actions relating to disaster recovery/fall back scenarios (such as compromised LAS estates or technical disruption).Neither does it give guidance as to the use of paper operations across Control Services. (See OP66)

Whilst every effort has been made to ensure it is inclusive, it does not claim to be exhaustive. Caution should be raised against using it as the sole guide to making Dispatch decisions and managing incidents – scenarios vary from case to case. Those reading and applying this procedure are encouraged to use their initiative and expertise in assessing the appropriateness of the actions detailed within this document and to consider additional actions as may be required.

The actions described herein are provided to support the senior managers responsible for managing service provision and are not intended to replace or limit normal problem-solving responsibility.

3. Objectives

This operational procedure aims to provide clear guidance as to the roles, responsibilities and actions that are required to provide the most appropriate response for complex or specialist incidents, in an appropriate timescale to meet patients' needs as understood at the time of decision making.

4. Responsibilities

4.1 The *Chief Executive* has overall accountability for having an effective operational and risk management system in place and an effective system of internal control within the Trust. The day to day responsibility for risk and operational management is delegated to nominated directors.

4.2 The *Medical Director* has delegated responsibility for managing the strategic development and implementation of clinical management, clinical governance, and infection prevention and control.

4.3 The *Director of Operations* has overall responsibility for core operational delivery.

4.4 The *Deputy Director of Operations (Control Services)* has delegated responsibility for managing risks associated within Control Services (CS), and has responsibility for the development of operational strategy in order to meet national performance and clinical targets.

4.5 *General Managers (GMs)* have responsibility for the day to day delivery of core services within CS. The senior Control Services (CS) manager on duty maintains overall responsibility for ensuring adherence to the contents of this procedure. Whilst this would normally be the on duty CS General Manager, if a GM is not present a nominated Watch Manager (WM) may take on this responsibility.

4.6 *Watch Managers (WMs)* have tactical responsibility for the day to day delivery of core services and line management within CS.

4.7 *Emergency Medical Dispatchers (EMD's)* are responsible for triaging, and handling all calls received and dispatching resources to the patient. This can involve giving the patient/caller information to assist the crew on arrival or giving life saving instructions.

4.8 *Operational Staff* are responsible for the day to day delivery of core services.

5. General Guidance

Detailed below are some general guidelines that assist in developing a high level understanding of this procedure. Additional, more granular descriptions of these are captured within each section of this policy, in which the individual actions are outlined, further supported if necessary by appendices found at the end of this document.

5.1 Recording
To ensure that all decisions and deviations from this procedure (along with their rationale) are available, CPCAD should be used in BAU to provide a basic (and automatic) log of all actions combined with additional free-text detail in the relevant call or unit log (known as the EVA or Unit History). For clinicians it is often appropriate to record information on the PRF (patient report form) as well as request it to be recorded on CPCAD. In the event of CPCAD not being available due to technical or communication issues then details should be recorded on appropriate Trust paperwork (such as an AS1 or an IML) and collated and stored by the relevant department. Use of an IML is also considered as good practice by any manager involved in a complex, large or protracted incident or event.

5.2 Triage of Calls and Categories and Priorities
MPDS and the Manchester Triage System (MTS) are the Trusts current preferred structured triage tools but alongside these sit decisions made by nominated clinicians (sited in the Clinical Hub) based on their knowledge, experience and sets of guidelines. All of these result in every call received in the Dispatch area of EOC having a category and priority attached to it at some point. Often the priority of calls will change at varying points of the call process as different information is obtained.

5.3 Complex Incidents with Pre-determined Attendances or Specific Considerations
There are some calls which are likely to be more complex than others and these would generally include CBRN, firearms, prisons, bariatric patients and serious trauma. These are normally more complicated due to the patient(s) condition, the number of patients, the environment and/or other external factors. There are plans/criteria that have been drawn up in advance for these types of incident which are likely to require the attendance of specific and specialist resource types such as LAA, HART, IRO, CBRN trained personnel, etc.

5.4 Types of Response
For complex or specialist incidents, the range and quantity of responses may be significant and could include; varying physical vehicle type and/or varying clinical skill set (with different time parameters attached for our attendance at the patient). The choice of response will be impacted on by: the patient's clinical condition; the environment in which the incident has occurred; the cause of the incident; actual or potential hazards; Department of Health targets and directives; internal Trust policies, and current/anticipated capacity issues for the Trust (including factors such as Surge, REAP and numbers of calls holding/number of resources within a relevant distance of the patient). CPCAD will attempt to automatically activate

resources to calls within pre-determined criteria but there will also be occasions where manual activation by Dispatchers' is required.

6. Prioritisation and Dispatch of Calls

OP023 explains the process behind general prioritisation and dispatch of all calls received within EOC. Some aspects of triage, prioritisation and dispatch methodology referred to in this policy document may be unclear unless OP061 is read in conjunction with OP023. A very brief summary though is that a system referred to as MPDS uses structured questioning to gain information from all callers. This information is recorded in an 'Event' on CPCAD. All calls that are received within EOC regardless of the source have a priority applied to them which should influence the response received by the patient.

CPCAD uses a set of rules to automatically dispatch resources to most calls. The purpose of auto-dispatch is to provide a system that has a pre-planned set of responses for any given MPDS triage which should ensure a quick activation of the appropriate resource(s) and also reduce the workload on Dispatchers thereby releasing time for other decision making processes.

If the Event has automatic dispatch enabled, the automatic processes should always attempt to meet the response plan (the pre-planned number and type of resources required to initially deal with that incident) until the first resource starts conveying to hospital. During this time the Dispatcher can request a unit suggestion which will also display the quickest responders based on the response plan, which can be dispatched manually at any time.

Automatic dispatch will re-evaluate the response plan each time the Event Type changes, and will look to send the quickest resource of the types required by the response plan.
This may result in multiple resources being sent during different stages of the event, when
the Type is changed I.e. Chief Complaint and Determinant. Should this happen the Dispatcher will be sent an urgent message, informing them the response plan has been exceeded by said resources and advising that they should be cancelled.

Should the response plan not be met by automatic dispatch, this will be shown on the unit suggestion display, as the deficiency tab will be highlighted. The response profiling system determines which resources are needed to attend each event, and are based on unit type and skill levels. The response plans have been assessed by MPDS determinant and agreed by the Deputy Medical Director and Director of Operations.

As there are normally only a few of any resource type with a particular specialist skill on duty at any one time, it is likely to mean that running time to scene for any specialist resource type is longer than the response time of an ambulance or car and therefore 'reasonable' running time should be based on the information available from scene at that time as to whether that particular skill is required and also an awareness of what the response plan is still indicating is required.

All staff working in the dispatch area should always ensure that every attempt is made to meet the response plan assigned to each individual call. The details of the response plan can be seen on the unit suggestion display of each event either in Suggestion Info and / or Response Plan tabs.

7. Potentially Dangerous Incidents

This section covers incidents where there is the potential for violence or risk to the health and safety of ambulance staff. Examples of potential causes are; firearms, public disorder, Chemical, Biological, Radiological & Nuclear (CBRN), knives, domestic disputes, etc.

OP010 which is available on the LAS website 'The Pulse' details how we manage calls where we have information from a previous attendance or from another appropriate agency and what this will mean for any attendance in the future. Addresses will be flagged as 'High Risk Register' entries and will contain guidance on how any response should be managed including indicating the need for dynamic risk assessment once a response is on scene, awaiting the arrival of Police before making contact with the patient, sending IRO support, etc.

On receiving a call which identifies information appearing to fit within the definitions above (and where there is no 'High Risk Register' information indicating that call should be dealt with differently):

- EOC staff will determine a Rendezvous Point (RVP), ideally in conjunction with the police, but if not then using information on the mapping system within CommandPoint or with local knowledge of the area. This RVP may be temporary and is intended to keep the crew safe until the police establish an official RVP. It is also important that the location of the actual incident should be considered so that responding resources do not attempt to reach the RVP through the scene and where possible they will be advised of a safe route in by the Dispatcher.

- Arrival at the RVP should be considered as the on-scene time to be recorded in the Event on CommandPoint.

- Where incidents involving firearms are identified, an Incident Response Officer (IRO) must always be sent to the scene to liaise with the Police and to manage and support the incident/staff.
- Dispatch staff should ensure that the Area Controller and Watch Manager are aware of the incident details.

- Operational staff that are likely to arrive at an RVP before a IRO should be instructed to wear personal issue stab vests until the IRO arrives. All IRO's routinely carry ballistic armour for such incidents but a check should be made by EOC to ensure that the assigned IRO does have adequate armour for the assigned number of operational staff.

- Requests for support at 'Rapid Entry' incidents from the police should not normally be received by LAS as they have medics to manage these

scenarios. However there may be occasions where the Police do ask for assistance and this should result in the duty WM providing guidance as to how/whether the LAS provides a response. (These requests should not be confused with requests for attendance at pre-planned firearms operations).

8. Pre-planned Firearms Operations

Pre-planned firearms operations as the name implies allow an element of planning and also briefing to take place. Requests (which will be received from the Police) will be logged on an Event by a Call Handler using the Event Type 'RVPAI' and will include the information supplied regarding the time and location that the LAS response is required at. This will often be a Police station to allow operational staff to be appropriately briefed by the Police but if not will always be an RVP rather the location of the actual operation. Pre-determined attendance for these operations is one IRO, a Central operations resource and one ambulance crew (ideally with a Paramedic). If there are multiple target address, a request for multiple resources should be considered alongside current operational pressures and a response then agreed with the Police and the IRO(s).

Once the IRO and other resources required are at the briefing or on scene, contact with them is likely to be limited therefore it may be beneficial to get a contact name and number for the Police (usually the CO19 Team Leader) in charge of the operation and also supply it to the IRO. Other relevant points to consider are:

- Once briefed, no member of LAS staff will be released from the operation.
- Calls to IRO's and operational staff must be made in an emergency situation only.
- EOC should not expect regular updates from the IRO once they have booked on scene at the RVP. (This is to maintain the integrity of the operation).

9. Active Shooter Incidents

This type of incident involves an individual who is actively engaged in killing or attempting to kill people with the use of firearms weapons, often in a confined and populated location. The attack will normally end with the shooter taking their own life or being shot by the Police. This type of incident has been prominent in the United States during the last decade often with schools being targeted.

These incidents pose an increased risk to those responding, and set actions must be taken by EOC to ensure responder safety. The senior EOC manager will have responsibility for ensuring the appropriate actions are taken. CPCAD has a specific event type to be used on identification of an incident.

The procedure on responding to these incidents by the LAS or partner agencies is classified as restricted information and cannot be shared in this document.

On identification, advice must be immediately sought from the on-call Emergency Planning & Resilience Officer.

10. Marauding Terrorist Firearms Attack (MTFA)

An MTFA incident involves multiple terrorist attackers moving between high profile locations attacking indiscriminately with the use of firearms, potentially explosives, fire or the taking of hostages. The incident could become protracted lasting several days and is likely to see large numbers of casualties.

These incidents pose an increased risk to those responding, and set actions must be taken by EOC to ensure responder safety. The senior CS manager will be responsibility for ensuring the appropriate actions are taken. CPCAD has a specific event type to be used on identification of an incident.

The procedure for how the LAS or partner agencies plan to respond to this type of incident is classified as restricted information and cannot be shared in this document.

On identification, advice must be immediately sought from the on-call Emergency Planning & Resilience Officer.

11. Activation of the Police and Use of the LAS/MPS CAD Link

Greater London is covered by three Police forces; Metropolitan Police Service (MPS), City of London Police (CoLP) and the British Transport Police (BTP). The appropriate one of these forces will be advised of a request for their attendance, the responsibility for this rests with the Dispatcher that receives the Event in their Dispatch Group.

The relevant Police force must be requested to attend calls where a crime has or is suspected to have taken place, where there are scene safety concerns or where a scene is required to be controlled or contained. The primary role of the Police forces is crime prevention, detection and investigation.

Types of calls where Police should be requested include, but are not limited to;

- Assaults (all types) & fights
- Armed incidents and other calls involving weapons
- Confirmed collapsed behind doors
- Deceased patients in public places or believed to be a suspicious death including suicides
- Criminal activity – including burglaries, theft, trespass, drug taking
- Mental health issues involving violence
- Road traffic collisions with injuries
- Accidents on the rail/underground network including “one-unders”
- Suspect packages, IED or explosions
- Serious or major incidents
- If requested by responding crews

In some instances, each Police force will provide assistance to each other’s calls, particularly where specialist assets are required, such as firearms officers.

LAS/MPS CAD Link

The CAD link is designed to provide a messaging system between the LAS and MPS to request attendance and provide updates in a speedy manner. All messages received on

the CAD link are prioritised dependent upon the information provided by the Police. This is based on the Secondary Emergency Notification of Dispatch (SEND) process which is part of MPDS. As a result of this these calls do not provide a full or comprehensive triage of the patient (see priorities below).

All calls received have an event type of METPOL. Some calls may require this to be changed to provide an appropriate response. Options available are:

METR1	Red 1 – possible cardiac arrest
METR2	Red 2 – other life threatening condition

If the event is better handled using an RVP event type the Dispatcher must use these as appropriate:

RVP	Rendezvous Point
RVPAI	RVP Armed Incident
RVPTRA	RVP Train Stuck in Tunnel
RVPFE	RVP Aircraft Full Emergency
RVPAGI	RVP Aircraft Ground Incident
RVPAGG	RVP Airport Act of Aggression
RVPACC	RVP Aircraft Accident / Imminent Accident

The CAD Link does not replace the need to communicate verbally with the police and in some instances where the nature of the incident requires immediate information or has potential for crew safety implications dispatch staff are encouraged to speak to the police to gain the appropriate information.

MPS Event Priorities	
Ambulance Request Responses	**Event Priority**
Not Breathing	**R1**
Unconscious	**R2**
Chest Pain	**R2**
Stab / Shot	**C1**
Severe bleeding	**C1**
Under 2 years old	**C2**
None of the above applicable (no priority symptoms)	**C3**
Standby Request	**C3**
Information Only	**C3**

Communication on the CAD Link must remain professional at all times not using familiar language.

In the event of a CAD Link failure all communication must be made by phone to the relevant Police force. Event references or initials if CPCAD is unavailable will be exchanged and documented on the appropriate Event log.

12. Activation of the Maritime Coastguard Agency

The Maritime Coastguard Agency (MCA) is responsible for the coordination of incidents on the River Thames and the Royal National Lifeboat Institute (RNLI) undertakes the search and rescue of patients. The MCA Thames control is based at the Thames Barrier Navigation and Control Centre.

There are four lifeboat stations on the Thames:

- Gravesend
- Tower lifeboat station (Victoria Embankment)
- Chiswick lifeboat station
- Teddington lifeboat station

With the exception of Teddington station which operates staff on an on-call basis, the stations are staffed 24 hours a day.

The MCA must be informed of all calls involving the Thames, their banks and piers where the rescue of persons or vessels are involved.

Types of call include, but are not restricted to:

- Persons in the water
- Persons on the banks, piers or jetties
- Persons threatening to jump in to the water
- Medical emergencies on boats
- Vessels on fire, that have capsized or been involved in an accident

The MPS and LFB (London Fire Brigade) also have dedicated resources working on the Thames and may be requested as appropriate, but this must not prevent the MCA from being informed as they have primacy over the rescue of patients.

The MCA should be contacted on the relevant phone number and advised of calls for their attendance. References should be exchanged and documented on the Event log.

13. Activation of the London Fire Brigade (LFB)

The London Fire Brigade (LFB) covers the same geographical area as the LAS and are responsible for the safety of the scene during incidents. Their main roles are to undertake fire fighting and search & rescue of patients.

The Dispatcher receiving an appropriate call in their Dispatch Group is responsible for ensuring the LFB have been requested.

Types of calls the LFB should be requested for include many that the LAS HART resources should also be dispatched to and some examples are:

- Fire calls
- Explosions or IEDs
- Fuel / chemical spillages
- Gas leaks
- Transport accidents involving entrapments or unstable vehicles
- Accidents on the rail/underground network including “one-unders”
- Urban search and rescue incidents including collapsed or unstable buildings, incidents at height or underground / in tunnels
- Flooding
- Incidents where persons are requiring rescue from open water (rivers, lakes, reservoirs, estuaries etc)
- Incidents involving a CBRN element or other hazardous material
- Serious or major incidents
- If requested by responding crews

The LFB should be contacted on the relevant phone number and advised of calls for their attendance. References should be exchanged and documented on the Event log.

14. Attendance at Chemical Incidents

Calls to incidents where chemicals are involved are likely to have a response plan within CommandPoint that will require the deployment of HART and a IRO alongside ambulances and response cars. This is partly because of the potential for multiple patients and also because of the risks associated with chemicals and contact with them or patients that have been exposed to them. There is also likely to be a degree of liaison with other emergency services at the scene. As with any potentially dangerous incident an RVP may be appropriate; other sections of this document may also need to be taken into consideration and also the Trust’s Major Incident Plan (available on the LAS website ‘The Pulse’). The following actions are required from EOC:

- All available details of the incident and RVP will be passed to all responding resources
- STEP 123 should be invoked when more than one patient has collapsed or is taken unwell with the cause being unknown, or is known to be hazardous, and responders should consider their own safety and the cause being of a potentially hazardous nature until proven otherwise. Further information about STEP 123 can be found in the Emergency Preparedness section on the LAS Trust website.
- Due regard and consideration must be given to the potential of explosion/airborne chemicals or biological hazard and whether the incident may be deliberate or accidental
- An LAS Officer (usually a IRO) must be dispatched to scene and assume responsibility in accordance with Major Incident Plan (MIP)

- HART should be dispatched in the manner described within this policy.
- The first operational resource on scene should be reminded to submit a 'METHANE' report – see MIP,
- The duty WM must be advised of the incident.
- The duty**/**on call Emergency Planning and Resilience Officer (EPRO) and Tactical Support Officer (TSO) will be contacted and informed of the incident.

15. Attendance at Her Majesty's Prisons

Calls to prisons are generally treated and handled as any other call; using MPDS as normal to triage the call, followed by the dispatch of an ambulance or solo response appropriate to the patients needs in line with the appropriate time scale. EOC staff should check the 'Sitplan' button on the Event; where it is highlighted any instructions contained within it must be adhered to.

Any additional information or requests from the member of staff making the call should be logged within the Event or if appearing more urgent should be escalated through the Call Handling Manager at the time of the call.

There are certain codes used nationally within the Prison Service which refer to more serious patient conditions and often align with Ambulance Service Cat A priorities (they may be referred to as any of the following: Code Blue, Code Red, Code One or Code Two). If the caller from the prison makes reference to any of these codes the call should be deemed as requiring a Category A response until proven otherwise through full MPDS interrogation without having to use 'unknown' to answer any of the questions. This means that the Call Handler should log the "Code" that has been mentioned in the Event and then continue using all available information to triage the call through MPDS as normal.

Until the Event has been completed by the Call Handler, the Dispatcher should treat the call as a Category A priority, only reducing the response sent to a lower level if the call gains a lower priority and all MPDS questions have been answered without any answered as "unknown". (OP23 provides guidance on Dispatch of resources to different priorities of call).

There are occasions where the call is being made by (or on behalf of) a Health Care Professional and where this can be verified as the case, the call may be processed using 'Protocol 35' in MPDS.

Any call for a patient at a prison that receives a 'no send' outcome, a referral for a ring back from a clinician, or a C3 or C4 priority, (especially due to a lack of available information surrounding the patient's condition), should be discussed with the Call Handling Manager or a member of the CHUB before ending the call, to reduce the risk of providing a lower level of response than is actually required.

The duty WM should also be advised of any call to a prison once the call has been completed.

Bear in mind that responses to prisons are subject to the following for operational staff:

- All persons entering prisons are subject to the terms of the Offender Management Act 2007. Ambulance Staff do not have Crown Immunity when entering prisons for certain items, and as such, depending on the category of the prison, may be subjected to stringent security checks of varying levels by prison staff. Ambulance Staff should expect to be asked to surrender items such as personal mobile phones. Mobile phones issued solely for ambulance purposes, airwave radios, ambulance equipment etc. will be allowed in.

Responses to HMP Belmarsh have some specific guidelines which should be observed by EOC and operational staff, due to the category of prisoner detained there and are also likely to be applicable to Feltham Young Offenders Prison. The current instructions relating to HMP Belmarsh which were issued in October 2006 are;-

- All persons entering the prison are required under Home Office protocols to be subjected to stringent security checks by prison staff.

- Where the call is triaged through MPDS as a life threatening incident, LAS staff will continue to be afforded immediate access and escorted directly to the patient.

- EOC will also advise prison staff of the names of the attending LAS staff, the fleet registration and type of vehicle and subsequent patient destination hospital.

- In respect of all other priorities of emergency calls, staff must comply with the prison protocol of electronic searches, 'pat' searches and vehicle mirror checks, when required to do so. ‘Pat’ searches will only be conducted on female members of LAS staff by female prison staff.

- Operational staff are reminded that they must carry personal protective equipment (PPE) with them on any occasion they are required to attend HMP Belmarsh. Staff must also ensure that they are in possession of their LAS identification pass (as normal and in line with OP01).

- In situations where the patient has a high security classification, EOC will always endeavour to dispatch a IRO to attend the incident to accompany the attending staff.

16. Attendance at Airports/Heliports

Requests to attend at airports/heliports or at aircraft crashes may come from a variety of sources, especially if the incident is highly visible from inside or outside the facility. If it is unclear whether the request for attendance has been made officially by staff at the actual location (or a local airport/heliport), then this facility should be contacted through the contact numbers listed within the EOC Resource File, while a response is being arranged.

Not only does this ensure the facility is aware of the incident but it also means that they are aware that LAS are attending – it is also likely that this contact will result in additional information being made available to LAS, such as the most appropriate RVP to attend, potential or actual numbers of casualties, type of incident/aircraft, etc.

Where calls are being received from a member of the public, MPDS should be used as normal and if the call relates to an accident involving an aircraft then Event Type and Protocol 29 (traffic accident) should be selected.

If the call is being received from another emergency service or from an airport/heliport then the following Event Types should be selected:

- "RVPACC" should be used initially to identify an "aircraft accident on/off airport" or an "imminent aircraft accident" notification from an airport/heliport. This ensures that the correct response plan is selected by CPCAD allowing the appropriate pre-determined attendance to be displayed to the Dispatcher. If a major incident is then declared at any point the 'Event Type' can then be amended to "MAJORB" which will identify the full pre-determined attendance required in such circumstances.

- "RVPFE" and RVPAGI" should be used initially to identify a "full emergency" or an "Aircraft Ground Incident" (AGI); the pre-determined attendance is two ambulances and two IRO's.

- "RVPAGG" should be used initially to identify an act of aggression against an airport infrastructure or an aircraft (including a hijack).

During a large incident at any airfield, responding resources must attend the RVP and not enter a runway or taxiway until either they are escorted by a "follow me / leader vehicle" or until confirmation is received that the airfield has been closed. The first resources arriving at the RVP will establish information such as this from the airport RVP officer and report to EOC.

Heathrow (LHR) airport is the largest and busiest airport within the catchment area of LAS and some specific details to consider and assist when dealing with a request for attendance there can be found in Appendix 2 and gives useful detail relating to LAS resources based at the LHR and responses to medical and trauma calls not related to large incidents, as well as RVP information.

17. Attendance at Motorway Incidents

Incidents on motorways and other fast roads that require an ambulance service response can bring a unique set of difficulties and risks not always encountered on other parts of our road network.

In 2014 additional potential issues were created by the introduction of “smart motorways”. These motorways affect multiple stretches of motorway within the LAS boundaries and may result in “all-lanes running” where the hard shoulder becomes an additional lane for traffic and also “managed lane control” where there will be a variable speed limit and the hard shoulder becomes an additional lane for traffic during periods of high traffic flow – these are managed by overhead signage. However the following information should not just be used for those areas and in fact EOC should assume that all sections of motorway are ‘smart’ and therefore that access via the hard shoulder may be restricted.

When a call is received to any part of the motorway network, EOC should still attempt to dispatch appropriate resources in line with the response plan contained within CommandPoint for that particular call and also in line with OP23. **Appendix Four** contains a flowchart of other parties that EOC should be in contact with for information sharing purposes so that the incident can be managed effectively with minimum delay for patients and maximum safety for all involved.

Contact with the Highways Agency is essential, as they will be able to provide additional information on the location using CCTV and in-road technology and also provide advice on the best access for responders. They must be informed of every call where LAS respond to an incident on the motorway network, (regardless of whether within the LAS catchment area or assisting outside this area).

The Highways Agency are also able to facilitate access on some occasions by using overhead signage to create an empty lane for incident access, or by reverse access from the next junction on from the incident, allowing travel against the normal flow of traffic. Responding staff will contact EOC prior to travelling against the normal flow of traffic to check whether it is safe to process and it is the Highways Agency who can provide the required information; that the road is closed; that all traffic has been stopped behind the incident; and that it is safe to proceed.

Giving information back to the Police, Fire Service and the Highways Agency is also important once we have updates from scene and this also links in to the vital multi-agency liaison role that the IRO takes on when attending all of these incidents. The IRO also provides a key role in staff safety and incident management and resolution and must always be dispatched to a motorway incident, no matter the nature of the call, number or types of patients.

18. EOC Management of Obstetric Emergencies

Obstetric emergencies relate to calls such as pregnancy with high risk complications, imminent birth, or a baby born before the arrival (BBA) of ambulance staff. A medical or traumatic emergency may also put the life of the mother and/or baby, in imminent danger
e.g. trauma/epilepsy related seizure. These conditions can be clinically difficult to deal
with and often need fast identification so that an appropriate response can be sent. Where this type of call is identified to the Call Handling manager they will

verbally contact the Dispatcher or Area Controller to ensure the call has been correctly identified.

Dispatch staff must make every effort to dispatch a crew for each patient, e.g. if twins are expected then three crews will be required, one for each baby and one for the mother. The pre-determined response for this type of call requires at least one of the operational staff members attending the incident to have a Paramedic skill level.

The appropriate treatment for the presenting condition must be initiated if the patient has a medical or traumatic emergency and the mother should then be transported to the nearest Emergency Department, preceded by a pre-alert if any complications arise relating to the labour and/or the mother's condition. If conveying with no significant clinical concerns it is likely that the conveying crew will request a courtesy call to be passed to the receiving unit. Patients may not always be taken to the hospital they have previously been managed under if an alternative unit is deemed more appropriate, (this is not an EOC Dispatch decision but a clinical decision taken by the crew, hospital or Clinical Hub).

If the patient is experiencing a normal labour/delivery, it is likely the crew will request a midwife to scene, however where complications of any sort are present, a midwife would not normally be sent to scene as that could delay the crew transporting the mother; the exception being if the baby is in the process of being delivered and the mother cannot be moved. As soon as a BBA situation is identified the Dispatcher should ensure always ensure that a midwife is contacted requesting their attendance to scene.

If additional advice/guidance is required, this can be provided by the Clinical Hub in EOC, or an obstetric unit. If on scene support or support once the call is complete is required for the ambulance staff, then alerting/deployment of a Team Leader or IRO may be appropriate.

19. Patients' Requiring Specialist Lifting or Moving Equipment and/or a Bariatric Vehicle for Conveyance

There are a number of situations where the environment or a patient's size or weight may indicate a requirement for specialist training for access, specialist lifting or moving equipment or a specialist ambulance to facilitate transport to a treatment centre. Some simple cases may just require an additional person or two to ensure a patient can be safely lifted or moved whilst other situations can become more complex, especially where access is limited or a patient exceeds the weight limit of the equipment available at scene.

It is good practice and advisable to deploy either a Team Leader or IRO to scene once these situations are identified, as this often provides additional experience in finding solutions, a manager to co-ordinate the scene and/or an additional member of staff to provide physical assistance. An example of an exceptions could be due to the distance away from scene of the nearest available Team Leader or IRO and in these instances telephone contact between them and scene may provide a suitable alternative option.

HART are likely to be able to assist especially in situations where additional numbers of
staff are required to move a patient or where working in a confined area, at height, or any of the other criteria listed in **Appendix 3** of this document.

It is important that an accurate understanding of the patient's clinical condition is obtained by EOC at the earliest opportunity, as this will influence the time parameters which may affect the way in which the patient is managed. For example various different options can be considered to successfully manage a non-injury fall for a bariatric patient, including
waiting on scene for specialist equipment or staff to be sent from a distance if necessary. A patient with a condition which is life threatening is unlikely to be able to be afforded the same option without further detriment and therefore options may have to be considered which although not ideal, meet the more urgent need of the patient.

Utilising the Clinical Hub in EOC to liaise with the caller/patient prior to arrival on scene or to liaise with operational staff on scene, may provide benefit in understanding any time constraints and any other aspects relevant to the patient's clinical condition and care. It is not the role of Clinical Hub staff to decide what resources should be sent to move a patient, only to gain information regarding the clinical condition and needs – a dynamic on scene assessment is the preferred route to understand what physical needs are evident to resolve on each occasion of attendance.

Some patient's needs can be planned for, especially where another Health Care Professional or Emergency Service is involved in requesting the attendance, while other needs may only be identified after dynamic assessment of the situation by operational staff on scene.

The Fire Service continue to provide support to the ambulance service where additional help is required due to the size or weight of a patient, but only where the patient's condition is deemed life threatening and other internal options have been attempted/considered and failed/considered inappropriate.

A form is in place in EOC with a series of questions to be answered which will support the decision making as to whether a bariatric vehicle is required. The Area Controller or WM should ensure this is completed and consider the guidance given within it.

Where a bariatric vehicle is required, the WM should initiate contact with the London Ambulance Service PTS (Patient Transport Services) department to see if they are able to provide this resource. Where this is not available the WM for EOC will be able to access a list of private providers who have been signed off as appropriate to provide this service. The duty EOC General Manager should be made aware prior to booking a bariatric vehicle to ensure that this is the appropriate option for the patient.

20. Significant Incidents

Declaration of a 'Significant Incident' by LAS is normally in response to an incident where, although it doesn't meet the criteria at that time to be a 'Major Incident', it still has the potential to require significant management and responses due to a potential or actual high number of casualties. A 'Significant Incident' could also be declared due to the nature, type or duration of incident, or because it requires special arrangements/specific resources required to attend. There are still many occasions where a 'Serious Incident' will not need to be declared but where the incident or skill types referred to in this document are present.

Examples of Incidents that might need to be declared as 'Serious Incidents' include:

- Persons Reported Fire calls 6 pumps and above or large scale evacuation
- Explosions
- Single location incidents with 6> patients
- Train stuck in tunnel/railway incidents

- Public order situations
- Multi-casualty incidents at high profile sites
- COMAH sites
- Marine/waterways/river accidents
- Declared Major Incident by other London emergency service or neighbouring Ambulance Trust requesting assistance

The event type 'SIGNIF' should be used in CPCAD which has a priority of Red 2, with automatic dispatch turned off.

The majority of the specialist resource types discussed in this document may well be required to attend a 'Significant Incident' and confirmation can be found within each of the resource types if needed. If in doubt, check with your line manager or contact the lead on duty for the resource type, for confirmation as to whether their skill set would be appropriate for the type of incident being dealt with.

Please note that for a 'Significant Incident', the London Air Ambulance (LAA) Paramedic should be informed and will dispatch the air ambulance team. All LAA reports will then be reported back in from the LAA Paramedic to the WM or GM managing the incident for EOC. The LAA will assume the role of a Medical Emergency Response Incident Team (MERIT) as per the LAS Major Incident Plan and are the first MERIT team deployed by LAS for a 'SignificantIncident'. The LAA Paramedic should inform Silver for the incident of any additional resources available but will not actively dispatch any of them as this will be dealt with by the EOC team in SOC in liaison with Silver.

21. Major Incident Event Types

To ensure that identified Major Incident's can be appropriately dispatched upon (either via Automatic or Manual Dispatch), specific Major Incident Event Types

should be selected by EOC at the point of identification regardless of whether still in Call Handling or if the call is being dealt with in Dispatch.

(i) MAJORA Event Type:
This Event Type will be enabled for automatic dispatch to ensure that appropriate levels of resources are activated to support the initial management of the event.

Automatic Dispatch will move to a suspended status once the response profile has been reached or once the first resource moves to a transporting status.

The default event priority for MAJORA event type is Red 1.

Due to the number of ambulance resources likely to be sent should this event type be selected, caution needs to be exercised before utilising this event type. If at any stage there is uncertainty staff should liaise with a supervisor or manager for further guidance.

(ii) MAJORB Event Type:
This event type is to be used after the initial cohort of ambulance resources have been activated and / or arrived on scene, to allow further manual management of the incident to occur. This will allow for further units to be activated based on the response profile.

Automatic dispatch will be disabled based on this Event Type and the default event priority for MAJORB event type is Red 1.

(iii) RVPACC Event Type:
This event type is used to identify an aircraft accident on / off airport or an imminent accident. This should be selected by either call handling or dispatch.

Should an aircraft accident be declared as a major incident, (either by EOC or operational staff on scene), the Event Type must be changed to 'MAJORB'.

22. Dispatch of Incident Response Officers (IROs)

The Incident Response Officer (IRO) is an operational manager with responsibility for real time operations management pan-London. This section provides details relating to matters that should be brought to the attention of a IRO and these can generally be broken down into three types of incidents; operational, welfare and performance related. A summary of the more usual incidents within those groups is contained in **Appendix 1.**

(i) Operational Incidents

1.1. In the case of operational incidents it should always be the *nearest* available IRO that is notified. (Whilst consideration should be given to the utilisation of a Team Leader or Training Officer in some instances, it should be noted that they may not have received the appropriate training to manage certain operational incidents).

1.2. A preliminary discussion is to take place between the Area Controller and IRO prior to dispatch (telephone handshake). If the Area Controller is unavailable this may be delegated to the Dispatcher working with that dispatch group.

1.3. The IRO and Area Controller (or delegated Dispatcher) should enter into a preliminary discussion to agree the appropriate response to any given incident with due regard for pre-planned attendance requirements.

1.4. Where the decision is made for IRO attendance, the event details are to be sent to the IRO in the usual manner.

1.5. The Area Controller should draw upon the operational experience of the IRO when deliberating the best course of action.

1.6. The corresponding event chronology is to be updated with the agreed course of action.

1.7. The Area Controller retains the primacy regarding immediate IRO activation.

1.8. The matter may be escalated through the arbitration process as outlined in this document once the incident has concluded.

(ii) Welfare Incidents

2.1. Welfare incidents are to be brought to the attention of the relevant complex IRO.

2.2. Where the complex IRO is not available, the neighbouring complex IRO is to be utilised.

2.3. A IRO is to be alerted to welfare matters via Airwave or telephone by a member of the Dispatch function within EOC.

2.4. Once the IRO has been alerted, ownership of the issue is transferred to the informed IRO.

(iii) Performance Incidents

3.1. Performance incidents are to be brought to the attention of the complex IRO.

3.2. Where the complex IRO is not available, the neighbouring complex IRO or nearest ’99 IRO is to be utilised.

3.3. IROs will be made aware of vehicle off the road matters via text or phone by CSU and/or VRC unless already Dispatch staff have already carried this out.

(iv) Arbitration Escalation

4.4. The aim of any arbitration is to ensure learning opportunities are identified and that matters are resolved expediently with those directly involved.

4.5. Arbitration is to take place after the incident has been managed.

4.6. Where a IRO discovers this protocol has not been followed or would like to discuss the dynamic decisions made, the first point of escalation is with the Area Controller on duty.

4.7. Should this remain outstanding or unresolved for either party, the matter is to be referred to the WM on duty and then with the GM on duty.

4.8. Where matters are discovered historically, details are to be forwarded to the Control Services Business Development Manager who will register the matter and refer it to the watch GM who will undertake enquiries or delegate this to a member of the watch management team.

23. Dispatch of the London Air Ambulance (LAA)

The London Air Ambulance (formerly known as the Helicopter Emergency Medical Service (HEMS)) has a trauma doctor and paramedic on board and is targeted at severe trauma calls in order to get the skills of a doctor to the scene quickly when needed. The London Air Ambulance is based at the Royal London Hospital in Whitechapel. When the helicopter is “off line” the team are normally available to attend scene by road in a response car.

A LAA paramedic is based in EOC and will assess incoming calls for suitability for LAA deployment – there is also a responsibility for any Dispatch/Call Handling/operational staff who identify patients who may benefit from the attendance of LAA to bring the relevant call to the attention of the EOC based LAA paramedic. Operational staff may well be requested to ‘report on arrival’ (ROA) to provide further information for the decision making process of the EOC based LAA paramedic.

The paramedic in EOC will either immediately dispatch the LAA response to a call (based on information given by a member of staff, information contained in the Event on CPCAD
or after listening in to the call being taken by a Call Handler), or they will speak to the original caller to gain further information before making the decision to deploy. The following list of call types indicates those which will or may result in the attendance of LAA:

Immediate Dispatch based on detail in the CPCAD event without the need for further interrogation:

- Falls higher than two floors
- RTC’s including: trapped under vehicle; ‘one under’ a train; ejections; associated fatalities
- Traumatic amputations (proximal to wrist/ankle)
- Request from operational staff on scene
- Request from other emergency services including police, fire service and other ambulance services

Further interrogation required prior to dispatch, due to limited or unclear information on injury or mechanism of injury, to ensure benefit from dispatch of LAA:

- Any other fall with serious injury
- Any other RTC with serious injury
- Assaults including stabbings and shootings
- Drowning
- Head injury
- Electrocution
- Industrial Accidents
- Explosions

On occasions where multiple calls fitting the criteria for LAA deployment exist concurrently, the decision on which call to attend will be based on factors such as; the number of casualties at each call and the severity of their injuries; distance from scene for each of the calls for LAA; distance from scene and number/skill level of other responding resources; distance of the scene from an appropriate hospital; liaison with the personnel on the LAA response. This list is not exclusive but gives an idea of the considerations that will influence the decision making of the LAA paramedic in EOC.

For all cases of declared Serious or Major Incidents, the air ambulance team must be dispatched as they assume the role of a Medical Emergency Response Incident Team (MERIT), as per the LAS Major Incident Plan. This is likely to apply to many multi-casualty incidents as well but will sit within the assessment methodology listed earlier in this section.

24. Dispatch of the Hazardous Area Response Team (HART)

HART teams consist of a number of staff and vehicles and the types of calls they attend will often be those which do/may involve a number of casualties. **Appendix 3** lists the main types of incidents that HART should be considered for dispatch to and the majority of them involve patients exposed to some sort of hazardous substance or those who are affected by difficult access or extrication factors. HART not only have additional equipment for managing patients in these situations but they also have additional equipment and training to keep them safe when entering these environments or coming into contact with patients who have been exposed to harmful substances.

CPCAD will identify certain calls as requiring HART as part of the response plan for that
incident type (and where available HART should always be dispatched in line with this), but there are also occasions where EOC staff should dispatch HART to incidents where additional information is identified but not reflected within MPDS or where a specific request is received from operational staff on scene, other emergency services or other ambulance services (as they form part of a national mutual aid agreement).

When a HART suitable call is identified by EOC for any of the reasons listed above, the nearest available HART resource is to be dispatched by assigning the Event to the relevant (nearest) HART call signs; there is no requirement to make contact with the

Team Supervisor however the Dispatcher must ensure that the resource attending is aware of the reason for their attendance if it is not clear from the call details that will be sent to the MDT. The HART team that have been assigned to the incident will book mobile to scene and make contact with their Team Supervisor whilst en route, to advise of the call details. The Team Supervisor will then decide if further HART resources are required or if a closer or more appropriate resource is to be sent. If so, they will contact EOC on their normal working talkgroup and advise of the call signs to be dispatched.

HART resources attending scene must provide a report to EOC which will be logged on the relevant Event on CPCAD. The outcome of the call is to be recorded. (If not provided, EOC are to request it).

Partner agencies requesting the attendance of HART are to request HART through established EOC contact mechanisms. HART resources are not to deploy unless directed by EOC.

EOC will dispatch an operational officer to all incidents attended by HART, who will act as a Forward Incident Officer. The deployment of HART should not negate the need to page the on duty/on call Emergency Planning & Resilience Officer or Tactical Support Officer via the WM desk. (HART staff are not trained to offer advice to ambulance officers in command roles).

STEP 123 and carbon monoxide (CO)
Dispatch staff are reminded that HART is to be informed of all calls involving STEP 123 incidents and calls involving, or suspected to involve, carbon monoxide poisoning.

STEP 123 is invoked when more than one patient has collapsed or is taken unwell with the cause being unknown, or is known to be hazardous, and responders should consider their own safety and the cause being of a potentially hazardous nature until proven otherwise. HART must attend these calls to provide an on scene assessment. Further information about STEP 123 can be found in the Emergency Preparedness section on the LAS Trust website.

HART must also attend any suspected or confirmed carbon monoxide (CO) poisoning as they are the only resources in the Service that carry CO monitoring equipment, and are able to provide specialist advice regarding definitive treatment. Indications of CO poisoning include single or multiple patients with symptoms that could include a headache, nausea, shortness of breath, potentially confusion or reduced level of consciousness. Babies and young children are the quickest to display signs. Carbon monoxide poisoning can be fatal and EOC must make all effort to recognise it and dispatch appropriate resources, including HART.

25. Dispatch of Paramedic Skill Level I

Due to the increased potential of pre hospital intervention and benefits to clinical outcomes that can be provided to the patient for certain types of emergency requests, Dispatchers should always attempt to activate Paramedic trained personnel to certain types of events and this is reflected in the response plan (as directed by the Medical Directorate) for any Event. Dispatchers' should always strive to meet these response profiles to ensure the best possible patient care can be provided. Should this not be completed, the Dispatcher must fully record the reason on the Event Chronology.

The Medical Directorate have stipulated the following event types should always be responded to by a paramedic skill level or above:

- Cardiac Arrest
- Continuous Fitting (as at end of 999 call)
- BBA and / or obstetric emergency

Every effort should also be made by the Dispatcher to ensure that a minimum of three LAS personnel should attend a cardiac arrest, one of which should have a minimum of Paramedic training and registration. This will ensure that the most effective pre hospital treatment can be provided. The response profile for the call should indicate the requirement for this and should also ensure that if not already provided, that a conveyance capable resource forms part of the response rather than just 3 staff working on cars which might have been the initial response.

26. Retrieval of a Category 4 Patient

Category Four patients are those with a confirmed or highly probable category four infection - special measures for infection control apply to diseases such as; Rabies, Plague, Viral Haemorrhagic Fevers (Lassa, Marburg, Ebola and Crimean/Congo (CCHF))

The High Security Infectious Diseases Unit (HSIDU) at the Royal Free Hospital will contact EOC and identify that a patient requires transportation to the unit under category four conditions. They will inform EOC of the following details:

- Name, diagnosis and clinical condition of the patient
- Current location (which may be a hospital or could be an aero medical repatriation)
- Contact details of the referring clinician

On receipt of the information EOC should page the on call Tactical Support Officer (TSO) and the Head of Infection Prevention & Control (HA05). EOC will then communicate status details to the HSIDU of the progress with the transfer of the patient.

It is possible that the information may come from a source other than the Royal Free Hospital (such as an airport or the RAF) and if this occurs (identifying a confirmed or highly probably category four infection patient) then HA05 should be

contacted initially for guidance (if unavailable contact with the Royal Free Hospital should provide guidance).

Once the request has been made for a transfer either the TSO or Head of IPC will identify an officer who will undertake the role of the Transfer Officer. The Transfer Officer will co-ordinate the transfer arrangements and will act as the liaison between the referring clinician, the HSIDU, EOC and the transfer crew. The officer will travel with the crew to the patient and directly oversee the transfer and subsequent decontamination to ensure patient and crew safety.

If the patient is situated within a 3 hour time radius of London, the on duty Hazardous Area Response Team (HART) will be used for the transfer. If the patient is outside the 3 hour radius, the HART members will be paged for their availability and be brought into one of the HART stations for deployment.

The transfer officer will identify an available vehicle for the transfer. (If no vehicle is available EOC will be directed to release the nearest available appropriate resource for the transfer). The crew will be given a rest break prior to the transfer if applicable and then make their way to the referral point under emergency conditions.

The crew and officer must satisfy themselves that all necessary decontamination procedures and debrief have been completed before reporting their status to EOC as available after the transfer.

27. The Role of the Clinical Co-ordination Desk (CCD)

The main activity of the Clinical Co-ordination Desk (CCD) is to receive details of priority patients from operational staff conveying patients to hospital and then to pass on those details to the appropriate receiving hospital. These priority calls are often referred to as ‘Blue Calls’ and will normally be received by the CCD on Airwave talkgroup ‘PD09’. Contact with the hospitals will be made by telephone on the dedicated Blue Call numbers listed in the Resource File.

In conjunction with the LAA paramedic and operational colleagues, the EMD’s on the CCD also co-ordinate admissions to Major Treatment Centre’s (MTC), Hyper Acute Stroke Units (HASU) and Heart Attack Centres (Cath Labs) located across London.

In the event that an operational resource is not acknowledged when calling the CCD on PD09, they may pass the details of the Blue Call to EOC on their normal dispatch talkgroup. The Dispatcher must log all the details and pass them to the receiving hospital without delay. Should the Blue Call be going to a MTC, HASU or HAC then the CCD should be updated afterwards by the Dispatcher to ensure that hospital capacity can continue to be accurately monitored.

All the details of every Blue Call must be fully recorded on the Event Chronology of the call the resource is dealing with (regardless of who receives the details in

EOC), including full details of the patient diagnosis, crew conveying, the hospital patient being conveyed to, the time details received and the time passed.

The EMD working on the CCD may also be asked to monitor incoming events to assist the LAA paramedic and also to assist the staff on the Clinical Support Desk (CSD). Whilst EMD's should be encouraged to follow the Trauma Triage Tool in providing assistance to operational resources, they should not give clinical guidance under any circumstances. Any clinical questions should be directed to the appropriate clinician.

28. Loss of Technical Functionality Impacting Upon the Dispatch Process

There are a number of technical aspects that could fail and affect the Dispatch and management process of the resources and incident types discussed in this document, including elements such as ProQa, MDT's. Airwave, CPCAD, etc. Information relating to these potential failures and actions to take if they do occur can be found within OP61 and may result in the use of OP66 or OP68.

IMPLEMENTATION PLAN				
Intended Audience	Control Services Staff			
Dissemination	Available to all Staff on the Pulse			
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.			
Training	EOC – Watch training leads to ensure dissemination and familiarity of staff with 1-2-1 and scenario based sessions.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Operational Aspects	Monitoring compliance on a day to day basis will be undertaken by all managers by observing staff during duty hours. 3 yearly review to be conducted	EOC WMs will monitor watch and produce a report for the Performance Improvement Manager EOC, for reporting to the Control Services Change Board (CSCB)	Control Services Change Board (CSCB)	Bulletins and amendments to procedure as deemed necessary A revised Procedure to be published as above
Technical Aspects	Monitoring compliance on a day to day basis will be undertaken by all managers by observing systems during duty hours. 3 yearly review to be conducted	EOC WMs will monitor watch and produce a report for the Performance Improvement Manager EOC, for reporting to the Control Services Change Board (CSCB)	Control Services Change Board (CSCB)	Bulletins and amendments to procedure as deemed necessary A revised Procedure to be published

Table of Appendices:

Quick Guide IRO Activation

Operational Incidents

EOC must notify a IRO of the following types of incidents, most of which are likely to require immediate attendance:
Major incidents/serious incidents
Multiple ambulance/resource attendance at one call
Railway incidents
Ambulance Vehicle Collisions
CBRN / HAZMAT incidents
Public disorder / demonstrations
Aircraft incidents
Incidents involving weapons or threats of weapons
Major trauma calls/LAA activations
HART activations
Paediatric cardiac arrest
Fire calls persons reported
Incidents that may attract media attention
Serious untoward incidents
Vehicles impounded by Police

Staff Welfare

EOC must notify a IRO of the following types of incidents:
Crew staff assaulted
Crews requiring assistance
Crew staff injured
Staff reporting sick on duty/booked into hospital

Performance

EOC must notify a IRO of the following types of incidents:
Delayed hospital turnaround times / under pressure / requesting diverts
Vehicle Off The Road (no vehicle, breakdowns, staff lateness, singles)
Staff ending O/T early unplanned

London Airport Heathrow (LHR)

LHDG PD02 EXT 2152

LHR Star Centre s/s 024 (02087457216)

Call Handling:

When Receiving calls to LHR, where the patient is onboard an incoming flight, the call should be triaged through PROQA and not completed as an RVP. Additionally the flight number, and terminal should be recorded in remarks and the ETA recorded in the Cmt line
For all calls Call Handlers should remember to record in Cmt if the patient is Airside or Landside

Cycle Response Units (CRU's):

Cycle responders cannot access remote stands and are not to attend calls on aprons, taxiways, or airport RVPs either. In many cases when a CRU is dispatched you do not need to dispatch an ambulance unless the CRU requests one - if in doubt ask the CRU.

Callsign	Terminal	
CR11 CR12 CR13	Terminals 1-3 and central Area	
CR14 CR16	Terminal 4	NO facilities for rest break
CR15 CR17	Terminal 5	NO facilities for rest break
CR18	CR18 uses a car not a bike and can access all Terminals and Stands. When available the cycles should be used before CR18	

Follow me Vehicles requested via Star Centre if required

Location of Call	Control Post	Location of control Post
Terminals 1, 2, 3 Central Area)	CP 8	Between T3 and D'albiac House
Terminal 4	CP 24	Beacon roundabout (near RVP South)
Terminal 5	CP 19	RVP West entrance (off Western Cargo Road)

RVP'S

NORTH	J/O Nothern Perimeter Road and Nene Road	Map Ref 53 R 106
SOUTH	Beacon Road	Map Ref 58 Q 106
WEST	CP 19 Woodcock Road, TW6 Entry via T5 Main Entrance	Map Ref 56 K 105
EAST	Airport Fire Training Ground, off Eastchurch Road	Map Ref 54 U 106

Additional information

PAS AND VAS ambulances can attend emergency calls at LHR and when possible the Star Centre is to be advised of the vehicle's registration number. They should not routinely be sent to an RVPFE or RVPAGI call as they may not have had training to deal with these incident types.
Airside passes are not required for emergency calls but if going Airside a "follow me vehicle" must provide an escort.
A505 and CR18 can attened Cardiac Arrest calls up to a mile off airport if no other units are available; if they are assigned off airport the Star Centre is to be advised.
A402 is based at LHR but is available for calls anywhere as required
LHR has an Airport Fire Service, if required they can be requested via Star Centre
Star Centre to be invormed of any callsfrom Members of the Public or calls received via the MPS Cad link
Hilton London Heathrow Terminal 5, is not in Terminal 5 its address is POYLE ROAD, COLNBROOK, SLOUGH. This is a Berkshire call.

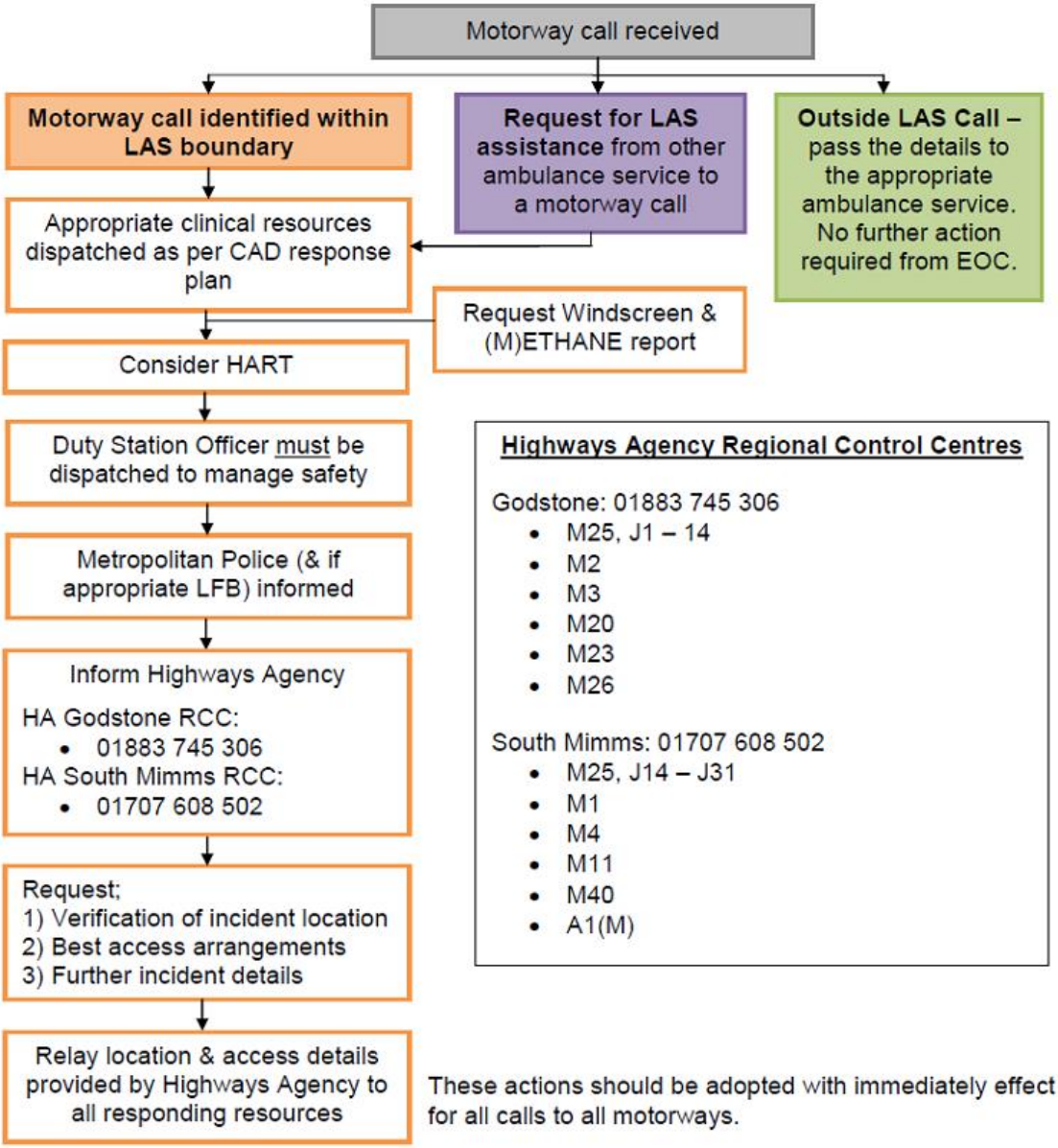
Appendix 3

HART Dispatch Criteria

The following types of incident form the HART dispatch criteria:

- Serious / major incidents
- COMAH site incidents
- Suspect packages / IED
- Fire / explosions
- Calls to illicit drug laboratories
- Carbon monoxide / smoke inhalation
- Collapsed structures / buildings
- Casualty trapped at height or confined location
- Urban search and rescue
- Railway incidents
- Airport / aircraft incidents
- RTC with multiple patients or vehicles
- CBRN / HAZMAT incidents
- STEP 123 incidents
- Chemical suicide
- Incidents on or near water
- IRO / crew requests
- Requests from other services
- Assistance with bariatric patients

Appendix 4


Motorway call received
Motorway call identified within LAS boundary
Request for LAS assistance from other ambulance service to a motorway call
Outside LAS Call – pass the details to the appropriate ambulance service. No further action required from EOC.
Appropriate clinical resources dispatched as per CAD response plan
Request Windscreen & (M)ETHANE report
Consider HART
Duty Station Officer must be dispatched to manage safety
Metropolitan Police (& if appropriate LFB) informed
Inform Highways Agency
HA Godstone RCC:
01883 745 306
HA South Mimms RCC:
01707 608 502
Request;
1) Verification of incident location
2) Best access arrangements
3) Further incident details
Relay location & access details provided by Highways Agency to all responding resources
Highways Agency Regional Control Centres
Godstone: 01883 745 306
M25, J1 – 14
M2
M3
M20
M23
M26
South Mimms: 01707 608 502
M25, J14 – J31
M1
M4
M11
M40
A1(M)
These actions should be adopted with immediately effect for all calls to all motorways.

OP61

DISPATCH

Control Services

CHEMICAL INCIDENTS

SEND HART, DSO and AEU as minimum. FRU if appropriate. **Approach from upwind.**

ADVISE Area Controller, OCM, on duty Tactical Support Officer, EPRO

CHECK RVP has been set, METHANE report has been requested. Police & LFB have been requested.

- Take Major Incident Plan actions into consideration
- Patients not to be conveyed until confirmed not contaminated. Seek HART advice

RAPID ENTRY

SEND Resources as agreed with OCM

ADVISE Area Controller

CHECK If firearms involved and for RVP information

FIREARMS INCIDENTS

SEND DSO + 1 Central Ops + 1 Hotel DCA per

ADVISE Area Controller & OCM

CHECK DSO has ballistic armour

RVP is in the location field and incident location is sent as urgent message

- Crew to wear stab vest until DSO arrives
- Any messages sent should be confirmed by radio
- EOC is unlikely to receive regular updates from DSO once incident is in progress

CATEGORY 4 (INFECTION) PATIENTS

SEND As instructed. HART deal with these transfers.

ADVISE Area Controller, OCM *(who informs TSO and Head of Infection Prevention & Control (HA05)*

- HA05/TSO to nominate a Transfer Officer who will coordinate the transfer
- Transfer officer to identify a vehicle to be used.
- If journey <3hrs from London, on duty HART deal. If >3hrs HART are paged.
- Crew given break before transfer
- Transfer Officer to ensure decontamination is complete before becoming available

HIGH RISK REGISTER

SEND Response appropriate to category – do not delay unless advised in Locality Information

Category	Criteria and Actions
1	Subjected to physical violence.
2	Received specific threat/verbal abuse or intimidation.
3	Verbally abused.
4	Medical condition a major factor in incident.

- Category 1 & 2 automatically activate police
- Category 3 is for crew info, police are not to be automatically activated
- Category 4 are case specific – follow Locality Info
- Arrival at RVP is taken as on scene time

HER MAJESTY'S PRISONS

SEND Usual response as appropriate to call

ADVISE Area Controller and OCM

BELMARSH & CATEGORY A PRISONERS

SEND Usual response as appropriate to call. DSO if a Category A prisoner

ADVISE Area Controller and OCM. Advise Belmarsh of the resources' type, fleet number, registration, names of LAS staff and patient destination

CHECK Resources attending have PPE and ID cards. Also check for EPRR Contingency Plans

NOTE: *Feltham Young Offenders also houses Category A prisoners.*

OTHER EXCEPTIONAL INCIDENTS

- Dispatch HART to all Carbon Monoxide and STEP 123 incidents
- Ensure a paramedic is sent to all patients who are in cardiac arrest, continuously fitting, or in an obstetric emergency
- Dispatch DSO/TL to all bariatric patients to manage the scene and provide experience

OP61

Management of Complex Incidents with Pre-determined Attendance/Specific Considerations and Specialist Response Types

Quick User Guide (DISPATCH)

CHEMICAL INCIDENTS

ADVISE Caller not to approach emergency services as they arrive to avoid contamination

USE CommandPoint to document other useful information given by the caller such as:

- Providence - Where did the chemical come from (e.g. car, package, lorry)?
- Air conditioning - if present, has it been turned off?
- Isolate people affected by the chemical
- Non affected people should wait upwind of people affected by the substance

This information is directly useful to resources attending in the early stages of an incident.

RAPID ENTRY

ADVISE Call Handling Manager and/or OCM whilst call still in progress.

CHECK If firearms involved and for RVP information. Obtain number for police officer in charge

USE RVPAI Event type if firearms in use or hostage situation

PRE-PLANNED FIREARMS INCIDENTS

ADVISE Call Handling manager

CHECK RVP is in the location field and location of the incident is tagged as an urgent remark. Ensure contact number for firearms officer is obtained

USE RVPAI Event Type

ACTIVE FIREARMS INCIDENTS

ADVISE Call Handling manager, HEMS if appropriate

CHECK Information on where assailant is and who else is on scene if possible

HIGH RISK REGISTER

CHECK Locality information has been ticked if it matches

- If possible and appropriate, ask who else is on scene with the patient as this information can be useful to resources attending the incident when conducting a dynamic risk assessment.

CATEGORY 4 PATIENTS

ADVISE Call Handling manager of incident

CHECK You have documented:

- Name of patient
- Diagnosis and clinical condition
- Current location
- Contact number of referring HCP

Additional info:

Call likely to come from Royal Free HSIDU, and will be as for a patient infected (or likely to be infected) with one of several highly contagious diseases including, but not exclusively Rabies, Plague, Viral Haemorrhagic Fevers (Lassa, Marburg, Ebola and Crimean/Congo Fever (CCHF)

HER MAJESTY'S PRISONS

CHECK You have obtained the category of prisoner

If a DMP no-send **ALWAYS** check with CTC/Clinical Floorwalker first, particularly when there is limited information available.

OP61

Management of Complex Incidents with Pre-determined Attendance/Specific Considerations and Specialist Response Types

Quick User Guide (CALL HANDLING)

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