North West Ambulance Service NHS Trust

CNTW(C)01
Appendix 4A

EMERGENCY OPERATIONS CENTRE PROCEDURE

EOC0001

Allocation & Utilisation of NWAS Resources

SOP Title:	Allocation & Utilisation of NWAS Resources	**Ref Number:**	EOC0001

Author & Designation:	Andrea Williamson – Assistant Business Support Manager – Business Support Unit
Recommended by:	EOC Management Team
Directorate:	Service Delivery – Contact Centres
Approved by:	EOC Management Team
Version number:	Final 9.2
Supersedes:	9.1
Changes made:	Added updated Crew Skill Mix v11.6 – 12.05.20
References:	https://greenroom.nwas.nhs.uk/content/uploads/2019/07/CQC-glossary-of-terms.pdf Demand Management Plan Resource Escalation Action Plan NWAS Policy On Meal & Rest Break EOC0004 - AP, MR, CP and Serv Del Mgr Sign On EOC0062 – Management of Critical Incidents
Approved date:	11 May 2020
Issue date:	12 May 2020
Live date:	12 May 2020
Review date:	31 October 2023
Date obsolete:	-

Any comments or concerns surrounding this NWAS EOC procedure should be addressed via your supervisor/manager or member of the Education Team. If you wish to raise any feedback please make contact to the following inbox:

DispatchReview.Committee@nwas.nhs.uk

Introduction

1 The aim of this procedure is to ensure all Emergency Operations Centres (EOCs) across the Trust continue to use the operational resource in the best way to meet the clinical needs of the patient and ensure that responses to emergency calls (including cross area allocation) are initiated at the earliest opportunity, whilst also ensuring operational staff safety at all times.

2 NWAS uses an Auto Dispatch Module to allocate to pre alerted **Category 1 incidents** that meet auto dispatch criteria only, which ensure either the allocation of an available vehicle or diversion of a vehicle on a lower category of case.

This procedure should only be used for incidents NOT auto dispatched.

3 To enable NWAS Emergency Operations Centres (EOCs) to deliver the right care, at the ***right time, in the right place, every time***, we must make decisions in dispatch which ensure that our patients receive a response which meets their needs.

4 In order to provide our patients with the most appropriate response and outcome, based on individual patient needs, deployment guidelines have been provided (see Appendix 1), to promote resourcing for clinical and non-clinical dispatch staff, in line with the Ambulance Quality Indicators (AQIs).

5 These guidelines should be followed consistently across all three EOCs.

6 This procedure should be followed in conjunction with EOC0004 – Advanced Paramedic (AP), Medical Responders & Service Delivery Managers Signing on Duty, EOC0008 – Advanced Paramedic & Medical Responders Deployment and, where feasible, used in conjunction with the NWAS Resource Escalation Action Plan (REAP) and Demand Management Plan (DMP).

Procedure

7 Incidents will only move from the incoming to the waiting stack when any of the following three apply:

a) Identification of possible Category 1 call via Pre-Triage Sieve, Nature of Call (NOC) or Key Words
b) MPDS code established
c) 180 seconds from Call Connect

RESOURCE ALLOCATION TO CATEGORY 1 CALLS ONLY

Dispatcher Actions

8 Dispatchers must allocate resources in accordance with Dispatch Allocation Guidelines in **Appendix 1**.

It is expected that some calls that initially predict Category 1 do not subsequently code as a Category 1; in these situations, dispatch decisions and allocations should be considered and amended where appropriate.

9 EOC Dispatchers will use the NWAS resource set out in Appendix 2 when they deem no alternative resource can achieve the incident in a timely fashion and after consulting the EOC Duty/Performance Manager.

10 EOC Duty Manager, Tactical Commander and/or Area Operations Control Centre (AOCC) have the autonomy to activate an AP to support the EOC with managing high demand/any levels of outstanding emergencies.

11 In the event it is considered there will be an excessive delay, EOC must utilise other NWAS resources (as in **Appendix 2**) which have made themselves available within C3.

12 Once all NWAS resources available to respond to an incident have been utilised/considered, EOC must identify other resources as identified in **Appendix 2** and update the notepad to show which resources they attempted to utilise.

13 Once one of the resources from **Appendix 2** has been allocated to an incident, the Dispatcher should continue to follow guidelines in **Appendix 1**. However, in the event the Dispatcher is still unable to identify a response, this must be documented within the incident/C3. EOC Duty/Performance Manager must be made aware.

14 The incident owner Dispatcher, who may have taken a resource from another area, is responsible for ensuring mobilisation has taken place if the resource is diverted from one incident to another within that area or if the resource has not booked mobile after one minute. The incident owner Dispatcher should re-contact the resource via Airwave (using the sub search facility within ICCS) to ensure they have received the emergency and are mobile.

15 The incident owner Dispatcher is responsible for managing all communications with the responding crew for the duration of the incident, including incident updates, scene safety alerts, manual and system warnings and hospital pre-alerts, etc. using the sub search facility on the ICCS.

16 When a vehicle has been auto-dispatched from another area, the owning incident dispatcher will contact the relevant EOC to inform that a vehicle has been taken where possible.

EOC Management Actions

17 **In times of high demand** the identification of NWAS resources to respond to patients will need to be broader than just Emergency Ambulances (EA), Rapid Response Vehicles (RRV) and Urgent Care Service (UCS) resources.

18 To assist with the decision-making process, use of the complementary resources as a result of escalation within REAP should be sought from ROCC Tactical Commander.

19 If it is deemed appropriate by a Clinician, complementary resources should be considered during normal demand parameters where on occasion, NWAS is delayed getting a response to a single incident. Particular attention should be paid to vulnerable patients who are, for example, alone, very young, elderly or in a poor environment e.g. public place.

20 All available resources must be used to ensure patients get the best service possible; to this end, the mobilising of resources, in order (see **Appendix 2**), should be done once the EOC Duty Manager considers this is the best way to respond.

RESOURCE ALLOCATION TO ALL OTHER CATEGORIES

Dispatcher Actions

21 Dispatchers should allocate resources in accordance with Dispatch Allocation Guidelines in **Appendix 1**.

22 If the designated resource is a Rapid Response Vehicle (RRV), the incident will be passed via MDT, with any further information/updates being passed via voice radio.

23 If the designated resource is an ambulance, the Dispatcher will pass the information to the crew, using the Mobile Data system or voice radio.

24 Ambulance/RRV crews should not attend an incident without prior knowledge of its nature (main problem). To assist in ensuring that this information is available, the following should be observed:

- No incident details (main problem) within two minutes of mobilisation – crew will contact EOC and stand-off at a safe distance (or in the general vicinity if in an unknown area) until the incident details have been received.
- Additional Crew Responder Information will be sent as per current procedures.
- Resources without a full ICT/Comms set or with ICT/Comms issues or problems, will only be dispatched when the nature of the incident is known.

25 **Both CH** and **EOC Dispatchers** are **JOINTLY** responsible for monitoring the timescales on all CH referrals, which display on the RC stack, and ALL Category 3 and Category 4 calls.

26 Unless UCS or RRV appropriate, Category 3 and 4 calls showing for Dispatch on the Waiting Stack should be allocated an Emergency Ambulance (EA) if transport is required.

27 Any excessive delay in allocation must be recorded in the notepad of the relevant incident and reported immediately to the Performance Manager who will refer to EOC0062 – Management of Critical Incidents.

UCS Resources

28 Following MPDS prioritisation, UCS can be deployed (without the need of the call being MTS triaged or clinically reviewed by a clinician) to all Category 4 calls (HCP/IFT/999) as a primary response.

UCS can only be deployed to appropriate Category 3 (999) calls following a clinical review by a clinician, or a full MTS triage.

UCS can be deployed to Category 3 (IFT/HCP) calls following review by a clinician.

29 The above procedure is to be followed with the appropriate level of autonomy from Dispatcher, Performance Managers and Duty Managers. There may be occasions, due to operational activity, that the above may be adjusted which will be in line with the Demand Management Plan.

CFRs/ECFRs – Normal Business

30 If an incident is paged out to CFRs/ECFRs and an 'able to attend' message is received, the dispatcher should double-click on the IMQ message and "Res Alloc" the incident. However, if CFR attendance is NOT required, Dispatch must immediately send a stand down message immediately following the "able to attend" offer.

31 If the CFR/ECFR has a closer ETA than other resources, they should be allocated and all appropriate information should be paged.

32 Upon receiving a Serious Call warning for a cardiac arrest, detailing an approximate age of the patient, Dispatch should:

- **Check the age of the patient is >12 years old**
- **If so, perform a ResAlloc and search for a CFR**
- **If CFR available, manually allocate to the incident**

33 If the incident is a cardiac arrest and CPR is already in progress, a CFR/ECFR may be utilised as a fourth response if necessary.

34 Scene safety should be taken into consideration before allocating a CFR/ECFR to any incident (refer to **CFRs/ECFRs - COVID-19 Guidelines Card 36 – Pandemic/Outbreak** below for updated COVID-19 guidelines).

35 NWAS responders can stand down vehicles as they have the training to do so, as long as skill level allows; however, CFRs cannot stand down medical resources as they do not have the skills/knowledge and equipment; Dispatchers will be notified by CFRs if nothing found.

36 CFRs can request call back from one of the clinicians to discuss patient's condition; any decision to stop the call is the responsibility of the Clinician, after discussion with the CFR.

37 All information must be logged in the notepad of the call and documented on patient report form accordingly.

CFRs/ECFRs – COVID-19 Guidelines Card 36 – Pandemic/Outbreak

- CFR have appropriate PPE Level 2 issued and correct guidance
- No mobilisation of CFRs to any CARD 36 Pandemic/Epidemic/Outbreak and not knowingly mobilise to any confirmed or possible COVID-19 incidents
- CFRs to continue to attend codes already in place, unless safety concerns raised through EOC – then stand down to be made
- CFRs to attend Cat 1 & 2 only; they do not attend any Cat 3 & 4 codes
- CFRs will continue to be mobilised to cardiac arrest and appropriate PPE Level 2 issued – they DO NOT carry out any Aerosol Generating Procedures (AGP) and are instructed to remove themselves from immediate scene upon arrival of ambulance crew

Allocation of Resources at End of Shift

38 Category 1 and 2 incidents can be allocated a resource at any point up to the crew finish time.

39 Category 3 incidents will not be routinely given to PES EA and RRV staff within the last 30 minutes of their shift. Staff will be aware that some time critical patients fall within these categories and as such by exception some incidents within these categories will be allocated.

40 Category 4 incidents will not be routinely given to PES EA and RRV staff within their last hour of shift.

41 The decision to not routinely allocate as per points 40 and 41 can only be made taking into account all facts held within an incident.

42 For substantial delays at scene, wherever possible/feasible, EOC will facilitate an oncoming crew or another member of staff to make their way to scene in order to allow a safe clinical handover to be completed.

43 It is necessary that once the new crew has arrived at the scene the correct names are recorded for the crew within the incident. This can be achieved by the Dispatcher standing the vehicle down and asking the new crew to log on with their new shift and reallocation of the vehicle to the incident where appropriate and necessary.

Resource Stand Down Guidelines

44 If the consequence of the resource being stood down may result in an excessive delay, then the decision to stand down must be authorised by a Performance Manager/Duty Manager.

NB: Consideration should be made for calls where 30 minutes has elapsed and an EMD is still on the line with the caller.

45 Should it be necessary to stand down a responding resource for a **second** time, then escalate to Performance Manager should be made and recorded in the notepad of the incident.

Respond & Refer

46 Following an on scene assessment, the clinician will contact EOC Dispatch and request a NON-PES response within 90 minutes and advise whether the patient can travel with other patients.

47 The dispatcher will enter into the notepad ***"FtoF response within 90 minutes, patient can/can't travel with other patients"*** (FtoF response within 90 minutes is from time of assessment). The dispatcher will then downgrade the incident using override code PATHG, then MDC with the appropriate HCP Code to provide a 90 minute response.

48 CH Dispatchers will identify these downgrades from this override code and take ownership, checking the notepad, which will show the timescale for FtoF allocation, e.g. 90 minutes.

49 As soon as the downgrade is complete and referred to Clinical Hub, the EOC Dispatcher, together with the crew, must ensure the RRV/solo responder is clear for another incident.

50 If there are no CH resources available, the CH Dispatcher will apply a warning ***"No UCS resource available"*** and pass the call back for EOC Dispatcher to allocate a PES resource.

51 If no resource is available within the 90 minute time frame, the Clinical Hub Dispatcher will highlight this to a CH clinician for a further triage, if appropriate.

APPENDIX 1

Dispatch Allocation Guidelines

1 **Ambulance Quality Indicators (AQIs):**

Category 1 (C1) – **Mean Response of 7 minutes**
90% Calls reached within 15 minutes
CFR/RRV/EA count towards performance: This is due to most patients within this category of call requiring immediate clinical intervention. I.e. Cardiac arrest, Anaphylaxis, Respiratory Arrest. Rapid early deployment to these most immediately life threatening C1 calls should be identified through the Nature of Call (NoC) and pre-triage questions whenever possible.

Category 2 (C2) – **Mean Response of 18 minutes**
90% Calls reached within 40 minutes
First CONVEYING resource count towards performance, unless patient is NOT CONVEYED VIA AMBULANCE: This is due to most patients within this category of call requiring rapid transport to hospital, i.e. Stroke, Heart Attack, and Sepsis. If the patient does not require transport, then it is deemed that the solo responder (or first resource to scene) will have likely met their clinical needs and therefore will count towards performance.

Category 3 (C3) – Mean Response of 60 minutes
90% Calls reached within 120 minutes
First CONVEYING resource count towards performance, unless patient is NOT CONVEYED VIA AMBULANCE: This is due to most patients within this category of call requiring urgent assessment, if the patient requires conveyance to hospital then the conveying resource counts towards performance. If the patient does not require conveyance then the first resource on scene (including solo responder) counts towards performance.

Category 4 (C4) –
90% Calls reached within 180 minutes
First CONVEYING resource count towards performance, unless patient is NOT CONVEYED VIA AMBULANCE: This is due to most patients within this category of call requiring urgent assessment, if the patient requires conveyance to hospital then the conveying resource counts towards performance. If the patient does not require conveyance then the first resource on scene (including solo responder) counts towards performance.

2 A link to the AQI's can be found here: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/09/20190912-AmbSYS-specification.pdf

3 Incidents closed with a **Hear and Treat** have no response target and are closed with a separate stop code which is reported nationally.

4 Whenever possible, utilise Dispatch on Disposition (DoD) to enable the most appropriate response to be determined, following MPDS call categorisation, in line with the principles of "**respond, review and revise**".

5 The sections of this document below set out arrangements for the following:

- Emergency double crewed ambulances (EA) and core rapid response vehicles (RRV) i.e. not specialist solo responders such as falls cars etc.
- Priorities for deployment and resource diverting
- NWAS skill mix matrix

6 This guidance should be considered in line with this procedure and other associated EOC procedures or guidelines as outlined on page 2 of this procedure.

Incident Deployment Guidance (Call Stages)

Call waiting to be answered

Emergency call in progress → **Review** available resources (don't dispatch[1])

Call in process of being coded (PTQ/NoC prediction)

Predicted C1

Review any auto dispatch/divert deployment and approve, if not auto dispatch **immediately allocate (Respond) closest resource** (or divert resource already running on any call except confirmed C1, consider P1 backup divert)

Emergency call in progress

Review available resources (Plan but do not dispatch) [1]

Clock start or coded

C1	C2	C3	C4/C5	Emergency call in progress **240 seconds** [2]
Review and revise if appropriate - dispatch decisions made**. Allocate** closest resource (RRV or EA) if unallocated (or divert as per guidance) and confirm back up allocated.	Allocate closest EA, regardless of location up to 40 mins response **(Respond)** [3]**.**	Allocate appropriate resource (RRV or EA) and **review** incident[4].		**Allocate (Respond)** closest available EA resource. **Review and revise** when coded

Additional Dispatch Guidance

[1] Where a resource is within the vicinity and it is clear that a response will be needed (i.e. problem is RTC etc.) it may be appropriate to dispatch before the clock start at 240 seconds.

[2] If an emergency call remains un-coded at 240 seconds (i.e. at clock start) it will turn pink - consider divert based on available information.

[3] Allocate nearest EA up to 40 mins response.

- If above this, discuss with PM to review in conjunction with clinician
- If using resource outside area, PRIOR to allocation, the PM owning the incident should contact the PM of the EOC Controlling the resource
- Update notepad if awaiting resource to clear from break/rest or hospital etc.

Consider deployment of RRV or supplementary resource (i.e. SP/TL, AP) if clinical concern for C2 call in which **no EA will be available to respond within 18 minutes.** These incidents should be discussed with a clinician if available.

[4] Deploy RRVs to **C3** calls if an EOC clinician reviews and determines an RRV is the appropriate response **OR** there is **obvious evidence that alternative to transport will be a likely outcome**.

Deploy RRVs to **C4** calls if an EOC clinician reviews and determines an RRV is the appropriate response **OR** there is **obvious evidence that alternative to transport will be a likely outcome OR there are no UCS/INT resources available to attend.**

Proactively dispatch CFRs as soon as call is predicted C1, or coded C1/C2, in line with CFR dispatch guidance.

RRV – Backup

Back up RRV's immediately for: all C1 and C2 calls

DO NOT AWAIT BACK UP REQUEST

RRVs will advise EOC as soon as possible after arriving scene if back up is not required

For HCP calls, the principle is that these calls should only be resourced by a non-paramedic/technician ambulance (e.g. UCS/VAS crew) unless there is a specific reason (e.g. clinical requirement)

Resource Divert Guidelines

DIVERTS

General notes

- **Based on the available information, consider a divert to an emergency call in progress from a C2, C3, C4, C5 coded call if the clock has started**
- **Divert to a higher priority call where appropriate (consider areas such as distance, length of time patient waiting, known resource coming available)**
- **EOC dispatch clinicians should be consulted when incidents of concern are raised as they are able to expedite the response of an incident and co-ordinate senior clinicians to scene.**
- **Any concerns relating to patient safety MUST be escalated to a manager or clinician**
- **All decisions on dispatch, including when a resource isn't available or hasn't been dispatched, must be documented in the notepad**
- **Remember the core dispatching principles:**
  - ✓ **Respond, Review, Revise**

Call Category / Back Up Request	Divert From	Resource
P1 Back Up	**C1, HCP1, IFT1, C2, C3, C4, P2, P3, P4**	**Closest Resource Available** **(consider use of complimentary resources)**
Cat 1 / HCP1 / IFT1	**C2, HCP2, IFT2, C3, C4, P2, P3, P4**	**Closest Resource Available** **(consider: use of complimentary resources / P1 backup divert)**
P2 Back Up	**C2, HCP2, IFT2, 3, 4**	**Closest Appropriate Resource, review with requesting clinician for appropriate skill mix**
Cat 2 / HCP2 / IFT2	**C3, C4**	**Closest Appropriate Resource** **(Review skill mix matrix)**
P3 Back Up	**C3, C4, P4**	**Closest Appropriate Resource, review with requesting clinician for appropriate skill mix**
Cat 3	**C4**	**Closest Appropriate Resource** **(Review skill mix matrix)**
P4 Back Up	**C4**	**Closest Appropriate Resource** **(Review skill mix matrix)**

To ensure that an appropriate resource is sent, all clinicians requesting back-up will also advise on any specialist response required (HART/HEMS/Senior Clinician) and/or if an Urgent Care Service vehicle or Voluntary Ambulance Service (St.John/Red Cross) vehicle would be suitable

Clinician Back-up Requests to EOC

Name	Descriptor	Divert Status
Priority 1 **Back-up**	**This request will be used for patients who are in cardiac arrest, have catastrophic haemorrhage, unmanageable airway or unsupportable breathing and immediate assistance is required to save life.** Resources en-route to any other category or priority requests can be diverted to P1 priority requests. • EOC will immediately allocate the appropriate resource to the incident. • EOC will disturb meal/rest breaks **(in conjunction with the meal break policy)** • EOC will allocate resources to the incident, before allocating to incidents with no resources active. • EOC may use 'complementary' resources **NB: Back up to a CFR should not be diverted to a further Category 1 call** **All other diverting rules still apply**	No divert
Priority 2 **Back-up**	• EOC will immediately deploy the closest resource • The response will be 'HOT' i.e. with full Audible and Visual Warning Systems (AVWS)	May divert for P1 back up request or Category 1 coded incident
Priority 3 **Back-up**	• EOC will deploy the closest back-up vehicle • The response will be 'HOT' i.e. with full AVWS	May divert for P1 or P2, Category 1 or Category 2 incidents
Priority 4 **Back-up**	• EOC will allocate the most appropriate vehicle • The ambulance crew will respond 'COLD' with no AVWS • The resource allocated may be an Urgent Care Service vehicle, a St John Ambulance, British Red Cross or at times of peak demand, an NWAS Patient Transport Service (PTS) ambulance. • A request should then be made to the **Incident Support Desk** to downgrade the call using override code "PATHG" (PDA suitable for UCS/VAS) then MDC with the appropriate HCP code	May be diverted for incoming 999 calls or requests for back up of a higher response

Strategic Meal Break

To support the maximising of resource availability throughout a shift, the EOCs will use early window dining to effectively manage the meal breaks of operational vehicles.

Dispatcher Actions

The Dispatcher should use the following guidelines when deciding whether or not to protect drive time for a vehicle back to station and the duration of their meal break:

1 **Cover available in the area?**

 If No – The vehicle remains available to be allocated to further calls
 If Yes – Protect the vehicle running back to base (SMB) and for the duration of the meal break, only allocating to Category 1 and P1 back up requests.

2 **Only two vehicles per dispatch board are to be protected at a time** (including drive time and meal break completion)

3 **RRVs are not to be protected**

Vehicles with protected drive time **must** have the resource status set to strategic meal break (SMB) as follows:

SMB – RTB MEAL

Vehicles that are out of the meal break window **must** have the resource status set as strategic meal protection (SMP) as follows:

SMP – RTB MEAL

Rostering and Response Matrix Version 11.6

This matrix is designed to assist rostering and EOC teams to help the population of rosters, dynamic Staffing movements at shift start times and the deployment of resources to incidents

Group	Matrix Code	Descriptor
Paramedic	1	Paramedic, NQP1, NQP2
EMT	2	EMT1, EMT2, Legacy IHCD Technician
PES Assistant	3	Year2 Student Para, UCS & PTS upgrade, Apprentice EMT 1
UCS	4	Standard UCS

Rostering Management Matrix - Best Practise Guidelines

Staff Group	1	2	3	4
1	Consider Splitting	Yes	Yes	Split
2	Yes	Consider splitting	Yes	Split
3	Yes	Yes	PTS vehicle only	Yes
4	Split	Split	Yes	Yes
Staff group rule 4	Urgent Care Assistants who are identified as only able to respond to Urgent calls should not be rostered to work with staff in staff group 1 or 2 to enable maximum use of clinical staff			

Response Management Matrix

Staff Group	1	2	3	4
1	All calls	All Calls	All Calls	Urgent Care
2	All Calls	All Calls	All Calls	Urgent Care
3	All Calls	All Calls	Urgent Care	Urgent Care
4	Urgent Care	Urgent Care	Urgent Care	Urgent Care

General Rule	Any query of the Staff Skill mix, being appropriate for the Incident, should be discussed with the EOC Dispatch Support Clinician.
Vehicle Rule 1	Only staff who have C1 qualification on their license are allowed to drive a blue light front line ambulance.
Vehicle Rule 2	PTS Conversion Vehicles should only to respond to Cat 3 and Cat 4 Emergency and Urgent Care. They do not have blue lights and sirens. If, by exception, they are tasked to higher priority calls dispatch must monitor closely for backup.
Vehicle Rule 3	Standard UCS resources are able to assist and manage urgent care cases following face to face or remote assessment.

APPENDIX 2

NWAS Complementary Resources

In order:

FIRST RESOURCE OPTIONS

Resource	Comments
All resources from all NWAS areas (including single manned resources, i.e. EMTs)	You must check for resources from cross-area EOCs before moving on to this list, and if appropriate, vehicles from neighbouring Trusts
Air Ambulances	Mobilising Helimed should only be done via the Airdesk at Broughton
Advanced Paramedics	When on clinical days or available
HART	All HART resources. The decision to utilise HART in this procedure has to be agreed by the on call Gold. On call Gold is to contact the Duty NARU Officer on 08717 041 855 (the Duty NARU will inform the respective Lead Commissioner and NHS England's EPRR Team of the report to disruption to HART capability
Community Specialist Paramedics (CSP)	Available to respond to 999 calls and can also access calls 'off the stack' to auto-respond or receive calls from other operational colleagues, who attend or support patients on scene
Any Assistant Ops Managers or Senior Paramedics not on vehicles	NB These staff might not have vehicles

SECOND RESOURCE OPTIONS (Unless made unavailable via Airwave)

Advanced Paramedics (non-clinical days) and Operational Managers	Then:
Sector Managers	The nearest appropriate clinician from this list should be allocated if necessary. It is not in hierarchical order.
Resilience Managers	
Consultant Paramedics	
Heads of Service	
Assistant Medical Directors	
Mountain Rescue	To render aid

THIRD RESOURCE OPTIONS

Directors	e.g. of Emergency Services
All other Service Delivery Managers	e.g. staff from support services