NHS Emergency Planning Guidance

Planning for the development and deployment of Medical Emergency Response Incident Teams in the provision of advanced medical care at the scene of an incident
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The NHS Emergency Planning Guidance planning for the development and Deployment of Medical Emergency Response Incident Teams in the provision of Advanced medical care at the scene of an incident

DH Emergency Preparedness Division

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Best practice guidance in developing and deploying Medical Emergency Incident Response Teams...

NHS Emergency Planning Guidance

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This material should be read in conjunction with the NHS Emergency Planning Guidance. All material forming the guidance is web based and prepared to be used primarily in that format. The web-based versions of the Guidance including underpinning materials have links to complementary material from other organisations and to examples of the practice of and approach to emergency planning in the NHS in England.

The web version of the guidance is available at [www.dh.gov.uk/emergencyplanning](http://www.dh.gov.uk/emergencyplanning)
Executive summary

The Civil Contingencies Act and national risk and capability assessments now place clear obligations on NHS organisations to cope with disruptive challenges. Consequently, there needs to be a robust system in place in all organisations to be able to plan and respond to a range of such disruptive challenges and their consequences in the pre hospital environment. In the recent times, a number of incidents such as bombings, extensive flooding and consequent loss of power, water and telephony have served to emphasise the importance on being able to continue to provide appropriate pre hospital services in emergency situations.

The NHS Emergency Planning Guidance includes an underpinning section Immediate Medical Care at the Scene of a Major Incident. It became clear that this Guidance needed refreshing and that particularly the function of the Medical Emergency Response Incident Teams (MERITs) introduced in that document needed to be reviewed and developed.

In 2008, an expert symposium was held at the National Policing Improvement Agency at Ryton-at-Dunsmore to provide the opportunity to focus discussions on Medical Emergency Response Incident Teams (MERITs), to explore the key issues, identify best practice, identify what further work was needed, and provide the basis for the publication of interim guidance on MERITs by the Department of Health.

The recommendations made by the symposium are those considered most likely to improve:

- the response of NHS organisations to incidents and emergencies that require the provision of advanced medical care at the scene of an incident
- the care and treatment given to such patients at scene;
- the ability of MERITs teams to work in collaboration with NHS ambulance trusts; their personnel and those from other emergency services and agencies on scene; and,
- the integration of MERIT within the Command and Control Structures established in the event of major incidents.

These recommendations were used as the basis for the development of this Guidance.

Work is in progress to develop trauma networks for the NHS in England and in some regions these are close to implementation. The development of MERITs will facilitate the establishment and operation of trauma networks in the pre-hospital treatment and care of critically ill patients.

Many areas have already started introducing MERITs. This Guidance is intended to augment those already in existence and also to support arrangements being made to introduce MERITs at the earliest opportunity in all remaining areas.
Background

1. Provision of a mobile medical response in the form of a Mobile Medical Team (MMT) was a requirement of earlier versions of NHS emergency planning guidance published before 2005. The MMT concept was that the control team in the acute hospital dealing with a major incident might be asked to send an MMT to the scene of an incident. The role of the MMT was to work closely with their ambulance service colleagues. In selecting the team, the acute hospital was asked to strike a balance between sending experienced staff and not depleting staff at the hospital. The ambulance service was asked to try to avoid requesting a mobile medical team from the main receiving hospital. In protracted incidents or those spread over a wide area, more than one MMT may have been needed. They might have been requested from several receiving hospitals and in a protracted incident may have been deployed in rotation.

2. In some parts of the country, there were volunteers who provided a mobile medical response not from an acute hospital. These volunteers included General Practitioners (GPs).

3. When the NHS Emergency Planning Guidance underwent major revision in 2005 the role of MMTs was reviewed, it was agreed that where there were active immediate medical care teams working regularly with the ambulance service and with the emergency care practitioners being trained by the ambulance services, the need for the traditional mobile medical team response was diminishing in some areas. It was further agreed that this role could be undertaken by others with specific training and experience in pre-hospital care and thereby leave key acute hospital staff available in receiving hospitals. It was also recognised that many MMTs were inadequately equipped, had little chance to prepare, exercise, and select appropriate members with the relevant skills and experience.

4. The NHS Emergency Planning Guidance specified that “SHAs would be accountable for ensuring that Ambulance Trusts and Acute Trusts including Foundation Trusts work together to provide a model for immediate medical care at the scene and the organisation of Medical Emergency Response Incident Teams (MERITs) or their equivalents appropriate to the area’. The Guidance acknowledged that the models developed would have to vary around the country taking into account of, for example, the introduction of trauma networks, the number of accident and emergency departments in an area and the distance between them, the availability of appropriately trained immediate care clinicians and the organisation of ambulance services.

5. Whatever model was to be adopted, the Guidance specified that it should ensure that at the scene it is possible to;

- Triage
- Treat
- Provide appropriate specialist interventions

Scope of the guidance

6. The NHS Emergency Planning Guidance gives the Chief Executive Officer of each NHS organisation responsibility for ensuring that their organisation has a Major Incident Plan in place that will be built on the principles of risk assessment, co-operation with partners, emergency planning, communicating with the public and information sharing. The plan will link into the organisation’s arrangements for ensuring business continuity as required by the CCA. Planning
for the provision of MERITs services forms part of that responsibility for Chief Executives of Ambulance Trusts.

7. This section gives best practice guidance to National Health Service (NHS) organisations in developing and deploying Medical Emergency Response Incident Teams (MERITs). It builds on the guidance given in the underpinning section of the NHS Emergency Planning Guidance; immediate medical care at the scene. The principles apply regardless of the number of patients being treated. The guidance covers adults and children.

8. This section must be used in conjunction with the NHS Emergency Planning Guidance and the relevant underpinning sections including:
   - Strategic Health Authorities (SHAs)
   - Primary care organisations
   - Ambulance Services
   - Acute Trusts
   - Burn Injured Patients
   - Critical Care
   - Blast Injured Patients
   - Mass casualties
   - Strategic command arrangements for the NHS during a major incident
   - Psychosocial care for people affected by disasters and major incidents

9. The NHS Emergency Planning Guidance and its underpinning documents provide general guidance, information and context for NHS organisations. This includes an overview of important related legislation including the Civil Contingencies Act 2004 (the CCA) and its categorisation of organisations as Category 1 or Category 2 responders. The CCA is currently being reviewed. This guidance will be revised if changes to the CCA necessitate this.

10. It is essential that there is good communication between different health care services in order to ensure that responses are structured and cohesive.

11. The purpose of the NHS Emergency Planning Guidance is therefore to describe a set of general principles to guide all NHS organisations in developing their ability within the context of the requirements of the Civil Contingencies Act 2004 (CCA) to:
   - respond to a major incident or incidents or emergency
   - manage recovery whether the incident(s) or emergency has effects locally regionally, or nationally.

12. Throughout this underpinning document, the term emergency is used as in the CCA, i.e. to describe an event or situation that threatens serious damage to human welfare in a place in the UK or to the environment of a place in the UK, or war or terrorism, which threatens serious damage to the security of the UK. To constitute an emergency this event or situation must require the implementation of special arrangements by one or more Category 1 responders.

13. This Guidance is built on best practice and shared knowledge, while also acknowledging that in certain circumstances restrictions or limitations of normal standards of care will be inevitable. It is intended to provide a platform for all NHS organisations to undertake major incident and emergency planning and to provide information on associated activities that may also be required. In the context of this Guidance, the terms NHS organisation and NHS Acute Trust includes NHS Foundation Trusts.
Roles and responsibilities

14. The Department of Health fully supports the development of MERITs and is committed to providing leadership and guidance to NHS organisations in the development and introduction of MERITs. In addition to the general roles and responsibilities set out for the Department of Health, the Health Protection Agency and for NHS organisations in the NHS Emergency Planning Guidance, the following roles and responsibilities specific to the development and deployment of MERITs are proposed:

Department of Health
- provide support and advice to SHAs for the provision of MERITs
- facilitate data gathering on a national basis about the deployment of MERITs to enable
  - clinical governance audit
  - monitoring and review of their use and function
  - access to lessons learned within as short a period of time as possible
  - research.

Ambulance Trusts
- define a MERITs specification for the functional area of the ambulance Trust in accordance with the national model for the service taking account of the local geography
- develop the specification for the MERITs within the area of the Ambulance Trust including staffing, equipping (including PPE appropriate to the role), logistic support, training, clinical governance, mutual aid, etc
- make arrangements for the development and deployment of MERITs within the area of the Ambulance Trust
- be responsible for developing the appropriate organisation to commission MERITs including monitoring arrangements
- either deliver or monitor the HR elements of provision of the MERIT via the usual contract mechanisms. This to include explicit arrangements for insuring and indemnifying MERIT members.
- agree and provide detail of mechanisms locally for issues such as activation, communications, methods of deployment, accountability for the team when deployed, etc
- arrange appropriate training, exercising and testing of MERITs. In line with national guidance, this would be for a live exercise annually and a communications test every six months.

Primary Care Trusts
- ensure that a MERITs service will be commissioned in accordance with the requirements specified by the ambulance services
- support the provision of MERIT members including logistic support if required locally
- ensure, if appropriate, that the contract for provision of MERITs clearly specifies the service required locally including, for example, the cost of the service including any backfill costs, the requirements of NHS Trusts to release staff to provide the service, for training, etc.

Strategic Health Authorities
- SHAs are accountable for ensuring that effective arrangements are in place for the provision of MERITs as appropriate for local needs
NHS Acute Trusts
- support the provision of MERIT members including training and logistic support if required locally
- provide services as specified by local commissioners
- work with and respond positively to approaches from ambulance services for the provision of MERITs services
- work collaboratively with appropriate voluntary groups to deliver MERITs service

Not For Profit, registered charities and voluntary organisations
- work with the NHS for delivery of a defined service that is appropriately contracted and commissioned.
Medical Emergency Response Incident Teams (MERIT)

Purpose

15. The purpose of a MERIT response is to provide advanced medical care on scene at a range of emergency incidents, up to and including major and mass casualty incidents. This may include provision of advanced airway procedures, surgical interventions, and critical care over and above current levels of ambulance clinical practice. It will also include provision of advice and support to emergency services staff already on scene.

Aims and Objectives

16. The key aim in providing a MERIT response is to get advanced, specialist medical intervention to casualties in the pre-hospital environment where it is recognised that this would increase their chances of survival and improve clinical outcomes further than can be currently undertaken by ambulance Trusts. MERITs should be regarded as an extension of available medical care with the provision of specialised skills to enhance pre-hospital patient management.

17. At this stage it is not proposed that MERITs would be trained or equipped to work within the Inner Cordon (Hot Zone) of a CBRN incident.

18. The key benefits of developing and providing MERITs services are:

- Lives saved and clinical outcomes improved medical implications reduced for casualties by using advanced specialist clinical interventions at the point of delivery in the pre-hospital environment
- To bring senior clinical decision making and critical care interventions closer to the point of injury.
- Speedier and more detailed and informative feed into the tactical health command system
- Greater public confidence in anticipated clinical assistance in the event of becoming a casualty.

19. The overall objective in developing MERITs is to bring a number of benefits to patients, the NHS and to society as a whole.

Definition and scope

20. The specifics of a MERIT response will vary according to the type of incident and the required clinical intervention or specialist knowledge and experience. It will provide a team of one or more experienced doctors supported by other clinicians drawn from an established team who meet the person specification for the role and can demonstrate the required competencies for working as a member of a team in the emergency, pre-hospital environment. The response will integrate with and support the initial and concurrent responses of other service providers, such as ambulance, police and fire services.
21. The constituents of the team will vary in different areas of the country to suit local needs, geography and demography. Local arrangements and agreements will need to be made regarding rostering, minimum response times, on-call arrangements, travel to and from scene etc to reflect local needs.

22. The scope of incidents that would warrant a MERIT response is difficult to define specifically, but would include any incident where ambulance personnel at scene attending an incident identify a potential benefit, following assessment and triage, of having specialist or advanced clinical care at scene and decision making and critical interventions for adults and children. Examples would include:

- Trauma – requiring, for example, advanced management of pain; advanced airway management; fracture manipulation; specialist extrication including amputation
- Prolonged scene times for whatever reason e.g. entrapment over an extended period
- Advanced triage including management of deteriorating situations
- Critical care including specialised patient monitoring
- Chemical, Biological, Radiological, Nuclear (CBRN) contamination or suspected contamination
- Peer-to-peer communication
- Hypo / hyperthermia management
- Psychiatric and psychosocial assessment

23. These are specialised functions that need expertise above and beyond normal medical and paramedical practice. It is the performance of these complex medical interventions by the team that make MERIT unique and an essential part of the development of improved pre-hospital patient care.

24. MERIT would be a complementary response to the emergency services and therefore would arrive on scene to provide appropriate support. The initial call or an on scene assessment made by the emergency services will determine whether a MERIT is required. MERITs will operate on a guaranteed on call basis as determined by the local ambulance Trust in conjunction with the SHA.

25. Members of MERITs must be formally trained and assessed in the performance of these skills. It is important that MERIT functions as a team and that the skills are a function of the team and are not dependent on particular individual members of a team.

26. A MERIT response will be required to interface with a number of other agencies and personnel on scene. This will include the conventional ambulance response, and where applicable, the ambulance Hazardous Area Response Team (HART) personnel including Urban Search and Rescue (USAR) requiring further specialised training and exercising to ensure the ability to understand specialist roles and operate accordingly.

27. In the event of large scale and/or protracted incidents, there may be a requirement to support mutual aid to other areas of the country.

28. Other specialist services where interface may be required will vary according to location and may include, for example, mines rescue; the Royal National Lifeboat Institution (RNLI); mountain rescue; the Maritime Incident Response Group; and others.
Person Specification

29. A person specification is being developed to enable MERIT members to be specifically selected for this role, against a set of evidence-based skills, competencies and attributes. A team specification will also be developed for MERITs with the purpose of ensuring that the requirements of the person specification can be met across the team rather than necessarily by each individual member of the team. A fundamental requirement for individual team members would be a requirement to attend agreed training and development sessions. In addition, on an individual basis team members will need to include the MERIT role in their Job Plan, if appropriate, to ensure succession planning.

30. The competencies will include:
   - Recognition and clinical management of patients with serious trauma in the highly variable and unpredictable pre-hospital environment
   - Advanced assessment, triage and communication skills
   - Clinical decision making skills
   - Command and control skills
   - Medical care during the transportation of seriously ill patients.

31. Individual team members will be required to have demonstrable clinical competencies in a pre-hospital environment and to be able to function as part of a team to deliver advanced patient care.

32. The precise competencies for each team will vary according to the geography of the area e.g. the balance between rural and urban settings.

Contracts of employment and Service Level Agreements

33. Those recruited to a MERIT will operate under a formal contract held with the commissioner of the MERIT service locally e.g. the local NHS Ambulance Trust. This may be an honorary contract if appropriate. As such, MERIT members will be included within the Trust’s clinical governance arrangements and will work within the ambulance command and control structure on scene. Any remuneration will be agreed by the employing Trust based on the service specified by the commissioners and the locally agreed contract. It is recommended that individual contracts be reviewed on a regular basis in accordance with current guidelines for formal professional appraisal, the requirements of local appraisal mechanisms and local audit requirements.

34. It is recommended that the Job Plans of individual MERIT members should recognise formally their role and commitment to help ensure individual and organisational commitment. This recognition of their role in MERITs also needs to form part of the formal professional appraisal and revalidation process for individual team members.

Responsiveness

35. Day to day responsibilities of individual MERIT members should be determined in advance of employment. These responsibilities would be expected to include agreement about expected time to travel to scene, method of travel to scene, method of delivery of MERIT skills, and any on call and call out arrangements.

36. It is desirable that the constituents of each MERIT will allow for sufficient personnel to ensure 24/7 on-call cover from an agreed minimum number of appropriately trained, key individuals, depending on the local model. Appropriate plans will need to be in place however for predicted
periods of longer absence (e.g. overseas duties) and turnover, to ensure that the required specialties are available as far as is reasonably practicable.

37. Individual people recruited to MERIT must be able to come out of their normal NHS practice and have the support of their employer to do so. This requires that:
   - The employer must know of the proposed commitment to MERIT of an individual person, understand its potential impact on the provision of service and agree to this;
   - The contracted clinical commitment of the individual person appointed to MERIT must not be compromised;
   - The individual person appointed must give their commitment to ensuring the functioning of the MERIT.

38. It will be the responsibility of the contracting authorities to audit responsiveness of individual team members and of the team and to modify the style of service to ensure that service quality and standards are maintained.

Training

39. Training and development is a core feature of MERIT membership. Appropriate training and development activities will be undertaken to meet the scope of the locally determined service. Training programmes should be developed to support the key competencies required of the MERIT team. Individual appraisal will form the basis of training and therefore training and assessment of individual team members will need to be made in the training room and in the field.

40. Local teams will complete data sheets on activity and use of specialist skills. These will form the basis of local audit and clinical governance. It is proposed that a national review of this data be undertaken by the Department of Health on a regular basis in a similar manner to that for HART. MERIT in collaboration with local emergency services will develop locally appropriate Standard Operating Procedures (SOPs).

41. Development of MERIT is a continuous process – and is an important element of the care of patients in pre hospital environment. It is envisaged that following introduction of MERIT there will be a review of structure and function that will further enhance patient care.

Exercising

42. There is a requirement for Ambulance Trusts to arrange appropriate training, exercising and testing of MERITs. In line with national guidance, this would be for a live exercise annually and a communications test every six months. (see section 14, Ambulance Trusts)

Work in progress

43. Work is in progress to develop both a person specification and a team specification. These will be published as soon as they are available.