**Medical & First-aid Cover at Events**

The aim of this guidance is to set out the responsibilities of an event organiser to ensure appropriate medical, ambulance and first-aid provision is available to all those involved in music and similar events, whatever their type and size. All event organisers need to minimise the effects of their event on the healthcare resources of the local population. By arranging high-quality event medical facilities, there should be minimal impact on local NHS ambulance services, primary care and acute hospital provision. However, it is acknowledged that even the best-equipped on-site facility may need to transfer some patients to hospital.

The Health and Safety (First-Aid) Regulations 1981 require employers to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work. These Regulations apply to all workplaces, including those with less than five employees and to the self-employed. What is 'adequate and appropriate’ will depend on the circumstances in the workplace which may differ during the build-up, running and break down of an event. Event organisers should carry out an assessment of first-aid needs to determine what to provide for employees and, although the Regulations do not place a legal duty on employers to provide first-aid for non-employees, the HSE strongly recommends that non-employees should be included in this assessment and that appropriate provision is made for them. It is the event organiser’s responsibility to ensure the availability of medical, ambulance and first-aid assistance as appropriate for all those involved.

Further information can be obtained at <http://www.hse.gov.uk/firstaid/index.htm>

The number of people requiring medical treatment at event will vary considerably with the activities being undertaken, along with the environmental conditions surrounding the event. Even at small, low-risk events, there is the possibility of collapses or other medical emergencies. There is extensive evidence demonstrating the importance of rapid life-saving first-aid in these circumstances. There should, therefore, always be provision of first-aid at every event, regardless of size. The range of medical conditions can also vary enormously and there should be adequate capability to manage a wide range of traumatic and medical situations, varying from the trivial to the life threatening. Special consideration needs to be given to drug and alcohol issues, along with psychiatric problems.

It is important to ensure that the spectrum of care is available, commensurate with the size of event. This may encompass the competencies of doctors, nurses, paramedics, ambulance and first-aid staff, who bring different skill levels to the event. At a small, low-risk event, it is likely that provision will be first-aid based..

This guidance will review the various aspects of event medical, first-aid and ambulance provision, starting with the planning process before the event, moving through the event itself and into the post-event phase. The principals outlined within the chapter relate to large and small events, and a proportionate approach should be taken.

**Event Pre-planning**

**Medical, ambulance and first-aid resource assessment**

In order to ascertain the skill mix and how many personnel will be appropriate, it is important to undertake a medical, ambulance and first-aid resource assessment. Consideration needs to be given to:

For some events there will be a need for just a few first-aiders working from a suitable base. In other cases, several first-aid posts, and ambulances may be required, with staff on-hand with the full skill mix – from first-aiders to medical consultants.

It is important to establish the terminology to be used for the various facilities on-site so that all staff consistently refer to the facility using the same words, e.g. at large events there may be a 'medical centre’ and a 'site hospital’ and all staff need to be clear about which is which in order to assist customers. The Cabinet Office UK Civil Protection produce a lexicon of terminology which event organisers may find of use.



**Appointing a competent medical, ambulance and first-aid provider**

Before contracting a medical, ambulance and first-aid provider for an event, it is important to ensure that they will be able to supply what is needed. It is good practice to take up references from other customers who have used the provider for an event of similar type and magnitude. Check that they hold appropriate insurances and ask questions about some of the events they have covered. For example: Did they do all of the medical, ambulance and first-aid provision, or just provide a handful of staff to support the main provider?

If the event needs staff that must be on the professional registers of the Health and Care Professions Council, Nursing and Midwifery Council or General Medical Council, it is advisable to check that their registration status is correct.

If the event requires ambulances, the provider maybe required to be registered with the Care Quality Commission for the provision of some services. The various registrations can normally be checked via the organisations’ websites.

**Multiple medical/first-aid services providers**

The majority of events can have their medical needs covered by just one provider, however this may not be the case at very large (and/or long) events. Where more than one supplier is required, it is important for all the providers involved to be aware that they will be working alongside other organisations and agree, in writing, that this is acceptable. There will need to be very clear written roles and responsibilities, as well as which provider is covering which particular area and who is to be the senior medical officer (or similar title) for the event. It may be that the most straightforward way to split this cover is for one provider to cover a particular area (e.g. campsites).

If more than one ambulance provider is required, it is beneficial for their control to be undertaken from one central point to ensure no duplication of dispatch.**Medical plan**

The medical plan should give outline details of the event and the resource assessment from the medical risk assessment in as outlined at the end of this guidance , clearly stating:

* the name and roles of the provider(s)
* the skill mix of staff, with numbers of each
* start and finish times of the cover
* the name of the medical manager, their contact details and other relevant contact information
* the intended receiving hospital(s) for casualties from the event, along with confirmation that they have been advised of the event (if appropriate)

Except for small low-risk events, organisers should not rely on NHS (SWAST - South Western Ambulance Service NHS Foundation Trust) ambulances to convey patients from site to hospital. Plans should cater for conveyance of all casualties from the scene to the hospital as part of the medical provider’s service.

The plan will also need to be communicated to SWAST, even if they are not involved. This document should be available to the licensing authority in sufficient time to assist with the licence decision-making process, if requested – usually presented to the Council’s Safety Advisory Group for Events (SAGE). The Medical Provider should consider liaising with the local Acute Trust Emergency Liaison Manager. An exchange of contact details is also recommended in the event of advice or guidance being required on-site.

**Planning**

**Named Medical Manager**

One person with responsibility for coordinating the medical provision should be named and available on-site for the majority of the event. This should preferably be someone from the primary medical, ambulance or first-aid contractor, although the responsibility for having appropriate levels of medical, ambulance and first-aid cover at the event will always remain with the person/organisation purchasing the service. At large events it is inappropriate for the medical manager to be involved with the clinical decisions being made, as it detracts from their primary role.

**Confirmation**

All details of cover being provided should be made in writing. The medical plan should include an information-sharing protocol agreed between the named medical manager, senior medical officer and the event safety manager where one is employed. Medical providers should ensure that injuries occurring on-site are reported to the event safety manager, who needs to be aware of accident trends, to enable any remedial actions to be implemented.

**Specific considerations**

**Queuing**

It may be necessary to provide first-aid facilities for the queues at large events. This will depend:

* on expected numbers of attendees
* how long they are likely to queue for
* the season
* the time of day
* extremes of weather

Thought should also be given to assisting crowds leaving at the end of an event.

**Information**

Attendees should be able to access first-aid assistance readily and all medical facilities should have appropriate signage. All staff on-site should be briefed as to how to summon assistance for customers and also the locations of the various medical facilities.

**Campsites**

At events where caravan or camping sites are part of the organised event, consideration needs to be given to the provision of appropriate 24 hour first-aid and medical services.

**Location**

First-aid and medical services should be readily accessible to the attendees of the event.

**Vehicle movement**

Every effort should be made to avoid conflict between vehicle and pedestrian movements. Prior to any vehicle movement into crowds there must be agreement from event control/organiser; there should be full prior liaison with security and stewards.

**SiTe access, egress routes and sterile routes**

It is important to plan, identify, record and share information about the accepted access and egress routes for the emergency vehicles that may be required to attend the event in case of a medical incident (event contingency plan) or a major incident plan This route may have shared elements with other routes around the event, but should always be kept clear and not blocked by parked vehicles at any time.

Rendezvous points (RVPs), marshalling and the location of any other holding areas should be shared with all staff within an event to assist a smooth flow to any incident, whether major or not. Ambulance control rooms and area managers surrounding the event should be aware of these areas prior to the event, as should the other emergency services, where appropriate.

Emergency vehicles must be able to access any point on the site in an emergency situation, including locations just outside the site where event related incidents might occur. The stewarding plan should aid this point.

**Liaison with traffic management planners**

When a site is being designed, consideration should be given to providing sterile routes for emergency vehicles, especially ambulances. In order to ensure that the emergency route is appropriate and able to be kept free-moving and uncompromised, close liaison will be necessary with traffic management planners. At the times at which traffic is likely to be heavy around the site (main ingress and egress times) it is imperative that traffic management plans ensure that emergency vehicles may still be able to move freely. Any change to the routes prior to the event should be shared with the emergency services to ensure on-duty personnel and the emergency service’s control room are aware of the amendments.

Vehicle recovery/support should be discussed and agreed with the traffic-management planners in the case of extreme wet conditions to ensure that ambulances are not compromised, especially if a patient is on board.

**Four wheel Drive Capability**

Provision of four wheel drive ambulances and other response vehicles should be considered.

**During the event**

**Site build and preparation**

During the period of site build, there are likely to be many workers from a number of different employers on-site, often undertaking hazardous tasks, e.g. working at height or with electricity. Tight production deadlines may also increase the risk of accident in this period.

Provision of first-aid services for staff & contracors working on site during this period is covered by the Health and Safety (First-aid) Regulations 1981. The legal obligation is on each individual employer with staff working on-site to ensure that appropriate cover is in place for their staff.

Particularly for large events and sites it is good practice that the promoter makes provision for first-aid cover for the entire site, taking into consideration numbers of staff working, work activities, hours of work and any particular site hazards (e.g. water hazards, distance to hospital, weather conditions). If this is the case, all contractors should be given information on how to access these services. For large sites, it should be remembered that accidents might require the attendance of first-aid staff at distant parts of the site. A procedure should also be put in place for summoning NHS (SWAST) ambulance assistance if required and how an arriving ambulance will be guided to the incident.

**Command, control and communications**

The organiser must ensure that there are robust and reliable communications that are essential to effective medical service provision. All medical resources should be coordinated by a control facility set up by the medical provider. The Medical control should have clear lines of communication to the event organiser and the NHS Ambulance service (SWAST). At larger events the medical control should be an integral part of a multi-agency control.

It is important that one person is identified as the lead and with overall responsibility for medical, ambulance and first-aid provision for the event. For the larger events, they will coordinate medical resources during the event and ensure there is sufficient medical, ambulance and first-aid cover in place during the build-up and breakdown. In the event of the NHS ambulance service (SWAST) being requested (if not already on-site), or the declaration of a major incident, this person would be the liaison point between the site medical provider and the NHS ambulance service (SWAST).

All communication relating to medical, ambulance and first-aid requests and deployment should be documented and kept as part of the overall event records

**Medical and first-aid provision**

**First-aiders**

A first-aider is a person who holds a current certificate in first-aid competency, issued by an organisation that meets the HSE guidelines on first-aid training – see <http://www.hse.gov.uk/firstaid/first-aid-training.htm>

First-aid requirements should include:

* the ability to recognise and manage common conditions; competence in the use of Automated External Defibrillators (AED)
* safe manual handling of patients
* evidence of Disclosure and Barring Service (DBS) checks or local equivalent, in accordance with current government standards
* evidence of training in the safeguarding of children and vulnerable adults.

The holding of a Health and Safety at Work, or three-day First-aid at Work certificate, does not in itself qualify a person as competent to administer first-aid to the public at events.

**Medical practitioners – doctors**

A medical practitioner is a doctor who currently has a licence to practise with the General Medical Council of the UK. The competencies required of the event doctor(s) will vary according to the nature of the event. A medical resource assessment will determine the type and level of care required. Where the resource assessment indicates that specific advanced skills may be required, such as trauma management, the practitioner engaged should hold a valid and appropriate competence, such as Advanced Trauma Life Support or Pre-hospital Trauma Life Support, amongst others.

If primary care for event spectators is required, the doctor engaged should be competent in managing conditions/injuries that commonly present at those events. Where a doctor is deployed to provide medical management at major incidents, they must hold a valid competence, such as Major Incident Medical Management and Support (MIMMS).

**Nurses**

A registered nurse is a person who is currently registered with the Nursing and Midwifery Council (NMC) having undertaken and successfully completed an approved education programme.

The competencies required for nurses may vary according to the nature of the event. A medical resource assessment will determine the technical competencies, together with the type and level of care required. Competencies include dealing with emergencies in pre-hospital or accident and emergency care.

**Paramedics**

A paramedic is a person who is currently registered as such by the Health and Care Professions Council (HCPC).

The competencies required by paramedics may vary according to the nature of the event. A clinical assessment will determine the type and level of care required. The paramedics’ scope of practice must be such that they can demonstrate that they meet the standards as detailed in the paramedics’ Standard of Proficiency, as issued by the HCPC.

**Emergency care practitioners**

An emergency care practitioner is a registered nurse or paramedic who has extended skills as a result of post-registration qualifications. Courses will have been completed in:

* minor injury
* minor illness
* advanced patient assessment
* autonomous emergency practice

Additional educational courses in the following may also have been taken:

* advanced life support
* pre-hospital trauma course
* conflict resolution
* emergency driving
* thrombolysis
* prescribing

**Ambulance personnel**

**Non-emergency patient transport**

Competencies required:

* hold the relevant class of licence for the vehicle being driven
* first-aid
* skilled in the use of a range of lifting and patient-handling equipment
* the appropriate use of oxygen and analgesic gases
* airway management
* Drivers of non-emergency transport vehicles shall hold the relevant licence and competence to drive such vehicles.

**Emergency patient transport**

In addition to non-emergency competencies, emergency transport personnel shall show competence in:

* the assessment and management of emergency patients, as defined by their professional registration
* Drivers of emergency transport vehicles shall hold the relevant competence to drive vehicles in emergency (blue-light) situations

**Ambulances**

An ambulance is defined in law as a vehicle that is 'constructed or adapted for no other purpose than the carriage of sick, injured or disabled people to or from medical centres or places where medical or dental treatment is given, and is readily identifiable as a vehicle for the carriage of such people by being clearly marked “Ambulance” on both sides.’ (Source: Vehicle Excise and Registration Act 1994.)

Accordingly, an ambulance should not be used as a first-aid post at an event. It should be at the event to convey patients from an incident on the site to an appropriate on-site healthcare facility, or, where the condition of the patient requires transfer off-site, to take the patient to a designated hospital. It is not acceptable to routinely call for an NHS (SWAST) ambulance for transport to hospital, as this places an unacceptable burden on the surrounding healthcare services. First-aid and medical provision should be structured in such a way that the event is not compromised when an ambulance leaves the site. This will normally be through the establishment of a fixed treatment centre or first-aid post alongside the ambulance provision. Patients should be transported appropriately as indicated by their medical condition, with a crew skilled to a suitable level.

**On-site medical and first-aid facilities**

The number, role and location of on-site medical facilities should be planned to provide suitable capacity and ease of access. This should take into account the provision of other services on-site, such as fire, police and welfare. Larger sites may require more than one facility. The role of each facility should be planned around workload and illness/injury severity expected throughout the active phase of the facility.

Suggested roles include:

* First-aid post or unit –an area capable of providing first-aid and basic life support. This area should have immediate access to an Automated External Defibrillator (AED) and should have staff trained in the use of this equipment
* Minor injuries/illness unit – an area capable of providing an extended spectrum of care beyond that given in the first-aid unit. As such, it should have more comprehensive diagnostic and treatment capabilities. Staffing and equipment should reflect this extended care. Basic life support capabilities and immediate access to an Automated External Defibrillator should be in place. This type of facility should have the capability of short-term patient observation
* Medical centre – an area housing a full medical centre providing care that may include, but extends beyond, the care given at a first-aid or minor injury/illness unit. The centre should be able to provide triage, assessment and primary care. It should also be capable of providing advanced techniques with regards to critical illness and major trauma assessment, and resuscitation. As such, it should be equipped and staffed appropriately
* Specialist triage areas – an area close to a large crowd site – eg. the pit of a stage - where the following factors make medical care difficult:
* noise levels or other environmental factors
* potential for casualty presentation with a serious injury
* potential for multiple casualty presentations in a short time



The area terminologies given above are suggestions only. The naming of each facility is at the discretion of the medical provider. However, the role of each centre should be clearly understood by the medical provider and the event organiser. The chosen name for the facility should not mislead the public with regards to its capabilities. Not every site will require all the above services.

If different types of facility are present, reliable lines of communication between units and a robust referral system should be in place to upgrade care from one centre to another. There should be safe transfer arrangements to make this plan possible. This will ensure that patients are streamed to the most suitable facility, with relevant staff and equipment to provide necessary care.

Factors to take into account when considering facility position include, but are not restricted to:

* pedestrian and vehicle access routes and one-way systems
* location of main camping sites and entertainment/production areas
* anticipated crowd movements and density
* location of other medical facilities
* location of welfare facilities
* ground conditions in adverse weather conditions, e.g. mud, flooding

When setting up a medical facility, it should:

* be of an adequate size for the anticipated throughout
* be easily accessible for patients who self-present on foot and patients who arrive at the unit on an ambulance trolley or in a wheelchair
* have adequate hard standing or parking facilities for ambulances and other emergency vehicles. The position and nature of this should assist the rapid loading and offloading of patients in and out of the medical facility. Appropriate measures should be in place to prevent inappropriate pedestrian access to this area
* provide a suitable patient waiting area that protects patients from the environment. This should be separate from the clinical working area in order to protect patient confidentiality
* have working areas of adequate size within the facility to allow patient treatment to take place, e.g. around an ambulance trolley
* have working areas that contain suitable worktops or tables for equipment and documentation
* be set up to maintain patient dignity and confidentially
* be provided with appropriate medical and resuscitation equipment for the designated role of the unit. This should be separate from the equipment carried on ambulances
* have areas to store equipment, drugs and medical gases in an appropriate, safe and secure manner
* be maintained in a clean and hygienic state
* hand cleansing facilities must be provided
* have easy access to the clinical waste area
* be designated a non-smoking area
* have an area for staff rest during shifts. This should be away from clinical areas

Agreements on role, position, layout and provision of equipment should be made between the event organisers and the medical provider in the planning phase before the event.

**Specific considerations for the main medical facility**

If there are multiple medical facilities on-site, one should be designated as the main unit. This should ideally be the facility that can provide the most comprehensive care. If all facilities on-site have the same role then the most appropriate unit should be selected based on other factors, including location.

The main medical facility should have a clear communication line with the joint command and control to allow free flow of information. It should be able to function as a casualty-clearing station in the event of a major incident. However, this role may need to be reallocated to another unit should the main facility be inoperative because of the incident.**Structures and infrastructure**

Medical facilities may be engaged in resuscitative efforts and lifesaving interventions at any time. For this reason, event organisers must make the set-up and maintenance of the medical infrastructure a priority before and throughout the event.

The medical facility should be set up in an appropriate permanent or temporary structure. Temporary structures should be erected in accordance with accepted safety standards. For both temporary and permanent structures, the following infrastructure should be in place:

* the structure should be able to withstand adverse weather conditions
* appropriate hard flooring should be in place. This should be even and stable
* the structure should have effective heating that can be controlled as required
* an adequate and safe electrical supply should be provided. There should be enough sockets to run all equipment, both medical and non-medical, within the unit. Medical equipment should have a back-up battery in case the electrical supply fails. If it is impossible to provide an adequate power supply, a plan to charge and change batteries of medical equipment should be in place
* the unit should be well lit
* there should be an adequate water supply, ideally with hot and cold-running water. However, it is understood that this is not possible on all sites. Cold-running water or bottled water are alternatives, but all efforts should be made to provide the above
* there should be a supply of drinking water. Again, this may have to be bottled
* there should be easy access to toilets with appropriate attention to wheelchair access. Public toilets and staff toilets should be separate
* the unit should have facilities to clean patients if required. For example, patients contaminated with stool or vomit
* suitable clinical waste and sharps bins must be provided in all clinical areas. Appropriate arrangements must be made for the safe on-site storage of full waste containers, and their appropriate disposal in line with current legislation (Hazardous Waste Regulations 2005)
* a suitably licensed contractor should ultimately dispose of clinical waste; documentation relating to this disposal should be retained in case of future query.

**Staffing plan**

A medical staffing plan should be made prior to the event to cover both static medical facilities and mobile medical teams. Staffing should take into account training and experience so that appropriate personnel are deployed to the most appropriate areas. The following factors should be taken into account:

* staffing numbers should reflect the expected workload, but there should also be contingencies for times of unexpected high workload
* contingencies should also be made to cover unplanned staff shortages to ensure safe medical cover continues
* inexperienced staff should be supervised at all times and must have had appropriate training
* medical staff should not normally work alone
* Medical staff should not undertake another role e.g stewards being classed as first-aiders
* the working pattern of any staffing plan should take into account breaks during shifts and an appropriate rest period between shifts. Contracted staff should work within the limits of the European Working Time Directive. For safety reasons, it is recommended that the staffing plan for voluntary staff be based on the European Working Time Directive too.

**Maps and plans**

A detailed map or plan of the site should be available in advance of the event. To avoid miscommunication, on-site groups and agencies should be working from this single map. The map should use grid coordinates, e.g a letter and number system. Larger-scale versions of specific crowded areas of the map should be provided, if appropriate. The position of all static medical facilities should be clearly marked, as well as site access and egress routes, sterile routes and planned helicopter-landing sites. Copies of the maps should be immediately available for external agencies in the event of a major incident or emergency, and correlation of the chosen grid system with the British National Grid system should be known.

**Welfare**

**Staff**

Arrangements should be in place to ensure the welfare and wellbeing of medical staff. The extent and nature of these facilities will be determined by the nature and duration of the event.

Consideration should be given to the provision of:

* suitable rest areas separate from clinical areas and appropriately shielded from excess noise levels; heated or cooled as necessary
* access to suitable refreshment facilities, again separated from clinical areas
* access to suitable washing/showering facilities at prolonged events
* suitable sleeping accommodation at multi-day events. Consideration should be given to the sleep requirements of staff working night shifts, for whom accommodation on-site might not be suitable

**Documentation**

**Patient-related information and records**

Medical providers should ensure that they comply with the requirements of the Data Protection Act 1998 and the obligation for patient confidentiality when considering what information they collect from patients, who has access to it, and how it is processed and used.

**RIDDOR reporting requirements**

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) place an obligation on employers, the self-employed and people in control of work premises to report a specified list of injuries and occurrences to the Health and Safety Executive. Agreement should be reached between the medical provider and the event organiser as to how patients meeting these criteria will be identified, and how information will be passed to the event organiser (who has a legal duty to report it). Sharing of information in this way falls within the definition of 'appropriate use’ for the purposes of data protection legislation.

Any accident affecting an event worker, even if not RIDDOR reportable, should be communicated to the worker’s employer and recorded in his or her own accident book. Normal practice would be to remind the event worker of this responsibility.

**Medical Log**

The medical provider should maintain an up-to-date log of all patients seen. This is invaluable in providing timely information to the event organiser about numbers of patients treated and those removed to hospital.

It should also allow early identification of any trends in the nature of illnesses or injuries presenting, and allow remedial action to be taken by the event organiser, where appropriate.

The other purpose of this log is to assist in dealing with enquiries from police and other agencies in respect of missing or lost persons.

**The importance of correct and full completion of documentation**

Medical records made at the time of a patient’s presentation are often required at a later date to assist with investigation into accidents or when dealing with insurance claims. It is important, therefore, that they provide a full and accurate record of that episode of patient care. The bodies responsible for registering healthcare professionals in the UK (GMC, NMC and HCPC) all produce guidance on standards of documentation. Medical providers should ensure that they meet these standards.

Once completed, medical records should be stored in secure conditions in a filing system that allows for easy retrieval in case of query. There are varied retention schedules for different types of record and current best practice guidelines, such as those issued by the Department of Health in England, should be adhered to.

**Interface with emergency services**

Discussions should take place between the medical provider and the NHS ambulance (SWAST) service to enable calls that are received from the event, made by members of the public, to be redirected to the medical provider on-site via the on-site control.

Pre-event site visits for the emergency services to view the site is good practice. This enables considerations for the emergency services coming to the site to be agreed and for the event provider to seek advice and guidance as required.

**Major incidents**

A major incident can be defined as any emergency that requires one or more of the emergency services to implement special arrangements. Event medical providers should consider that they might have to provide an initial response to a potential major incident. They will also have to supply intelligence on which the decision to declare a major incident can be made by the emergency service representatives overseeing the event.

Once a major incident is declared, the statutory ambulance service for the area in which the event is being held becomes responsible for the management of the NHS response to the incident. It is important that the arriving NHS staff are aware of the key personnel on-site to liaise with and whether the event medical provider has commenced effective triage and initial casualty management. Clear communications between the on-site provider and the NHS ambulance service (SWAST) are key to ensuring effective handover and coordination of the incident. As soon as appropriate command elements of the statutory ambulance service are on-site they will take over management of all the event medical provider’s staff and assets.

At large events it is best practice that a Handover of Responsibility document is drawn up between the statutory ambulance service and the event medical provider ready for use should a major incident occur. This will detail when the assets of the medical provider were handed over to the statutory ambulance service for the duration of the incident. Part of the document will also outline the hand-back procedure when the recovery from the major incident commences.

When drawing up the medical plan for large occasions, event medical providers should allocate major incident roles to staff. They should consider how they would initiate triage and start casualty management pending the arrival of the statutory service in sufficient numbers.

**After the event**

**Stand-down of medical and first-aid services**

Just because an event has finished does not mean that the medical and first-aid services can stand down. The risks change and, depending on the size of the event, the focus can move to crowd egress, car parks, transport hubs, park-and-ride sites and external roadsStand-down of medical and first-aid services should be agreed by all agencies and logged.

**Site breakdown**

Most event organisers will commence the breakdown of their site as the last member of the public has left. The risks change back to a building site, but are heightened by the desire to vacate the site in the fastest possible time. Many different contractors may be on-site, all with their own pressures and priorities. There can also be a considerable amount of traffic exiting the site including concessions, amusement rides and large transporters.

It is essential that the medical, ambulance and first provision for the breakdown is considered and agreed within the overall medical plan, as this period can run for days. **Event medical report**

The event medical provider should produce a medical report of the event for their client, usually the event organiser. In the event of the provider being sub-contracted by another provider, relevant information should be passed to the lead medical contractor who should be preparing a report.

An event medical report should have a number of well-defined headings, but clearly its layout and content will be defined by the size and type of event. Some likely headings are:

* introduction and summary of the task
* resources and capability delivered
* casualty statistics
* issues identified in the medical plan
* wider event issues
* recommendations for future similar events

**Investing in lessons learned**

Lessons will be learned from any event and it is important that medical providers draw on those experiences relevant to their operation. With recurring events, it is important that this information is used to inform the planning process for the next occasion. From the standpoint of the medical provider, the lessons may be related to shortfalls in manpower or equipment that would need addressing before the next time.

Identified shortfalls of equipment are of considerable importance because the type and range of casualties should have been considered and planned for appropriately during the medical resource assessment.

It has not been possible to define a single table that identifies the correct medical, first-aid and ambulance provision for a range of events. Instead, the principles of resource assessment based on risk should be followed, as indicated throughout this chapter. The tables below offer some outline guidance.

|  |
| --- |
| **Examples of medical cover at events & Event Risk Assessment** |
| Every event is unique and the level of medical provision needed to make it safe can only be determined after a comprehensive risk assessment. There are no off the peg solutionsThe following guidance is drawn from experience of a range of different events and aims to give a broad overview of the sort of cover that might be appropriate. It should be read as guidance only and is not intended to be prescriptive in any wayIndicative staffing levels refer to staff on duty at peak periods and these levels may be scaled down at less busy timesRisk assessment should include:* Numbers attending
* Audience profile
* Activities on site
* Location and access
* Distance from definitive care
* Duration of the event
* Time of year
* Overnight camping
* Specific hazard
* Past experience of the event
* Local knowledge
 |

|  |  |  |
| --- | --- | --- |
| Very Small Event |   | Up to 3000 attenders |
| First-aid cover | Minimum: 2 first-aiders2 first-aiders or first responders/1000 attenders | Consider:Paramedics, ECPs or ENPs to increase casualty assessment and stabilisation capability where circumstances dictateSite ambulance and crew if event held across a large area |

|  |  |  |
| --- | --- | --- |
| Small Event |   | 3000 – 10,000 attenders |
| Paramedic or Nurse-led cover | 1-2 paramedics or ECPs1-2 nurses or ENPs6 first-aiders or first responders for first 3000 attenders + 1/1000 above 3000 | Consider:DoctorRapid Response VehicleAmbulance(s) and crew for on-site service and transfers to hospital |

|  |  |  |
| --- | --- | --- |
| Medium Event |   | 10,000 – 50,000 attenders |
| Doctor-led cover | 1-2 doctors2-4 nurses or ENPs2-4 paramedics or ECPs10 first-aiders or first responders for first 10,000 attenders + 1/5,000 above 10,000Ambulance(s) and crew for on-site service and transfers to hospital (minimum 1 ambulance)1 Rapid Response Vehicle | Consider:Specialist doctors, pit crews, substance abuse team etc where indicated |
| Large event |   | Over 50,000 attenders |
| Doctor-led cover with specialised support | 1 doctor/20,000 attenders1 nurse or ENP/10,000 attenders1 paramedic or ECP/20,000 attenders2 first responders/25,000 attenders20 first-aiders for first 50,000 attenders + 2/10,000 above 50,000Ambulance(s) and crew foron-site service and transfers to hospital (minimum 2 ambulances)1-2 Rapid Response Vehicles | Consider providing on site:* Emergency department
* GP facilities
* Pit crews
* Mental Health Team
* Pharmacy
* X-ray
* Physiotherapy, podiatry, dentistry et
 |

This guidance is based upon the “Purple Guide” to Health, Safety and Welfare at Music and other events.

24th July 2015