Scottish Ambulance Service

National Risk and Resilience Department

Generic Contingency Plan – Capacity Management

Incorporating the

Resource Escalatory Action Plan - REAP

(Including Out of Hours and Winter Planning arrangements for 2015/16)

Version 5.1

September 2015

Equality & Diversity Impact Assessment – November 2015

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Executive Summary

In preparation for Winter 2015/16 the Scottish Ambulance Service has developed its Winter Plan and reviewed the Resource Escalatory Action Plan (REAP). The principles of this plan should be applied regardless of the cause of the capacity challenge or the time of year at which the pressure arises. However, it is recognised that the plan is most likely to be implemented during the winter and festive periods and therefore it contains lessons and experience gathered from managing activity over several winters, where such arrangements have been required. The Winter Plan will be tested with a Table Top Exercise which is scheduled for 3rd December 2015.

The plan pays particular emphasis to the 6 Essential Actions as set by Scottish Government, Healthier Scotland.

- Clinically Focussed and Empowered Hospital Management.
- Capacity and Patient Flow Realignment
- Patient rather than Bed management
- Medical and Surgical processes arranged for optimal care
- 7 Day Services
- Ensuring Patients are cared for in their own homes

The REAP Plan contains usable information to assist with the management of surge demand, including those that can be normally anticipated (upper and lower respiratory tract...
infections, limb fractures, etc) during the winter. The plan consists of a generic central framework supplemented by local Divisional Level Plans. The Service has prepared its plan in wide consultation with all relevant stakeholders, particularly at local level and explores jointly a means of managing the consequences of additional demand.

As in previous years the service has adapted its preparations for the winter period based on previous experience and planning assumptions shared by local and national stakeholders. This year is no exception and these requirements have been factored into this year’s delivery model.

In addition to REAP the Service aims to provide additional enhancements this winter, these include:

The provision of Hospital Ambulance Liaison Officers (HALO) nationally, this model is supportive of improving patient flows and discharges. Tasks will include:

- Assist with improving hospital turnaround times
- Act as a point of contact for bed site management and capacity
- Provide ambulance input into the daily huddle
- Inform the requirement for additional resources to meet discharge/transfer peaks

In order to provide a more clinically focused service to requests from Health Care Professionals (HCPs) urgent desks are being established by 30th November 2015 within the Ambulance Control Centre (ACC), these will be staffed by clinicians, dispatchers and call handlers and will ensure patients receive the most appropriate ambulance response based upon their clinically assessed needs.

The utilisation of PTS resources to underpin unscheduled low acuity work will enable the appropriate skilled resources to be sent to higher acuity patients at the appropriate time.

Paramedic Practitioners where available can be deployed to integrate with GP surgeries to increase the number of Hear & Treat / See & Treat patient outcomes.

The identification of additional alternative care pathways will also reduce the number of treat and transfer patients where it is safe and appropriate to do so. We are also working with NHS 24 on a joint ‘speak to doctor’ pilot.

The Service has identified the availability of additional managers over key dates across the festive period to ensure access to local senior decision making is readily available in addition to the national on call structure. Availability and mapping of staff such as ACC bank staff and Community First Responders has also taken place to ensure maximum availability at predicted peak demand times.

The plan requires users to assess pressures and capacity and then sets out triggers for escalation and implementation through various stages of activity. In this, it establishes a framework for action by ACCs, the Operational Service and the Clinical Directorate against those triggers to support operational decision making and safeguard the most critical aspects of service delivery. It also aligns closely with the existing Scottish Ambulance
Scottish Ambulance Service

National Risk and Resilience Department

Generic Contingency Plan – Capacity Management. REAP (including Out of Hours and Winter Planning arrangements)

1. Introduction

There is a necessity to maintain a comprehensive contingency planning framework to manage the consequences for the ambulance service of a level of demand rising to a point where it exceeds the ability of the Service, or other parts of the healthcare system, to meet that demand. This may arise when, either in isolation or in combination, there is a rise in demand or a reduction in the capacity of those organisations to deliver services.

Changes to the system of delivery for unscheduled care have driven the requirement to plan for a failure of out of hours services or other health services, due to the consequences of internal or external threats to service continuity.

Should such a situation arise, health care provision may need to be planned or delivered differently, services prioritised or re-scheduled and partnership working, including mutual aid, extended or special contingency arrangements invoked.

For example, this plan may need to be implemented in circumstances when:

a. There is a significant surge in demand for services provided by the ambulance service, NHS 24 or an NHS Board for which that organisation does not have the capacity to compensate immediately (e.g. a flu outbreak, extreme weather challenge or significant major incident – which could escalate to the point where the ambulance service, NHS 24 or an NHS Board is unable to sustain or provide a service compatible with patient safety).

b. There is a significant reduction in the capacity of the Ambulance Service, NHS 24 or an NHS Board, which severely restricts its ability to respond to patient demand or deliver care (e.g. understaffing - major staff sickness, localised IT system failures, wider failures of service continuity, including external suppliers of goods and services, which could escalate to the point where the ambulance service, NHS 24 or an NHS Board is unable to sustain or provide a service compatible with patient safety).

c. Escalating demand exceeds the capacity at Divisional level to provide services within an appropriate timeframe.
d. There is a significant reduction in the capacity of the local Health Board to provide services (e.g. too few medical staff to sustain centre, systems or infrastructure failures.)

Note: Services over Festive Periods. Routine practice closure for 4 consecutive days on two consecutive weeks will occur in certain years. In addition to pressures due to capacity challenges within NHS out of hours services, trends for 999 calls indicate that demand may rise from between 10% - 150% above normal Friday night levels at certain times over that period. The patient care consequences and potential for uncompensated major incident at special events over the festive period and a certain other times also contribute to the pressures on the Service, requiring the implementation of this plan.

2. Capacity Management - Planning Rationale

In order to plan effectively for the impact of escalating demand, reduced resources or other unanticipated disruption, including significant systems or infrastructure failure, an assessment of existing demand and capacity is necessary together with an accurate assessment of the impact and range of consequences likely to impinge on service delivery. At given levels of escalation, a pre-determined consistent framework for action is required to support decision making and to manage and preserve the mission critical aspects of the operational service.

Therefore, managers, with the assistance of risk, resilience and business continuity colleagues have been required to consider the likely consequences of any realistically foreseeable occurrence on service delivery, and consider the action required to best maintain critical services and to identify any action that could reasonably be taken in advance of an adverse situation to reduce the impact.

Generic action in preparation for a capacity management challenge may include participating in immunisation programmes, issue of PPE or other buffer stocks, predetermined increases in operational or other staffing or deployment of special resources such as personnel, vehicles (including four-wheel drive) or equipment, to cover anticipated pressures. Preparation may also include training of additional staff or volunteers in specific priority duties and effective, planned communication with external stakeholders.

A common understanding of these planning assumptions and the development of consistent inter-agency contingency plans, escalation triggers, communications and management policies may be of particular value in reducing the adverse effect of disruptive challenge.

Internally, the Service has been advised to continue to develop policies to underpin its ability to enhance capacity or reduce demand at times of peak pressure, introduce alternative arrangements for Service delivery, identify staffing and logistical requirements, consider the likely cost implications and where necessary, ensure that arrangements are appropriately validated through exercises and audit.
3. Related polices and plans:

- Pandemic Outbreak Contingency Plan
- Fuel Business Continuity Plans
- Divisional / Departmental Business Continuity Plans
- Major Incident Procedure
- ACC Procedures
- Crisis Management Plan
- Risk Management Policy – Incident Reporting and Risk Registers
- Seasonal Influenza Vaccination Programme
- Health and Safety Policy
- Output from Local Out of Hours / Unscheduled Care Groups and Strategy Project Boards
- SGHD Exception reporting requirements (distributed annually)
- SAS National Command and Co-ordinating Centre (SAS-NCCC) Procedures
- UK Ambulance Service Mutual Aid Procedures (National Ambulance Resilience Board)
- Preparing Scotland – Scottish Resilience
- Preparing for Emergencies – Scottish Government Health Directorates
- Scottish Government Health Directorates – specific plans and procedures
- National and Local Service Bulletins

4. Co-ordination Arrangements

a. External:

- Scottish Government Resilience Advisory Board (RABS)
- SGoRR (O)
- RABS Sub-Groups – other mechanisms as relevant – CBRN, Fuel etc.
- CONTEST Board
- Regional Resilience Partnerships x 3
- Local Resilience Partnerships
- NHS Resilience
- Health and Safety and Infection Control Team
- Territorial Health Boards (x14)
- Usual liaison arrangements with SGHD, NHS Boards, HPS, NHS24, VAS etc.
- Other Ambulance Services (National Ambulance Resilience Unit)

b. Internal

- Executive Team – through established reporting. (Reporting to the SAS Board)
- SAS National Command and Co-ordinating Centre (SAS-NCCC) (if established)
- Senior Management Team
- Daily Conference calls
- Operational Management Team
- Resilience Committee
- Divisional Management Teams / Local Operational Management Teams
- Partnership Forum – National and Divisional / Departmental

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Equality & Diversity Impact Assessment – November 2015

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- Health and Safety Committee – National and Divisional / Departmental
- Clinical Governance mechanisms – Clinical Governance Committee
- Fleet Department

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Date of Release: 30th September 2015</td>
<td>Date Intranet Posting: (Capacity Management Plan)</td>
<td>Implementation: Immediate by ACC / Divisions / Departments</td>
<td>Approved by SAS Board 30th September 2015</td>
</tr>
</tbody>
</table>

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5. Resource Escalatory Action Plan - REAP

Capacity Management Contingency Plan and Resource Escalatory Action Plan (REAP)

5.1. Introduction

a. Since 2004, the Scottish Ambulance Service has maintained a Capacity Management Contingency Plan which has been implemented during times of capacity challenge. This plan was developed by NRRD to meet the needs of the Service, including arrangements for re-prioritisation and suspension of activity, structured reduction in service provision and redeployment of personnel.

b. The English and Welsh Ambulance Services under the direction of AACE through NARU are undertaking a review of REAP. The Scottish Ambulance Service has taken the opportunity to accelerate their review so that it may be launched in conjunction with the 2015/16 Winter Plan.

c. The plan has been designed to be a predictive tool in conjunction with the SAS Pandemic Outbreak Contingency Plan, Major Incident Plan and Business Continuity Plans at a local level, all of which are designed to manage capacity issues.

5.2. Background

a. Unlike the operational model within some other emergency services, it is recognised that Ambulance Services work operationally at, or near, capacity, especially in urban areas for much of the time. This fact causes a degree of vulnerability in the delivery of patient care, due to lack of surge capacity, an inability to make available additional resources to deal with significant increases in demand.

b. There have been occasions, e.g. Winter Pressures, when the SAS has established its Strategic, National Command and Co-ordination Centre (SAS-NCCC) to coordinate and allocate resources across operational divisions consistently in accordance with national priorities.

c. This Plan follows the REAP model, but with triggers and specific measures provided by the Operational Divisions including ACCs, NRRD and Airwing for implementation when the Service is operating at capacity.
5.3 Intention

a) It is the intention of the Scottish Ambulance Service to continue to deliver a high level of patient care for the population of Scotland when experiencing capacity pressures, in keeping with the ethos and strategy of the Service. This recognises the need to maintain public confidence and the good reputation of the Service.

b) During periods of increasing demand, the SAS will consider a variety of operational, tactical and strategic options that are considered most suitable to address the prevailing operational situation. These options are designed to safeguard the most critical and vulnerable patients, by re-deploying resources from other functions in order to protect mission critical activities.

c) REAP recognises the benefit of a national organisation to support functions through the application of internal mutual aid.

d) There will be an overall REAP level for the Service. This should be expressed by the Chair of the conference call on a Monday and revised weekly or as disruptive challenges dictate. Each Operational Division will declare a REAP level, which will contribute to the national REAP level.

5.4 Actions

a) Decisions may be made at a national level for the benefit of the Service overall. Therefore, this may result in resources being redeployed from an area of lower concern to one with a greater need.

b) All Managers must be fully conversant with the content of this plan and the actions required to implement it.

c) Table 1 shows the different REAP levels which will be applied.

d) Table 2 illustrates the triggers for determining the REAP level.

e) Table 3 illustrates mitigating action.

f) The National Operations Manager will be responsible for informing the on Call Strategic Manager of any considerations that may give causation to review the Services (National) REAP level at any given time.
5.5 Structure

a) Having been made aware of a developing, deteriorating or potentially serious situation, the Strategic Manager On Call may call a ‘capacity management’ meeting at the necessary level, to take action.

b) Core attendance (Conference Call) will vary depending on the trigger that has been reached.

c) The duty ‘Strategic Manager On Call’ will lead the recovery effort, supported by all Departments.
Table 1: National REAP Levels

<table>
<thead>
<tr>
<th>REAP Level</th>
<th>Critical Impact / Service Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>REAP Level 4</td>
<td>Critical Impact / Service Failure</td>
</tr>
<tr>
<td>REAP Level 3</td>
<td>Significant Impact</td>
</tr>
<tr>
<td>REAP Level 2</td>
<td>Moderate Impact</td>
</tr>
<tr>
<td>REAP Level 1</td>
<td>Normal Service Delivery</td>
</tr>
</tbody>
</table>

Table 2: Triggers for implementation of a REAP level (based on range of factors affecting the Service)

<table>
<thead>
<tr>
<th>Triggers</th>
<th>Staff</th>
<th>Fleet</th>
<th>Supply</th>
<th>Demand</th>
<th>System Pressures</th>
<th>Weather</th>
</tr>
</thead>
<tbody>
<tr>
<td>REAP 1</td>
<td>Operational abstraction rate ≤ 10%</td>
<td>Fleet provision reduced by ≤ 10%</td>
<td>Essential supplies being delayed by ≤ 4 Days</td>
<td>Predicted demand is forecast to be ≤ 10% of normal</td>
<td>Hospital turnaround times ≤ 30 mins</td>
<td>Be aware weather warnings issued from Met Office</td>
</tr>
<tr>
<td>REAP 2</td>
<td>Operational abstraction rate 11 - 15%</td>
<td>Fleet provision reduced by 11 - 15%</td>
<td>Essential supplies being delayed by 5 - 7 Days</td>
<td>Predicted demand is forecast to be 11 - 15% of normal</td>
<td>Hospital turnaround times 31 - 40 mins</td>
<td>Be prepared weather warnings issued from Met Office</td>
</tr>
<tr>
<td>REAP 3</td>
<td>Operational abstraction rate 16 - 20%</td>
<td>Fleet provision reduced by 16 - 20%</td>
<td>Essential supplies being delayed by 8 - 10 Days</td>
<td>Predicted demand is forecast to be 16 - 20% of normal</td>
<td>Hospital turnaround times 41 - 50 mins</td>
<td>Take Action weather warning issued from Met Office</td>
</tr>
<tr>
<td>REAP 4</td>
<td>Operational abstraction rate ≥ 21%</td>
<td>Fleet provision reduced by ≥ 21%</td>
<td>Essential supplies being delayed by ≥ 11 Days</td>
<td>Predicted demand is forecast to be ≥ 21% of normal</td>
<td>Hospital turnaround times ≥ 51 mins</td>
<td>Weather conditions have a significant and sustained impact on critical infrastructure</td>
</tr>
</tbody>
</table>

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Table 3: Mitigating Actions

<table>
<thead>
<tr>
<th>Actions</th>
<th>Staff</th>
<th>Fleet</th>
<th>Supply</th>
<th>Demand</th>
<th>System Pressures</th>
<th>Weather</th>
</tr>
</thead>
<tbody>
<tr>
<td>REAP 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Business As Usual</td>
<td></td>
</tr>
<tr>
<td>REAP 2</td>
<td>Maximise ALL resources to cover core shifts. Request VAS and redeploy PTS resources.</td>
<td>Prioritise workshop capacity to maximise patient carrying fleet capacity.</td>
<td>Ensure redistribution of existing stock to areas of need.</td>
<td>Secondary triage all Omega and Alpha Calls through the Clinical Queue. PTS resources prioritise Renal, Discharges and Low Acuity Mid Tier.</td>
<td>Local Management Discussions / Interventions with Integrated Health &amp; Social Care Partners and Acute Units daily.</td>
<td>Managers to monitor local predicted impacts and gain assurance from key services in relation to preparedness.</td>
</tr>
<tr>
<td>REAP 3</td>
<td>Postpone ALL activities/meetings that do not directly assist in resolving or managing the current/imminent pressures.</td>
<td>Redeployment of ALL resources to core business (Ambulances/Lease Cars/4x4). Outsource service, MOT and repair for lease hire/pool vehicles.</td>
<td>Invoke plan with National Distribution Centre to ensure essential patient care supplies can be obtained.</td>
<td>Secondary triage Bravo calls through the Clinical Queue. NO SEND Policy invoked for Omega and Alpha codes.</td>
<td>NCCC to review the deployment of key staff and managers in response to points of pressure at appropriate locations.</td>
<td>Managers to ensure ALL appropriate actions are invoked. Ensure that specialist transport arrangements (4x4) are prioritised.</td>
</tr>
<tr>
<td>REAP 4</td>
<td>All available clinical staff to be redeployed to frontline duties. Managers and support staff to be redeployed to directly assist with Service Delivery.</td>
<td>Extended hours of operation across 7 days. Outsource all service, MOT and repair work to minimise out of service time.</td>
<td>Obtain essential patient care supplies from any available supplier.</td>
<td>Secondary triage Charlie calls through the Clinical Queue. NO SEND Policy invoked for Omega, Alpha and Bravo.</td>
<td>NCCC to coordinate Service Priorities and resources ensuring appropriate deployment of National Assets</td>
<td>NCCC to seek, prioritise and coordinate all available national resources to respond to Service need.</td>
</tr>
</tbody>
</table>

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6 Winter 2015/16

As in previous years the service has adapted its preparations for the winter period based on previous experience and planning assumptions shared by local and national stakeholders. This year is no exception and these requirements have been factored into this year’s delivery model.

The areas which the service aims to provide particular enhancements this year will be:

6.1 Clinically Focused and Empowered Hospital Management

6.1.1 To provide a Hospital Ambulance Liaison Officer (HALO) model in line with winter planning funding that is supportive of improving patient flows and discharges. Tasks would include:
- Assist with improving hospital turnaround times
- Act as a point of contact for bed site management and capacity
- Provide ambulance input into the daily huddle
- Inform the requirement for additional resources to meet discharge/transfer peaks

6.1.2 In order to provide a more clinically focused service to our requests from Health Care Professionals (HCPs) Urgent Desks are being established within the ACCs. The Urgent Desk, staffed by clinicians, dispatchers and call handlers will ensure that patients receive the most appropriate ambulance response based upon their clinically assessed needs. In addition to this we are working with NHS 24 to consider a joint ‘speak to doctor’ pilot designed to support our clinicians with professional to professional support.

6.1.3 Both the above resources will liaise regularly to ensure early escalation and improved communication.

6.1.4 The service will ensure that SCOTSTAR services are fully integrated into the winter arrangements to ensure their skills can be deployed to support pressures.

6.2 Capacity and Patient Flow Realignment

6.2.1 The HALO will provide information identifying discharge peaks which will allow us to profile the additional winter resources subject to funding at the appropriate time. This will ensure there are reduced delays due to transport need therefore assisting with patient flow.

6.2.2 The Real Time Analyst will monitor NHS System Watch to provide live information on bed capacity. This will prompt a discussion with the HALO to identify any actions required in relation to early escalation.

6.2.3 Reviewing the arrangements with the British Red Cross Society to identify the availability for the use of volunteers to underpin the increased call demand.

6.2.4 Confirm the availability of Bank Staff in the Ambulance Control Centre for use during periods of high pressure to meet the increased call demand.
6.3 Patient rather than Bed Management

6.3.1 Early dialogue between the HALO and Bed Site Manager to facilitate resources are available at the time required to meet the demand for earlier discharge and transfer to community care.

6.3.2 The SAS will prioritise and roster additional resources to support early morning discharges.

6.4 Medical and Surgical Processes for optimal care

6.4.1 Clinicians based within the ACCs will utilise the Manchester Triage System by contacting patients who initially present as low acuity to ensure that the most appropriate resource is provided. This system will offer a number of options, including, an emergency response, alternative transport, alternative care pathways and self-care advice.

6.4.2 The Urgent Desk provides additional capacity within the ACCs to inform patients of extensions to waiting times. If the patient’s condition has deteriorated the call will be upgraded as appropriate, therefore ensuring patient cantered care.

6.4.3 Currently Paramedic Response Units report the requirement for ‘back up’ following an initial patient assessment. Development of the Low Acuity Model will enable patients to receive a more clinically appropriate conveying resource within an agreed response time. Utilisation of Low Acuity resources will protect A&E resources to be deployed to emergency calls.

6.5 7 Day Services

6.5.1 The bid for additional funds is primarily to ensure resources are available across 7 days to support discharges earlier in the day and also across greater hours.

6.5.2 The utilisation of PTS resources to underpin unscheduled low acuity work will enable the appropriate skilled resources to be sent to higher acuity patients at the appropriate time.

6.5.3 Mapping the availability of volunteers namely Community First Responder schemes to ensure maximum availability at predicted peak demand times.

6.5.4 Identifying the availability of additional managers over key dates across the festive period to ensure access to local senior decision making is readily available in addition to the national on call structure.

6.6 Ensuring patients are cared for in their own homes.

6.6.1 The deployment of Paramedic Practitioners where available to integrate with GP surgeries will increase the number of Hear & Treat / See & Treat patient outcomes.

6.6.2 The identification of additional alternative care pathways will also reduce the number of treat and transfer patients where it is safe and appropriate to do so.
6.6.3 Collaborative working with GP’s through the Urgent Tier desk clinician will improve local professional to professional networks and smooth out peaks in demand for urgent admissions, reducing diverts to the emergency departments.

6.6.4 The provision of a palliative care vehicle will enable the specialist transport of patient’s home at the appropriate time in line with their end of life care wishes.
7. Contact details

a. Routes of Communication – ACC

<table>
<thead>
<tr>
<th>ACC</th>
<th>Primary and Contingency</th>
<th>Routing if not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (Inverness) ACC</td>
<td></td>
<td>Re dial East or West Numbers</td>
</tr>
<tr>
<td>East (Edinburgh) ACC</td>
<td></td>
<td>Re dial West or North Number</td>
</tr>
<tr>
<td>West (Glasgow) ACC</td>
<td></td>
<td>Re dial East or North Numbers</td>
</tr>
<tr>
<td>Other Divisions and Departments</td>
<td>Normal arrangements apply NHQ 0131 314 0000</td>
<td>Via local ACC, Edinburgh ACC for National Departments</td>
</tr>
</tbody>
</table>

b. Routes of Communication – SAS National Command and Coordination Centre (SAS-NCCC)

Primary

Contingency

c. Routes of Communication – NHS 24

<table>
<thead>
<tr>
<th>NHS 24 Public Access</th>
<th>08454 24 24 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS 24 North</td>
<td>Landline</td>
</tr>
<tr>
<td></td>
<td>Mobile</td>
</tr>
<tr>
<td>NHS 24 East</td>
<td>Landline</td>
</tr>
<tr>
<td></td>
<td>Mobile</td>
</tr>
<tr>
<td>NHS 24 West</td>
<td>Landline</td>
</tr>
<tr>
<td></td>
<td>Mobile</td>
</tr>
</tbody>
</table>

d. NHS 24 Dial-in details for conference calls:

- BT Meet-me dial-in number
- Participant Passcode

e. NHS 24 Partner SPOC information:

<table>
<thead>
<tr>
<th>Partner Organisation</th>
<th>Contact Role (e.g. Hub Duty Manager)</th>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clyde</td>
<td>Linda McGregor</td>
<td></td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>DGPSOC</td>
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<tr>
<td>Fife</td>
<td>Hub</td>
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<td>Forth Valley</td>
<td>Hub</td>
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<tr>
<td>Alloa</td>
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<td>Glasgow</td>
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</table>
f. Scottish Government Health Department Performance Management Division: Officials on-call: emergency contact details.

Note: NHS 24 may be required to report to the Scottish Government Performance Management Division any issues and exceptions in respect of out of hours service and resources, including those of partner agencies. Therefore, if requested, partners must advise NHS 24 / SGHD of capacity or technological problems and implementation of contingency measures.

<table>
<thead>
<tr>
<th>Date</th>
<th>Official</th>
<th>Contact Number</th>
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<tr>
<td>TBN</td>
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<td>TBN</td>
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Note: Normal office contacts can be used during working days between Christmas and New Year.
Duty Press Officer: - Contact through general number 0131

g. Scottish Government Health Department EPU: emergency contact details.

<table>
<thead>
<tr>
<th>Department</th>
<th>Official</th>
<th>Phone</th>
<th>Fax</th>
<th>Mobile</th>
<th>Pager</th>
<th>Generic Email</th>
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</thead>
<tbody>
<tr>
<td>SG Health Department Resilience Unit</td>
<td>Mike Healy Head of NHS Scotland Resilience</td>
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<td></td>
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<tr>
<td></td>
<td>Deputy: Ray Desouza</td>
<td></td>
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<tr>
<td></td>
<td>Deputy: Roy Sturrock</td>
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8. Divisional / ACC local action plans - General

Common principles, as outlined in this plan apply. Territorial General Managers will be responsible, in liaison with appropriate representatives of NHS Boards, other planning partners and stakeholders, and in collaboration with National Operations Managers, for planning local provision and will manage local resources in the event of exceptional or extraordinary pressures on emergency services. National Operations Managers will be responsible for operational systems within those Centres. Adverse occurrences will be notified to the NRRD and Directors, as required, in keeping with existing risk management policy regarding escalation.

Local arrangements in place currently vary, but typically may include:

a. Regular dialogue with local NHS Managers at multiple levels (including NHS 24) and involvement in national and local project or working groups about capacity planning, including out of hours provision and consequences of service redesign. Local planning should include requirements for communication with patients.

b. Area Service Managers / NOM’s empowered to vary resource levels / patterns of work to take account of high demand or otherwise reduce the impact of disruption.

c. A planned increase in staffing levels within the operational service and ACC at times of historical or anticipated peak demand. See the ACC winter plan for forecasting data.

d. Variation to existing levels of PTS provision, including additional resources to limit any effect on the A&E service due to the needs of renal patients or for inter-hospital transfers. Typically would include additional discharge or patient transfer resources or additional support for renal or oncology patients.

e. Redeployment of specific personnel with defined skills (such as ACC call taking or FPOS) to alternative duties.

f. Regionalisation of resources such as relief staff, officers and vehicles.

g. Provision of additional dedicated ambulance resources, including managers at major crowd gatherings to limit the effect of additional or surge demand on the Service.

h. An understanding that it may be necessary in extreme circumstances to prioritise workload, scale-down or suspend the PTS, training or meetings and redeploy managers and support staff to assist the accident and emergency service / ACC.

i. Management of local personnel and welfare issues.

j. In the event that activity and resource allocation needs to be prioritised at a pan-Scotland level, the Scottish Ambulance Service, National Command and Co-ordination Centre will provide this function and territorial Divisions will provide situation reports and other information to that centre.
9. Local Winter planning arrangements

Each Division within the service is required to have local winter planning arrangements in place and have a document outlining the operational issues that they will face and the contingencies and actions identified to mitigate the seasonal capacity and demand issues. This plan will also incorporate local input from territorial NHS Boards and reflected in NHS Board planning arrangements.

Local Annexes are owned by Divisions, ACC, Air Ambulance and critical support services and are working documents that are updated regularly to reflect the operational challenges. Updates are then sent to the National Risk & Resilience Department and the Business Continuity Advisor to facilitate and co-ordinate. Further information can be requested from NRRRD.

These plans are available in support to this document