Lothian NHS Board

Lothian NHS Board
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Date 09/06/2025
Your Ref
Our Ref 10086

Enquiries to Richard Mutch
Extension 35687
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Dear

FREEDOM OF INFORMATION – REH CAPACITY

I write in response to your request for information in relation to the Royal Edinburgh Hospital and capacity.

Question:
1. A copy of the Adult Acute Mental Health Capacity Action Plan dated 02/06/2019;
2. Minutes of the 10/06/2019 meeting attended by senior managers at Royal Edinburgh Hospital regarding the site's Capacity Action Plan;
3. A copy of the most up-to-date version of the same Capacity Action Plan document;

Answer:

We do not have the Action plan from 02/06/19 but have a later version dated 21/06/19. This lists the actions discussed at the meeting held on 10/06/19. We do not have a minute of the meeting

The last version of the Action plan we have is 01/11/19 (v25 attached).

Question:
4. A copy of the communication from Prof McMahon to all colleagues, dated 24/06/2019 (your ref AMcM/KAL), referring to (and making staff aware of) the above Capacity Action Plan;

Answer:

Enclosed.

Question:
5. A copy of communications sent to both the Scottish Government and the Mental Welfare Commission in or around June 2019, notifying them of the use of contingency beds (as referred to in the letter sent by Prof McMahon as in item 4, above);

Answer:

See enclosed email. Please note that NHS Lothian has a policy of not releasing the names and details of staff below a senior level. This is considered exempt under Section 38(1)(b) of the Freedom of Information (Scotland) Act 2002 – personal information.

Question:

6. Copies of occupancy data for acute MH services at REH, demonstrating "bed status" as at the end of each week over the past 12 calendar months. That is to say: where occupancy data is provided to senior management at the end of each day, I wish only for a copy of the table as sent to management on the Friday afternoon of each week; and,

Answer:

Enclosed is the collated copy of occupancy data sent each Friday afternoon by e-mail to those staff/teams which would have an out of hours role. These e-mails would also be cc'd to the senior management team here at the Royal Edinburgh Hospital.

To put this in context

- Information was shared via e-mail and not all e-mails have been saved/archived – I have highlighted the dates in yellow where there is no e-mail available to take data from (=8 of 52 weeks).
- The structure of the report has changed a couple of time over the period in question, so where there is a "table" I have included this. Earlier in the period information was presented in a different way and I have included the relevant section which comments on occupancy.

Please note that figure of five or fewer have been redacted. To protect the identity of the individuals involved any figure of 5 or less has not been shown in the enclosure. Since we do not have their consent to release this data from their records, the information is exempt under section 38(1)(b) of the Freedom of Information (Scotland) Act i.e. to provide it would breach the Data Protection Act (2018).

Question:

7. A copy of the Tactical Incident Management Plan (REAS) 2024-25.

Answer:

See enclosed - Tactical Plan REAS 2024/25.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information

Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive

Adult Acute Mental Health – Capacity Action Plan

Name of service: Adult Mental Health – Acute (Royal Edinburgh Building**)**

Version 7 - date: 2[1st] June 2019

		Action planned	**Term**	**Responsible person(s)**	**Update / Outcome**
	Actions from Meeting Held in REB Monday 10th June 2019				
1.	Transparency of current bed capacity issues	Professor McMahon will write again to Scottish government and Mental Welfare Commission to inform them of a recurrence in bed capacity pressures in Adult Acute MH	Short	A McM	**Complete** Chief Executive also engaged in communications with SG Updates being provided to SG
2.	Contingency care arrangements for patients currently in acute adult mental health beds awaiting supported accommodation	Explore the possibility of re-opening of Ward 13. Look at workforce requirements V's availability	Short/ Medium Feasibility to be confirmed by w/b 24th June 2019	KO/AMcM/TMcK	Known workforce barriers to re-opening of Ward 13 – based on previous staffing data: Nursing: 16 wte nursing staff required. Current vacancy numbers do not support staffing from existing employed workforce and nurse bank fill rates indicate existing shortfalls in services. Require to explore agency nursing Medical: 1 wte Locum Consultant Psychiatrist would be required if patients are to retain

					a hospital based RMO (locum psychiatrists difficult to secure) **Decisions Required:** Could short term contract Agency Staff be recruited? KO/AMcM/TMcK If Locum Psychiatrist cannot be secured, would patient's own GP be able to provide medical input if required and patients be followed up by locality. KO/AW **UPDATE** – confirmed opening Ward 13 as a contingency ward would have to be staffed through Nursing Agency and Locum Costs to be added
		Discuss with EHSCP if Leamington Terrace accommodation could be commissioned as a 'step down' facility.	Short	K Ozden A McM	**Complete** Discussed with Chief Officer J Proctor and T Cowan – this is not a short term option. Possibly a long term option See action X below
3.		Consider using capacity in older adults step down ward (Comiston) for adult patients	Short	REAS SMT	Review Staffing model – week commencing 24th June. Agreed at Adult Mental Health Executive that this option is the best REH site option for patients

					awaiting supported accommodation / POC. Preference is for those patients to be looked after in alternative community provision rather than onsite
4.	Review admission bed arrangements across all acute admission beds (REH and St John's). There is generally less pressure on acute beds in SJH compared with REH. Review admission protocols to best ensure equity of access including geographical boundaries and current hospital catchments for REH /SJH Adult Acute	Review catchment areas for admissions to SJH and REB	Short Decision by 28th June	P LeFevre	Possibility of change to inpatient admission only. Pete Lefevre reviewing. Formal arrangement to change boundaries would not be acceptable to West Lothian HSCP P LeFevre, N Clater, E Clark, L Henderson, J Martin, E Eddington to discuss best use of Ward 17 beds.
5.	Additional staffing to ease pressures of having extra patients above capacity in Adult Acute wards	Proposal to be taken to SMT for additional half a session of consultant time for IPCU. Consultant to take over Mental Health Act work for IPCU patients, releasing extra capacity into job plans for admission ward Consultants Email nursing staff to remind them to book additional nursing staff from staff bank if they feel additional staff are required	Short	A Watson K Ozden	**Complete.** Medical staffing proposal approved by SMT 12th June 2019 with immediate effect. Email sent from Chief Nurse to all Coordinating Charge Nurses

6.	Timely access to Social Workers and 'Positive Steps' support service to support earlier discharge from hospital for patients	Direct recruitment of Social Worker to Adult Mental Health REAS (existing model of direct recruitment in Orchard clinic) Discuss with EHSCP if service from 'Positive Steps' can be more responsive and / or resource capacity increased	Medium Decision by 28th June Short	K Ozden	Action re social worker to be progressed – job description being sourced. Action re Positive Steps to be progressed
7.	Transport and nurse escort options for patients having to be admitted out of area.	Look at possibility of contract with local Taxi firm for responsive transport solution for transferring of patients Further discussion required with East / Mid Lothian Community and IHTT teams and Edinburgh Community Teams about how nurse escorts are provided – current arrangement is reliant on REH staffing having to be released to undertake escorts,	Medium	L Clark K Ozden	**Commenced;** Work already underway with Flow Centre alternatives to ambulance transport via Psychiatric Emergency Plan (PEP) Review. Mapping completed re existing transport options for certain scenarios. L Clark has meeting with commodities manager w/b 1st July to meet Taxi contractors and option
8.	Service level needs are standardised in consultant job plans for Adult Acute Mental Health	Ensure that job planning framework at a team level is standard to ensure that there is consistency of service delivery and service needs are prioritised.	Medium	A Watson	**Complete** Inpatient job planning is complete for 19/20, but ongoing work to develop community consultant job plan template. Inpatient job plans are standardised.

9.	Use of private sector beds for acute admissions	Explore if private sector services at Ayr Clinic, Surehaven and Priory would accept referrals of acute admissions	Short	K Ozden	**Complete** Ayr clinical and Surehaven do not accept patients who do not require low secure. The Priory do not accept patients who are too unwell to participate in their treatment programmes for anxiety, depression or substance misuse
10	Management Team visits to wards	Management team to undertake specific visits to wards in relation to concerns raised about use of recliner chairs to give opportunity for staff and patients to engage face to face	Short	REAS SMT	Attendance at Huddle Visit wards 13th & 14th June Visit to wards 21st June Will be ongoing
11	QI approach to patient flow	Focussed QI programme of work to improve patient flow to continue	Medium / Long	QI Leads Adult Exec Team	**Complete** Additional resource secured. Meeting of group held on Tuesday 18th June 2019. Initial focus MHAS – agreed stage 2 is In-patient.
	Additional Actions from Teleconference with Chief Executive Friday 14th June 2019				
12	Provision of folding beds in wards as alternatives to mattresses	Options explored for a design of folding bed that would be compliant with infection control standards and would be safe for use in acute psychiatric ward	Short	K Ozden	Normal hospital standard folding beds have significant ligature risks in their design and are therefore not an option Other options explored but very limited re above requirements

					Sofa bed design from Langstane identified that would be compliant and would be safer **Complete** 3 sofa beds purchased – 3 week delivery time as are made to order (negotiated reduced delivery time from 6 to 3 weeks). Delivery circa 8th July
13	Use of private sector beds for delayed discharge patients or patients requiring support packages	Explore if the Priory would accept patients who are awaiting supported accommodation as a temporary care placement until available	Short	K Ozden	**Complete** As Action 7 above - The Priory do not accept patients who are too unwell to participate in their treatment programmes for anxiety, depression or substance misuse
14	Communication with SG	Send email to SG before weekend to update on actions taken and to respond to request for assurance re use of mattresses.	Short	K Ozden	**Complete** 14th June 2019 Will provide every Friday until position is stable.
15	Communication with clinical teams	Send email to clinical teams to update on actions being taken in response to concerns raised at meeting on Monday 10th June Reinforce escalation pathway in the event there are no beds in Adult Acute MH at REH for admission.	Short	K Ozden	**Complete** 17th June 2019 Further communication sent 24th June 2019
16	Communication when patients being admitted without an allocated bed to Chief Executive and Nurse Director	Chief Executive and Nurse Director to be notified directly each day if any patients admitted	Short	K Ozden	**Complete** Email / Spreadsheet on CCN shared drive to be completed by CCN by 8am

		could not be accommodated in a bed		TMcKigen	
	Actions from Teleconference with EHSCP Chief Officer 19th June 2019				
17	Alternative community care arrangements for patients currently in acute adult mental health beds awaiting supported accommodation	Re-profiling of patients currently listed as awaiting supported accommodation to identify if they can be sent home with community package of care as an alternative – breakdown by 4 localities		FWilson; A Watson; J Martin; N Paul; Locality Managers;	**Underway** 1st Locality SW already completed Monday 17th June. **Complete -** 2nd Locality NW to be completed Monday 24th June. 3rd Locality NE to be completed Monday 1st July
18	Leamington Terrace accommodation	Possibility of Leamington Terrace being commissioned as a 'step down' accommodation for patients awaiting other community care arrangements – business case to be developed by EHSCP	Medium / Long	J Proctor T Cowan	**Underway** Agreed on 19th June that Edinburgh IJB Chief Officer will progress viability
19	Alternative community care arrangements for 17 patients currently in rehabilitation wards who require HBCCC	Identify alternative community based options for these patients	Review current pts and agree by 25th June	J Proctor T Cowan F Wilson A Watson	Existing HBCCC facilities to be considered re suitability of patients for this group as a medium term option – issue remains re several patients being under the age of 65 and existing criteria of Ellen's Glen is 65+

				J McKenzie	Draft paper developed by A Watson **Decisions Required:** Review criteria for functional HBCCC be revised including under 65's Longer term - Strategic plan required in Edinburgh IJB re existing unmet need of this patient group Work underway to profile the 17 patients currently in rehab at REH against the HBCCC criteria with a view to some of the patients possibly being transferred to Ellen's Glen (HBCCC Functional). Delayed Discharge coordinator discussing criteria with Consultant Psychiatrist and manager for Ellen's Glen
20	Alternative on site arrangements for 17 patients currently in rehabilitation wards who require HBCCC	Explore the possibility of re-commissioning a closed ward for these patients - old Meadows Ward, 1st floor Andrew Duncan Clinic REH site	Medium Decision required by 28th June	K Ozden T McKigen J Proctor T Cowan	Capital costs for refurbishment estimated £200k – timeframe for building works 8 weeks **Decisions Required:** will need capital and revenue funding. **Critical** -Standard Business Case ; Backlog Maintenance Grant; other source

					Staffing – identical issues to Action 2 above
21	Joint working with EHSCP and engagement with other HSCPs	Partnership working with service commissioners essential to solutions	Short / Medium / Long	T McKigen REAS SMT	REAS Services Director will attend HSCP Chief Officer Group w/b 24th June T Cowan / F Wilson to be invited to attend REAS Adult MH Exec Group
22	Review progress of anti ligature work in ward 17.	Can the work be progressed faster	Review done and appended with plan to SG 21st June		**Complete** Nick Clater has provided update of works and rationale
23	Seek support from Staff Side	Attend Lothian Partnership Forum 25th June	Short	AMcM	**Complete** Request for agenda item
24	Assessment capacity at the REH	Consideration of converting existing rooms in the REB into assessment suite with capacity for 2 people to sleep overnight whilst awaiting bed – crisis suite concept.	Medium	A Watson/KO	Meet to discuss options. Initial view by 28th June. Meeting with Architects 27th June
	Additional Actions from Adult Mental Health Executive Meeting 25th June 2019				
25	More proactive engagement with carers to support discharge	Carers appointments and engagement to be discussed at Rapid Rundowns each day in each ward to encourage family	Short 1st July	E Clark	

		and carer involvement in facilitating discharge home			
26	Use of Estimated Date of Discharge to be recorded for patients admitted to adult acute	Difficult to give a single day of discharge, Would be more meaningful to estimate projected discharges at the beginning of each week at the Monday morning huddle to estimate capacity for the coming week	Short 1st July	J Martin E Eddington	

Name of person completing / updating action plan version: Karen Ozden Chief Nurse & General Manager REAS on behalf of REAS SMT and Edinburgh HSCP **Date:** 21/6/2019

Lothian NHS Board

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EH1 3EG

Telephone

www.nhslothian.scot.nhs.uk

Date 24 June 2019
Your Ref AMcM/KAL
Our Ref

Enquiries to [redacted]
Extension
Direct Line
Email

Dear colleagues

Current Bed Pressures in Acute Adult Mental Health, Royal Edinburgh Building

As many of you know we have recently struggled at times to find a bed within NHS Lothian for those patients needing admission to an adult mental health ward. This is a far from ideal situation and senior clinical staff and managers are working together to look at all options available to resolve this situation.

Attached is the list of actions that are being worked on at present to try and resolve the current pressure and improve both patient and staff experience.

Due to a lack of adult mental health beds in NHS Lothian and across the wider Scottish health system, we have on occasion for immediate patient safety reasons, taken the decision to care for a small number of patients by placing a mattress on the floor in the quiet room areas in some wards. We would all acknowledge that this is not ideal by any standards. We certainly do not wish to condone their use at all, but safety for the individual patient is our primary focus.

We recently purchased some recliner chairs thinking that if required, these might be a better option than the mattress. This option has proven to be unacceptable to patients and staff.

We have therefore agreed that these will be removed from all wards. We have organised to have three sofa beds (which can fold up and be put away) delivered which would be suitable for occasional use and are also compliant with Healthcare Associated Infection requirements. These will take a few more weeks to arrive but would we hope, if required for immediate patient safety reasons, be a better option for patients and for staff if we find ourselves in the position of having no beds available in mental health in Lothian or outwith Lothian. Delivery of these is expected arond the 8th July.

Headquarters
Waverley Gate
2-4 Waterloo Place
Edinburgh EH1 3EG

Chair Brian G. Houston
Chief Executive Tim Davison

Lothian NHS Board is the common name of Lothian Health Board

What patient's sleep on is one consideration, but a further consideration is the rooms in which we can currently accomodate patients. As you are aware, the Quiet rooms were not intended to be areas where patients are accommodated without observation, and as such there are several aspects of patient safety that must be taken into consideration if these rooms are to be used for patients in unavoidable circumstances. The Royal Edinburgh Building Room Usage Standard Operating Procedure (attached) has now been approved and should be consulted as part of individual patient risk assessments when decisions are being made for alternative care arrangements for patients and securing additional staffing resource if required.

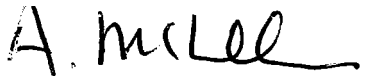
We have explored these options in such detail because the only other option, when a bed is not available, is to arrange transfer for the patient to a bed in other board. Currently, working to keep our patients in our area has been prioritised based on considerations about providing care close to home for patients. For patients at a time of illness and distress, further travel after waiting in an assessment area, often in the care of staff without expertise, is additionally distressing.

It's important that staff have the opportunity to discuss their concerns and also to offer up any ideas. So whilst we work to resolve the current pressure we will set up a series of staff engagement sessions early next week and also involve trade union representatives . We will be in touch about these shortly. I have also asked to discuss this position at the Lothian Partnership Forum on the 25th June.

We have in the meantime notified the Scottish Government and the Mental Welfare Commission of the current pressures we are facing and the actions we are taking. We will continue to work with them as well as with the Edinburgh Health and Social Care Partnership colleagues /Integration Joint Board who are working on medium to long term strategies to resolve this position.

Your support is hugely appreciated in what can at times be a stressful situation. At all times we need to keep patients safe, even if the option available isn't ideal. But we also need to ensure that our staff are safe and feel listened to and supported.

Best wishes



PROFESSOR ALEX McMAHON
Executive Director Nursing, Midwifery & Allied Healthcare Professionals
Executive Lead for REAS & Prison Healthcare

30/5/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 30th May 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)		TOTAL (105)	Comments *
Total Occupancy for Adult Acute Service	18	19	20	18	21	10	17		123	
Patients on pass tonight		**5<**		**5<**	**5<**				**5<**	*
Patients Boarding elsewhere in REH tonight					**5<**		**5<**		**5<**	*
Additional pass or boarding TBC									**0**	
In acute hospital for physical assessment/period of treatment	**5<**	**5<**					**5<**		**5<**	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**				**9**	
Admissions outstanding/assessment TBC									**0**	*
People in RIE ED as part of Divert									**0**	
Reviews outstanding to confirm or deny further discharge today									**0**	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)	**5<**	**5<**	**5<**						**5<***	*also 1x further directly to St Johns wd17
Planned discharges at 10am					**5<**				**5<**	
Discharge decision subject to final review today noted at 10am		**5<**							**5<**	
Actual discharges achieved since 10am		**5<**			**5<**				**5<**	*
Available beds	Male	Female	Flexible	IPCU	Totals/available					

If overall capacity below 105	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

23/5/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 23rd May 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)		TOTAL (105)	Comments *
Total Occupancy for Adult Acute Service	**18**	**18**	**18**	**20**	**22**	**10**	**16**		**122**	
Patients on pass tonight				**5<***	**5<**				**5<**	*5<x AWOL
Patients Boarding elsewhere in REH tonight	**5<**				**5<**		**5<**		**5<**	*
Additional pass or boarding TBC									**0**	
In acute hospital for physical assessment/period of treatment		**5<**							**5<**	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		**10**	
Admissions outstanding/assessment TBC			**5<**						**5<**	*seeking warrant – may need to wait until next week
People in RIE ED as part of Divert									**0**	
Reviews outstanding to confirm or deny further discharge today									**0**	*
Discharges predicted this weekend									**0**	*

Actual admissions since 10am(Huddle)		**15<**		**5<**					**5<**	*
Planned discharges at 10am			**5<**						**5<**	
Discharge decision subject to final review today noted at 10am		**5<**		**5<**	**5<**				**5<**	
Actual discharges achieved since 10am		**5<**	**5<**	**5<**	**5<**				**5<**	*

Available beds If overall capacity below 105	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

16/5/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 16th May 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)		TOTAL (105)	Comments *
Total Occupancy for Adult Acute Service	**17**	**18**	**20**	**18**	**23**	**10**	**16**		**122**	
Patients on pass tonight				**5<***					**5<**	*1x AWOL
Patients Boarding elsewhere in REH tonight					**5<**		**5<**		**5<**	*
Additional pass or boarding TBC									**0**	
In acute hospital for physical assessment/period of treatment									**0**	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		**12**	

Admissions outstanding/assessment TBC									**0**	*
People in RIE ED as part of Divert									**0**	Last transfer enroute at time of writing
Reviews outstanding to confirm or deny further discharge today									**0**	*
Discharges predicted this weekend		**5<***							**5<**	***IF** emergency accommodation can be sourced
Actual admissions since 10am(Huddle)	**5<**	**5<**	**5<**	**5<**					**5***	*also 5<x further admission to SJH IPCU
Planned discharges at 10am		**5<**	**5<**						**5<**	
Discharge decision subject to final review today noted at 10am		**5<**	**5<**	**5<**	**5<**	**5<**			**5<**	
Actual discharges achieved since 10am		**5<**	**5<**	**5<**		**5<**			**8**	*

Available beds If overall capacity below 105	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

9/5/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 9th May 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)		TOTAL (105)	Comments *
Total Occupancy for Adult Acute Service	17	20	20	20	25	10	16		128	

Patients on pass tonight				5<*	5<				5<	*AWOL
Patients Boarding elsewhere in REH tonight		5<		5<	5<		5<		10	*
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment		5<							5<	*
Contingency on ward being used	5<	5<	5<	5<	5<		5<		13	
Admissions outstanding/assessment TBC									0	*
People in RIE ED as part of Divert	5<								5<	
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)		5<	5<	5<	5<	5<			*	*
Planned discharges at 10am						5<			5<	
Discharge decision subject to final review today noted at 10am			5<	5<	5<		5<		5<	
Actual discharges achieved since 10am		5<	5<	5<		5<	5<		*	*

Available beds If overall capacity below 105	Male	Female	Flexible	IPCU	Totals/available	
	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

2/5/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 2nd May 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10*)	Braids (15)		TOTAL (105)	Comments * 1x room damaged and out of use
Total Occupancy for Adult Acute Service	17	20	**5<**	19	24	9	17		127	
Patients on pass tonight				**5<***	**5<**				**5<**	*AWOL
Patients Boarding elsewhere in REH tonight		**5<**	**5<**		**5<**		**5<**		8	*
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment		**5<**							**5<**	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**				12	
Admissions outstanding/assessment TBC									0	*
People in RIE ED as part of Divert									0	
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)				**5<**					**5<**	*
Planned discharges at 10am									0	
Discharge decision subject to final review today noted at 10am	**5<**								**5<**	
Actual discharges achieved since 10am	**5<**				**5<**				**5<**	*

Available beds If overall capacity below 105	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

25/4/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 25th April 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10*)	Braids (15)		TOTAL (105)	Comments * 1x room damaged and out of use
Total Occupancy for Adult Acute Service	17	19	22	19	23	9	17		126	
Patients on pass tonight				**5<**					**5<**	*
Patients Boarding elsewhere in REH tonight		**5<**	**5<**	**5<**	**5<**		**5<**		10	*
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**				12	
Admissions outstanding/assessment TBC									0	*
People in RIE ED as part of Divert		**5<**							**5<**	
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend						**5<**			**5<**	*
Actual admissions since 10am(Huddle)			**5<**						**5<**	*

Planned discharges at 10am				5<					5<	
Discharge decision subject to final review today noted at 10am		5<							5<	
Actual discharges achieved since 10am		5<		5<					5<	*

Available beds If overall capacity below 105	Male	Female	Flexible	IPCU	Totals/available	
	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

Thursday 17/4/25 (fri 18th PH)

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 17th April 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10*)	Braids (15)		TOTAL (105)	Comments *1x IPCU room out of use awaiting repair
Total Occupancy for Adult Acute Service	17	18	20	20	24	9	15		123	
Patients on pass tonight									0	*
Patients Boarding elsewhere in REH tonight			5<	5<	5<				7	,*
Additional pass or boarding TBC					5<				5<	
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	5<	5<	5<	5<	5<				12	
Admissions outstanding/assessment TBC									0	*

Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted tomorrow									0	*
Actual admissions since 10am(Huddle)					5<				5<	*
Planned discharges at 10am			5<		5<				5<	
Discharge decision subject to final review today noted at 10am				5<					5<	
Actual discharges achieved since 10am			5<	5<	5<				5<	*also 1x transfer to SJH IPCU

Available beds If overall capacity below 105	Male	Female	Flexible	IPCU	Totals/available	
	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

11/4/25

Out of Hours ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute) DATE 11th April 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)		TOTAL (105)	Comments *
Total Occupancy for Adult Acute Service	18	19	21	19	23	10	15		125	
Patients on pass tonight		5<							5<	*
Patients Boarding elsewhere in REH tonight			5<	5<	5<				6	,*
Additional pass or boarding TBC									0	

In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	5<	5<	5<	5<	5<		5<		14	
Admissions outstanding/assessment TBC									0	*
People in RIE ED as part of Divert	5<	5<	5<		5<				8	
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)						5<			5<	*
Planned discharges at 10am			5<						5<	
Discharge decision subject to final review today noted at 10am	5<								5<	
Actual discharges achieved since 10am			5<						5<	*

Available beds	Male	Female	Flexible	IPCU	Totals/available
If overall capacity below 105	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute

4/4/25

Out of Hours									
ROYAL EDINBURGH HOSPITAL	**Meadows**	**Merchiston**	**Hermitage**	**Craiglockhart**	**Balcarres**	**Blackford**	**Braids**	**TOTAL**	**Comments**
(80 Acute beds, 10 IPCU &15 Sub-acute)	**(16)**	**(16)**	**(16)**	**(16)**	**(16)**	**(10)**	**(15)**	**(105)**	*
DATE 4rd April 2025									

Total Occupancy for Adult Acute Service	19	21	20	19	21	10	15		125	
Patients on pass tonight		**5<**		**5<**					**5<**	*
Patients Boarding elsewhere in REH tonight		**5<**		**5<**	**5<**				**5<**	,*
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment					**5<**				**5<**	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**				13	
Admissions outstanding/assessment TBC									**5<***	*all currently in RIE A+E assessed and now on of DIVERT
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)		**5<**	**5<**						**5<**	*
Planned discharges at 10am			**5<**						**5<**	
Discharge decision subject to final review today noted at 10am									0	
Actual discharges achieved since 10am			**5<**						**5<**	*

Available beds	Male	Female	Flexible	IPCU	Totals/available	
If overall capacity below 105	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

28/3/25

Out of Hours

ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute, 3 temp Surge beds) DATE 28h March 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)	"YPU" (3)	TOTAL (108)	Comments *
Total Occupancy for Adult Acute Service	19	19	22	19	19	10	16	3	127	
Patients on pass tonight			**5<**					**5<**	**5<**	*
Patients Boarding elsewhere in REH tonight		**5<**	**5<**						**5<**	,*
Additional pass or boarding TBC				**5<**					**5<**	
In acute hospital for physical assessment/period of treatment	**5<**						**5<**		**5<**	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		14	
Admissions outstanding/assessment TBC									0	*
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)						**5<**			**5<***	*also further 1x direct admission to Harlaw/OPMH
Planned discharges at 10am	**5<**								**5<**	
Discharge decision subject to final review today noted at 10am				**5<**					**5<**	

Actual discharges achieved since 10am	**5<**					**5<**			**5<**	*

Available beds **If overall capacity below 108**	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

21/3/25

14/3/25

Out of Hours

ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds) DATE 14th March 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)	"YPU" (12)	TOTAL (117)	Comments *
Total Occupancy for Adult Acute Service	17	17	22	19	19	10	16	10	130	
Patients on pass tonight			**5<**		**5<**				**5<**	*
Patients Boarding elsewhere in REH tonight			**5<**	**5<**					**5<**	,*
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		11	
Admissions outstanding/assessment TBC									0	*
Reviews outstanding to confirm or deny further discharge today									0	*

Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)	**5<**		**5<**		**5<**				**5<**	*
Planned discharges at 10am		**5<**					**5<**		**5<**	
Discharge decision subject to final review today noted at 10am	**5<**		**5<**						**5<**	
Actual discharges achieved since 10am	**5<**	**5<**	**5<**				**5<**		**5<**	*

Available beds	Male	Female	Flexible	IPCU	Totals/available	
If overall capacity below 117	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

7/3/25

Out of Hours

ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds) DATE 7th March 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)	"YPU" (12)	TOTAL (117)	Comments *
Total Occupancy for Adult Acute Service	18	19	19	18	19	10	15	10	128	
Patients on pass tonight		**5<**							**5<**	*
Patients Boarding elsewhere in REH tonight	**5<**				**5<**				**5<**	,
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment									0	*

Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**				11	
Admissions outstanding/assessment TBC	**5<**								**5<**	*GP review in community – possible detention
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)			**5<**					**5<***	**5<**	* Clozapine
Planned discharges at 10am								**5<**	**5<**	
Discharge decision subject to final review today noted at 10am									0	
Actual discharges achieved since 10am				**5<**				**5<**	**5<**	*

Available beds	Male	Female	Flexible	IPCU	Totals/available	
If overall capacity below 117	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

28/2/25

Out of Hours

ROYAL EDINBURGH HOSPITAL **(80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds)** **DATE 28th February 2025**	**Meadows (16)**	**Merchiston (16)**	**Hermitage (16)**	**Craiglockhart (16)**	**Balcarres (16)**	**Blackford (10)**	**Braids (15)**	**"YPU" (12*)**	**TOTAL (117)**	**Comments** ***Awaiting repairs x1 YPU**
Total Occupancy for Adult Acute Service	17	17	17	17	19	10	16	12	125	
Patients on pass tonight							**5<**	**5<**	**5<**	*

Patients Boarding elsewhere in REH tonight					**5<**				**5<**	’
Additional pass or boarding TBC									0	*explore to create additional capacity
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**				*	*
Admissions outstanding/assessment TBC									0	*
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)									0	*
Planned discharges at 10am		**5<**		**5<**					**5<**	
Discharge decision subject to final review today noted at 10am									0	
Actual discharges achieved since 10am		**5<**		**5<**					**5<**	*

Available beds	Male	Female	Flexible	IPCU	Totals/available	
If overall capacity below 117	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

21/2/25

Out of Hours

ROYAL EDINBURGH HOSPITAL **(80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds)**	**Meadows**	**Merchiston**	**Hermitage**	**Craiglockhart**	**Balcarres**	**Blackford**	**Braids**	**“YPU”**	**TOTAL**	**Comments**
	(16)	**(16)**	**(16)**	**(16)**	**(16)**	**(10)**	**(15)**	**(12*)**	**(117)**	***Awaiting repairs x1 YPU**

DATE 21st February 2025										
Total Occupancy for Adult Acute Service	18	18	18	18	18	10	16	12	128	
Patients on pass tonight									0	*
Patients Boarding elsewhere in REH tonight									0	,
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		11	
Admissions outstanding/assessment TBC									0	*
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)	**5<**	**5<**	**5<**						**5<**	*
Planned discharges at 10am							**5<**		**5<**	
Discharge decision subject to final review today noted at 10am	**5<**		**5<**						**5<**	
Actual discharges achieved since 10am	**5<**		**5<**				**5<**	**5<**	**5<**	*

Available beds	Male	Female	Flexible	IPCU	Totals/available	
If overall capacity below 117	0	0	0	0	0 x Acute assessment beds +0 x IPCU	

					+0 x Sub acute					
14/2/25										
7/2/25										

Out of Hours

ROYAL EDINBURGH HOSPITAL (80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds) DATE 7th February January 2025	Meadows (16)	Merchiston (16)	Hermitage (16)	Craiglockhart (16)	Balcarres (16)	Blackford (10)	Braids (15)	"YPU" (12*)	TOTAL (117)	Comments *Awaiting repairs x1 YPU
Total Occupancy for Adult Acute Service	17	18	18	18	23	10	16	10	130	
Patients on pass tonight					5<*		5<**		**5<**	*weekend **only tonight
Patients Boarding elsewhere in REH tonight					**5<**				**5<**	5<x Harlaw, 5<x Ritson,
Additional pass or boarding TBC			**5<**						**5<**	Pass?
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		11	
Admissions outstanding/assessment TBC									0	*
Reviews outstanding to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)			**5<**		**5<**				5<*	* also 5<x further admission to SJH wd1 (enroute)
Planned discharges at 10am			**5<**						**5<**	

Discharge decision subject to final review today noted at 10am					**5<**				5<	
Actual discharges achieved since 10am			**5<**					**5<**	**5<**	*

Available beds **If overall capacity below 117**	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute

31/1/25

Out of Hours **ROYAL EDINBURGH HOSPITAL** (80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds) DATE 31st January 2025	Meadows (16)	Merchiston (16)	Hermitage (16) CLOSED	Craiglockhart (16)	Balcarres (16)	Blackford (10#)	Braids (15)	"YPU" (12*)	TOTAL (117)	Comments *Awaiting repairs x1 YPU #1 room out of use IPCU
Total Occupancy for Adult Acute Service	17	18	17	18	23	9	16	12	130	
Patients on full weekend pass tonight		**5<**	*				**5<**	*	**5<**	*Also further pass for 1 or 2 nights only in YPU + Hermitage over weekend
Patients Boarding elsewhere in REH tonight			**5<**	**5<**	**5<**				6	5x Harlaw, 1x Ritson,
Additional pass or boarding TBC				**5<**					**5<**	
In acute hospital for physical assessment/period of treatment									0	*
Contingency on ward being used	**5<**	**5<**		**5<**	**5<**		**5<**		7	
Admissions outstanding/assessment TBC									0	*

Reviews to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)				**5<**					**5<**	*
Planned discharges at 10am				**5<**					**5<**	
Discharge decision subject to final review today noted at 10am	**5<**			**5<**					**5<**	
Actual discharges achieved since 10am	**5<**			**5<**					**5<**	*

Available beds **If overall capacity below 117**	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

24/1/25

Out of Hours

ROYAL EDINBURGH HOSPITAL **(80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds)** **DATE 14th January 2025**	**Meadows (16)**	**Merchiston (16)**	**Hermitage (16)**	**Craiglockhart (16)**	**Balcarres (16)**	**Blackford (10)**	**Braids (15)**	**"YPU" (12*)**	**TOTAL (117)**	**Comments** ***Awaiting repairs x1**
Total Occupancy for Adult Acute Service	17	18	18	20	23	9	16	12	133	
Patients on pass tonight				**5<**	**5<**			**5<**	**5<**	
Patients Boarding elsewhere in REH tonight					**5<**				**5<**	5x Harlaw
Additional pass or boarding TBC									0	

In acute hospital for physical assessment/period of treatment				**5<**					5<*	*awaiting medical fit to return (+identification of bed)
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		9	
Admissions outstanding/assessment TBC		**5<**							5<*	*aware of warrant issued for access but will be out of hours = outcome of assessment TBC
Reviews to confirm or deny further discharge today									0	*
Discharges predicted this weekend	**5<***	**5<***							**5<**	*day to be confirmed with families traveling from England - for both
Actual admissions since 10am(Huddle)				**5<**					**5<**	*
Planned discharges at 10am			**5<**	**5<**					**5<**	
Discharge decision subject to final review today noted at 10am					**5<**				**5<**	
Actual discharges achieved since 10am			**5<**	**5<**	**5<**			**5<**	6	*

Available beds	Male	Female	Flexible	IPCU	Totals/available	
If overall capacity below 117	0	0	0	0	0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

17/1/25

Out of Hours

ROYAL EDINBURGH HOSPITAL	**Meadows**	**Merchiston**	**Hermitage**	**Craiglockhart**	**Balcarres**	**Blackford**	**Braids**	**"YPU"**	**TOTAL**	**Comments**
(80 Acute beds, 10 IPCU &15 Sub-acute, 12 temp Surge beds)	**(16)**	**(16)**	**(16)**	**(16)**	**(16)**	**(10)**	**(15)**	**(12*)**	**(117)**	***Awaiting repairs x1**
DATE 14th January 2025										

Total Occupancy for Adult Acute Service	17	18	21	17	23	9	16	11	132	*
Patients on pass tonight			**5<**		**5<**		**5<**		**5<**	
Patients Boarding elsewhere in REH tonight					**5<**				**5<**	5<x Harlaw
Additional pass or boarding TBC									0	
In acute hospital for physical assessment/period of treatment		**5<**							**5<**	
Contingency on ward being used	**5<**	**5<**	**5<**	**5<**	**5<**		**5<**		10	
Admissions outstanding									0*	*
Reviews to confirm or deny further discharge today									0	*
Discharges predicted this weekend									0	*
Actual admissions since 10am(Huddle)	**5<**			**5<**					**5<**	*
Planned discharges at 10am									0	
Discharge decision subject to final review today noted at 10am	**5<**								**5<**	
Actual discharges achieved since 10am	**5<**	**5<**							**5<**	*

Available beds **If overall capacity below 117**	Male 0	Female 0	Flexible 0	IPCU 0	Totals/available 0 x Acute assessment beds +0 x IPCU +0 x Sub acute	

10/1/25

Activity (REH)

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
0	**5<**	**5<**	**5<**

Summary REH

Female capacity - 1 contingency beds

Male capacity - 1x bed (Braids)

At current occupancy, use of identified contingency can only be considered in discussion with REAS on-call manager

*****Inpatients 125 ****

3/1/25

27/12/24

Extended/long Christmas holiday weekend

20/12/24

13/12/24

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
0	**5<**	**5<**	0

leaves **115** beds occupied (inc. pass [5<x Hermitage])

6/12/24

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
5<	0	**5<**	**5<**

leaves **118** beds occupied (inc. pass [5<x Hermitage, 5<x Craiglockhart, 5<x Braids])

29/11/24

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted

5<	0	**5<**	5< + 5< others 5<x NHS Tayside, 5,x St Johns

leaves **114** beds occupied (inc. pass [5<x Merchiston])

22/11/25

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
5<	**5<**	**5<**	**5<**

leaves **115** beds occupied (inc. pass [0 ,])

15/11/25

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
5<	**5<**	**5<**	0

leaves **113** beds occupied (inc. pass [5<x Meadows, 5<x Hermitage])

8/11/25

Activity (REH)

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
5<	**5<**	**5<**	**5<**

leaves **115** beds occupied (inc. pass [5<x Hermitage, 5<x Merchiston, 5<x Balcarres])

1/11/24

Activity

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted

5<	0	**5<**	**5<**

leaves **113** beds occupied (inc. pass [0 ,])

25/10/24

Activity

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
5<	0	**5<**	**5<**

leaves **114** beds occupied (inc. pass [5<x Hermitage, ,])

18/10/24

Activity

predicted discharge today	Further reviews to confirm discharge	Discharges achieved	Admissions accepted
6	**5<**	8	**5<**

leaves **116** beds occupied (inc. pass [5<x hermitage, 5<x Merchiston 5<x Craiglockhart, 5<x balcarres])

11/10/24

Today (17:00 Hrs) we have **118** beds occupied (inc. pass [5<x Merchiston, 5<x meadows, 5<x Balcarres, 5<x Craiglockhart,])

4/10/25

Today (18:00 Hrs) we have **119** beds occupied (inc. pass [5<x Braids,])

27/9/24

Today (18:00 Hrs) we have **114** beds occupied (inc. pass [0,])

20/9/24

13/9/24
Today (17:00 Hrs) we have **111** beds occupied (inc. pass [5<x Hermitage])
6/9/24
Today (17:00 Hrs) we have **111** beds occupied (inc. pass [5<x Meadows, 5<x Merchiston, 5<x Hermitage])
30/8/24
Today (17:00 Hrs) we have **110** beds occupied (inc. those on pass [5<x Meadows, 5<x Merchiston, 5<x Balcarres,])
23/8/24
16/8/24
Today (17:00 Hrs) we have **109** beds occupied (inc. those on pass [5<x Hermitage, 5<x Balcarres,5<x Craiglockhart, 5<x Braids])
9/8/24
2/8/24
Today (17:00 Hrs) we have **104** beds occupied (inc. those on pass [0])
26/7/24
Today (17:00 Hrs) we have **106** beds occupied (inc. those on pass [5<x braids, 5<x Balcarres, 5<x hermitage])
19/7/24
Today (17:00 Hrs) we have **104** beds occupied (inc. those on pass [5<x Balcarres,])
12/7/24
Today (17:00 Hrs) we have **110** beds occupied (inc. those on pass [0])
5/7/24

Today (17:00 Hrs) we have **109** beds occupied (inc. those on pass [5<x hermitage]**)**
28/6/24
Today (17:00 Hrs) we have **104** beds occupied (inc. those on pass [0]**)**
21/6/24
Today (17:00 Hrs) we have **105** beds occupied (inc. those on pass [5<x Braids]**)**
14/6/24
Today (17:00 Hrs) we have **105** beds occupied (inc. those on pass [5<x Craiglockhart, 5<x Braids]**)**
7/6/24
Today (17:00 Hrs) we have **106** beds occupied (inc. those on pass [5<x Hermitage]**)**

From: Ozden, Karen
To: "[redacted] (MENTAL WELFARE COMMISSION FOR SCOTLAND)"; [redacted] (MENTAL WELFARE COMMISSION FOR SCOTLAND)"
Subject: FW: REH Acute MH Capacity Updated Action Plan
Date: 14 August 2019 15:49:20
Attachments: REH Capacity Pressures action plan 070819 v15.docx

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Dear [redacted],
Please find attached our REH capacity action plan at last week – I will update again at the end of this week and forward next week after it is circulated internally.
Please don't hesitate to get in touch if you require clarification or information on anything enclosed.
Kind Regards
Karen

From: Ozden, Karen
Sent: 14 August 2019 11:42
To: Lo[redacted]
Cc: Mckigen, Tracey; [redacted] McMahon, Alex
Subject: Acute MH Capacity Updated Action Plan / REH Sofa Beds as alternative to Mattress for patients who cannot be accomodated

Hi Everyone,
As you are aware we ordered 3 sofa beds as alternatives to patients having to be accommodated on mattresses on the floor (although as said previously we are absolutely not stating this is a tolerable position).
The sofa beds should be arriving this week – perhaps later today. The sofas will be placed in 3 quiet rooms and will not be moved between wards due to their size. They can of course be used as normal sofas during the day in the rooms they are placed in. Claire will liaise with each ward later today. **Can I ask that you ensure your clinical teams are aware of this if you have not already communicated this** (it has been detailed in several previous versions of the Action Plan)
We have procured a design that is the safest we could find – the side arm of the sofa pulls out to extend the sofa into a single bed and they are made of wipe-able fabric.
As is the current position when mattresses have been used, in the event of sofa bed use, there needs to be a clinical risk assessment of the individual needs of the patient and if necessary the patient placed on enhanced nursing, given the quiet rooms have ligature points that the bedrooms don't (Please refer to the room useage SOP that will highlight the environmental considerations for each room).
We are continuing to work with the Health and Social Care Partnership to find medium and longer term solutions to the current capacity pressures and I attach last weeks' version of the action plan to advise on the range of actions we are undertaking.
I would like to draw your attention to Action 3 – we are working to transfer the current 4 contingency beds from Margaret Duguid Unit to Ward 13 towards the end of August, which will

give us an added 5 beds. Thsi ward will continue to serve the function of being a ‘step down’ from adult acute admission for those patients who require a bit longer in hospital to have their onward care arrangements in place before discharge. This will be dependent upon available staffing which we are currently working on sourcing.

If anyone has any queries or suggestions, please do get in touch.

Kind Regards

Karen

Dr Karen Ozden (Nurs D.)
Chief Nurse & General Manager
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[redacted]

Adult Acute Mental Health – Capacity Action Plan

Name of service: Adult Mental Health – Acute (Royal Edinburgh Building**)**

Version 25 - date: 1st November 2019

		Action planned	Term	Responsible person(s)	Update / Outcome
Short Term Actions – up to 3 months					
1.	Set expected discharges per day at 3 to enable flow through acute beds	Projections to be collated from Rapid Rundowns at 10am Huddle and reviewed daily at MATT meeting Establish standard discussion at the daily MATT meeting around planning for 3 discharges per day to support flow	Short	T McKigen J Martin E Eddington	**Update** The approach, alongside other improvements described in this action plan, continue to show improvements in capacity. Capacity has not reached 100% since August 2019.
2.	Establish a way for wards to communicate with locality teams robustly and consistently on a daily/weekly basis – possibly as an adaption or extension to rapid run downs	Work with locality teams and ward staff to establish a method of daily communication which supports timely decision making	Medium	EHSCP Locality Managers	**Update** NE trial experiencing problems with technology – getting Skype call to work regularly. Weekly Patient Flow Meeting being adapted as of 9 Nov to include review of all patients by MDT and locality staff.
3.	Review alternatives for LD inpatient admissions when over capacity	Review capacity at RFU to establish if capacity could be	Short	S Taylor	**Update** T McKigen has asked A Short if there is an area in RFU that is

		used for LD patients as an alternative to adult acute MH		L Clark	discreet to others and could be used for LD
4.	Start case review meeting for people who are in adult acute wards over 6 months	MDT complex case review to be established to monitor progress for patients in acute wards over 6 months	Short	A Watson	**Update** There has been support for these but they are yet to be established due to A Watson's role change
5.	Improve the use of daily rapid run downs	Clinical nurse manager for acute mental health to support staff to improve the use of daily rapid run downs to support discharge planning	Short	C Borthwick	**Update** A number of QI ideas generated and underway. Senior charge nurses involved with taking forward improvements
6.	Identified that patients who are currently an inpatient, are more likely to be allocated a cluster social worker. Evidence suggests from monitoring the length of stay that this impacts on timeliness and responsiveness.	All people in Hospital and HBCCC will be allocated to a Hub SW.	6th September 2019	T Cowan	Monitoring the process. Still improvements to be made.
7.	Capacity in Edinburgh City Care Homes	Action Plan to create movement for 15 LA Funded Dementia Care Home waits through a series of care home moves	October 2019	T Cowan/ A Nabussi	Plan is for an additional 15 bedded Dementia care home capacity to be available at Royston Care Home in January 2020
8.	Admissions involve EHSCP on admission to influence a pathway focused on setting a planned date of discharge. Admission checklist, use of collateral, correct pathway identified, set planned discharge	Site teams signed up to early partnership influence which impacts on planned discharge date. Discussion how this can be reviewed within 24 hours of admission and fed into RRD.	27th September 2019	TMC/ KO/ FW/ TC MHSM/ AW	Ongoing - Meeting to discuss opportunities to influence pathways looking to see how MATT can influence this.

	date.	Potential for early supported discharge pathways with Locality pull.			
Medium Term Actions 3-6 months					
9.	Timely access to required community resources to ensure 'home first' approach as alternative to hospital admission where safe to do so, and support timely discharge from hospital	**Action revised:** Recruitment of Discharge Coordinator rather than any specific discipline, to give more flexibility of approach – 12 months fixed term post	Medium	K Ozden	**In Progress** Job description drafted and to be shared and sent for evaluation.
10.	Transport options for patients having to be admitted out of area.	Possibility of contract with local Taxi firm for responsive transport solution for transferring of patients	Medium	L Clark	**Commenced;** Update required
11.	Nurse escorts – expectation from community services in Edinburgh, East and Mid Lothian on REH nurses to escort and transport patients being admitted from community services to other localities / NHS Boards	Further discussion required with East / Mid Lothian Community and IHTT teams and Edinburgh Community Teams about how nurse escorts are provided – current arrangement is reliant on REH staffing having to be released from their wards to undertake escorts,	Medium Aim for PEP to be finalised October 2019	K Ozden	Being progressed as part of Psychiatric Emergency Plan Review. Has resource implications for all areas therefore partnership approach required between community services and REH **Update** Agreement to trial escorts from REH for 4 week period. C Borthwick / C Stenhouse to

					confirm start date by 20/9/19
12.	Identify longer term inpatient capacity within existing commissioned service estate	Recognition by Executive Team that additional beds are required on a medium to longer term basis whilst community infrastructure and pathway reviews are being undertaken and put in place	Medium	T McKigen K Ozden N Paul	Consider where capacity from existing estate could be created and models of care changed. Areas being explored: Comiston Ward – change of clinical model for rehabilitation of older adults with functional mental illness Meadows Ward – in progress of being refurbished to act as a decant ward
13.	Re-establish the bed management SOP and explore admissions checklist	Ensure that previously established bed management SOP is being utilised and is understood. Roll out admissions checklist.	Medium	K Stewart	**Update** K Stewart continuing to work on the SOP. Admission to discharge checklist template drafted. This needs to be compatible for TRAK. Initial draft being tested in Blackford.
14.	Adopt Home First Approach- roles and responsibilities/ agreed principles. Short term There needs to be agreement on principles for Edinburgh – eg- no long term decision made in crisis, greater influence of partnership in the	Agreed principles for REH patients around Home First approach.	13th September	JP FW/ TC	**Ongoing;** J Proctor working with Chief Officers and Executive Lead re Partnership approach- Fiona Wilson/ Tom Cowan to work with MHSM managers and REH Management team on short

	planning and decision making decision re future planning.				term options. Teams participating in DOC for rehab, Work being led through Home First Steering Group.
Long Term Actions – 6-12 months and beyond					
15.	Review of current 'Wayfinder' model for matching of patient need to service provision.	Alternative community based provision to be identified for patients awaiting in hospital bespoke supported accommodation / packages of care (inc feasibility of Leamington Terrace). EHSCP will lead a review of the Wayfinder Model	Long	J Proctor T Duncan T Cowan A Watson N Paul	**Update** New process for supported accommodation allocation in Edinburgh has commenced.
16.	Alternative community care arrangements for 17 patients currently in rehabilitation wards who require HBCCC	Identify alternative community based options for these patients	Long		**Underway** Reviews have been conducted for all patients currently in rehabilitation wards who are not receiving active rehabilitation. The factors keeping people in hospital are varied and complex – the findings from the reviews will be written into a report by 31 October.
17.	Assessment facilities and capacity at REH	Consideration of converting existing rooms in the REB into an assessment / crisis suite with	Long	K Ozden A Watson	Feasibility to create crisis suite confirmed with architect and project team.

		capacity for 2 patients to sleep overnight			Business case under development
18.	Review of Crisis Care models	Current crisis care pathway to be reviewed	Long December 2019	L Irvine Fitzpatrick A Watson	Workshop suggested initial ideas, to be continued

Name of person completing / updating action plan version: Nickola Jones, Strategic Programme Manager, REAS on behalf of REAS SMT and City of Edinburgh HSCP **Date:** 01/11/2019

Completed actions

1.	Transparency of current bed capacity issues	Professor McMahon will write again to Scottish government and Mental Welfare Commission to inform them of a recurrence in bed capacity pressures in Adult Acute MH	Short	A McMahon	**Complete** Chief Executive also engaged in communications with SG Updates being provided to SG Weekly MWC being copied into updates
2.	Communication when patients being admitted without an allocated bed to Chief Executive and Nurse Director	Chief Executive and Nurse Director to be notified directly each day if any patients admitted, could not be accommodated in a bed	Short	K Ozden T McKigen	**Complete** Email / Spreadsheet on CCN shared drive to be completed by CCN by 8am.
3.	Contingency care arrangements for patients currently in acute adult mental health beds	Opening of Margaret Duguid Unit – 4 beds	Short/ Medium	K Ozden	**Complete** Ward 13 opened on the 26th August, which provides a capacity of 9 beds.

			Revised date week ending 25th August		
4.	Management of beds at St John's Hospital to support the REH site	Manage planned ligature works to support maximum capacity	Short	A McMahon N Clater	**Complete** Anti-ligature works at Ward 17 at SJH were completed on 5th September, the ward is now open at full capacity of 24
5.	Provision of folding beds in wards as alternatives to mattresses	Options explored for a design of folding bed that would be compliant with infection control standards and would be safe for use in acute psychiatric ward revised	Short	K Ozden	**Complete** 6th August 2019 – sofa beds are now in place within 3 ward areas
6.	Acute Consultant Psychiatrist engagement	Additional Meeting with Acute Consultant psychiatrists to advise of role of L Clark over the next few weeks and to engage support in respect of progression of actions within action plan	Short	L Clark	**Complete** Meeting with Adult Acute consultants 25 July 2019. Consultants liaising earlier in patient admission with L Clark on any discharge barriers they are experiencing (Consultants previously highlighted access to SW and social care support as delays to discharge progression). Two patients on Matt Tracker already identified for different approach and support to

					discharge ie, alternative options for POC, housing or transportation.
7.	MATT Meeting	Extra support at Daily Matt to assist Patient Flow coordinator with liaison work with wards and partner agencies	Short / Ongoing	L Clark	**Complete** K Ozden, T McKigen and D Gunner Pickering to attend daily MATT on rotational basis
8.	Improving recording of expected date of discharge	Identify opportunities to improve expected date of discharge and discharge planning recording on TRAK	Medium	A Watson G Mollon	**Complete;** EDD has ongoing improvement, feedback received from patient flow. Continued monitoring required. Various QI projects underway to try different models of implementation

REAS – Tactical Plan

Royal Edinburgh & Associated Services (REAS)

Tactical Incident Management Plan

▲ **In an Emergency:**

- If you are coordinating the response: Go to the Quick Start Page (page 4)
- Everyone else: Go to ♦ PART III - ACTION CARDS (page 31) and follow your Action Card

NHS Lothian Strategic Objectives:

- Save Lives and Restore Health
- Safeguard Staff, Patients and the Public
- Minimise the Impacts on Normal Services

Contents

Document control

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♦ PART I - RESPONSE

This section contains:

- Quick Start to Coordinating the Response
- Activation Flow Chart
- Initial Assessment Action Card
- Who to Involve and Activate
- Escalation Criteria

Action Cards are in ♦ PART III - ACTION CARDS

Information on specific topics, including Major Incident Call Out, is given in ♦ PART IV - INFORMATION CARDS

Quick Start to Coordinating the Response

▲ Read this page

You will need to do these things:

- Get enough information to make an initial assessment of the incident → see Initial Assessment Card (page 5)
- Decide the likely severity & urgency of situation
- Respond at the right pace – do not delay responses unless it is safe to do
- Involve the right people → see Who to Involve List (page 7)
- Ensure staff are clear about their roles, who is in charge and how the response will be coordinated → see activation flow-chart (page 5) and context diagram (page 7)
- Ensure that you can contact the staff who are leading front-line teams, and they can contact you → see resilience contacts directory in Control Rooms
- Keep a log of key pieces of information, actions and decision, with times and reasons
- Possibly, advise Executive level staff e.g. Exec On Call or Waverly Gate (if in doubt, call them) → see activation flow-chart (page 5)
- Possibly, request via Chief Executive of Exec On-Call that a major incident be declared or activate the control room → see Info Card 1: in ♦ PART IV - If in doubt go to Major Incident Stand By and consult Exec On-Call.

Please remember:

- Use your Action Card – read it often – make sure others use theirs.
- The site-wide response works by the Services Director (or deputy) and Control Room Staff coordinating and supporting front-line teams
- The control room must work with Team Leaders in the affected service areas and share information regularly so that:
  - Front-line staff receive the information they need to prepare and respond
  - Control Room staff know what is happening, whether the response is working and if there are any problems, they must address
  - Front-line staff receive clear direction and support.
- Making the right decisions depends on having the right information – make sure you have a good, up-to-date overview of both the incident and of the response.
- Good communication is essential, this includes communication with:
  - Staff that are responding (ours and other agencies)
  - Senior staff (Waverley Gate)
  - Relatives and wider public - the Communication Team can help with this
- If the situation is getting too complicated, pause – – then concentrate on doing the basic things well. Read your Action Card again and remember the Strategic Aims.
- There are Information cards about specific issues in ♦ PART IV - of this plan

▶ For fast paced incidents: 1. follow Quick-Start Pages; 2. use Action Cards in Part III

▶ For slow paced incidents & recovery phase 1. Follow Quick-Start Pages; 2. Hold Tactical IMT meeting. Agenda p. 105 (use Tactical Lead Action Card as aide memoir)

1. Initial Assessment

Action Card 1. Initial Assessment

For use of the Tactical Lead (Site Director or their deputy)

▶ Understand the situation — What?

- Determine what has happened: get an overview of all the important issues.
  - Ask: What? Where? When? Who is affected? What is being done? Who is in charge? Are reports reliable? What don't we know? Do not assume - ask
- Consider the context.
  - Are there significant events and possible impacts elsewhere? Who else has information or a clearer view?
- Start a log (with times) – record key events, facts, actions, decisions (+ reasons)

▶ Assess implications — So What?

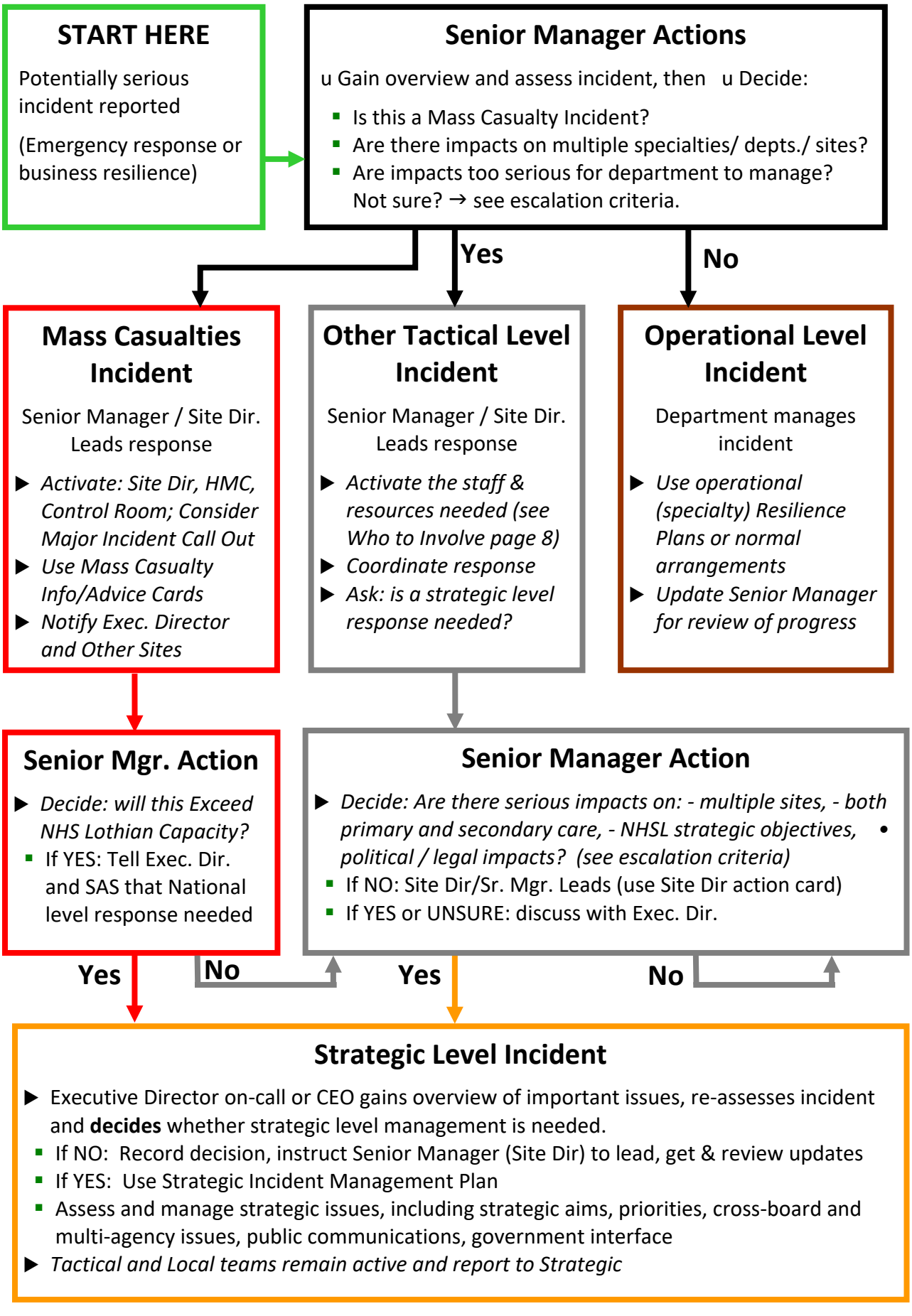
- What are the likely impacts and potential risks?
  - Who is/may be affected/need to help? Consider the wider context, other service demands, external events, cross-site/board/agency issues, public perceptions.
- What are the priorities?
  - Are people at immediate risk? Is urgent action needed? Is this a mass casualty or serious security incident (see action/info cards)? Are vulnerable groups affected? See also strategic objectives
- What options are available? Which is best?
- Who do I need to involve? – Who can help?
  - People from affected areas/services; ...with knowledge about the incident; ...with resources/capacity/skills; ... with specialist skills/knowledge; partner agencies.
- Who should lead the response?
  - Only one site affected and no strategic issues → Lead at Site level; impacts across-sites/ primary care or escalation criteria met → Lead at Strategic level
- Communications - who needs to know what? How will they be informed?
  - Staff involved in the response; other staff (warn & inform); Senior Staff (Exec. Dir); Public, visitors, patients, media; Government; Involve Communications Team

▶ Take Action — Now What?

- Activate front-line response and muster others you need to manage the incident
- Establish clear lines of communication: warn, inform, advise, listen (get phone no.s)
- Ensure all are clear about their roles, priorities & coordination arrangements;
- As required: call Major Incident (stand-by or full) and activate Control Room
- Lead the response - Provide focus, direction and support; maintain an overview and review the situation regularly

Pause, review, update log — **Use Site Director Action & Relevant Info Cards**

2. Activation, Notification, Escalation flow chart



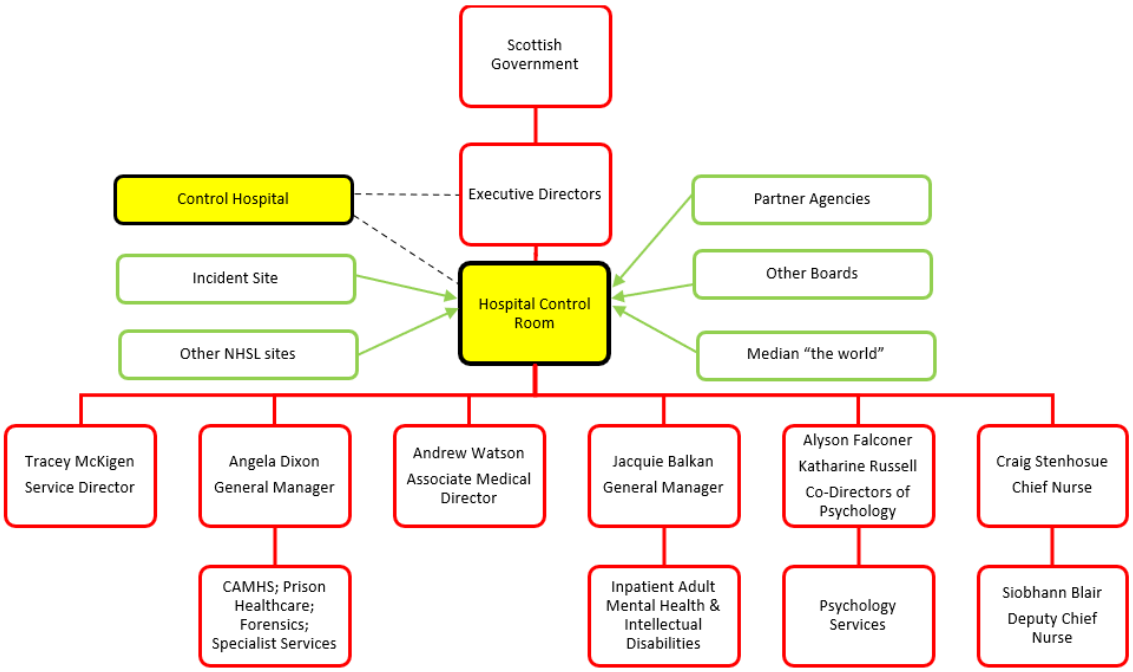
3. Who to Involve and Activate

Consider whether you need to involve any of these people and services:

- Control Room Team (inc. Hospital Medical Coordinator, Site & capacity, loggist)
- Facilities (transport, security, infrastructure)
- Other hospital sites / Other NHS Boards, including State hospital
- Health & Social Care Partnerships
- Partner agencies: Police, Scottish Ambulance, local authorities
- Scottish Prison Service and Sodexo
- Scottish Court Service
- NHS Lothian Communications Team
- Executive Team
- Emergency Planning Team
- Hospital Medical Coordinator should consider:
- ECT / Anaesthetics
- Pharmacy
- Health Records
- Restricted Patients Team (Scottish Government)

4. Hospital Control Room in Context

The diagram shows the coordinating, information gathering (context awareness) and reporting functions of a control room. Note, in the case of RIE the hospital control room is also the Control Hospital so it will report directly to the executive director team.



5. Information about specific topics

There are Information Cards in ♦ PART IV - INFORMATION CARDS with summary information on the selected clinical services and types of incident.

6. Escalation Criteria

Escalation is requesting that the incident response is coordinated at a higher management level.

Assessing the need to escalate

If an incident meets one or more of the tactical or strategic criteria listed below, staff are asked to advise their Senior Manager or Executive Director on-call, respectively, so that he/she can decide the appropriate level at which to manage the response.

The criteria listed are indicative and Senior Manager and Directors should also consider:

- Concurrent service requirement across the organisation as a whole;
- Assessments of how the current situation might evolve;
- Any risks to delivery of services;
- The external context and the needs of partner organisations;
- The requirements of the particular incident;

Generic criteria for Escalation to Tactical Management

- The additional demand for services is so great, urgent or unusual that normal arrangements may be unable to deliver safe or satisfactory care;
- The provision of normal services may be put at risk by the incident or the strategic aims of NHS Lothian may be compromised, including care quality, safety or government targets;
- The resource requirements or non-clinical decisions needed exceed the authority of local (operational) managers;
- There is a need to coordinate delivery of services across more than one department in ways that are not possible using normal arrangements;
- The degree of public interest in the incident may require NHS Lothian to issue public statements or brief the media;
- Close working or joint decision making is needed with partner agencies who are responding at "tactical" or "strategic" level.

Note: Some areas may have agreed additional local escalation criteria.

Generic Criteria for escalating to Strategic Management:

If an incident meets one or more of the criteria listed below, Tactical Managers should alert the Executive On-Call to agree the appropriate level at which to manage the response.

- Severe or widespread impact on health or the provision of health services which cannot be adequately managed at Tactical level;
- Impacts on the strategic aims of NHS Lothian, including care quality, safety or government targets;
- Serious political, legal or financial consequences;
- Requires significant redirection of resources to ensure an adequate response;
- Cross Board mass casualty response needed

♦ PART II - GUIDANCE & PRINCIPLES

This section describes the principles and concepts underlying resilience and incident management. These should be familiar to managers leading a tactical level/site wide incident response.

▲ ***If you are responding to an acute incident, go to ♦ PART I - RESPONSE before reading this section***

1. Introduction, Principles and Purpose

The purpose of this plan is to assist staff to provide care to patients in situations where normal services are disrupted or when an incident creates unusually complex or high levels of demand. This includes incidents that interrupt business continuity, external emergencies and major incidents.

This plan provides guidance for managers on how to coordinate the response to incidents. Separate, departmental and specialty Resilience Plans describe how specific areas and services will respond.

The guidance includes advice for managers about initial actions when notified of an incident, how they should structure the response and how they can coordinate and support the work of front-line staff. The relationship between different plans is shown in Notification and Activation diagram in ♦ PART I - RESPONSE (above).

This Plan, along with the Strategic Incident Management Plan, the other Tactical Incident Management Plans, and the Operational Resilience Plans for specialties and services form the NHS Lothian's Major Incident Plan.

Flexibility in using guidance and underlying principles

As incidents take different forms, differ in severity and progress at different speeds, the guidance in this plan should be used flexibly. **Tactical Level Managers** (e.g. Site Directors, General Managers, etc.) should **adapt the advice given here to the particular circumstances they face,** according to their judgement. Despite this, the following principles will apply to all responses:

Quality of care principle: notwithstanding unusual circumstances or high levels of demand for services, health care should be delivered in ways that are consistent with the requirements of relevant professional bodies and the ethos of NHS Lothian; this includes ensuring that care is safe, effective, person centred and appropriate to the cultural values of those involved.

Normal business principle: As far as possible staff will carry out their normal clinical or service roles, following normal procedures and using normal technologies, although service priorities and volumes may be different.

Tactical management principle: The role of the tactical managers during an incident is to ensure that issues which require more senior level coordination, support or decision making are effectively addressed, e.g. coordination across directorates or issues that affect multiple services on a site. Tactical level management is not there to replace local or departmental management.

2. Incident Management Structures

Three level management structure

When responding to emergencies or managing serious disruptions to services, it is useful to apply a simplified, three level management structure[1]:

[1] The emergency services may call these gold (strategic), silver (tactical) and bronze (operational)

- Strategic level e.g. Executive Directors
- Tactical level PH e.g. PH Tactical Lead, hospital Site/Service Directors
- Operational level e.g. Departmental Managers and Team Leaders

Strategic Level Management – Executive Directors

The Strategic Leads decide the overall Strategic Aims and priorities for the incident in the context of NHS Lothian's Corporate Objectives and Values as a whole. Unless otherwise agreed, staff should work to the following aims:

Default Strategic Aims:

- Save Lives and Restore Health
- Maintain Safety of Patients, Staff & the Public
- Minimise Impacts on Normal Services

Tactical Level Management – Site/Service Directors

Tactical level management during an incident will normally be led by the Site/Service Directors (for hospital sites), Heads of Health (for Health & Social Care services) or senior managers deputising for them out of hours. The Tactical will often work with the support of other managers in a Control Room or as a Tactical Incident Management Team (IMT).

The Tactical Leads determine how the strategic aims will be achieved and develops plans to do this. This will involve maintaining a clear overview of the incident, coordinating the work of different departments and services, and directing and supporting operational level teams. Tactical level management should enable and not seek to replace local or departmental management.

Operational Level Management – Departmental Managers and Team Leaders

Operational Leads implement the plans and decisions of the tactical level managers (the Tactical IMT) by coordinating the delivery of direct patient care or service provision. This involves leading their respective teams, communicating 'horizontally' with other operational leads team and communicating 'vertically' with the Tactical Lead in the **Control Room** or in a Tactical IMT. Team leaders might include the Emergency Department Lead, the Surgical Lead, the Facilities Lead etc. Details of these are given in below.

Hospital Medical Coordinator (HMC) – an experienced Consultant grade clinician who is not directly involved in the management of individual casualties.

The Hospital Medical Coordinator's role during an incident is to act as a link between tactical level management and medical staff, and to coordinate medical staff responses. The HMC will also work alongside the Tactical Lead in the Control Room to identify, advise on, and resolve issues in the delivery of clinical responses. The HMC is particularly important in mass casualty incidents but may be needed to provide advice in business resilience incidents too (see also section 4.1 Control Room Operation in Mass Casualty Incidents).

2.1. Escalation

Escalation is requesting that a response is coordinated at a **higher management level**. Generic criteria for escalating to more senior managers are given in ♦ PART I - RESPONSE

Smaller incidents can sometimes be managed effectively using normal departmental arrangements and resources – that is, at operational level. If this might not be sufficient to ensure an effective response, additional tactical (or, occasionally, strategic) level of management and support should be considered.

Escalation is not the same as calling in additional resources, which is activating 'surge management', however this may require authorise at tactical level depending on the scale.

Managers and Directors who are informed of an incident by junior colleagues should ensure there is clarity about how the incident will be coordinated by saying either, that they accept the escalation and will lead the response, or by agreeing whose responsibility this is.

The relationship between different plans and the escalation process is shown in Notification and Activation diagram given in ♦ PART I - RESPONSE.

Strategic Incident Management

Where an incident meets the strategic escalation criteria and cannot be effectively managed by tactical level staff, the Strategic Incident Management Team will be activated.

This comprises those members of the Corporate Management Team (CMT) that the Chief Executive considers necessary for the response. For a strategic level Mass Casualty incident this will normally include:

- Chief Executive and/or Deputy Chief Executive
- Corporate Management Team Members
- Medical Director
- Director of Public Health & Health Policy
- Chief Officer, Acute Hospital Services
- NHS Lothian Communications Team

However, depending on the type of incident, this may include the Chief Officer(s) Health and Social Care, other Executive Directors and others providing specialist advice (e.g. facilities, e-health).

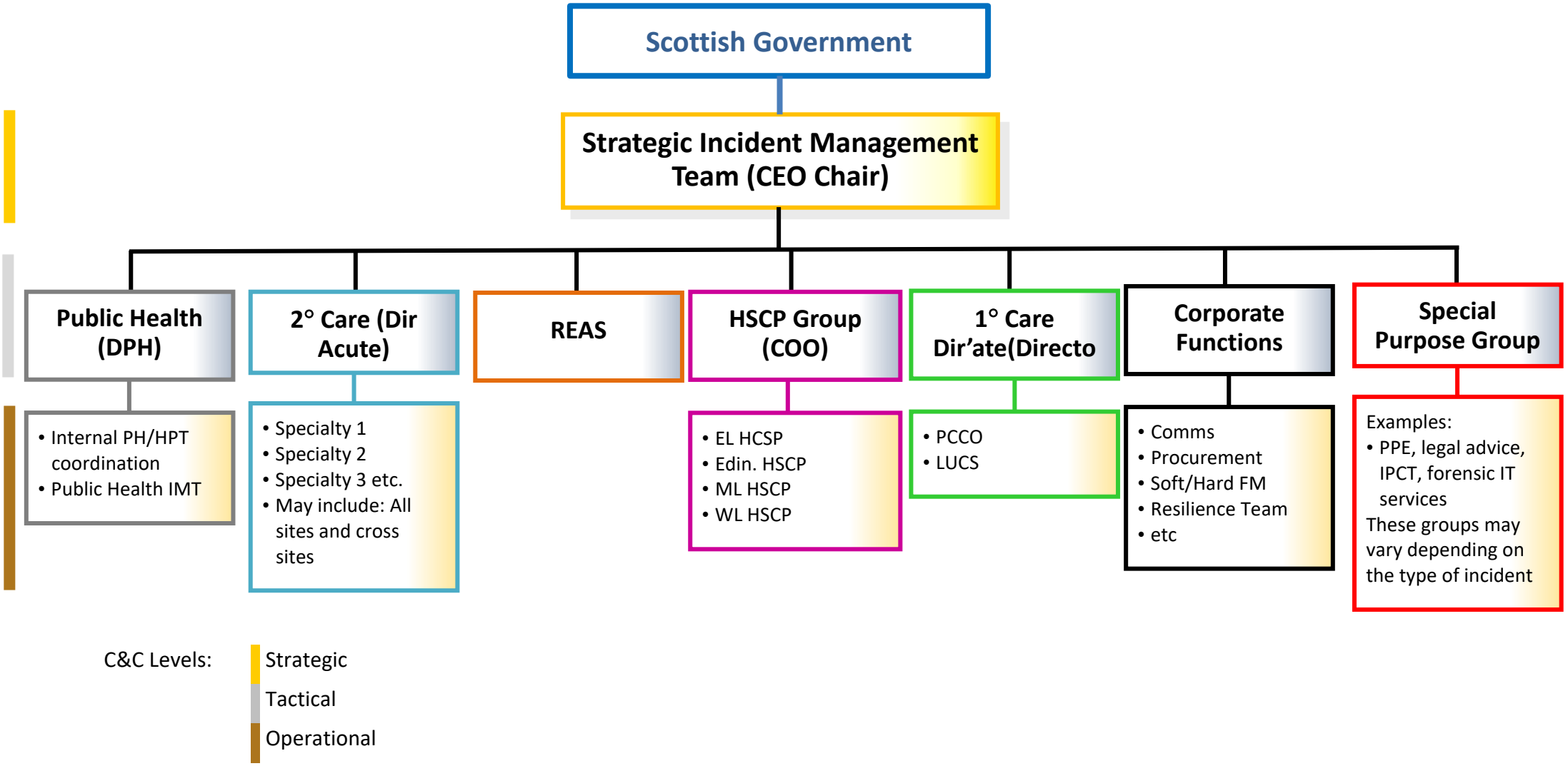
The secretariat function will be provided by the Corporate Services Manager's staff (who have a contact rota).

In hours, specialist advice on resilience issues will be provided by the Resilience Lead or the Business Resilience Lead (these staff are on on-call out of hours but may volunteer support where this is practicable).

2.2. Whole-system responses

When a whole system response is needed, involving primary care, secondary care and health & social care, the coordination structure given below will be used.

Coordination Structure



2.3. Modular approach: Coordination of Front Line Teams

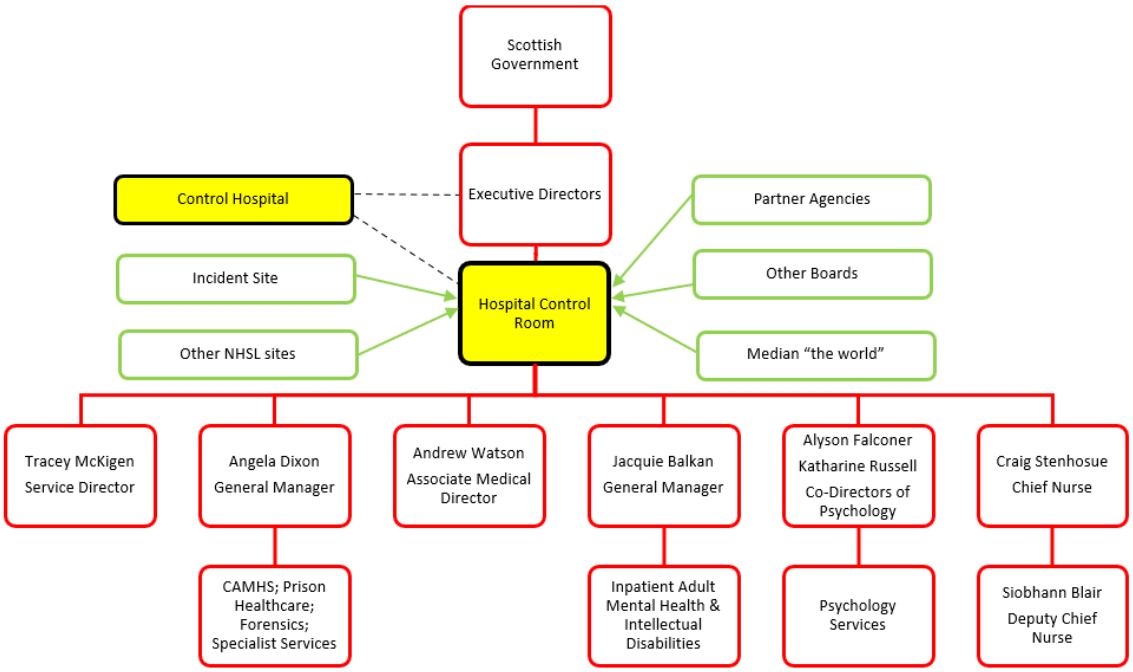
Different types of incident will affect different services and require different groups of staff to respond; the services affected will also change as the incident evolves. Rather than activating the full responses in all areas at the outset, Tactical and Strategic Managers should assess the situation and:

- activate the services / staff teams required to respond to the incident being faced;
- keep other staff informed;
- Activate / stand down responders as the incident evolves.

Managers and team leaders in specialties will coordinate responses in their area and keep the control room informed of progress, allowing Tactical Managers (Site Director) to attend to coordination and support. The diagram below illustrates this structure

Resilience planning and preparation work also follows this modular approach.

Modular response structure



*Note: different operational level teams will be involves according to the incident type

2.4. Fast & Slow paced incidents

Incidents may be fast or slow moving with some requiring immediate decisions (armed hostile intruder) and evolving much more slowly (communicable disease outbreak). The tactical lead should set the pace of the response to match that of the incident.

For rapidly changing incidents, the guidance in the quick start section should be followed and the relevant action cards used. For incidents that are changing more slowly, there may be time to arrange a tactical incident management team meeting hours or days ahead, using the Agenda in 105 Tactical Management Team Agenda.

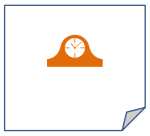
2.5. Control Rooms and the Control Hospital

Control Rooms

A control room is a room that provides space and equipment to assist tactical and strategic staff to manage larger incidents. It is staffed by a small team of people led by a tactical or strategic manager with administrative support. NHS Lothian has pre-identified control rooms at each acute site and at Waverly Gate. Details of locations and how to access these are given in Info Card 30: Control Room Locations [++].

The individual responsibilities of staff in the control room are set out in ♦ PART III - ACTION CARDS \Sections but taken together they will:

- provide leadership, coordination and support to responders;
- gather and share information about the incident;
- Identify priorities and assign resources;
- ensure there is effective communication;
- anticipate and resolve problems; and
- maintain a record of key events and decisions



This depends on having up-to-date information about:

- the incident and its likely health impacts;
- our capacity to respond e.g. available capacity and resources; and
- the effectiveness of the response so far.

This is sometimes called having good “situational awareness” or maintaining the “Information Picture”

Recommendations about the staff required for a control room are given in section5.3 Who To Involve in the Control Room / Tactical Team but for an acute major incident affecting clinical services this will normally be:

- Tactical Lead (Site/Service Director)
- Hospital Medical Coordinator (HMC)
- Senior Manager (Senior Manager)
- Site & Capacity Coordinator
- Administrative Support Officer
- Facilities (including NHS Lothian & Consort)

As soon as possible this should be extended to include

- Communications

REAS have 2 control rooms on-site at Royal Edinburgh Hospital. There is one located on the First Floor of MacKinnon House in the Site Directors office. The other control room is located within the Orchard Clinic.

Control Hospital

If a mass casualty incident affects more than one hospital site, the cross-site responses are coordinated from the Control Hospital. The **Royal Infirmary** is the control hospital for Lothian region and will coordinating responses at RHSC, WGH and SJH where necessary.

The **Control Hospital Control Room** is at the Royal Infirmary, on the 1st floor, near ward 109, across the corridor from the Site & Capacity Office. If this is inaccessible it will move to RIE Board Room 1.

If it is impossible for RIE to function as the Control Hospital, this function should be transferred to the Western General Hospital Control Room. If circumstances require this they will almost certainly constitute a strategic level incident and active management by Executive Directors will be required.

NHS Lothian Strategic Control Room

The NHS Lothian Strategic Control Room is at Waverly Gate; it is Meeting Room 11 on the 5th floor. The alternative location, if Waverley Gate is not available is: RIE Board Room 1.

Multi-site Business Resilience Incidents

Multi-site Business Resilience Incidents or Disruptions should be coordinated from Waverly Gate unless there is a concurrent mass casualties' incident, in which case the Strategic Lead may ask the control hospital to coordinate clinical responses while the Strategic Lead leads the management of other aspects

3. Activating Responses – Call-Out & Internal Communication

The practicalities of how to declare a major incident are summarised on Info Card 1: Major Incident Call Out in ♦ PART IV - INFORMATION CARDS

An activation flow-chart is given on page 5 of ♦ PART I - RESPONSE

Activating this Plan

Actual or potential resilience incidents will usually be reported to site directors and clinical coordinators by local managers, in conjunction with the activation of their local plans. Notification may also come from staff in the emergency services or partner agencies. The Tactical Manager should activate this plan if the incident cannot be managed locally, by the department affected. They should also activate this plan when:

- the anticipated demand for services is so great, urgent or unusual that normal arrangements may be unable to deliver safe or satisfactory care, or
- the provision of services is threatened in a way that requires management at tactical level or above, or
- requested by an Executive Director or the Chief Executive.

More specific "escalation" criteria are listed in ♦ PART I - RESPONSE along with the initial actions needed when responding.

3.1. Major Incident Call-Out

If a large-scale incident that cannot be managed within routine service arrangements has occurred or is suspected, staff should be alerted by using the **Major Incident Call-Out** process.

A major incident can be called by the Chief Executive Office or Exec On-Call and they may call either a **Major Incident 'Stand-By'** or a **Major Incident 'Declared'** (sometimes called a 'full major incident').

The **call-out process** has two parts:

1. **Alerting the leaders of the teams** needed to coordinate the response - this is the major incident call-out process which is initiated by a senior member of staff and carried out by switchboard
2. **Alerting other staff** needed for response – team leaders should direct relevant colleagues to:
   - Alert the staff in their areas/specialties required for the response, and
   - Call in additional staff as necessary to manage increased demand in their service area

Alerting and calling in staff[2] within specialties/directorates is not part of the centralised major incident call-out and is the **responsibility of each specialty/directorate**. This is because the number of staff needed and their skill-mix will depend on the type of incident, when it occurs and other demands on each specialty.

The person leading the incident response should also ensure that **staff not directly affected** by the incident are warned and informed about the situation, although other task may take priority over this initially.

In an emergency, the Tactical Lead (Site/Services Director or deputy) should ensure front line services have been activated before advising strategic staff (Executive Directors or Executive on call).

Major Incident Stand-By

A Major Incident Stand By results in calling-out only the "core team". These are the people needed to activate and coordinate the teams of staff most often needed in an incident. This team will be able to assess how to respond to an incident that is developing slowly or where there is uncertainty about whether an incident has or is about to taken place.

The **core team** comprises:

- Tactical Lead (Services Director)*
- Hospital Medical Coordinator (HMC)*
- Senior Manager (General Manager)*
- Site & Capacity Coordinator*
- Loggist (Business Manager)
- Facilities Manager
- NHS Lothian Communications Officer
- NHS Lothian Emergency Planning Lead

* these four staff, plus administrative support, make up the Control Room team

Major Incident Declared

A Major Incident Declared involves calling out the 'core team' plus other staff needed for the response. By default, the staff needed for a mass trauma response are called in the order they would be needed.

[2] Calling in staff is called 'Additional Service Capacity' Call-out.

The departments and specialties that have been alerted should then **cascade the call-out** to their own staff and activate their additional service capacity call-in arrangements as necessary.

Major Incident Call-Out – Business Resilience

For non-trauma incidents, (e.g. flooding, IT outage) the Tactical lead should give specific instructions to switchboard (or others) about which teams should be contacted. As different specialists may be needed and the pace of the incident may be slower, after an initial MI Standby call, a series of direct calls to key staff may be used instead,

Switchboard Major incident call-out lists

Major incident call-out lists for each acute site are held by Switchboard. Sites should ensure these are kept up to date by advising switchboard of any changes

3.2. Internal Communications / Warning and Informing Staff

Even if staff are not directly affected by an incident it may be important to inform them of what is happening because:

- There may be impacts on their work, although these may be relatively minor;
- False reporting and disinformation may result if they are not part of the coordinated information cascade and hear by informal roots;
- Visitors and patients may ask questions

Staff should also be warned about possible **hazards** and **security risks** affecting them or members of the public.

3.3. Informing Senior Managers and Comms

All significant incidents and all those requiring tactical level management should be reported to the relevant executive director (normally the Chief Operating Officer for Acute services or the Executive On Call).

Consideration should be given to informing NHS Lothian Communications team if the incident may attract media attention.

4. Mass Casualty Incident Management

Guidance in this section focusses on Mass Casualty incident management. Please read in conjunction with **section 5 Tactical Incident Management – Generic issues** (page 24)

A mass casualty incident is an incident that results in more casualties than can be managed using normal procedures.

A **National Mass Casualties Incident** is a mass casualty incident that exceeds the capacity of the health board where the incident(s) took place and requires the National Mass Casualties Incident Plan to be activated (see Info Card 12: National Mass Casualties Incident Plan & Mutual Aid)

Although the consequences of a mass casualty incident will be felt for many days (and much longer by the individuals affected), this section of guidance focuses on the initial clinical

response from the arrival of patients at hospital to their transfer to the clinical specialty that will manage their ongoing care.

The information provided in sections 4 are for reference for the REAS Senior Management Team. The information will be more relevant and focussed on the Acute Hospital Sites but the involvement of REAS will usually focus around additional capacity, for Acute Sites to move relevant patients to REH, or for REH patients to be expedited back to REH to create capacity on the Acute Sites. REAS would refer to the Generic Tactical Incident Management described in section 5.0 and to their own service resilience plans.

Action cards, Info cards & Trauma Check-list

See:

- Action Cards 2 – 9
- Info Card 4: Mass Casualties (1) – **Trauma Checklist**
- Info Card 5: Mass Casualties (2) – Additional Issues
- Info Card 12: National Mass Casualties Incident Plan & Mutual Aid

4.1. Control Room Operation in Mass Casualty Incidents

- Action cards for Control Room staff are given in ♦ PART III - ACTION CARDS
- Activating the hospital control room is described in Action Card 10 Setting Up the Control Room

The following control room staff have specific roles during a mass casualties' incident.

Tactical Lead (Site/Service Director)

The Tactical Lead (Site/Service Director) has overall responsibility for activity on the site and works in partnership with the Hospital Medical Coordinator (HMC).

The Tactical Lead will first ensure that:

- the clinical responses to the incident have been activated;
- the necessary coordination arrangements, including command, control and communications, are in place, and that
- these are working effectively.

Following this and while retaining an overview of clinical responses, they will consider the broader consequences of the incident and address:

- non-clinical aspects of the response
- impacts on normal services
- internal and external communications, warning and informing, media management and reporting
- consequences arising days or weeks later
- multi-agency issues

They will also

- Produce SITREPs and ensure that records of key events and decisions are maintained.

When the acute clinical aspects of the incident have been stabilised, the tactical lead will lead the management of the return to normal business arrangements.

Hospital Medical Coordinator (HMC)

The HMC's role is to

- Coordinate NHS Lothian's immediate clinical response to the incident up to the point where casualties have been received by their clinical specialities (beyond ED); and to:
- Provide a medical perspective on tactical issues being considered by the control room

To do this they must:

- Maintain an overview of the incident including the number and types of casualties
- Ensure that the necessary clinical teams have been activated and that the necessary clinical capacity is available;
- Act as the point of contact between medical and surgical leads and the control room, providing and receiving updates
  - brief clinical team leaders on the incident and on how it will be coordinated;
  - See section 4.3 Internal Communications, HMC Briefing clinical leads
- Anticipate and address probable future clinical requirements and difficulties
- Resolve issues regarding medical priorities and resources
- Anticipate impacts on normal services and resolve these

They will also

- Produce SITREPs in conjunction with the Tactical Lead and ensure that records of key events and decisions are maintained.

The Hospital Medical Coordinator reports to the Tactical Lead and is supported by the Tactical Lead and other staff in the Control Room, where he/she is based.

Senior Manager (General Manager)

The senior manager addresses the nursing and other resource requirements needed to allow the affected clinical areas to function well, across all sites.

Site & Capacity Coordinator

The Site & Capacity Coordinator provides the capacity data needed to manage the response, both capacity in acute specialties and the number and categories of potential cases at the incident scene. He/she will also assist in identifying where additional capacity may be made available.

Administrative Support Officer

The Administrative Support Officer's main functions are to keep a record of key events and to facilitate reporting and communication with other staff. This involves the production of:

- Situation Reports (SITREPS); and,
- An Incident Log

This should be done under the direction of the HMC and Tactical Lead. Templates for this are provided in ♦ PART V - FORMS & DOCUMENTS: SITREP etc. and on the Resilience intranet site

4.2. Situational Awareness and the 'Information Picture'

A lack of good information will make it much more difficult to manage the incident effectively. The control room should actively seek out information to ensure that the information picture is as complete, accurate and up-to-date as is possible and should establish systems to ensure staff provide timely updates from their areas. This is referred to as maintaining "situational awareness"

Initial information about a mass casualty incident will normally be provided by the Emergency Department. The Site and Capacity Coordinator should contact:

- emergency department (lead Charge Nurse) to be briefed and then,
- other people who can provide information about casualty numbers and locations e.g.:
  - Ambulance Incident Officer and/or
  - Medical Incident Officer;
  - Other organisations where relevant, e.g. Police;
  - Other health boards if mutual aid is being given/received.

The information picture will comprise not only casualty numbers but should include:

- Current and predicted demand for services;
- Where casualties are now (at scene, in ED, in ICU, at another hospital site etc.);
- Current and predicted hospital capacity;
- Significant events relating to the incident; and,
- Significant problems, solutions, decisions.

The current information picture should be displayed on the white boards to make it constantly available to Control Room staff. Hard copies should be produced at least hourly.

Scheduling updates from clinical areas

Staff from areas affected by the incident should be asked to submit regular updates to the Site and Capacity Coordinator about capacity in their area, progress of the response and any other significant events. This should be at agreed times, a short while before the next control room SITREP is due to allow new information from specialties to be included.

4.3. Internal Communications

The Control Room should actively manage both incoming and outgoing communications to:

- Maintain the information picture (see above);
- Provide direction and support to the staff teams that are responding;
- Ensure a consistent and coordinated response across teams, sites and agencies;
- Keep staff who are not directly affected and members of the public informed (and to counter false information and anxiety) – the Communications Team should be asked to lead on this;
- Provide reports and briefings to senior staff and partner agencies (see below).

HMC Briefing clinical leads

The Hospital Medical Coordinator should identify key clinical specialties and brief the Operational Leaders (Lead Surgeon, Lead Physician etc.) from them, at regular intervals (hourly at first) to:

- Share information about the incident and the response
- Review the effectiveness of the response and identify current and anticipated challenges
- Agree actions needed to address challenges and ensure an effective response.

The initial meeting may take place in the Emergency Department but thereafter a room adjacent to the Control Room should be used. This meeting should be tightly focussed and keep strictly to time, lasting no more than 15mins. A concise note should be made by the Administrative Support Officer and significant decisions added to the information picture.

Situation Reports (SITREPs) & Incident Logs

Record keeping is an important part of managing an incident. Attention should be given to maintaining a concise, accurate account of key events and decisions as they happen, even though there will be competing tasks. Staff are advised to keep a personal log of events and to retain all original notes from the incident.

Situation Reports (SITREPs) are concise summaries of the current state of the incident and responses to it. They will normally be required to:

- Brief senior staff (Exec. Directors);
- Brief Scottish Government;
- Form a basis of press statements;
- Brief partner agencies; and
- Communicate with staff not directly affected;

The Hospital Medical Coordinator and Tactical Lead (Site Director) should produce regular situation reports about the incidents for staff and other relevant people e.g. partner agencies. It is recommended that the first SITREP is produced within 20 minutes of the activation of a Control Room as a means to share information, establish situational awareness and to identify initial priorities.

A SITREP template is provided in ♦ PART V

Incident Logs are timed records of important events, decisions and communications. They will be required to:

- Help keep track of events and to check back on what has happened earlier;
- Provide a hand-over to subsequent staff shifts and to allow them to check-back on earlier events
- Support the decisions made if they are questioned later, including in any legal proceedings or public enquiries;
- Assist with debriefing;

An incident log template is provided in ♦ PART V

Hospital Medical Coordinator and Tactical Lead (Site Director) should give clear direction to the Administrative Support Officer, who may be unfamiliar with topics being discussed, to ensure all important information is recorded accurately on SITREPS and Incident Logs. The

Administrative Support Officer should distribute SITREPSs electronically to specified recipients as soon as they have been agreed by the Hospital Medical Coordinator and Tactical Lead

Scheduling communications, reports and meetings - "battle rhythm"

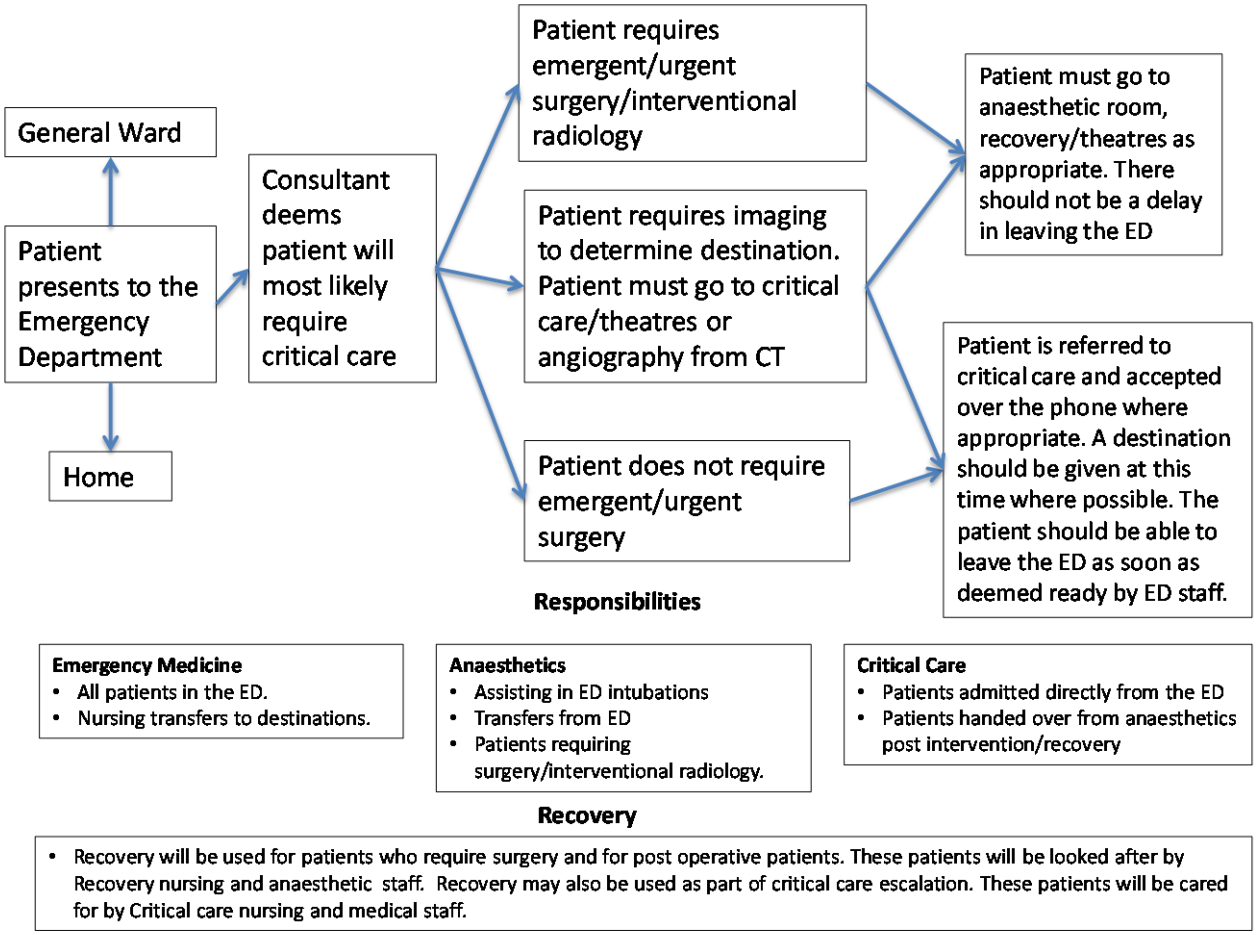
It is recommended that a schedule of reports and meetings is established so that:

- Reports and information are provided a short time before key meetings;
- Meetings and decisions are based on the most recent information;
- Staff know when to report information and when to expect updates (avoiding ad hoc enquiries); and
- Internal and external (multi-agency or Government) meetings are synchronised, do not clash and receive up to date information.

This series of meetings is sometimes referred to as the "battle rhythm".

4.4. Casualty Flow and use of space for site RIE

This Flow chart is for the Royal Infirmary Edinburgh site – for an example reference for the REAS service to understand the process from the Acute Sites



4.5. Mass Casualties involving children

The capacity to manage mass casualty incidents involving children in any single Territorial Health Board area is more limited than that for adults and national responses would be triggered at lower numbers.

The RHSC default maximum trauma capacity for P1+P2 casualties (combined) in the first 2 hours is **10 children under 12 years** (assuming 20% need immediate theatre and 25% need level 3 care).

SJH would not normally be used for paediatric P1 or P2 casualties but could be considered for paediatric P3 casualties – this **option would require careful risk assessment** as a wide range of injuries including some occult conditions fall within the P3 definition.

- See Info Card 19: Children & Vulnerable people

▲ This section will be updated ahead of the relocation of RHSC to RHCYP at Little France

▲ This section will be developed with RHSC and national agencies when the paediatric elements of the National Mass Casualties Major Incident Plan are completed

5. Tactical Incident Management – Generic issues

▲ **The Tactical Lead should begin by using the following Action Cards**
Action Card 1 - Initial Assessment in ♦ PART I - RESPONSE and
Action Card 2 - Tactical Lead / Site Director in ♦ PART III

▲ **The Tactical Incident Management Team Agenda is in ♦ PART V - FORMS & DOCUMENTS: SITREP etc. Form 6: page 105.**

Tactical level management during an incident will normally be led by the Site Directors (for hospital sites), Heads of Health (for Health & Social Care services) or senior managers deputising for them out of hours.

The Tactical Lead determines how the strategic aims will be achieved and leads the response on their site / area to deliver these aims. So, using the **default strategic aims** as an example, the Tactical Lead must decide what needs to be done in the given situation in order to:

- Save Lives and Restore Health
- Safeguard, Staff, Patients and the Public
- Minimise Impacts on Normal Services

5.1. Types of resilience incident

Major Incidents

A Major Incident[3] is:

- *an incident that cannot be managed within routine service arrangements and require special procedures to be implemented.*

This definition means that Major Incidents are always at least tactical level incidents and some will be strategic level, depending on the scale and the impacts on normal services.

Major incidents can vary considerably as different incidents will affect different services; they may be gradual or rapid in onset; they may have different causes, e.g. external events increasing demands on services or internal disruptions to business continuity, including failure of infrastructure or supply chains.

An incident that is a major incident for one of the emergency services need not always be a major incident for NHS Lothian.

Executive Directors should always be informed if a Major Incident is declared, even if it is expected that it will be led and managed at tactical level.

Mass Casualty Major Incidents

A Mass Casualty Major Incident is one where there is a large increase in demand for clinical services, sometimes very suddenly, often due to a major accident or communicable disease outbreak. If the scale of such an incident requires several hospitals in a region to respond then these are coordinated from the **Control Hospital.** In mass casualty incidents the **Hospital Medical Coordinator** (HMC) has a key role in working with the Tactical Lead (Site Director) to coordinate clinical responses at a tactical level, see Incident Management Structures in section 2 above.

In extreme situations where the capacity of a board has been exceeded, the **National Mass Casualties Plan** will be activated and a **Strategic Health Group** set up to coordinate.

Business Resilience Incident Management

Business Resilience is concerned with situation where normal services are disrupted to a substantial degree because of problems such as utility failure, supply chain failure, unavailability of a key resources (building, staff and equipment) or other infrastructure shortfall. Business Resilience disruption may arise from internal causes or external factors e.g. security risks, extreme weather or incidents affecting partner agencies.

Business resilience responses are similar to those of managing an emergency incident in that:

- Command and control arrangements are the same
- The Strategic objectives are the same
- Communication, service prioritisation and forward planning are essential parts
- All professional groups need to be informed and engaged with
- Planning for the recovery phase (return to normal) is important

[3] Preparing for Emergencies section 1.10, page 04

- Civil contingencies legislation applies to these too

Business resilience incidents responses differ from emergency responses in that

- Often, responses will focus on non-clinical aspects as much as clinical implications
- If the cause of the incident is internal, this must be managed as well as the consequences

In incidents of this sort, it is particular important that those managing responses ensure:

- clinical and non-clinical responses are managed in an integrated way and work towards the same strategic objectives
- assessment of priorities considers both clinical and non-clinical aspects of the incident
- there is good communication between clinical and non-clinical staff

Incidents in the Community

▲ **This section is at draft stage as resilience arrangements in some HSCP are under review**

Incidents which involve mainly Primary Care or Community Services will be managed by Health and Social Care Partnership staff from a HSCP Control room with appropriate support from other parts of NHS Lothian and the Local Authority, but without the need for control hospital or casualty coordination functions.

Incidents in the community should be reported to the NHS Lothian Executive Team if they meet the tactical or strategic escalation criteria, see ♦ PART I - RESPONSE Escalation Criteria

National Incidents 0

Some incidents may result in more casualties than can be managed by the Health Board in whose territory the incident took place. In these circumstances the **National Mass Casualties Incident Plan**[4] will be activated and arrangements made to distribute some of the casualties to other boards. The plan includes provision for a **Strategic Health Group** to lead and the cross health-board response and chaired by the Chief Executive of the home board, also arrangements for a Health Information Cell, to track patients and resources and details of the **NHS Scotland Mutual Aid Agreement**. Incidents of this scale would normally trigger the activation of the **Scottish Government Resilience Room** (**SGoRR**) and other multi-agency responses. (See also Info Card 12: National Mass Casualties Incident Plan & Mutual Aid

Major Incident Recovery Phase

The recovery phase of an incident is the part when the acute problems have been stabilised and staff are working to restore normal activity and managing any longer term consequences. This may last from a few hours to several months (or longer) in extreme situations.

The recovery phase of a mass casualty incident is the part of the response when the focus has moved from the initial management of casualties to resuming normal services. At this stage the casualties will be the responsibility of various clinical specialties but the additional demands on these may mean that normal services are still affected, e.g. mul;tiple surgical interventions over several weeks and late onset psycho-social effects.

[4] This is expected to be updated by SG in Spring 2019 – current version is at: https://www.readyscotland.org/media/1114/nhs_scotland_-_mass_casualties_incident_plan_-_february_2015.pdf

This stage of the response should be managed using the same generic arrangements as a business resilience incident. Ideally planning for the recovery should commence at the same time as the acute response.

Security Incident Management

▲ **CMAP is at different stages of development on different sites**

Security issues may arise as part of another incident or as incidents in their own right. These may be relatively minor, e.g. directing relative or closing corridors while repair work is done, or acute and severe if there is a hostile intruder. Details of how security issues should be managed are described in the **Controlled Movement and Access Procedures Guidance**.

As part of the assessment of an incident the Tactical Lead should assess any security issues that are involved and direct appropriate actions to be taken to manage these. It will rarely be possible to halt all movement onto and off a hospital site so the concept of 'lockdown' can be misleading. Rather than this, the Tactical Lead should assess potential security threats by considering the source of the threat and areas that are either particularly vulnerable or important to the delivery of services. They should then consider the mitigation options available and decide which are the most appropriate in the circumstances.

Further advice is given on Action Card 14 Security and 'Lockdown'

5.2. Generic Tactical IMT functions

Tactical Incident Management includes maintaining a clear overview of the incident, coordinating the work of different departments and services, and directing and supporting operational level teams. Tactical management is not there to replace local or departmental management.

The Tactical management team should consider and address the following issues, according to the requirements of the particular incident:

- Providing effective cross department and site management, leadership and governance of the response, especially the identification and communication of priorities;
- Determining which departments should be involved with the tactical management of the response and any departmental or other specific response plans that should be activated;
- Coordinating the responses of operational teams, including the management of any increased demand for services or any disruption to service provision, and ensure regular and effective communications with them (e.g. via a Control Room);
- Monitoring and maintaining an overview of the incident, the response to it and the wider context (situational awareness);
- Assessing and managing broader effects of the incident or the response including future challenges and consequences;
- Assessing and managing any risks to the delivery of the response or to the provision of other NHS Lothian services, including any additional resource requirements;
- Assessing and managing any impacts on the strategic aims and objectives of NHS Lothian, including escalating the response to strategic level where necessary (see section 2.1 Escalation);

- Facilitating effective joint working with partner agencies, including other NHS Boards, mutual aid arrangements and other category 1 responders;
- Managing the flow of information within NHS Lothian and with external partners, including briefing executive staff;
- Managing communications with the public and media (in conjunction with partner organisations).

5.3. Who To Involve in the Control Room / Tactical Team

Serious incidents will often affect several departments or clinical areas and sometimes partner agencies too. Who needs to be involved and which plans need to be activated will depend on the particular incident.

Mass casualties Incident

See section 4.1 Control Room Operation in Mass Casualty Incidents

Generic Incident

For other types of incident the **Tactical Lead** should decide the initial membership of the **Tactical Incident Management Team** (the Control room team) based on current and anticipated circumstances. It is recommended that the following are included:

- People with information about the incident and service areas that have been (or may yet be) significantly affected
- People with specialist technical knowledge who can analyse what has happened and suggest solutions;
- People who can help deal with the consequences, those who may provide capacity, staff or equipment to help.
- Communications/media specialist
- Representative of any partner agencies involved
- Administrative support: a loggist to keep an accurate record, and if possible a “runner”

Working with operational level responders

Staff in specialties and departments are asked to have local resilience plans which identify who their operational level lead (the department / specialty lead) will be and explain how issues such as the following will be dealt with:

- Increasing capacity
- Essential services and service prioritisation
- Changes to work flow
- Unusual service requirements – for clinical or other reasons
- Sustaining the response in their area, including business continuity arrangements

To improve communications, tactical leads should remind staff in all departments to be ready to provide summary reports on key issues, including:

- capacity in use (e.g. beds occupied with simple breakdown of severity)
- available capacity

- projected capacity in use and available over the next 24 hours
- recent significant events (e.g. deaths, loss of resources) or events causing concern
- serious or immediate risks to service delivery or safety (including risks to other departments that depend on theirs)
- ability to sustain service delivery
- requests for specific support or information

Where possible tactical managers should advise their operational leads in advance of what information will need to be reported and when and how to communicate this. When a control room is activated, this information can be mailed or phoned in a specific format at a specific time.

5.4. External Communications and Media Statements

Communications, both internal and external, are of great importance to the effective management of incidents and should be considered at all tactical incident management team meetings. Where possible the following areas should be considered or referred to specialists to consider:

- Communicating with Staff directly involved
- Communicating with Staff not directly involved
- Communicating with Partner agencies
- Communicating with the Public
- Awareness of communications by other agencies
- Awareness of communication by traditional and social media

Important generic communication issues are listed on the Info Card 8: Communications During Incidents but others may arise in specific incidents.

To ensure these are effectively managed **specialist communications advice should always be sought and a media strategy developed**.

The Communications Lead should be asked to prepare media statements and "all staff briefings" based on the most recent SITREP.

Media statements and strategy should be developed in conjunction with other agencies. Media statements about mass casualty incidents should be signed off at Executive Director level. Scottish Government Health Resilience Unit and SG Communications should be kept informed of statements being issued.

♦ PART III - ACTION CARDS

Part I of Plan

1. Initial Assessment – see page 6.

Part III of Plan

2. Tactical Lead / Site (Service) Director
3. Hospital Medical Coordinator
4. Senior Manager
5. Site & Capacity Coordinator
6. SAS Calls to Site & Capacity (Strategic Requests)
7. Facilities On-Site Team Lead
8. Administrative Support Officer
9. Communications Officer
10. Setting Up the Control Room
11. Security and 'Lockdown'
12. Casualty Tracker

Action Card 2. Tactical Lead / Site (Service) Director

The Tactical Lead (Site Director) role will be carried out by the Services Director or the person deputising for them. If they are not immediately available, then the General Manager or equivalent will fulfil this role. The main duties of the Tactical Lead are to:

- Maintain an overview (**situational awareness**) of the incident including actual and potential impacts and risks and the effectiveness of incident responses;
- Determine the significance of the incident and **identify priorities**, taking into account the needs of normal business and longer term consequences;
- **Direct the response**: decide what needs to be done, access specialist advice, coordinate staff teams, provide resources – declare Major Incident if necessary;
- Ensure **effective communication**: between responders across all sites and services, with partner agencies and with the public; brief Executive Directors on the incident;
- Ensure an incident **log** is maintained and Situation Reports are shared regularly.

Initial Actions – See also initial assessment action card

1. **Gather information** necessary to assess the situation.
2. Make an **initial assessment** of the incident and identify initial priorities.
3. Take any **urgent actions** or direct others to do so, activate relevant staff teams/plans
4. **Establish communications** with incident locations and staff teams who are responding; agree who will be your contact/lead in each, share information and schedule reports.
5. Get an assistant then **establish the team of your need** to manage the response. Activate the Control Room (MacKinnon House for REH Site/The Orchard Clinic also has a control room which will be established if the main Control Room requests this) / Control Hospital as necessary
6. **Start a log**

Ongoing Actions

7. Establish a cycle of: reviewing the situation, assessing what is happening, and deciding on the actions required i.e. What? So What? Now What?
8. Early actions to consider in first 10 minutes
    - Decide whether a Major Incident call is needed? – "Stand By" or full "Declared"
    - Produce an initial SITREP. Update this regularly and use it to brief Exec. Dirs etc.
    - Ask Communications Team to produce a media statement based on the SITREP and a communication strategy to support the response and manage enquiries.
    - Check that control room staff understand their roles and are using action cards
    - Check you have the right mix of skills in your tactical team
    - Set a pace of work which matches that of the incident. Consider a more concise and directive management style than normally, whilst remaining polite!
9. When reviewing the incident/response consider
    - What is happening at different places? Incident scene and different NHSL sites.
    - Reports from different teams/specialists: aim for a complete "information picture"
    - Current and future consequences of the incident

- Impacts on patients, staff, other agencies, other locations and the general public
- Current and future normal service priorities that could be affected
- Perceptions as well as actual impacts
- Actions taken by other agencies and other parts of NHS Lothian
- Things you may not know – uncertainty, information gaps, wrong information

10. When assessing consider

- What are the priorities, both currently and in the future? How these will be addressed?
- What risks / problems are there and how will these be minimised / solved?
- What are the options available to us?
- What resources are needed for the response, both currently and in the future?
- How effective has the response been so far? Is it working? Can it be improved?
- How is the incident changing? Do we need to activate other teams / plans?
- How will we sustain the response? How long will this last?
- Do we need to escalate the response to strategic level or de-escalate/stand-down?
- Who needs to be kept informed about this?

11. Decide on actions needed

- Take the decisions that are needed;
- Give clear direction to staff involved and allocate resources;
- Communicate clearly and concisely both internally and externally, update Exec Directors;
- Update incident log and SITREP – tell the Adim support what to record

12. Maintain a clear overview of the whole incident - avoid a fragmented response; do not give undue attention to some issues at the expense of other priorities;

13. Focus on tactical level issues; do not be drawn into the operational. Delegate if possible

14. Watch the clock or set a timer/alarm (time flies)

15. Schedule e-mail/phone updates for departments 15 min. before meeting/SITREP due

16. In meetings, get all updates before starting discussions so discussions of most important issues are not delayed. (1min per person is often enough for update)

17. Be aware of non-NHS agencies which may be coordinated by Police, through a Local Resilience Partnership. Get representation there if necessary (via. Public Health)

18. Anticipate fatigue before it affects the response: plan for rest and handovers

Stand Down

19. Plan for how the longer-term issues will be managed, the return to normal working or the change to special arrangements in just a few areas.

20. Review the incident to identify lessons and arrange for debriefing

Document Responsibility: Danielle Shearer Last Up-Date: 13.10.2024; Review Date: 10.2025

Action Card 3. Hospital Medical Coordinator

The Hospital Medical Coordinator (HMC) role will be carried out by the Associate Medical Director or the on-call Consultant. If he or she is not immediately available, then the next available Consultant (or the most senior Consultant) will fulfil this role.

The **main duties** the Hospital Medical Coordinator are to:

- Maintain an overview of the incident and responses, including the number and types of casualties requiring hospital assessment, at scene or at any NHS Lothian hospital site;
- Ensure an effective clinical response to the incident across all hospital sites, including the availability of the necessary clinical capacity and resources;
- Identify clinical priorities, potential difficulties and options to address these;
- Ensure that all clinical areas are ready to receive the expected volume and types of patients, and the flow of patients is not delayed;
- Communicate and cooperate with Site Director to facilitate a coordinated overall response and to provide regular Situation Reports (SITREPs).

The HMC should not become involved in direct patient care.

The Site Director is the Tactical Lead, leading the Tactical Incident Management Team of which the HMC is part. As well as supporting clinical responses they will address non-clinical issues (portering, security, public communications, relatives/visitors, mutual aid, etc.), impacts on normal services, comms and the interface with management.

Initial Actions – when notified of actual or potential Major Incident

1. **Contact Services Director or Coordinating Charge Nurse** (and/or other affected Services) to find out the number and type of casualties, and any actions already taken
2. Decide whether **major incident "standby**" or full **major incident "declared"** is needed. Direct switchboard to do this: dial 2222 and say "I am the Hospital Medical Coordinator, please begin Major Incident Declared REH Site Call-out. - Contact me when completed."
3. Start **log** of significant actions and communications (delegate to loggist when available).
4. **Go to REH** control room, 1st Floor MacKinnon House) and receive update from Services Director and Coordinating Charge Nurse
5. If more information is needed consult Medical Incident Officer (MIO) at scene or Ambulance Incident Officer (AIO) or Police Scotland Incident Officer or Scottish Fire & Rescue Service Incident Office at the scene.
6. Deploy Medical Incident Officer (MIO) to scene if required and this is safe to do so
7. Meet Coordinating Charge Nurse, Services Director, Senior Manager, Facilities Coordinator (or their deputies) in the Control Room (Nurse Director/Deputy Chief Nurse Room, 1st Floor Mackinnon House). Put on the HMC Tabard.
8. Ask Coordinating Charge Nurse for available bed capacity in specialties
9. Review estimated / projected casualty numbers and types, and available hospital capacity. Create additional capacity to match anticipated caseload by instructing:
    - Areas to clear all non-urgent patients.
10. Ensure roles and responsibilities are understood by Control Room staff and senior staff. Delegate distribution of action cards and tabards within Control Room.

11. Provide initial incident briefing to specialty team leaders (who should have gone to the Control Room at Call-out) inc. Leads for, Adult, Rehab, Orchard Clinic, Older People, Intellectual Disabilities, Forensic, and CAMHS.

Ongoing Actions

12. Establish a cycle of assessing and interpreting the incident and its consequences, and taking action needed to ensure an effective clinical response.

13. Consult Control Room staff, request regular (hourly) reports from all affected areas to ensure you have the full picture, particularly: capacity, patient numbers/status, problems

14. Maintain awareness of significant activity and events re:

- Incident scene, particularly the expected numbers and types of patients still to arrive at the hospital (speak to MIO or AIO)
- Capacity of support services (speak to Senior Manager and Estates Coordinator)
- Number and status of incident patients in each hospital

15. Ensure Coordinating Charge Nurse maintains the incident status board (whiteboard) with information about patient numbers and status at all locations.

16. Ensure specialties are aware of and prepared for cases they are expected to receive

17. Identify current and potential problems, giving advice and direction to clinical leads:

- to create suitable capacity (discharge patients, defer non-urgent work)
- to resolve delays and bottlenecks
- to change service priorities as required
- to reallocate staffing and other resources (consult others sites about this)
- to ensure the response can be maintained for the required time

Meet specialty team leaders regularly (hourly at first) to share information and to:

- Review the effectiveness of the response and identify current/anticipated challenges
- Agree actions needed to address these issues.

18. Liaise with other agencies as necessary e.g. Police at REH

19. Provide regular (hourly) situation reports to Senior Managers (and through them NHS Lothian as a whole), including: patient numbers, progress of the response, major interventions, problems and significant events (inc. deaths)

20. Maintain a personal log of significant events, decisions and communications.

Stand Down

21. Instruct Switchboard to issue Major Incident Stand Down notification

Action Card 4. Senior Manager

The Senior Manager role will be carried out by the Senior Manager (General Manager) or the person deputising for them. If he or she is not immediately available, then a Clinical Service Manager or a Clinical Nurse Manager will fulfil this role. At night this will be the Coordinating Charge Nurse.

The main duties the Senior Manager are to:

- Assess and prioritise the staffing and resource requirements of the incident response
- Ensure that clinical areas are staffed, resourced, supported and managed effectively, across all NHS Lothian sites
- Ensure effective communication with, and reporting from, all affected areas

Initial Actions

1. Unless otherwise advised **go to Control Room, 1st Floor MacKinnon House**

2. Identify the service areas most likely to be affected by the incident:

- assess their potential resource requirements
- instruct them to be ready to activate their local response plans

3. Speak with Site & Capacity Coordinator to obtain an overview of clinical capacity and staff resources. Agree any proposed actions to increase clinical capacity.

4. Identify a suitable administrative assistant to keep a log of actions and decisions

Ongoing Actions

5. Request regular updates on the incident and asses the likely impacts:

- For mass casualty incidents, updates will be provided by the Coordinating Charge Nurse and the Hospital Medical Coordinator
- For other incidents, updates will be provided by the staff at the incident location or those with specialist knowledge (these staff may be from other agencies)

6. Request regular updates on clinical capacity and staff resources from the Coordinating Charge Nurse. Agree any actions needed to increase clinical capacity.

7. Identify the current and future resource priorities both for the response and normal services, and determine how these will be addressed

8. Consider directing referrals and other emergency admissions to other hospitals

9. For the area's most directly affected by the incident:

- brief them on the incident and what is expected of them
- assess their staffing requirements and ensure that sufficient resources are available
- instruct them to activate their local response plans
- Give particular consideration to: ECT, in-patient wards and the Outpatient Department

10. Ensure that the equipment and non-human resources necessary to support the clinical response in these areas are in place

11. Establish effective communications arrangements with the affected areas and agree a communications schedule to enable them:

- to be kept informed about the incident

- to coordinate their response
- to ensure they report on significant events or difficulties promptly (to maintain an accurate and complete information picture)
- schedule communications to feed into key senior meetings to inform decision making (default is hourly updates from all affected areas at 20 min to each hour hh:40)

12. Ensure that the health and safety needs of nursing staff are met, including appropriate personal protective equipment (PPE), advice about possible hazards and rest periods

13. Ensure that sufficient nursing resources are available in other areas that are not directly affected by the incident so that other work can be maintained.

14. Ensure that, as part of the broader internal communication response, there is effective and appropriate communication about the incident with all nursing staff.

15. Assess the likely future impacts and future resource requirements and put in place arrangement to ensure these are addressed.

16. Brief the Hospital Medical Coordinator and the Tactical Lead on nursing and resource aspects of the response, including any difficulties that are anticipated.

17. Review the effectiveness of the nursing response giving particular consideration to:

- Clinical priorities
- Current and future resources
- Communications with staff

18. Consider restricting access to parts of the site, redirecting traffic, restricting normal visiting, and assigning specific areas for the reception of relatives and the reception of media. Discuss this with other control room staff.

19. Address any professional issues arising for nurses involved in the incident response.

20. Maintain a personal log of significant events, decisions and communications.

Stand Down

21. Assist the Tactical Incident Management Team to commence the management of the return to normal working

22. Review the incident to identify lessons and arrange for debriefing

Document Responsibility: **Danielle Shearer** Last Up-Date: **14.10.2024**; Review Date: **10.2025**

Action Card 5. Site & Capacity Coordinator

The Coordinating Charge Nurse – CCN role will be carried out by the senior member of the Coordinating Charge Nurse Team on duty. If he or she is not immediately available, then the Senior Manager will fulfil this role.

The main duties the Site & Capacity Coordinator are to:

- Ensure the relevant control rooms are activated and made ready for use (delegate this if possible).
- Maintain an accurate real-time summary of (i) the number and categories of current and potential casualties (ii) how clinical capacity is being used throughout the acute specialties and (iii) capacity may become available in the near future.

Initial Actions

1. Unless otherwise advised **go to Control Room, 1st Floor MacKinnon House.**

2. Ensure the control room is made ready for use (delegate this if possible) and use the action cards for the room.

3. Log on to the Site & Capacity PC.

4. Consult HMC, Senior Nurse and find out the currently expected number of casualties

5. Work with Senior Manager to **Warn and Inform** areas not directly affected by incident

6. Ask clinical areas to identify how additional capacity could be created urgently

7. If necessary, consult other services and find out the expected number of cases from other sources, e.g., from other Hospitals and Health Boards, from on-site/at scene treatment centres, from local authority reception centres and as self-presenting cases

Ongoing Actions

8. Maintain an accurate and up to the minute overview of:

- current and expected casualty numbers
- how clinical capacity is being used throughout the acute specialties
- what capacity may become available in the near future

9. provide this data to the HMC, by maintaining the casualty overview board (or otherwise)

10. Consult relevant departments, sites and partner agencies frequently to maintain a current and accurate overview of capacity.

11. Alert the HMC to potential capacity shortfalls or delays in providing service capacity.

Action Card 6. Site & Cap. – National Trauma Response Strategic Activation

Action Care is not applicable to REAS Service

Document Responsibility: **Danielle Shearer**; Last Up-Date: **13.10.2024**; Review Date: **10.2025**

Action Card 7. Facilities On-Site Team Lead

The Facilities Manager role will be carried out by the senior facilities staff member on duty or the on-call representative. If he or she is not immediately available, then most senior member of facilities team on site during the incident will fulfil this role.

The facilities On-Site Team Lead will

- Attend the initial incident briefing in the **Control Room, Nurse Director/Deputy Chief Nurse Room, 1st Floor MacKinnon House** or, if this is impossible, assign a deputy to attend
- provide a single point of contact for the Control Room for all facilities issues, including Soft FM, Hard FM and Services
- establish contact with appropriate agencies to ensure the necessary arrangements are in place for effective joint working and information flow for all facilities service providers
- ensure the necessary security and patient movement arrangements are activated as soon as possible
- assess the likely impact on facilities and manage staffing resources so as to address these
- Activate an additional service capacity call-in of facilities staff where necessary
- resolve any issues relating to competing demands for services in consultation with the Control Room

Initial Actions

1. Unless otherwise directed go to the **Control Room, Nurse Director/Deputy Chief Nurse Room, 1st Floor MacKinnon House,** to be briefed on the incident by the Hospital Medical Coordinator.

2. Consider the need for traffic control points at the internal roads leading to impacted areas to limit non-essential traffic. Implement these as needed.

- Liaise with the Portering Services and the Police Liaison Officer

3. Identify any current or potential risks relating to infrastructure, utility, buildings, traffic flow, security, or similar areas.

Ongoing Actions

4. Coordinate provision of Facilities services.

5. Liaise with the following staff to assess the status of facilities services and to identify and implement any actions needed to support the incident response:

- Head of Facilities

6. Report to the HMC and senior manager on any significant changes to normal operations or risks to the provision of services

Action Card 8. Administrative Support Officer

The Administrative Support Officer role should be carried out by Business Manager for Adult Acute Service Manager with acute mental health services. If no admin staff are available, then the Site/Service Director may nominate a competent person to carry out this role.

The main duties the Admin. Support Officer are to:

- Keep an Incident Log - a timed record of important events, decisions and communications; and
- Prepare and distribute Situation Reports (SITREPS) – a concise summary of the current state of the incident and responses to it

See also "setting up the control room" Action Card

Initial Actions

1. Unless otherwise directed **go to the Control Room, Nurse Director/Deputy Chief Nurse Room, 1st Floor Mackinnon House**

2. Obtain a supply of stationery and begin a timed log of decisions and other significant events noted by HMC and Tactical Lead (Site Director)

3. Log on to Administrative Support Officer PC in the Control Room and be ready to:

- Produce a handwritten or an electronic log of decisions and other significant events noted by HMC and Tactical Lead (Site Director)
- An hourly situation report (this will be drafted/dictated by the HMC and Tactical Lead)
- Use the templates provided in the Control Room or on the Resilience Intranet Site for these

4. Locate the "spider phone" in case this is needed for teleconferences (kept in the draws below the printer) see Contacts Directory for teleconference number and participant numbers.

5. Optional: Use the laptop computer in the Control Room (kept in the draws below the printer) so it can be used for record keeping

Ongoing Actions

6. Continue to maintain a timed log of decisions and other significant events as directed by HMC and Services Director.

7. If updates to the log have not been provided, prompt the HMC and Services Director for updates every 20 min

8. Maintain a concise, accurate record of Hospital Medical Coordinator (HMC) briefings

9. When requested:

- produce a situation report (drafted/dictated by HMC and Site Director)
- circulate this as requested by HMC and Site Director

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Action Card 9. Communications Officer

The Communications Officer role will be carried out by the Duty Communications Officer. If he or she is not immediately available, then the Director of Communications will fulfil this role.

The main duties the Communications Officer are to:

- Develop an external communications strategy for the response
- Monitor media responses to the incident, including social media
- Provide advice on media statements

Initial Actions

1. Unless otherwise directed go to the **Control Room, Nurse Director/Deputy Chief Nurse Room, MacKinnon House,** to be briefed on the incident by the Hospital Medical Coordinator.

Note use additional seating/breakout area in "hot desk" area adjacent to Control Room where necessary

Ongoing Actions

1. Consult with Tactical Lead (Services Director) to develop an external communications strategy for the response
2. Monitor media responses to the incident, including social media
3. Update the HMC and other senior staff about media responses to the incident
4. Draft initial media statements and review these
5. Provide advice about communications with different groups and communities affected by the incident

Action Card 10. Setting Up the Control Room

1. Unlock the Control Room - Keys for the Control Room (located with CCN or REH Security Officer, Site Director, or Personal Assistants)

2. Switch on all PCs and ask staff to log off (leaving PCs at logon screen)

3. Ask staff in the Business Manager's Office area to vacate area. Switch on PCs

4. Test phones and remove any diverts (type ##9)

5. Remove unnecessary papers etc from desks in the Control Room

6. Note: Control Room paperwork and reference documents are kept in the red plastic Major Incident box

7. Place action cards on the appropriate desks (white/red signs on walls)

8. Place phone directories, Logbooks and note pads On each desk

9. Place blank SITREP (situation report) forms on the central desk

10. Place copies of the Tactical Incident Management Plan (parts 1 & 2) on the desk of the Services Director and Hospital Medical Coordinator

11. Place information picture summary sheets (info snapshots) on the Site and Capacity Coordinator Desk

12. Test the whiteboard markers

Other Information: The "spider phone" for teleconferences is located on top of the contingency box. Pens and pencils are in the small draws in the bookcase. Tea & coffee are located in the kitchen in the corridor.

Action Card 11. Senior Surgeon

Not Required at REAS Service

Card responsibility: **Danielle Shearer**; Last up-date:**13.10.2024**; Review date: **10.2025**

Action Card 12. Lead Physician

Not required for the REAS Service

Document Responsibility: **Danielle Shearer** Last Up-Date: **13.10.2024**; Review Date: **10.2025**

Action Card 13. Anaesthetist 1 (Bleep Holder 2200)

Not Required for the REAS Service

Card Responsibility: **Danielle Shearer**; Last Up-Date: **13.10.2024**; Review Date: **10.2025**

Action Card 14. Security, 'Lockdown' and CMAP

▲ **CMAP is currently under development**

This card should be used by the **Tactical Lead** in situations where security or controlled movement and access issues may arise. It should be used in conjunction with the Controlled Movement and Access Procedures (CMAP) Resource Pack for the site.

Context

The Tactical Lead should manage security issues within the context of

- the duties of care to staff, patients and the public;
- the strategic aims of the incident response;
- the legal duties and authority

They should use the resources in the CMAP Resource Pack, including the Decision-Making Model and take into account any time pressures and uncertainty about information that may apply during the incident.

Assessment

1. The Tactical Lead should assess any security issues that may arise by

- Gathering information about the situation, particularly
  - the source(s) of the actual or potential threat(s)
  - areas of the site that are either particularly vulnerable or important to the delivery of services
  - risks to staff, patients or the public
  - considering any advice or information from the Police or other security service
- Considering capabilities, policies & procedures e.g.
  - Resources available and actions they could reasonably take
- Assessing risks, and developing a working strategy
  - Consider competing priorities and the strategic aims of the response
- Identify options & contingencies
  - What type of CMAP is needed? How extensive?
  - What practical options are available?

2. Decide which the most appropriate security interventions in the circumstances are and:

- Take action & review what happened

Card Responsibility: **Danielle Shearer**; Last Up-Date: **13.10.2024**; Review Date: **10.2025**

Action Card 15. Friends & Family Coordination

Not Required by the REAS Service

Document Responsibility: **Danielle Shearer**; Last Up-Date: **13.10.2024**; Review Date: **10.2025**

Action Card 16. Casualty Tracker

Not Required for the REAS Service

Document Responsibility: **Danielle Shearer**; Last Up-Date: **13.10.2024**; Review Date: **10.2025**

♦ PART IV - INFORMATION CARDS

This section contains introductory information and advice to assist tactical managers (Site/Service Directors and Senior Managers on-call) until such time as they are able to obtain the relevant specialist advice from their colleagues.

The advice given is necessarily generic and not prescriptive. Staff responding to specific incidents should decide on the extent to which it applies to the particular circumstances they are managing.

Info Card 1: Major Incident Call Out [REAS]

A Major Incident can only be called by the Chief Executive Office or the Exec On-Call. The Site Director may request via Chief Executive or Exec On-Call that a major incident be declared or activate the control room

To declare a Major Incident Call-Out, the Hospital Medical Coordinator or the Services Director (or the person deputising for him/her) should:

- Call Switchboard on 2222
- Instruct Switchboard to begin the call-out, either as:
  - "Major Incident Stand By" or
  - "Major Incident Declared";

    and
  - Specify which hospital(s) this applies to.

For example:

"I am Dr Smith the Hospital Medical Coordinator and a Full Major Incident for the Royal Infirmary.

"Do you need me to repeat any of that? Please notify me when you have done this."

Major Incident Stand By

This activates the "**Core Team**" which comprises:

- Services Director
- Hospital Medical Coordinator
- Acute / Rehab Nurse in Charge
- Older People MH Nurse Manager
- Learning Disabilities
- Lead Consultant
- NHS Lothian Communications Team
- Emergency Planning Lead
- Facilities / Estates Manager
- Orchard Clinic CNM

Full Major Incident (Major Incident Declared)

This activates the Core Team plus

- Staff needed in urgently
- Department / Specialty Lead staff leads in other clinical and non-clinical areas (in the order they would be needed in a mass casualties incident)
- Public Health
- Pharmacy
- eHealth

Departmental and Specialty responsibilities - Cascade of Major Incident Call

The Department / Specialty Lead should ensure that

- Other staff in their specialty are informed a major incident has been declared
- If needed, extra staff are called in using Additional Service Capacity arrangements.

Alerting Other Specialties and Sites

- The Control Room should advise other sites of a declaration of Major Incident as soon as possible.

Major Incident Stand Down

- A stand-down call should be made using the same process as the full major incident call-out when:
- A call-out has been made in error or based on false information;
- All acute major incident responses are complete

Notes:

- This call-out arrangement defaults to calling staff needed for a mass casualties incident.
- The major incident Stand By call is intended for use when an incident is slow moving and an initial assessment needs to be made before going further;
- A **major incident called by another agency** does not necessarily require an NHS Lothian site to go to major incident, senior staff should decide but and consider a Standby call.
- Major Incidents in other areas that might require a cross-Board response or other strategic interventions may be notified to REH Coordinating Charge Nurse for relaying to Site Director, even if there is no immediate clinical response needed by Lothian.
- Additional Service Capacity (ASC) Call-out ('local call-out') is the process that specialties use to call in extra staff in their service area to deal with a surge in demand. Activation of the 'ASC' call-out is at the discretion of senior staff in each specialty.
- Ensuring specialties have ASC Call-out in place and that it is exercised regularly is the responsibility of each service. Some areas have found 'WhatsApp' useful for this and NHS Lothian has agreed that this can be used for this.

HMC personnel

The Hospital Medical Coordinator for acute sites are provided from the following groups:

Site	HMC provider
RIE	Crit Care 2nd On Call
WGH	AMD Medicine
SJH	Obstetric On Call
RHSC	AMD paediatrics
REH	AMD Mental Health

Info Card 2: Warning & Informing Staff (site name) [REAS]

Placeholder text:

If staff need to be alerted urgently as part of an incident response (e.g. hostile intruder alert, vulnerable lost person, FYI messages about ongoing incidents etc.) the following process will be used.

REAS/REH have a process in place for these incidents through the Coordinating Charge Nurse.

RIE=site specific card

Info Card 3: Out Of Hours [REAS]

This is process is in place for REH/REAS through the Coordinating Charge Nurse

Info Card 4: Mass Casualties (1) – Trauma Checklist

The information provided here is for reference only. Not applicable for REAS Service

This checklist is for the Control Hospital, Site Director and Hospital Medical Coordinator and concerns responding to **large scale trauma**. It should be used in conjunction with generic action cards for Site Director and Hospital Medical Coordinator. See also Info Card 5: Mass Casualties (2) – Additional Issues and the National Mass Casualties Major Incident Plan.

Key elements in the mass casualty response are:

- Command, control and communication arrangements: clear information picture, role clarity, clear communications between departments/sites and control room(s)
- Triage: (i) pre-hospital (to other sites and Boards) (ii) Surgical Triage in Emergency Department: some casualties may need to go directly to theatre;
- Maintaining patient flow to avoid blocking ED resuscitation, theatres, recovery; note: patient leaving ED should not return;
- Rapid availability of imaging, especially CT
- Optimising the use of capacity: Theatres, Recovery, ICU and downstream capacity: (i) Theatre Recovery will be used for both pre- and post-op care, (ii) the Surgical Lead will advise on the appropriate surgical interventions, sometimes time-limited 'damage limitation' procedures to avoid delays in treating other casualties;
- Determining whether NHS Lothian capacity will be exceeded and activating mutual aid / National Mass Casualties Plan if it will;
- Managing risks: (i) allowing safe departures from normal processes to increase capacity and (ii) managing specific risks e.g. contamination, security, paediatric casualties
- Anticipating problems: activating capacity early, equipment shortage, planning for day 2 and beyond, calling in more staff

Specific initial actions when coordinating response

- Confirm deployment of the Site Medical Team and Medical Incident Officer (Medic 1);
- Get an estimate of the number casualties and severity of their injuries (P1, P2, P3 status) - consult Emergency Department, Medical Incident Officer or SAS Control Room as necessary;
- Find out if the casualties present any additional management issues or risks apart from high numbers, e.g. contamination or security risks;
- Ensure the following clinical responses have been activated (unless there are specific reasons not to):
  - Declare Major Incident, request Core Team plus Surgical Responses
  - Clear the emergency department
  - Pause all theatre lists (complete current cases)
  - Clear theatre recovery
  - Redirected non-emergency cases to other hospitals
  - Identify options to create space in ICU and HDU

  - Alert SNBTS
  - Alert the Triage Surgeon – needed in Emergency Department
  - Alert Surgical Lead – to coordinate surgical resources and advise on interventions in theatre (e.g. 'damage control' surgery)
  - Hospital Medical Coordinator meets with Surgical Lead, Triage Surgeon, ED Lead consultant to agree approach to expected pressures and patient flows
- Ensure the following management and support responses have been activated:
  - Activate RIE Control Room (Control Hospital Control Room)
  - Instruct other acute sites to go to stand-by and activate their control rooms
  - Notify Facilities and Consort to manage security, traffic on site and movement of patients between departments;
  - Notify the Executive team: decide if Strategic Incident Management Team is needed (it is if NHSL capacity is exceeded or services are severely disrupted); Exec Dir or Resilience Team should notify Scottish Government;
  - Notify Communications team and instructed them to prepare advice to public about changes to services;
  - Prepare to support friends and relatives: designate an out-patient area, and staff lead, ensure clear messages, involve chaplaincy, and provide tea/coffee.

Ballistics

- Initial interventions are likely to be time limited, damage limitation surgery aimed at preventing loss of life; it is not expected that ballistics specialists will be available quickly enough to do this.
- The Surgical Lead will determine what procedures are needed to stabilise the casualty and to allow others with an immediate need of surgery to be treated without delay;
- Expect very high levels of demand for blood products initially and the need for more specialist and lengthy interventions in the following days/weeks, with ICU support.

Default 2hr Major Trauma Capacity and the National Plan

- The **RIE default maximum trauma capacity** for **P1+P2 casualties** (combined) in the first 2 hours is **28 adults** (assuming 20% need immediate theatre and 25% need level 3 care)
- Casualty distribution: P1+P2+P3→RIE; Children <12yr→RHSC; GP take→WGH
- When an incident is expected to exceed the capacity of one health board the National Mass Casualties Plan should be activated. This includes:
  - Scottish Ambulance Service asking neighbouring boards how many casualties they can take and how much specialist capacity they can offer (e.g. burns beds): a reply within one hour is needed;
  - A Strategic Health Group (SHG) is set up to coordinate cross-board responses: this is activated and chaired by the Chief Executive of the Board where the incident occurs.
- Scottish Ambulance Service will decide with the 'home' board if the National Mass Casualties Major Incident Plan is needed and will manage casualty distribution across boards.

Info Card 5: Mass Casualties (2) – Additional Issues

The information provided here is for reference only. Not applicable for REAS Service

Extraordinary Measures

All 'Mass casualty' incidents will require the creation of additional capacity but extreme forms may require "extraordinary measures in order to maintain an effective, suitable and sustainable response". "Doing more of the same is unlikely to be effective."[5] – SG (2009).

If normal protocols and approaches, including activation of the National Mass Casualties Incident Plan, are not sufficient to manage the incident, then other pragmatic options that are likely to assist should be considered. Lead clinicians (HMC & Medical Director) and strategic managers (Control Hospital and Exec. On Call) should assess extraordinary measures with reference to the Strategic Aims of the response and legal duties.

Groups of People Direct & Indirect Affected

The health needs of groups affected in different ways should be considered, including:

- people seriously ill or injured as a direct result of the incident, requiring treatment
- people not at immediate risk but needing treatment and subsequent monitoring or ongoing support, possibly in a non-acute or primary care setting
- people who are neither ill nor injured but in need of information, advice & reassurance
- people who are not part of the incident but who fall acutely ill during it
- others affected by the loss of service due to the incident / response (e.g. dialysis)
- people whose symptoms arise later, particularly mental health impacts
- NHS staff and other responders

Relatives & Friends – Social & Psychological issues

Provision for friends and relatives should be put in place as soon as possible including food & accommodation for those attending hospitals and reliable information about the incident, casualties and fatalities. Central to this is prompt and accurate communication and an understanding of the principles of psychological first aid (see related information cards)

Options to create capacity

The following pre-arranged options to free space and create capacity should be considered:

- Ceasing elective activity and redirecting other admissions to other services.
- Identifying patients suitable for rapid discharge and implementing this in conjunction with SAS, primary care and others affected;
- Using existing capacity more intensively to create extra capacity for higher levels of dependency, e.g. use less acute and specialist beds to deliver acute care, or general acute beds for critical care (with specialist staff).

[5] Mass Casualties Incidents A Framework for Planning NHS Scotland, Strategic Guidance for NHS Boards (2009); page 9; see http://www.sehd.scot.nhs.uk/EmergencyPlanning/Documents/MassCasualtyGuidanceNHSScotland-May-09.pdf

- Assess Equipment and supplies issues, e.g. medicines, theatre consumables, linen, and anticipate the demand for these in different areas as time moves on.
- Opening disused wards within NHS hospitals or intermediate care or community beds
- Arrange with Primary Care, NHS24 and SAS to maintain and treat patients in the community setting wherever possible, to avoid referrals to acute hospitals;
- Establishing triage facilities away from acute hospital sites to direct patients to community based care if appropriate.
- When NHS capacity is exceeded, using private sector capacity, e.g. hotels or schools or colleges for less clinically dependant patients – consider staffing and equipment needs

Staffing and Sustaining the Response

The clinical capacity needed will depend on the type of incident and will change over time, e.g. from Emergency Departments to clinical specialities (theatres, critical care etc.). Staffing and workforce arrangements may constrain this so consider:

- Not deploying all available extra staff at the outset
- Taking a staggered approach to deployment – matching the number and skill mix of staff to the changing demand profile.
- Pre-identifying staff with specialist skills (emergency care, ITU, theatre)
- Using non-specialist and non-acute staff in areas that would allow specialists to be redeployed in more acute areas (inc. community staff and GPs in secondary care)
- Addressing practical constraints on staff work, e.g. transport, child-care
- Using qualified staff working in non-patient contact areas and those recently retired.
- The sustainability and safety of permitting staff to work longer hours, more intensively or in unfamiliar settings for more than a short while, including duties of care for staff.
- Extending staff working hours (e.g. pre-identified part-time staff)
- Agreeing clinical indemnity for staff working away from their normal place of work.

The need to expand capacity may conflict with normal protocols and standards. Senior clinical leads and senior managers should consider the circumstances and apply triage protocols to all areas of clinical work that are affected. The aim should be to provide the best care possible under the circumstances, within the healthcare capacity available.

Complicating factors to be considered

- NHS staff may be amongst the casualties;
- Staff concerns about the wellbeing of their family preventing them from working ;
- Concurrent loss of services/infrastructure e.g. transport, utilities NHS buildings;
- Shortage of essential supplies, or other business continuity impacts;
- Mass movement of the population e.g. evacuation or relocation of people;
- Large scale and persistent media and public information challenges;

Longer term issues

- Begin to plan for longer term issues and the return to normality as soon as possible.

Info Card 6: Casualty Capacity & Distribution Across Sites [++]

The information provided here is for reference only. Not applicable for REAS Service

Casualty Distribution and initial default capacities

Age	Triage	Destination	Default initial capacity
Adult	P1 & P2	RIE	Up to 28 in first 2 hours
	P3	RIE	
Child <12yr	P1 & P2	RHSC	Up to 10 in first 2 hours
	P3	RHSC	
GP referrals		WGH	

These values assume that up to 25% of casualties require level 3 care and up to 20% require immediate surgery (typically damage control surgery).

P3 Casualties "walking wounded" should be seen at a hospital with an emergency department as:

- This triage category is very broad and some of these casualties may have serious injuries, despite meeting P3 criteria;
- Initial triage may not identify some occult injuries due to the pressure and limited resources available at an incident scene.

Children accompanied by adults, where both require hospital assessment, would normally be taken to RHSC if the adult is clearly a stable P3 without risk of deterioration and consents to this.

Self Presenters: All sites should be prepared for these

Info Card 7: Non-clinical Checklist for Site (Service) Director

Supporting Patient flow in a Major Incident

Overview of selected non-clinical support service and Facilities issues relating to patient flow in a major incident.

External Site traffic	Pre-discharge care	Ward to ward
Emergency arrivals	Increasing discharge lounge capacity	Movement of patients
Staff cars (additional)	Food	Room cleaning
Additional responder vehicles: Police, media, VIP	Reassignment / reconfiguration of rooms	Provision/Movement of clinical and specialist equipment*
Discharge transport	Pharmacy & equipment for discharge	Laundry
Public transport on site	Cleaning & waste disposal	Cross site equipment movement
Security and Closure of routes	Discharge lounge at night (laundry)	Deaths, mortuary transport & forensics

Response Management

Logistics of moves & security, Identifying options, decision making, working with Control Room and clinical services, cross site pressures

Normal Business

Meals, supplies, cleaning, other patient movement, & security etc.

* Particularly theatres, ICU, HAZMAT

Info Card 8: Communications During Incidents

Communications, both internal and external, are of great importance to the effective management of incidents and should be considered at all tactical incident management team meetings. Almost all health related incidents are of interest to the public and the media. Important generic communication issues are listed below but others may arise in specific incidents. To ensure these are effectively managed specialist communications advice should always be sought:

Internal communications - about the incident and response

- Respect patient and staff confidentiality at all times but note that preventing harm may sometimes require normally confidential information to be shared;
- Effective management and decision-making requires good "situational awareness" - get regular updates about how the incident and the response to it are progressing to ensure your understanding is complete and up to date;
- Match the frequency of updates with the speed of the particular incident;
- Advise staff in advance of what you will need to know, when and how to communicate this, e.g. casualty numbers and categories, each hour on the hour e-mailed to set address;
- Keep staff informed of developments (and of "no change") - consider issuing a SITREP or CRIP (commonly recognised information picture) at specific intervals or linked with key events or changes. Include people not directly involved;
- Work with other agencies to ensure all relevant people have access to the information they need as soon as possible - alert colleagues to when key information is expected;

External communications - wherever possible involve specialist media staff:

- Images from an incident may be circulating electronically within minutes of it happening;
- Not communicating creates a space for speculation and an impression of having something to hide;
- A holding statement is often needed soon after the incident to say it is being managed appropriately although specific information may not be available until later;
- Develop a media strategy: what will be told, to whom, when, how, by whom;
- In multi-agency responses, the media strategy should be coordinated across agencies - often the Police will lead on this;
- Consider the needs and interests of different audiences: people directly affected by an incident, their families and friends (including the bereaved), staff responding, other patients and other staff; the general public. Consider the reader's perspective;
- Inform people directly affected before the general public;
- Different media require different approaches: written statements; interviews to camera; social media; access to take photographs - get specialist advice;
- Consider the strategic, political and legal aspects of any statements - get specialist advice;
- Avoid speculation; do not confirm anything unless you are sure of the facts.

Info Card 9: Care of Friends and Families at REH

Some incidents will result in large numbers of friends and family members attending the hospital either with casualties or seeking information about them. Asking acute areas under extreme pressure to meet the needs of these people may compromise clinical services so friends and family members will be directed to a Friends and Family Area in the Spiritual Care Corridor.

The area will be staffed by a **Friends and Families Lead**, who will be a senior nurse or member of the Spiritual Care Team, supported by other staff, including facilities and security. This will also require close links with acute areas, the control room, NHS Lothian Communications, and Police Scotland.

This area will provide

- a waiting area, food and drink to people seeking information or waiting to see patients;
  - working with facilities
- information about the incident in general and about specific casualties in particular;
  - working with acute areas, control room and comms
- Psychological first aid;
  - See leaflet on intranet[6] and national guidance[7]
- Where appropriate, Spiritual care through the support of the Spiritual Care Team (see Spiritual Care Team Info Card)
- Advice on missing people, by working with the **Casualty Tracker** and referring to Police Scotland and links to Police Casualty Bureau

Normal activity in OPD will be rescheduled according to priorities of the incident, under the direction of the Control Room.

Contact & Coordination in Major Incident

- Coordinated by Service Manager/Clinical Nurse Manager (in working hours & out of hours it will be the individual identified by Site Control)
- Daytime Contact: Danielle Shearer : Mob: 07989761659 Landline 0131 5376163.
- Out-of-hours : Individual identified by Site Control via Switchboard

Casualty Tracker

The **Casualty Tracker** role will be held by a member of the Site and Capacity Team, appointed by the Control Room who will keep a record of where casualties within NHS Lothian hospitals are and their general condition, so that Friends & families and the Control Room can be kept informed (see Casualty Tracker action card).

[6] http://intranet.lothian.scot.nhs.uk/Directory/Resilience/Pages/PeopleSkills.aspx *Coping with the stress of a major incident*

[7] https://www.gov.scot/publications/preparing-scotland-responding-psychosocial-mental-health-needs-people-affected-emergencies/

Info Card 10: Spiritual Care & Bereavement Service

Normal Role and Context

- Chaplains provide and facilitate spiritual, religious and pastoral care to patients and relatives across all sites and departments
- Chaplains provide staff support (individual and group) at the time, and after traumatic events
- Office based (REH, Ground Floor, MacKinnon House), managing cases / incidents with 24/7 on-call
- Bereavement Coordinators provide practical advice and support to bereaved relatives (office hours only)

Service Priorities

- Spiritual, religious and pastoral support to patients, relatives (chaplains)
- Staff support (chaplains)
- Practical information, advice and support to bereaved relatives and staff (bereavement coordinators)

Additional Roles/adaptations in major incident

- General pastoral and practical support for relatives (chaplains and bereavement coordinators)
- Able to contact established faith/belief community representatives (e.g. local clergy) if requested by Site/Service Director
- Non-clinical support as needed

Risks to Response

- One chaplain is on call 24/7. Response from additional chaplains and bereavement coordinators cannot be guaranteed,

Work Around option

- Nil known

Contact & Coordination in Major Incident

- Coordinated by on-call Chaplain, initially from home, then from REH Spiritual Care Office, Ground Floor, MacKinnon House. Handover to Head of Service on his arrival.
- Daytime and OOH Contact: On Call Chaplain via switchboard

Document Responsibility: **Danielle Shearer**; Last Up-Date: **13.10.2024**; Review Date: **10.2025**

Info Card 11: Pre Hospital Responses [++]

FOR RIE ED ONLY

Placeholder Text: This Card is under development and awaits the outcome of national discussions by SG and Scottish Trauma Network about national Mass Casualties Major Incident Plan.

Info Card 12: National Mass Casualties Incident Plan & Mutual Aid [++]

The information provided here is for reference only. Not applicable for REAS Service

See also **Action Card 6 Site & Cap. – National Trauma Response Strategic Activation**

Some incidents may result in more casualties than can be managed by the Health Board in whose territory the incident took place. In these circumstances the National Mass Casualties Incident Plan will be activated and arrangements made to distribute some of the casualties to other boards. Details of these arrangements, including the NHS Scotland Mutual Aid Agreement, are set out in the plan, which is available on the Resilience Intranet site and in the Control Hospital Control Room. The following points should be particularly noted:

Incidents in NHS Lothian's area - NHS Lothian seeking Mutual Aid

- Scottish Ambulance Service will inform the Control Hospital of the estimated number and types of casualties, as is normal practice;
- Site and Capacity will be asked to assess whether NHS Lothian expects to be able to take the estimated number & type of casualties;
- Where this is in doubt, they should consult the Site Director and Hospital Medical Coordinator to decide on the volume of cases that can be accepted and any extraordinary steps needed to increase capacity. (timescale: urgent);
- Consideration should be given to the feasibility of providing pre-hospital care for "P3" cases and the rate at which cases may be received at hospitals;
- If, after taking all practicable steps to create additional capacity, NHS Lothian is unable to take all the casualties from the incident(s) then SAS should be advised and asked to activate the National Mass casualties plan activated.

The National Mass Casualties Incident plan requires NHS Lothian to:

- Deploy a site medical team (Medic 1)
- Set up a Strategic Health Group to lead and the cross health-board response, including the activation of mutual aid, this is led by the Chief Executive or his/her deputy (timescale: within 2 hours);
- Establish a Health Information Cell to coordinate information about patient locations across boards (timescale: within 3 hours of the SHG meeting);

Details on these functions are given in the National Mass casualties plan. By definition, this will also be a Major Incident for NHS Lothian with activation of the

- Control Hospital and the Strategic Incident Management Plan and Control Room (at Waverly Gate).

Incidents in outside the NHS Lothian's area - providing Mutual Aid

Scottish Ambulance Service will have activated the National Mass casualties plan and will ask NHS Lothian to provide details of the mutual aid it can provide as follows (timescale: 1 hour):

- ED capacity to accept P1 and P2 casualties directly from the scene;
- Capacity in the following specialties at three levels:

  - Specialties: Theatre, ICU, ITU, HDU and specialist units e.g., burn, paediatric ICU, surgical and medical capacity
  - Level 1 - make available capacity that does not disrupt planned work;
  - Level 2 - make available capacity including cancelling elective procedures;
  - Level 3 - make available capacity including cancellation of all elective procedures, implement early discharge and reassign non-acute areas for acute use procedures.
- The timescale for the return of this information is 1 hour

Scottish Ambulance Service, in conjunction with the Medical Commander at scene and the Tactical Medical Advisor at Ambulance Control (Glasgow) will then agree the distribution of patients and inform the receiving hospital.

In some cases, provision of mutual aid on a large scale might require a major incident response.

Info Card 13: Multi-agency responses & Mutual Aid

The Civil Contingencies Act 2004 and associated regulations defines “Category 1 Responders” who are: Local Authorities; Police; Fire; Ambulance; Health Boards; SEPA; Maritime and Coastguard Agency. Under the Act these agencies have duties: to assess risk; to co-operate; to share information; to maintain emergency plans; to maintain business continuity plans; to communicate with the public; (local authorities must also promote business continuity).

NHS Lothian is part of the Lothian & Borders Local Resilience Partnerships (tactical level) and the East of Scotland Regional Resilience Partnerships (strategic level). The RRP and LRP have many topic specific sub-groups including Communications, Care for People and Recovery. Representation is normally by the Director of Public Health (RRP) or the Emergency Planning Officer (LRP). MoD and Scottish Government are also represented on RRP

When working with operational responders on site at incident scenes (including hospital premises) tactical and operational managers should

- Wear NHS Lothian Tactical or Operational **hi-vis tabards** which identifies their role;
- Make contact with incident control staff in other agencies the Fire and Rescue "**incident commander**", the SAS **Ambulance Incident Officer** (AIO) an **Police Incident Officer** (PIO);
- The **Site Director**, or their deputy, should introduce themselves as the NHS Lothian **Tactical Incident Manager** or “**Silver Command for Hospital**” (an equivalent but older designation);
- Expect communications to be conducted in a concise, forthright and professional way.

As part of the multi-agency response, NHS Lothian Public Health may be asked to set up a Scientific and Technical Advice Cell (STAC). STAC provides expert advice on scientific and technical issues to the emergency services and other responders, which may include areas such as public health, environment, animal health, water, technical failures, etc. STAC is usually chaired by the Director of Public Health or a Consultant in Public Health Medicine (CPHM). Further guidance is available at http://www.readyscotland.org/ready-government/preparing-scotland/

Info Card 14: Blood Products [++]

Placeholder Text: This Card is under development – SN BTS input will be needed

Info Card 15: LUCS respones to Trauma Incident [+]

LUCS (Sian Tucker aware)

Please provide Information Card.

Give enough information to ensure the site director to can understand arrangements for

Leadership

Service Prioritisation

And how responses will interact with other service areas

Aim for 1 page, certainly <2

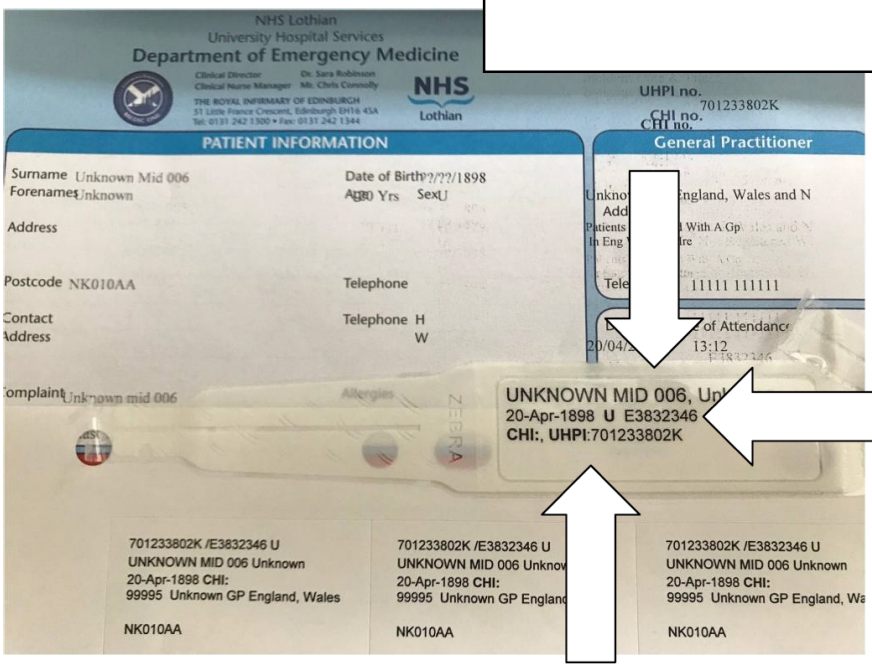
Info Card 16: Patient Identifiers in Major Incidents

****The information provided here is for reference only. Not applicable for REAS Service****

In a Major Incident Trak generate a sequential major incident number e.g. MID 006.
Patients should be referred to by this number in communication during the incident.

Major Incident Number e.g. MID 006

- Sequential number, generated for major incident only.
- Patients should be referred to by this number in communication during a major incident.
- e.g. Patient 006 moving from ED to theatres



E Number e.g. E3832346

- Sequential number generated for all ED attendances.
- Should not be used as patient identifier.

UHPI number e.g. 701233802K

- Number generated for this hospital attendance.
- **Should be used for BTS/lab/radiology requests.**
- **Should be used during transfusion checks.**
- Can search for the patient on TRAK using this number.
- This UHPI number will subsequently be merged with patient CHI.

The major incident record will be merged with any pre-existing record for the patient once the immediate pressures of the incident have lessened, e.g. after 24hours, as determined by the control room and e-health.

Info Card 17: Anaesthetics

****The information provided here is for reference only. Not applicable for REAS Service****

Normal Role and Context

- Provision of anaesthetic services to emergency and elective patients, including general/regional anaesthetic care, acute airway management, trauma team input, obstetric anaesthesia and acute pain service. 24/7 resident service.
- Based in RIE Theatres 1-24, SCRH, cardiovascular labs, interventional radiology and other non-theatre areas requiring anaesthetic services e.g. Emergency Department, ward 111. Scheduled provision for affiliated sites (Roodlands Hospital, PAEP, Royal Edinburgh Hospital)

Service Priorities

- Emergency anaesthesia, obstetric anaesthesia, elective anaesthesia, acute pain service

Additional Roles/adaptations in major incident

- Typical incidents: Mass Casualty Incident
- Expansion of emergency workload into elective theatres, redeployment of anaesthetic staff to emergency cases. Additional Service Capacity call-out.
- Use of Main Recovery as pre-operative holding area and Critical Care overspill.
- Use of alternative recovery areas to maintain patient flow for non-incident patients.
- Response coordinated by Anaesthetist 1 (Main Theatre based), supported by Anaesthetist 2 (ED based).
- Anaesthetist 1 based in 'control hub' between Theatre 19 and 20.
- All other anaesthetists to report to DSU coffee room.

Work closely with (interdependencies)

- 2118 bleep holder, Recovery Lead, Surgical Lead, ED Lead, Critical Care Lead, BTS, Radiology

Risks to Response

- Casualty numbers exceeding capacity (bed spaces, theatre space, surgical trays, equipment)
- Communication failure (mobile network)
- Complexity such as chemical exposure risks

Work around options

- National Strategy
- Use of land-lines, runners.

Contact & Coordination in Major Incident

- Coordinated by 2200 bleep holder (Senior Anaesthetist)

- Daytime and OOH Contact: Bleep 2200, CEPOD 1 mobile 07540 675036

Info Card 18: Mass Fatality Incidents

See East of Scotland Regional Resilience Partnership Mass Fatalities Framework. This is available from the Resilience Team or from the RRP Coordinator.

Note that

- **RIE is the default location for forensic pathology** in an "intensive" mass fatality incident, i.e. an incident requiring forensic investigations at the direction of the **Procurator Fiscal**. Very small incidents (1 or 2 fatalities) would be managed by CEC at the City Mortuary.
- A mass fatalities coordinating group will be established, chaired by the procurator fiscal;
- Mutual aid for addition staff may be needed, including APTs (discuss with mortuary manager)
- Mortuary services and imaging may be involved in this process. Links with Friends and Family and spiritual care services will also be important.
- **Police DVI** (disaster victim identification) under the command of a **SIM** (senior identification manager) are a key part of this process
- Often DVI processes at scene will limit the rate of work needed to manage fatalities, which may not begin for several hours after the deaths occur. Security issues may also affect this.

This does not include a **pandemic fatalities** or epidemic of known cause, which are extensive mass fatality incidents;

See also National Mass Fatalities Guidance at:

https://www.readyscotland.org/ready-government/preparing-scotland/

Info Card 19: Children & Vulnerable people

Children

Children can be affects by a major incident in several way, including

- Suffering physical injury
- Witnessing others being injured
- Hearing about the incident
- Having friends or family who have been injures

Specialist advice to assist in the management of their needs should be sought from:

- RHSC coordinating charge nurse or senior manager on call for RHSC

An information leaflet is also available from:

- Link: https://nhsnss.org/media/4013/information-leaflet-coping-with-stress-additional-children-information-june-2016.pdf

See also:

https://www.gov.uk/government/publications/support-for-children-parents-and-teachers-victims-of-terrorism/additional-advice-and-support-for-parents-children-and-teachers

https://www.ready.gov/coping-disaster - (US Government site)

Vulnerable people

"Vulnerable" and similar terms mean different things to different people and organisations. Vulnerability depends on external circumstance (incident type, support network in place etc.) and varies with time, as people become or stop being vulnerable when circumstances change.

Some organisations (including care services and utility companies) keep lists of vulnerable people, according to their definition, but maintaining up to date lists of all people with different types of vulnerability would be an impossible task.

During an incident we should consult partner agencies to determine who might be more at risk, sharing information via the multi-agency RRP care for people group (note – the duty of care would take precedence over confidentiality in some circumstances). We should then use established networks to communicate with and deliver what is needed to those in need.

There is national guidance on Care for People - see Ready Scotland at http://www.readyscotland.org/ready-government/preparing-scotland/

Info Card 20: RHCYP & RHSC Joint response from 2021 [++]

RIE / RHSC Only (others for information)

Please provide Information Card describing arrangements following move of RHSC to RHCYP, including:

Joint working of EDs

Decontamination facilities

Management of friends & family

Security issues affecting whole of little france site (inc. warning & informing)

Heli-pad use

Info Card 21: Patients of Interest to Media or Security (PIMS)

Some patients, their family or their visitors, might attract unusual levels of interests from the media or security services, e.g. celebrities, people under police or prison service protection, members of the UK royal family. As well as providing clinical care, additional arrangement will be needed to care for these people and to avoid disruption to other patients. This may include arrangements to ensure their security, to protect their confidentiality and to manage media interest.

The NHS Lothian PIMS protocol makes specific recommendations for the management of PIMS patients at different hospital sites and states that the same triage and treatment priorities will be applied to all patients (PIMS and non-PIMS).

- See separate **Patients of Interest to Media or Security (PIMS)** Protocol (on intranet and in control room) and
- Also consider security issues set out in the **Controlled movement and Access Procedures (CMAP**)

Info Card 22: Operation Unicorn Briefing Note

Operation Unicorn Briefing Note V.2.docx

Operation London Bridge is the code name for the overarching plan that will be implemented in the event of the death of the Monarch. Operation London Bridge incorporates **Operation Unicorn**, which is the code name for the plan that will be implemented if the Monarch dies in Scotland, or its territorial waters, and **Operation Kingfisher** which is the code name of the plan that will be implemented if the Monarch dies elsewhere.

The term Operation Unicorn is commonly used for both Unicorn and Kingfisher.

The events planned in Scotland for Operation Unicorn will have a significant impact on the country, in particular Edinburgh, while those that are planned for Kingfisher, although similar, are more ceremonial in nature and will have much less of an impact.

Event Island

In general terms the High Street, from the Castle to the Palace of Holyrood house, is where most of the ceremonial events will take place and this is known in planning terms as the Event Island. For certain ceremonies road closures and movement restrictions will be implemented on the High Street and the roads which cross it such as George IV Bridge and North Bridge. Also other areas of the city will become part of the Event Island on certain days and times which will require additional road closures and movement restrictions.

Edinburgh Impacts

If Operation Unicorn is activated there will be a number of ceremonial events in Edinburgh over a four day period which will result in:

- Road closures implemented for a number of hours or anywhere from 1-4 days
- Road diversions implemented for a number of hours or anywhere from 1-4 days
- Pedestrian movement restrictions in the Event Island for a number of hours on certain days
- Parking restrictions in the Event Island and nearby roads
- Public transport suspensions, diversions or cancellations
- Substantial traffic congestion on roads around the Event Island
- Increased police presence
- Large number of national and international media providers operating in the city
- Extensive media coverage of ceremonial events
- Substantial influx of visitors over a period of 4 days
- Extensive queues of people wishing to participate in or watch ceremonial events
- Increased attendance at Hospital ED and Minor Injury Clinics

NHS Lothian Potential Risks

While this is not an exhaustive list potential risks and impacts to NHS Lothian service delivery include:

- Disruption to attendance for medical treatment impacting on performance

- Traffic restrictions and transport disruption may result in patients being late or unable to attend medical appointments
- Controls, restrictions and traffic congestion in the City centre may delay, prevent or limit access for SAS Patient Transport Service accessing patients that require transport to attend outpatient appointments
- Controls, restrictions and traffic congestion in the City centre may delay, prevent or limit access for Flow Centre vehicles affecting patients that require transfer to or discharge from a medical facility
- Reduction in staffing levels
- The traffic restrictions, transport disruption and congestion may result in staff being late or unable to attend work
- Reduction in staffing levels will have a detrimental impact on service delivery
- Reduction in staff could potentially affect ability to deliver major incident responses
- RHSC and Lauriston Campus Impacts
- Traffic congestion may impede access to these facilities and affect service such as;
  - Clinical Waste uplift
  - Laundry uplift and delivery
  - Delivery of medical, clinical and non clinical supplies
  - Meals from AAH
  - Lab Van pickups
- Congestion and inappropriate parking may impede patient access to these facilities
  - Blue light transport to and from these facilities may be impeded due to congestion and inappropriate parking
- Primary Care Risks
- Movement restrictions around areas of the High Street may result in difficulties for Health and Social Care staff accessing patients
- Influx of British and foreign visitors to Edinburgh may place additional pressures on Primary Care
- Reduction in staffing would also affect Primary Care

NHS Lothian Response Arrangements

NHSL generic response arrangements will be followed in the event of Operation Unicorn, augmented by specific action cards noted below;

- NHS Lothian Chief Executive/Deputy
- NHS Lothian Executive On-Call
- NHS Lothian Representative in the CICC
- Flow Centre
- Alexandra Eye Pavilion
- Services located in the Lauriston Buildings

Info Card 23: Communicable Diseases, Public Health and HAI & Containment

The Public Health role concerns communicable diseases and environmental health incidents which pose a risk to the health of the public, e.g. emerging infections, food borne disease, chemical or radiological hazards. These may sometimes create impacts on hospital services, which may be over the course of hours or weeks. PH commonly work with other agencies including Local Authority environmental health services and primary care. The most acute part of PH is the Health Protection Team, based in Waverly Gate, which provides the PH on-call service, but other PH staff are involved with longer term work on health inequalities and health promotion.

The on-call CPHM (consultant in public health medicine) is the out of hours contact for multi-agency partners seeking a health opinion as part of their incident responses in the community, particularly those that do not trigger an ambulance service trauma response or when there are specific public health impacts.

Joint Working

Public Health will normally function as an operational level team, unless the incident is primarily within the scope of PH services and relevant escalation criteria have been met.

The Public Health role in complex incidents is to manage and deliver the Public Health response, communicating with other internal and external responders as required. When requested, Public Health and the Control Hospital should provide one another with information at agreed times and should, work from the NHSL strategic objectives to prioritise responses and set the pace of meetings and decision making.

Very occasionally, as part of a multi-agency response, they may be asked to comment on the overall NHS Lothian response to an incident or impacts for NHS services more generally. This would only be in circumstances when other NHS representation was not available. In such cases Public Health would consult with the appropriate service in advance (e.g. control hospital site director) and act as a communication line, avoiding any command and control role for areas outwith their expertise.

Containment, HAI & Poisons

Advice on HAI and containment should be obtained from Infection Prevention Control, Regional Infectious Diseases Unit and Microbiology according to circumstances. Public Health should be notified if a risk to the public is identified or suspected.

Public Health and poisons specialists may sometimes provide complementary perspectives on unusual incidents.

Card Responsibility: PH HPT; Last Up-Date: Feb 2019; Review Date: July 2018

Info Card 24: Cancellation criteria (2017/18) [+]

The following Cancellation criteria were used by acute services in 2017/2018 as agreed by Tracey Gillies, Executive Medical Director

Category	Definition
1	Admit as priority. Procedure to diagnose, stage or as the primary treatment for cancer and those clinically urgent where deterioration without procedure is likely
2	Clinically urgent but with no obvious deterioration by delay and those who have already received their main cancer treatment.
3	Those patients previously cancelled
4	Those listed for routine procedures

Service prioritisation for use by specialities are given in:

- Operational level Resilience Plans
- Site level pandemic plans

Info Card 25: Psychological responses

See Reception and Tracking of casualties etc (below)

- Psychological First aid advice under 'People & Skills' on Resilience intranet pages at: http://intranet.lothian.scot.nhs.uk/Directory/Resilience/Pages/PeopleSkills.aspx Coping with the stress of a major incident
- national guidance at: https://www.gov.scot/publications/preparing-scotland-responding-psychosocial-mental-health-needs-people-affected-emergencies

see also

- Care of Friends and Family info card
- Children & vulnerable people info card
- Casualty Tracker Action Card

Information leaflets:

- Link: https://nhsnss.org/media/4013/information-leaflet-coping-with-stress-additional-children-information-june-2016.pdf
- Link: https://nhsnss.org/media/4012/information-leaflet-coping-with-stress-february-2017.pdf

See also:

https://www.gov.uk/government/publications/support-for-children-parents-and-teachers-victims-of-terrorism/additional-advice-and-support-for-parents-children-and-teachers

https://www.ready.gov/coping-disaster - (US Government site)

Info Card 26: Police Casualty Bureau, Casualty Tracking etc [+]

{part of Paris Plan Blanc}

See

- Care of Friends and Family info card
- Casualty Tracker Action Card
- Psychological First aid advice under 'People & Skills' on Resilience intranet pages at: http://intranet.lothian.scot.nhs.uk/Directory/Resilience/Pages/PeopleSkills.aspx Coping with the stress of a major incident
- national guidance at: https://www.gov.scot/publications/preparing-scotland-responding-psychosocial-mental-health-needs-people-affected-emergencies

A casualty tracking form is provided on the next page

Placeholder Text: details about links with Police Casualty Bureau to be inserted here

Further development of this capability is to be scheduled.

This should include further work with Police on Casualty Bureau

Name, sex, d.o.b.	UHPI (or chi)	Time & Location	status	Distinguishing features	NoK aware? Possible Relative details
Marion Morrison (M) 26.05.1957		22:00 – ED →W109 @ 22:15	Green		Yes
# R arm					
Unknown Unknown (M) ?40-50yr		21:50 –ED →Mort @ ?time	Black	Medium build; white; short dark hair; white T-shirt, blue jeans; L-arm heavily tattooed; dark metal finger rings x4	No Jane McGregor (in OPD4)
Died 21:45; Gunshot to chest d/w Chaplin ?visit in mortuary					

Info Card 27: Chemical, Biological, Radiological and Nuclear (CBRN) and HAZMAT

CBRN incidents are those when Chemical, Biological, Radiological and Nuclear agents are used as part of a deliberate hostile act. This usually implies a terrorist incident.

The management of terrorist incidents is reserve to the UK Government, however the management of consequences remains with agencies in Scotland.

The **clinical responses** to CBRN incidents are largely the same as those for the corresponding HAZMAT (HAZardous MATerials) incidents where harm from the same substances may have arisen accidentally. However in CBRN incidents **particular attention must be paid to security risks** and consolation between the Tactical Lead and Police is recommended.

Emergency Planning Medicines Stockpiles

Extract from letter dated 18th December 2018, from Michael Healy, Head of Scottish Government Health Resilience

Chemical, Biological, Radiological & Nuclear (CBRN) incident countermeasures

For information on the clinical management and health protection elements of a response to a CBRN incident please see the handbook produced by Public Health England.

https://www.gov.uk/government/publications/chemical-biological-radiological-and-nuclear-incidents-recognise-and-respond

Access to CBRN pharmaceutical countermeasures from the national stockpile

Countermeasures are a group of medicines designed for use in specific scenarios held in central stockpiles to enable the protection and treatment of the public should Chemical, Biological, Radiological or Nuclear (CBRN) materials be released either in a terrorist act or during an industrial incident.

Should an operational need arise for access to any of the CBRN items held within the central stockpile, the Scottish Ambulance Service Strategic Operations Manager (SOM) should be contacted on **0141 8106106 / 07881 356395**.

The SOM will establish the identity of the caller, their direct contact number, the quantity of specified items required from the stockpile and where they are to be delivered. The SOM will be aware of the location of the items and will make the necessary transportation arrangements.

Countermeasures from the national stockpile that can be accessed this way are [listed below]. A list is held on Toxbase and will be updated with any changes. Pharmacy teams should have access to this site.

Please do not hesitate to contact the Scottish Government Health Resilience Unit (0131 244 2429) should you require any further information on the content of this letter.

Chemical Countermeasures

Type	Countermeasure	For the treatment of:	UK market authorisation	Courses / Unit of supply
Nerve Agent Pod	Atropine pre-filled syringe	Nerve agent poisoning	Licensed	Treatment for 45 people
	Pralidoxime	Nerve agent poisoning	Unlicensed	
Cyanide Antidote	Dicobalt edetate	Cyanide poisoning	Licensed	1-3 injections per patient
	Glucose	Required to be used with Dicobalt	Licensed	
Obidoxime	Alternative 'oxime'. Currently being withdrawn but some stock available until expiry.			

Biological and Radiological Countermeasures

Type	Countermeasure	For the treatment of:	Courses / Unit of supply
Biological Pods	500mg Ciprofloxacin	Exposure prophylaxis for anthrax, plague or tularemia	250 courses
	250mg Ciprofloxacin		250 courses
	250mg/5ml Ciprofloxacin suspension		50 courses
Antibiotic follow on treatment	Doxycycline capsules	Exposure prophylaxis for anthrax, plague or tularemia	100mg capsules in packs of 100 (5 treatment courses). One Pallet holds approx. 7,000 follow up treatment courses. Pack sizes may vary
Antibiotic IV	Ciprofloxacin IV	Exposure treatment of anthrax, plague or tularemia	400mg in 200ml. 10 bottles per pack (order per pack)
Potassium iodide	Potassium iodide tablets	Block the uptake of radioactive iodine, plus public information	The requirements for mobilising this stock is under review (to conclude Summer 2019)
Prussian blue	Prussian blue capsules	Treatment of thallium and caesium	500mg capsules in packs of 36 (order per pack)
Botulinum Antitoxin	Botulinum Antitoxin	For the treatment of botulism	1 person course (order quantity required)

Info Card 28: Contaminated Casulaties & Other Specific Risks [+]

Contaminated Casualties – Chemical

Casualties who may be contaminated with hazardous chemical substances will be:

- Directed to ... <location / entrance> ...
- Decontaminated by ... staff in .... <unit> .....<location> ...

PPE is stored at ... <location>

▶ *Further information is given in ... reference plan/action cards*

Site Directors:

Please provide missing text for your site

Contaminated Casualties – Radiological

Casualties who may be radiologically contaminated will be

- Directed to ... <location / entrance> ...
- Assessed by ... <staff>
- Decontaminated by ... staff in .... <unit> .....<location> ...

PPE is stored at ... <location>

Specialised equipment is available from

▶ *Further information is given in ... reference plan/action cards*

Communicable disease risk - HCID

Patients who may pose a significant communicable disease risk, including those with possible high consequence infectious disease (HCID) in will be

- Directed to ... <location / entrance> ...
- Assessed by ... <staff>
- Cared for in ... <initial isolation location> ...by ... staff in .... <unit> .....<location> ...
- notified to Public health

PPE is stored at ... <location>

Specialised advice will be sought from ...?RIDU/IPCT/?microbiology>

▶ *Further information is given in ... reference plan/action cards*

See also NHS Lothian Pandemic Framework

Info Card 29: Evacuation / Emergency Movement at REH [+]

{part of Paris Plan Blanc}

Placeholder text: Evacuation of complete hospital sites is unrealistic and would involve very severe risks to patients. Partial relocation of affected areas will be developed.

The interim arrangements for this are to apply fire evacuation arrangements, moving patients, visitors and staff to adjacent safe areas..

This risk/ capability needs more work.

Site Directors:

Sites are asked to summaries interim arrangements beginning with areas that are both highly specialised and acute e.g. ED/acute admissions, Crit Care, maternity, theatres

Info Card 30: Control Room Locations [++]

Location	Incident types	Access and Admin staff	Equipped for 'Teams' Video Conferencing
Waverley Gate meeting rooms 5, 8 & 9	NHS Lothian - Strategic	Waverley Gate Executive Secretaries	Yes
Royal Infirmary "Control Room" corridor across from ward 109, facing Site & Capacity Office	Control Hospital Control Room Clinical Incidents (e.g. mass casualties) and non-clinical incidents affecting RIE Tactical & Operational Level	Keys from: Resilience Team, or Site & Capacity, or ED Charge Nurse	??
Royal Infirmary Board Room 1	Alternative location for: Control Hospital Control Room, or, NHS Lothian - Strategic	Lauriston Rooms or via Site & Capacity team	??
Waverly Gate 2nd Floor	Public Health IMTs (operational) and Public Health Tactical	Public Health admin. Coordinator	No
Western General Hospital Site & Capacity Room, 1st Floor, ARU building	Tactical & Operational Level incidents affecting WGH (or in support of Control Hospital activation)	Site & Capacity	??
St John's Hospital, Site & Capacity Office	Tactical & Operational Level incidents affecting SJH (or in support of Control Hospital activation)	Site & Capacity	??
REH	Tactical & Operational Level incidents affecting REH (or in support of Control Hospital activation)	All Senior Manager within the On-Call Rota and PA hub.	No

		Site & Capacity	
Health and Social Care	Under review		??

Info Card 31: Related Plans for name-of-siteREH

Operational Resilience Plans

The Operational Resilience Plans for services and specialties at REH are:

- Adult Acute In-Patient Wards
- Mental Health Rehabilitation Services
- HMP Addiewell
- HMP Edinburgh
- Older People Mental Health Services
- Perinatal Community Mental Health Team
- Police Custody Healthcare
- Psychotherapy Department
- REDU and Lothian Eating Disorders Service
- Scottish Mental Health Service for Deaf People
- The Orchard Clinic
- CAMHS
- Addictions Treatment Recovery Service
- MNPI & PAIRS

These are held as hard copies within the relevant departments and also on the Civil Contingencies drive at:

Z:\Civil Contingencies\Resilience Plans Current\Secondary Care Sites\REAS - Royal Edinburgh & Associated Services

Specialist Plans

This plan will be used in conjunction with

- NHS Lothian Prep-Stat Protocol
- NHS Lothian Pandemic Framework
- NHS Lothian PIMS Protocol for Persons of Interest to Media and Security
- REAS CMAP for Controlled Movement and Access Procedures

Info Card 32: For future development

Information &/or Action Cards for future development

- Accelerated discharges from acute sites [+]
  - Coordination of discharges/those waiting in an extended discharge lounge (discharge lounge)
- Trak / Unique patient identifier [+]
  - Additional information about the Use of Trak and Unique identifier (Matt & Andrew)
- Exterior Site RIE Transport in an Incident [+]
  - Management of traffic flow during major incident, access and egress, staff attending to support major incident response, security of site etc.

♦ PART V - FORMS & DOCUMENTS: SITREP etc.

Form 1: Escalation & Reports to Strategic IMT

SBAR – Title.....

S	**Situation** • … • … •
B	**Background** • … • … •
A	**Assessment** • … • … •
R	**Recommendations** • … • … •

People are more user to SBAR than What/So What/Now What or SITREPS so

Completed by:

Notes on completing SBAR

This SBAR should be completed by **senior managers** when reviewing significant incidents and when reporting to strategic level managers / requesting escalation as part of Prep-Stat. Asking the What? So What? Now What? questions may help when preparing this.

What?

- Say what has happened? Give context, time and place
- Consider: What? Where? When? Who is affected? Actions taken? Who is in charge?
- Ask: What don't we know? Avoid assumptions.

So What?

- What are/were the likely **impacts**, **implications** and potential **risks**?
- What are/were the **priorities**? (see strategic objectives)
- **Look ahead** – consider the likely course of events over coming days/weeks (early senior intervention may be needed)
- Consider
  - the wider context, other demands on services, external events, public perceptions.
  - Has a **Prep-Stat trigger** been reached?
  - Who was **involved** in managing the situation? Or gave specialist advice? was this a multi-agency incident?
  - **Leadership**: Who was in-charge – were cross-site and cross-specialty responses coordinated as a whole?
  - **Communication**: Who was informed? Front-line staff, senior staff, other agencies, public, media Communications Team?

Now What?

- What are the **options available** to resolve the situation?
  - Who would implement them?
  - What are the resource requirements
  - What needs to be done first (consider lead time)
- Can this be resolved at tactical level OR
- Is **escalation** for leadership at a more senior management level needed?
- When will services be **back to normal**?
- What remains to be done?

Taking Part in a Strategic Incident Management Team Meeting

Strategic meetings should focus on strategic level issues and decision. They should choose between options presented to them rather than developing the fine detail of responses. If you are asked to report to a Strategic IMT you should be able to provide:

- A very concise report of issues/problems of strategic importance and
- Options available to resolve the problems identified.

To ensure priorities are addressed first, the chair will often get concise updates from those present before discussing how issues will be managed (typically, about 3 min for all reports).

Form 2: SITREP Template

Use this for the first SITREP. Edit the text as necessary.

SITREP No. 1	
Issued on date:	time:
SITREP for: Clinical Leads o; Exec. Team o; SG o; All staff/public o	

Description

** THIS INFORMATION SHOULD BE REGARDED AS PROVISIONAL AS THIS IS AN EVOLVING SITUATION. **

What? When? Where? Reported by?

Impacts

CASUALTIES - Initial estimates of the total number needing hospital assessment: ...

How many are in a critical condition (P1s) ...

How many has NHS Lothian has received so far? Adult: ... Child (<12yr): ...

SERVICES MOST AFFECTED Now or in next 2hrs (say in what way):

- ...
- ...
- ...

MAJOR INCIDENT for NHSL? ... Which Sites: ... declared at: ...

MI for any other agency? Who?: ...

Expected to affect other Board(s)? (Which) . . . . . .

Actions Taken

LEADING: Who is leading the NHSL Response?	Who is leading overall/multiagency response?

Actions taken (tick):

- ☐ Control Room activated at REH
- ☐ RIE is operating as the Control Hospital
- ☐ space created to receive casualties at
- ☐ Medic 1 has been deployed to the scene
- ☐ NHSL Comms Team alerted
- ☐ Site security increased at REH

Clinical teams activated:

- ☐ Emergency Department
- ☐ Surgical & Theatre
- ☐ Critical care
- ☐ Public Health

Other actions:

- ...
- ...

Priorities

The **current priorities** are: base on STRAEGIC AIMS

- ☐ Immediate lifesaving interventions at . . . . . and provision of care to . . . . . .
- ☐ Establishing command and control from Control Hospital Control Room
- ☐ Ensure safety of staff, patients and Public
- ☐ Communication with …
- ...
-

Future challenges: Within the next 3 hours we will need to

- ...
- ...

e..g. clinical response, staff, beds, non-clinical, equipment, Media, security, normal business

Authorised by Site Dir:

HMC: name & sign

Generic SITREP template

SITREP No. ...	
Issued on date:	time:
SITREP for: Clinical Leads o; Exec. Team o; SG o; All staff/public o	

Description

☐ Unchanged from last Sit-Rep issued at ... (or provide update)

- ...
- ...

Impacts

Sites affected, casualties (type/number); changes to normal service; Resource implications; Media/comms; other

- ...
- ...

Is this a Major Incident for NHS Lothian?: MI declared at:

Actions Taken

Leadership: NHSL Response being lead by:	Overall/multi-agency response being led by:

Actions Clinical, non-clinical, coordination, Communications, (other agencies)

-
-

Priorities

The **current priorities** are: base on STRAEGIC AIMS

- ☐ Immediate lifesaving interventions at . . . . . and provision of care to . . . . . .
- ☐ Ensure safety of staff, patients and Public
- ☐ Communication with …
- ...
-

Future Priorities for the next . . . . . hrs/days are:

- ...
-

- ☐ Minimising the impacts on normal services
- ☐ Restoring normal business

Authorised by Site Dir:

HMC: name & sign

Form 3: Specialty to Control Room Update Form

Specialty to Control Room Update Form		
date:	time sent:	time due:
Specialty:		time Ctrl. Rm say this is due by*

Impacts

Casualties

How many Casualties have you receive in **total** so far?

Minor: _____; Major & Stable: _____; Major & not stabilised: _____; ; Deceased: _____;

How many Casualties are currently **in your department**

Minor: _____; Major & Stable: _____; Major & not stabilised: _____; ; Deceased: _____;

Resources and capacity to address current demand:

Bed / Space: Sufficient: o; Borderline: o; shortfall (low risk): o; dangerous shortfall: o;

Staffing: Sufficient: o; Borderline: o; shortfall (low risk): o; dangerous shortfall: o;

Other: Sufficient: o; Borderline: o; shortfall (low risk): o; dangerous shortfall: o;

Details:

Priorities (for specialty)

Immediate:	Next 12 hours
1. ...	**4.** ...
2. ...	**5.** ...
3. ...	**6.** ...

Other comments:

Signed:

* Control Room will set dime when this is due, e.g. hourly on the hour

Form 4: Control Room Log Template

Example of log pages – a stand-alone version is available in control room and on Resilience Website:

This Incident Logs is a timed record of all important events, decisions and communications. It may be required to:

- Help keep track of events and to check back on what has happened earlier;
- Provide a hand-over to subsequent staff shifts and to allow them to check-back on earlier events
- Support the decisions made if they are questioned later, including in any legal proceedings or public enquiries;
- Assist with debriefing;

The Log must include:

- When the incident was notified to NHS Lothian;
- If/when a major incident was declared and by whom
- The names of the Service Director, Hospital Medical Coordinator, Senior Manager, Site & Capacity Coordinator
- The initial assessment of the incident – or refer to the first formal Situation Report (SITREP) if one is produced within the first 20 min.
- Any teams / responders activated

This Log should be updated at least every 20 mins. Ask the Site Director and Hospital Medical Coordinator if there is anything to add to the log. If there is not enter "nothing to report" against the time.

- All entries should be timed and dated
- All entries should be concise and accurate

time	Events, decisions, actions	Action complete
	Incident description (brief): Location: Notified to: At: Control Room activated at: <insert text> Major Incident Called by … at … included …<specialists> Staff team • Site Director: …. <insert text> • Hospital Medical Coordinator…. <insert text> • Senior Manager…. <insert text> • Site & Capacity Coordinator…. <insert text>	

time	Events, decisions, actions	Action complete
	• Loggist/Admin support: …. <insert text> **Initial Priorities:** 1… <insert text> 2… <insert text> 3… <insert text> Other information: … <insert text><insert text><insert text>	
	Every 20 min. update: • New information: <insert text> • Current Priorities: <insert text> • Decisions Taken: <insert text> • Actions Taken: <insert text> • • Actions requested (to…, by …) <insert text>	
	Every 20 min. update:	
	Every 20 min. update:	

Form 5: Preparing for Strategic IMT Meetings

Please see the **Strategic Incident Management Plan** before holding a Strategic Incident Management Team meeting.

Format of Strategic Incident Management Team meeting

Strategic meetings should be concise and should focus on strategic level decision making based on the strategic aims; they should choose between options presented to them rather than developing the fine detail of responses.

Strategic IMT meetings should follow the agenda given below.

Staff attending should be prepared to provide:

- A very concise report of issues of strategic importance and
- Options available to address these.

Please fill in the reporting form (next page) and submit it in advance of the meeting

Form 6: Tactical Management Team Agenda

AGENDA

1. Introduction

- Purpose, approach & membership of team
- Coordination of response: leadership and reporting arrangements
- Urgent actions

2. Situation Update

- Actions from previous meeting
- Reports from external agencies, internal departments & specialists

3. Assessment and Significance

- Clarify cause, if possible
- Assess consequences: current impact assessment, consider
  - patients, staff & services,
  - infrastructure,
  - partner organisations,
  - legal & finance,
  - strategic aims and performance targets, reputation,
  - perception of (imagined) impacts
- Future impacts, wider impacts & risks
- Priorities identified
- Options available
- Resource requirements & Service Capacity

4. Actions

- Actions needed to address impacts & risks
- Resource allocation
- Communications – internal & external

5. AOB

- Time of next meeting

Notes for Chairperson

Introduction

- Set out the context, purpose and approach briefly.
- Urgent actions: deal with these first;
- Membership: have the right people at the meeting? Involve those who know about the problem, those who are affected by it, those with specialist knowledge/skills; ensure good administrative support for logging actions and decisions taking;
- Remind the meeting of confidentiality; declare any conflicts of interest;
- Set the right pace, as set by the incident (anything from 5 to 60 mins.). Tell people how much time they have and that you may need to stop them. Watch the clock.

Situation Update – "What?"

- The aim is to see the gain "situational awareness" – build a complete, up-to-date picture; what has changed? get different perspectives; do not make assumptions;
- Keep reports and updates concise, (1 min for most people, 2min for key areas);
- Hear all the reports before starting to discussion (stops time being spent on low priorities that may be voiced first). Ask: has anyone not shared important information?

Assessment and Significance – "So What?"

- Current impact assessment - Consider impacts on: patients, staff, services, infrastructure, legal & finance, partner organisations, strategic aims and performance targets, reputation, perception of (imagined) impacts;
- Ask: Is our approach working?
- If possible clarify cause - this is to help inform the response. Not about blaming
- Future impacts & risks: horizon scan - Consider: consequences elsewhere, wider context. Is a future impacts / recovery planning group needed?;
- Capacity & response requirements - Does the response match the problem (skill, service mix, capacity), how will the response be sustained? Will the problem grow?
- Priorities – agree and record what is most important, not what is just urgent.
- Options – identify available options and agree which is best; be pragmatic;

Action - Now What?

- Take the decisions that are needed, allocate actions – delegate where you can;
- Update the log – record key facts, decisions and your reasons;
- Address the impacts & risks identified – current/future, local/remote; direct/ indirect. Can you remove cause, reduce likelihood, reduce impact;
- Address current & future resource requirements;
- Escalate? – is the response being led at the right level? Is it time to return to normal;
- Communications – manage both internal & external, ensure a consistent message, be aware of other agency Comms plans; involve Communications Team.
- Other business: There should be none, check for anything unspoken that should be said.