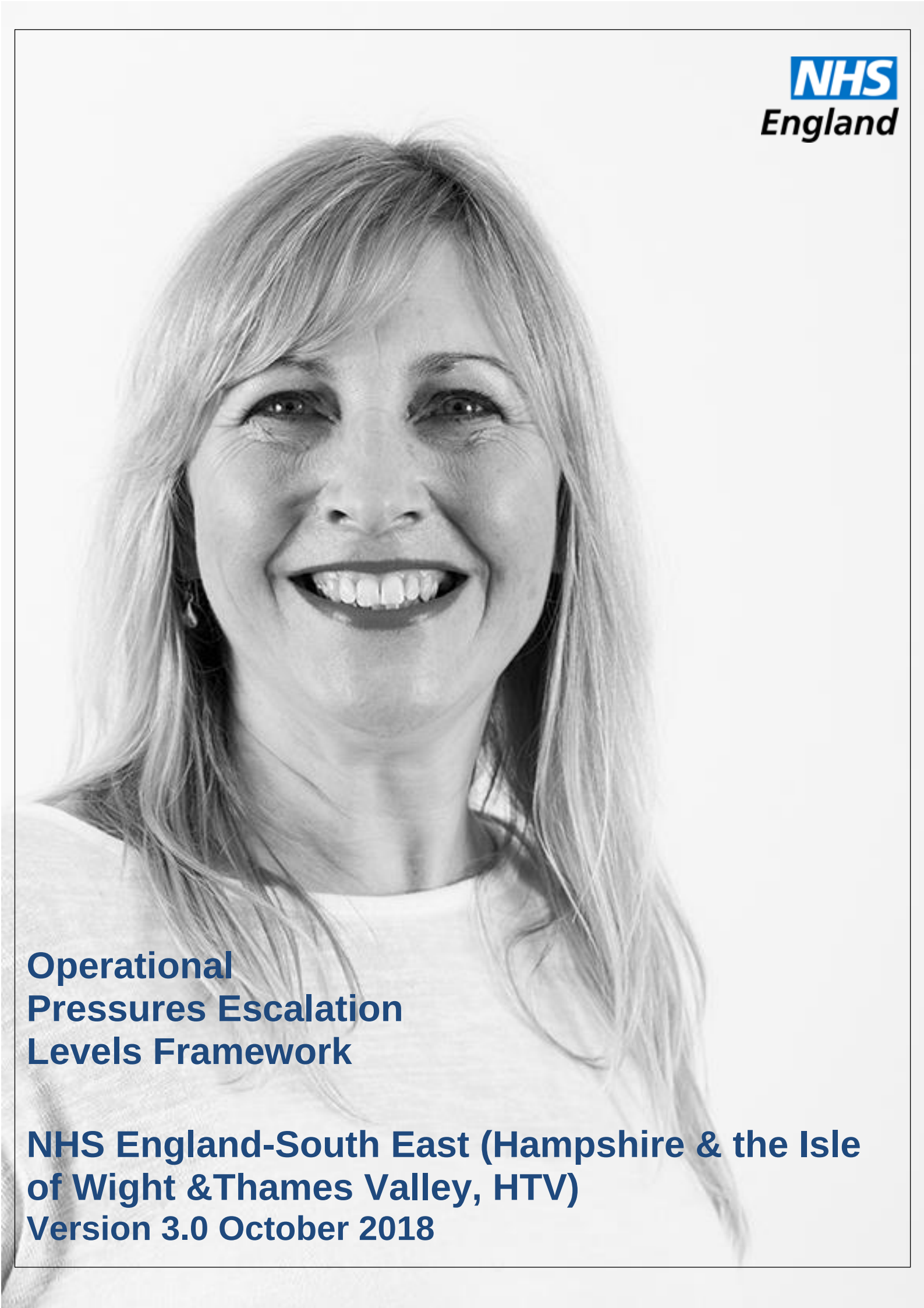

Operational Pressures Escalation Levels Framework

NHS England-South East (Hampshire & the Isle of Wight &Thames Valley, HTV)

Version 3.0 October 2018

NHS England-South East (HTV) Operational Pressures Escalation Levels (OPEL) Framework

Version 3.0 October 2018

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Classification: OFFICIAL

Contents

Amendments Section:

Section Number	Amendment	Date
	Terminology throughout	Oct 18
2	Updated name of SCAS Surge & Escalation Plan	
3.1	Raising of a Serious Incident following declaration of an internal critical incident	
3.1	Repatriation procedure following any divert Intelligent Conveyancing	
4	Inclusion of role of NHSI	
	Inclusion of declaration of an internal critical incident	
Appendix 2	National Triggers at OPEL Four updated	
Appendix 5	Role of HALO updated	
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1 Introduction

This NHS England-South East (HTV) Operational Pressures Escalation Levels (OPEL) Framework has been aligned to the national framework issued in October 2016. It sets out the procedures across the **Thames Valley only** at this stage, to manage day to day variations in demand across the health and social care system as well as the procedures for managing significant surges in demand. This framework has been updated for 2018 and now includes all lessons learned from last winter.

The aim of this OPEL Framework is to provide a consistent approach in times of pressure **7 days a week (24/7)** specifically by:

- Enabling local systems to maintain quality and patient safety;
- Providing a nationally and locally consistent set of escalation levels, triggers and protocols, for local A&E Delivery Boards (AEDB) to align their existing escalation processes to;
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level by all AEDB partners, by Directors of Commissioning Operations (DCO) and NHS Improvement local/regional team level; Influence short term, medium term and long term goals in conjunction with effective horizon scanning and pre-planning;
- Setting consistent terminology.

This framework is designed for managers and clinicians involved in managing capacity and patient throughput at a time of excess demand and/or other operational pressures, and is applicable all year round, and not just in response to winter pressures.
It is to be circulated to all staff who participates under such circumstances, to provide a practical working reference tool for all parties, thereby aiding co-ordination, communication and implementation of the appropriate actions in each organisation at each level.

It is imperative however that each system has their own plan in place to respond to escalation outlining a minimum set of expectations and actions which includes the localisations and initiatives that are in place for that system using existing cross organisational partnerships.

It should be read in conjunction with the NHS England South East (HTV) Onward Care Procedure Version 4.0 August 2018, the National Operational Escalation Levels Framework 2016, A&E Improvement Plans and local system Winter Plans.

It is recommended that this framework and action cards should be exercised along with local plans annually using a 'system reset' methodology referenced

locally as i.e. "Perfect Week" "Spring to Green" and "Breaking the Cycle" exercises. These exercises should also reflect lessons identified from previous events.

2 Principles and overview of the national framework

The National OPEL Framework has been designed to enable local A&E Delivery Boards to align their escalation protocols to a standardised process across local health systems.

The levels mirror the escalation frameworks already in use across systems around the country, and align with the national Resource Escalation Action Plan 2 (REAP) used by Ambulance trusts and the South Central Ambulance Service (SCAS) Surge & Escalation Plan 2018

Operational Pressures Escalation Levels	
OPEL One	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL Two	The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at local regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL Three	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL Two have not succeeded in returning the system to OPEL One. Further urgent actions are now required across the whole system by all A&E Delivery Board partners, and increased external support may be required. SE Regional Teams in NHS E and NHS I will be made aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/SE Regional Teams through internal reporting mechanisms.
OPEL Four	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. SE Regional Teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL Four for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Local A&E Delivery Board areas will operate Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named

accountable officer in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be executive level involvement across the A&E Delivery Board, as agreed locally.

3 Guidance for use of the NHS England-South East (HTV) Operational Pressures Escalation Levels Framework

Only when all escalation measures have been exhausted and the system is not recovering will organisations act from a position of last resort in response to the most unusual and exceptional pressures to access capacity beyond A&E Delivery Board boundaries. In such circumstances decisions must be made with the overall best interests of patients and service users as the top priority.

This framework should be utilised at all OPEL levels but especially where an A&E Delivery Board experiences pressure such that despite all escalation actions exhausted by the local system to reduce that pressure, an external whole system response for assistance is needed. This response must be clearly defined in local action cards / escalation plans and fully understood by all relevant Urgent Care Leads/Winter Leads Managers, Clinicians and Accountable Officers.

Each system must therefore define and agree local measures and triggers aligned to the indicators / actions, roles and responsibilities throughout the escalation process including those which trigger a request for external assistance.

The trigger for request for external support will be the declaration by the relevant A&E Delivery Board of whole system ‘OPEL 4’ status.

The implementation of external support must be agreed by all relevant parties, following which the A&E Delivery Board shall inform NHS England-South East HTV who in turn will liaise with NHS Improvement. This contact will be initiated and maintained by the executive director on call for the lead commissioners of the A&E Delivery Board.

3.1 Use of the Divert Protocol

Diverts **may** be agreed at OPEL 4 following use of the divert protocol (see Appendix 3 page 12). However if any diverts are agreed due to **the declaration of an internal critical incident** then the A&E Delivery Board which assistance was given to must:

- Raise a Serious Incident (SI) and undertake a full investigation; root-cause analysis including themes that are highlighted throughout the day and lessons learnt exercise in a timely manner
- Inform NHS England-South East and NHSI if any divert has been agreed and implemented.
- Equally if the CCG requires support in obtaining diverts this will be given by NHS England Director of Assurance and Delivery or nominated deputy or by the On Call Director out of hours.

Following any divert the diverting hospital must ensure all relevant patients are repatriated in a timely manner and in line with the NHS England South East (HTV) Onward Care Procedure 2018.
In the absence of a formal divert SCAS may have also implemented intelligent conveyancing across the systems and the border areas.

4 NHS England-South East HTV expectations of A&E Delivery Boards

Individual A&E Delivery Boards are expected to manage the escalation and de-escalation processes at local level and this framework does not seek to prescribe the detail of these processes and their management, however, for guidance a 'Terms of Reference' and 'System de-escalation Agenda' has been included for your assistance and for consideration of local adoption to help facilitate a coordinated whole system response – please see Appendix 7 and 8 for reference. System-wide teleconference calls can be a really useful way to co-ordinate a response to an escalating or de-escalating situation and can be managed at the discretion of individual organisations. The scheduling of these can be part of business as usual for system's resilience or when deemed necessary. It must be noted however that escalation to 'OPEL 4' status or the threat of such escalation at A&E Delivery Board or organisational level automatically triggers mandatory actions within this framework. Please refer to section 5 below.

The following points should be addressed as part of the process of planning for operational pressures escalation and are seen as a good practice checklist:

1. Each A&E Delivery Board partner organisation within a A&E Delivery Board geography must have a robust, up-to-date local Operational Pressure Escalation Level Plan signed off at Board level which aligns with the overarching A&E Delivery Board plan and focuses on early warning triggers and the prediction of potential issues/expected peaks in demand and be able to respond to unpredicted surges in activity and demand;

2. Each acute trust is also required to have a hospital and ambulance services handover plan and comply with its obligations under the plan

3. Operational pressures escalation planning must also form an integral part of winter planning or seasonal and geographical predicted demand and expected rise in activity, which will be specific to holidays or local events and be able to demonstrate at a system and local level both preparedness and resilience;

4. It is expected that all individual operational pressures escalation plans will have clearly defined escalation triggers, with corresponding actions to be taken to avoid the need for escalation and to enable de-escalation as quickly as possible. Example triggers (including to 'OPEL 4' status), actions and

further information for escalation in the OPEL 1-4 range are available in the OPEL Action Cards. It should be noted that these are neither exhaustive nor prescriptive and are for information only. **Please note that the decision to escalate to 'OPEL 4' status at organisational level or the threat of such decision automatically invokes mandatory action within this framework. Please refer to Section 5 below;**

5. Special measures and specific escalation action will be required where an Emergency Department (ED) is unable to take new attenders into a safe environment. Discussion with agreed actions **must be directed through NHS England-South East HTV and NHS Improvement (NHSI) in conjunction with the relevant CCG prior to any declaration of an Internal Critical Incident; An internal Critical Incident is any** localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions (see Appendix 9)

6. There must be clear identification of the system leaders and accountable officers (including identification of organisation, role/s and responsibilities) who will oversee all levels of escalation, especially those where whole A&E Delivery Board action is needed to avoid or mitigate pressure, and where external support might be required;

7. Where an organisation and / or an A&E Delivery Board have undergone escalation of status, it is expected that the executive directors of the lead commissioners shall lead the de-escalation process once review shows a managed and sustained reduced pressure.

Additional points for consideration:

- Timely and fit for purpose information is crucial to the management of the escalation and de-escalation process;
- Consideration must be given to the onward care of patients transferred or initially taken to a receiving organisation (please refer to the NHS England-South East Onward Care Procedure (HTV) 2018;
- An identified executive level director in each partner organisation will hold the responsibility for ensuring that escalation plans are actioned, reviewed and held to account on expected delivery and follow through;
- All escalation level plans relating to a given A&E Delivery Board should be readily available to all relevant managers and clinicians. All should have a clear and current understanding of the processes and their role and responsibility;
- The impact on ED facilities due to the knock on effect of a local systems must be considered;
- A stringent response to all ambulance handover delays is appropriate;

- Liaison with border areas is essential.

4.1 At system wide level

When it is determined at the daily teleconference by the leading CCG that the whole system is at ‘OPEL 4’, this will be escalated to NHS England-South East (HTV) on Call Manager for Thames Valley who will escalate to the relevant NHS England South East (HTV) Director on Call and NHS Improvement leads in and out of hours.

4.2 12 hour breaches

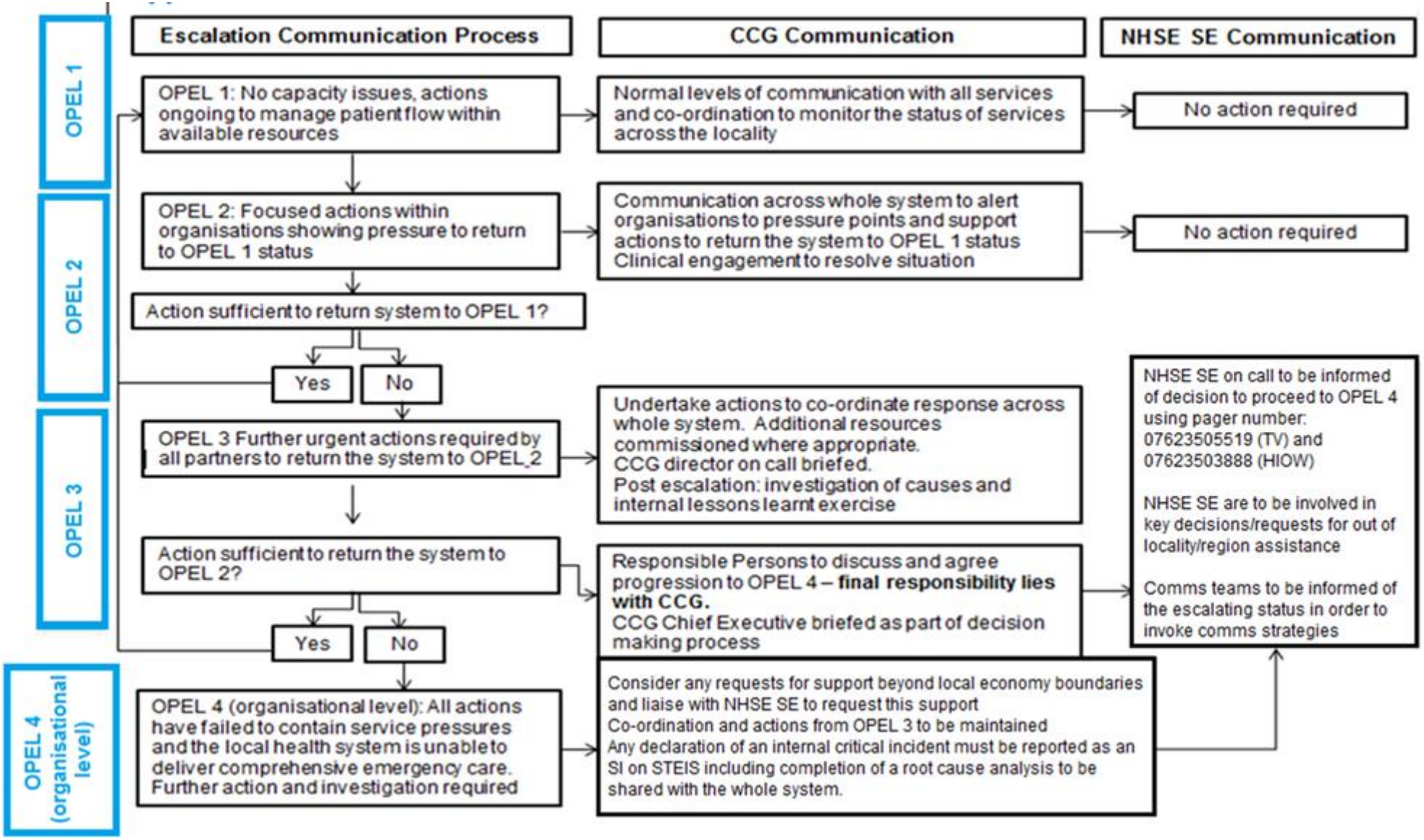
Any 12 hour breaches must be declared to the lead CCG who in turn will inform NHS England South East (HTV) and NHS Improvement.

5 Activation of the Local Resilience Fora

In extreme cases and when multiple systems are declaring OPEL 4 a response page may be activated on the national Information Sharing Platform Resilience Direct which will alert the Thames Valley and Hampshire & Isle of Wight Local Resilience Fora. These are made up of our **multi-agency** partner organisations
This will be done by the Emergency Preparedness, Resilience and Response Team in hours and the Emergency Response Management Team out of hours.

In the extraordinary event that provider organisations are also declaring internal critical incidents in addition to systems declaring OPEL 4 then a Strategic Coordinating Group may be convened by the Police in order to inform and keep updated all multi-agency partner organisations outside of health so that their awareness can contribute to reducing attendances at ED and signposting people to other health services.

Appendix 1 Escalation Communication Flow Chart



Appendix 2 National Escalation Status Triggers

Escalation level	Acute Trust (s)	Community Care	Social care	Primary Care Services	Other issues
OPEL One	• Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. No staffing issues identified • No technological difficulties impacting on patient care • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. Pressure on maintaining ED 4 hour target • Infection control issues monitored and deemed within normal parameters	• Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	• Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings	• Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand	•NHS 111 call volume within expected levels
OPEL Two	• Anticipated pressure in facilitating ambulance handovers within 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available but are sufficient to maintain services • Lack of beds across the Acute Trust • ED patients with DTAs and no action plan • Capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)	• Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services	• GP attendances higher than expected levels • OOH service demand is above expected levels • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services	• Rising NHS 111 call volume above normal levels • Surveillance information suggests an increase in demand • Weather warnings suggest a significant increase in demand
OPEL Three	• Actions at OPEL Two failed to deliver capacity • Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Trusts within 48 hour timeframe • Awaiting equipment causing delays for a number of other patients • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 2 hours	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Pressure on OOH/GP services resulting in pressure on acute sector • Significant, unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests an significant increase in demand • NHS111 and 999 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services • Infection control issues resulting in significant pressure on services
OPEL Four	**Chief Operating Officers should make decisions across the whole system covering all urgent care entry points;** • Actions at OPEL Three have failed to deliver capacity; • There is no capacity across all urgent care entry points; • There are severe handover delays; • The whole system is unable to manage effective flow/discharge capacity; • The acute trust is unable to manage DTOC and stranded patients effectively; • All emergency care pathways are significantly compromised; • Ambulances are unable to un load their patients; • The whole system is experiencing unexpected reduced staffing levels for example due to sickness, severe weather conditions in areas where this causes increased pressure on patient	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Acute Trust unable to admit GP referrals • Inability to see all OOH/GP urgent patients GP Streaming not alleviating ED pressures • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	

	flow is at a level that compromises service provision and patient safety; • There is severe capacity pressure on Critical Care, PICU, NICU and other intensive care and specialist beds (possibly including ECMO); • The whole system are experiencing infectious illness, Norovirus; severe weather and other pressures; • There are problems reported with support services (IT, transport, facilities, pathology etc.) that cannot be rectified within 4 hours; • Primary Care services to support the whole system are greatly reduced.				

Appendix 3 Intelligent Conveyancing

All accident and emergency departments experience peaks and troughs in pressure, often associated with the number of arrivals by ambulance. This can mean unnecessarily long waits for patients to be treated, with the possibility that they will breach the four hour target for treatment, admission or discharge, and increased pressure on staff. It can also mean hospitals face sudden demands for large numbers of beds for admitted patient

The public and healthcare personnel are already used to the idea that an ambulance may take patients to a more distant emergency department if it has better facilities for serious conditions, such as stroke or major trauma.

“Intelligent conveyancing” takes this one step further by avoiding departments that are known to be under pressure, with potential benefits for both the NHS and the patients.

Patients going to a specialist unit are excluded, along with patients receiving ongoing care from a particular hospital and those who might have an extended length of stay as a result of being taken to a distant hospital; for example, because their care package would be hard to restart.

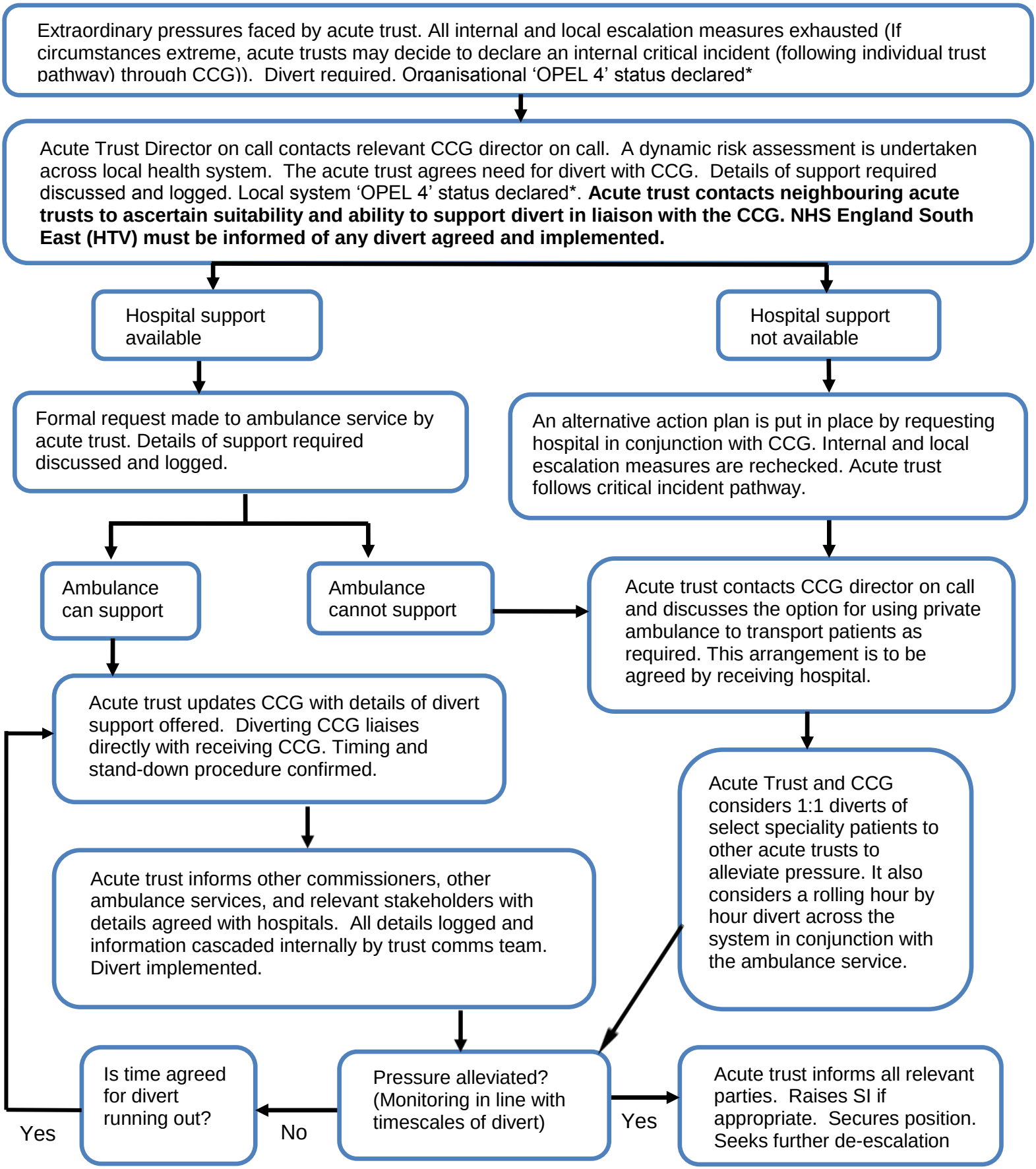
Intelligent conveyancing involves an agreed maximum number of ambulances per hour arriving at each emergency department with any beyond this diverted to other local emergency departments that have not met their maximum and therefore have “spare” capacity.

The principles of intelligent conveyancing could be coordinated with other parts of the urgent and emergency care system such as NHS 111. Using a similar approach with urgent care centres could smooth pressures and improve patient experience there.

This work will be led by South Central Ambulance Service and will commence this winter.

If a more formal divert is required then the following flow chart will be implemented.

Appendix 3a Implementation of a Divert



It would of course be expected that the whole health economy would work together in the usual way to avert escalation and facilitate e-escalation at all levels. This flowchart does not indicate that the acute trust should wait until it declare OPEL 4 before contacting

Appendix 4 Serious Incident Guidance

The Framework applies to serious incidents which occur in all services providing NHS funded care. This includes independent providers where NHS funded services are delivered.

The emphasis in the updated framework is one of open and honest discussion and 'if in doubt – report it'. Downgrading can be agreed at any time.

Definition of Serious Incident

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
- Unexpected or avoidable death of one or more people. This includes
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past;
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of the service user; or
  - serious harm;
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring10; or
  - where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see Appendix 2 for further information);
- Property damage;
- Security breach/concern;
- Incidents in population-wide healthcare activities like screening13 and immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)

Definition of Serious Harm

- Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care);

- Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or
- Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).

Responsibilities and Timescales

The first section (in bold) is the most likely to be needed by an on-call manager/director. Other timescales are included for further information if required

Event/Action	Timescale	Further Information/ Guidance	Responsibility
Serious Incident identified - Report to commissioner of service or lead commissioner (as agreed)	**As soon as possible and within 2 working days of the incident being identified.** **Or** **Immediate where:** - **The provider or commissioner Major Incident Policy is invoked** - **There is (or is likely to be) significant public concern and/or media interest** - **Incident will be of significance to the police.**	**Report via STEIS (or if no access to STEIS, via the serious incident reporting form agreed with the commissioner, sent via e-mail to agreed e-mail address)** **Where immediate notification is required, this must be also by telephone (including use of On-Call system Out of Hours)**	**Provider where incident occurred**
		If there is any doubt about whether an incident is serious or not, the principle is to report it as it can be downgraded later if necessary	
If provider has no STEIS access, input details of incident from report form from provider onto STEIS	On receipt of form.		Commissioner
Comply with any further reporting and liaison requirements with regulators and other agencies	Within 2 working days of the incident being identified.	See appendix 2 of the Framework.	Provider where incident occurred
Carry out an initial review of the incident and provide a copy of the report of this to the commissioner	Within 3 working days of the incident being identified.	This will inform the level of investigation required.	Provider where incident occurred

Serious Incident Framework, March 2015 can be obtained from the NHS England website: https://www.england.nhs.uk/ourwork/patientsafety/serious-incident/

Appendix 5 Supporting Information

Complete Closure
This is when an Emergency Department can no longer accept patients and is crowded to an extent where its occupancy levels have exceeded capacity and might be deemed as unsafe. This will happen in very extreme circumstances only, e.g. when an Internal Critical Incident is declared, and not normally for reasons of capacity shortfall or escalation.

Partial Closure
This is when an Emergency Department will accept only certain, clinically urgent patients, in life limiting or life threatening emergencies.

ECMO
In intensive care medicine, **extracorporeal membrane oxygenation** (commonly abbreviated **ECMO**) or **extracorporeal life support** (**ECLS**) is an extracorporeal technique of providing both cardiac and respiratory support to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function. Initial cannulation of a patient receiving ECMO is performed by a surgeon or anesthetist and maintenance of the patient is the responsibility of the perfusionist or ECMO specialist who gives 24/7 monitoring care for the duration of the ECMO treatment.

Emerging Emergency Issues and Horizon Scanning
In the event of an emerging issue from local/regional intelligence that **may impact on the system or may alert interest from the local media or then the normal command, control, coordination and communication arrangements should be initiated.** CCGs should be informed as well as NHS England-South Central for situational awareness and onward cascade if assistance is required. Both should consider who needs to be informed, who may be affected by the incident and who may be able to offer support and what actions need to be taken.

Escalation Level Triggers
All organisations have adopted the common triggers to ensure equity of pressure; capacity and access (see Appendix 2).

Hospital Ambulance Liaison Officer (HALO)
This is an operational management /supervisory presence for Emergency Department / Assessment Units during periods of high activity and demand. The Hospital Ambulance Liaison Officer (HALO) role is to; provide an ambulance interface with managers within the ED, monitor ED pressures and to facilitate the timely handover of patients, where possible assist in the monitoring and caring for queuing ambulance patients and dynamically manage the early turnaround of ambulances. HALOs are dispatched to ED at the discretion of the ambulance service not on request from the ED.

A&E Delivery Board
A health and social care whole system grouping (usually geographically defined). This is likely (but not exhaustively) to comprise a number of CCGs, acute trust(s), social care organisations, mental health trusts, ambulance service and OOH providers.

Where there is more than one CCG within an operational economy (e.g. one large acute Trust providing significant levels of service for a number of CCGs) there should be agreement of a lead CCG to co-ordinate communication and escalation within the system supported by other local CCGs. These responsibilities must be clearly identified within the local health economy plans. For local CCGs responsibilities regarding co-ordination and communication of escalation must be clearly defined and agreed.

Major Incident/Critical Incident
Any event which presents a serious threat to the health of the community, disruption to the service, or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by NHS England South East (HTV), NHS Trusts, Ambulance Services or CCGs. **Normal command, control, coordination and communication arrangements should be initiated.**
It is **not** normally expected that escalation would be the cause of a major incident as escalation is a result of general capacity and demand pressure rather than pressure caused by a specific event. However, there may well be actions that are common to escalation OPEL levels 3 and 4 and major incident plans and these should be considered within local economy escalation plans and action cards.

The latter however, should not be confused with general escalation due to wider resilience structures and processes in place. As such, local Acute Trusts may declare an **'Internal Critical Incident'** during times of great pressure or 'Business Continuity Incident' where they activate their Business Continuity arrangements but should **reserve the declaration of a major incident for when an organisation requires the formal multi-agency response as defined within Local Resilience Forum (LRF) plans. As an example this could be a fire, flood or an infectious disease outbreak.**
Please see appendix 9

Resourcing Escalatory Action Plan (REAP)
The REAP plan is a set of pre-agreed actions to manage escalating demand by increasing capacity. It is always in operation, normally at level one, but higher levels are triggered as demand increases.

Responsible Person / Accountable Officer
A senior employee authorised by the Chief Executive of an individual provider to implement agreed diversions and to notify relevant parties in accordance with this framework. The responsible person must have decision making ability and authority, and an organisation wide view. The responsible person may be specified as a post (e.g. Duty Emergency Department

Consultant, Duty Director, Operations Director) if desired. 24/7 arrangements must be in place for this person's role to be covered in person or by a deputy with clarity regarding communication. There must be a clear communication link between the responsible person and the Chief Executive.

Serious Incident Reporting: Refer to Appendix 4.

Appendix 6 Reverse Triage Algorithm Guide

Risk of Medical Event	Basis	Triage Category	Notes
1 - Minimum	No anticipated medical event during next 72 hours	Green	Deemed medically fit /stable
2 - Low	Calculated risk of non-fatal medical event. Consider early discharge	Green	Consider discharge home with assistance
3 - Moderate	Consequential medical event quite likely without critical intervention	Yellow	Discharge home not advisable
4 - High	Patient care cannot be interrupted without virtually assured morbidity or mortality	Red	Highly skilled care required
5 - Very High	Patient cannot be mover or readily transferred	Red	ITU care required

Appendix 7 System Resilience Calls Terms of Reference

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'*ORGANISATION ENTER HERE*' **(enter time) System Resilience Call** **Terms of Reference**	
Chairperson	***Enter respective chair of CCG/Urgent Care Lead as appropriate*** ***The chairperson is responsible for leading and facilitating an action focused discussion to coordinate and hold to account stakeholder and partner outcomes to enable de-escalation of the whole system.*** ***The chairperson will refer to both local/organisational and NHS England South East (HTV) OPEL Framework 2018 and supporting action cards using as a prompt to bring about the appropriate and desired actions in direct response to escalation, demand and activity and hold members to account on delivery, expected outcomes and follow through.***
Administration / Secretarial Support	If not available; Post call report, (***delete or amend*** including reporting tools i.e. use on Alamac /Shrewd) (Monday to Friday) report will be circulated to members by the nominated CCG lead chairing that day's call.
Accountable to	Each organisation on the call is accountable for taking forward agreed actions and working in line with the NHS England South East (HTV) OPEL Framework and their local surge/escalation protocols. On a daily (weekday) basis the Senior Manager within Urgent/Unplanned Care (or equivalent) chairing the call will ensure that the CCG Director on call is aware during the day of any system issues for escalation impacting on expected performance and delivery of standards; with a report at the end of the day (even when there is nil of note to describe). The conference call represents a virtual sub-group of the appropriate local operational group as determined in the local geography, as such the call will be a standing item on the ***(enter appropriate board/group)*** agenda; with the (**enter appropriate board/group)** in turn being accountable to the A+E Delivery Board.

Escalation Triggers	The agreed NHS England South East (HTV) OPEL Framework describes the required actions on each alert status. Should the System be on OPEL 3 ('Red alert'); then the CCG chair will escalate to the CCG Director on – call; a further call may be convened at (***enter and amend time)*** 1pm; or the chair may request for individual agencies to update the CCG on progress in relation to any agreed actions throughout the day as required. Individual members dialling into the System Call will have operational knowledge and be senior enough to positively influence de-escalation.
Escalation Triggers – cont'd	**The CCG on-call Director must be contacted in or out of hours should any part of the system find that they are continuing to escalate whilst already in OPEL 3.** ***It is a requirement to contact the CCG on-call Director should any part of the system need to declare OPEL 4.***
Purpose	The NHS England South East (HTV) OPEL Framework is the on-going means by which the system aims to collectively manage any sudden and unpredictable surges in activity impacting on the balance of demand over capacity in key services. A vital part of these arrangements is the (***amend as appropriate*** 9.30am) System Resilience Call (Monday to Friday, excluding Bank Holidays) – chaired by the CCG; which talks through any system pressures and the metrics adopted specific to your local system This is the means by which all providers and partners will be able to facilitate communication about operational system issues as they arise, supporting each other to ensure de-escalation is achieved as required. Actions to be taken locally to address, contain or accommodate demand with full details and responsibilities of providers will be shared during the call to ensure a consistent and appropriate response in the event of significant capacity pressures and demand. (***delete or amend subject to relevance*** The impact of the Alamac/Shrewd systems are measured through daily telephone conference calls, where the data, its impact and the performance support that this tool provides is assessed by the system.) The call also provides the valuable opportunity to monitor the actions of the system and to take action in advance of surge activity and to assess the performance of the system post a surge event.
	1. ***Enter acute provider details*** to inform the System Call chair if a 12hr

12hrs Breach process	breach has taken place or is likely during the next 24hrs. 2. Daily Calls Chair flags the possibility of a 12 hr breach to CCG Quality team and Head of Performance so that the CCG can prepare for necessary upwards reporting to NHS E. 3. Should the breach actually occur - Daily Calls chair requests immediate 12 hour trolley wait report from the Provider and shares with CCG Quality Team and Head of Performance. 4. Daily Calls Chair, if breach occurs, also requests/ensures SIRI 72 hr report is provided and shared with CCG Quality team and Head of Performance. 5. Normal SIRI process continues with CCG Quality monitoring 6. At 60 days SIRI report received by Quality and shared with Head of Performance and Urgent Care team. 7. ***CCG provide the same report for NHS England South East (HTV) and A+E Delivery Board Assurance***
Frequency of Conference Call	***Agreed locally*** Daily Monday – Friday (excluding weekends and Bank Holidays) at (***amend as appropriate*** 9.30am. Extra-ordinary calls at the weekend / Bank Holiday to be arranged by the on-call CCG Director as required or as directed by NHSE
Conference Call Telephone numbers	***Enter Telephone number*** <u>Access Codes:-</u> Chair – ***enter code*** Participant – **enter code**
Members key Responsibilities	**All members will have a positive 'can do' attitude ensuring that every opportunity to de-escalate is explored and acted on as appropriate; all members will be accountable for delivery of actions within their own areas of responsibility and be able to demonstrate and evidence progressing plans and mitigating actions and the necessary steps taken to de-escalate**
Reporting Arrangements	Each organisation will ensure that the required daily reports are entered into the local identified kitbag/toolkit by (***enter time)*** each morning; along with weekend activity as appropriate.

	This data is then summarised and reported regularly to the ***(enter details of approved board/group i.e. A&EDB)*** All members are responsible for providing responses and feedback *to* ***(enter details of approved board/group)***
Membership – usual contact details **Usual Representatives attending system call**	**CCG Urgent Care Chair (rota basis):** ***Enter Accountable officer name***, COO/Senior Executive Lead or Commissioning Manager, ***enter*** CCG, **Mobile: *enter details here*** ***Enter Accountable officer name***, Commissioning Manager, ***enter*** CCG, **Tel: *details here*** , **Mobile: *details here*** **<u>Usual Representatives attending system call:-</u>** ***<u>(all Health and Social Care Partners to be named below)</u>*** **Acute Providers** **Ambulance/PTS providers/NHS 111** **Community/Mental Health Providers** **CHC** **Social Care Providers** **County Council** **Local Authority** **GPs/OOH Services** **Other partners and stakeholders (NHSI)** **Comms**
Attendance / Quorum	The (***amend as appropriate*** 9.30am) System Resilience conference call will require sufficient and regular representation from across the health and social care system to ensure effective decision making and delivery of the agreed daily de-escalation plan. Quorum will include a minimum of one representative from: ***enter each health and social care partner as a minimum*** i.e. Acute, CCG, Social Care, Community, Council, Local Authority
Review of terms of reference	The membership and terms of reference shall be reviewed annually. Any proposals to change the terms of reference or membership must be approved by ***(approved body – enter details here)***

Date Ratified	Agreed by the ***(approved body – enter details here)*** Date approved ***(enter date)***
Review date	***(enter date)***

Appendix 8 System Management & De-Escalation Call Agenda

DATE / time of call		**Urgent Care System**	
Telephone No		**Weekday/Weekend/BHol**	
PIN		**Call Type**	System OPEL 1,2,3 or 4

PARTICIPANTS ON CALL

Organisation						**Names**
Chair						
Call Support						
OUH		OPEL Level		Cumulative days at this level		
RBH		OPEL Level		Cumulative days at this level		
BHT		OPEL Level		Cumulative days at this level		
HWP		OPEL Level		Cumulative days at this level		
MKUH		OPEL Level		Cumulative days at this level		
Other providers		OPEL Level		Cumulative days at this level		
Ambulance Service/NHS 111						
PTS						
Oxfordshire CCG						
Berks West CCG						
Bucks CCG						
East Berks CCG						
MK CCG						
Social Care						
Community Provider						
Mental Health Provider						
Comms						

ISSUES / PRESSURE LEADING TO ESCALATION

Exceptional issues arising from weekend or overnight	*i.e. surges in activity, increase in ED presentations, repatriation, workforce, DTOC*
What are the key issues affecting flow today	
Where is the biggest risk in the system a) How will this be mitigated b) By who c) By when	
What are the known blocks or barriers in the system and what support is needed	
Are there any major patient safety issues	
Are there any major workforce issues	
What benefit/ outcome do we need to achieve de-escalation	
Have all organisations confirmed that they have implemented all relevant actions from their own internal escalation plans	*What measures are in place* *What has already been exhausted other than business as usual*
Has any provider declared or is about to declare an internal critical	

Organisation Owner	Action	Date	Accountable	Delivery Deadline	Predicted Impact
Acute Trust Provider					
CCG					
Social Care					

Ambulance Service					
Other Provider					
What else is the CCG doing to manage and support the system					
Decision for further escalation / GOLD call	YES / NO	**Date**	**Lead**	**Time agreed**	**Directors on call**
Expected Impact on performance and activity					
Timeframes for de-escalation					
NHS England / NHS Improvement comments	*What support measures can be considered for extra resilience and / or to accommodate de-escalation*				
Comms/media issues					

Any other Business	*Weekend Planning* *Emergency preparedness* *Local events* *Weather warnings* *Security Alerts* *Bank Holiday / Easter Plans*
CHAIR **FINAL SUMMARY**	*Chair to make clear to all participants, task holders, accountable officers the minimum expectations and summary of actions agreed to de-escalate and by when*

OPEL LEVEL	**Acute**	**Whole System**
Declaration of position following call		

Appendix 9 Declaration of an Internal Critical Incident

Purpose:	To provide an operational checklist for the: **<u>Declaration of an Internal Critical Incident in a provider organisation</u>**
Definition	A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions. **(NHS England EPRR Framework 2015)**
Key Information	A provider may declare an internal "Critical Incident" during times of extreme pressure and when they are: ➢ At organisational OPEL 4 or REAP 4; ➢ Unable to deliver critical services; ➢ Experiencing incidents where patients safety and well-being are at risk; ➢ In need of support from other health and multi-agency partners to restore normal operating functions;
Notification	Agreement to declare an internal critical incident must be made at Executive Director level in conjunction with the Medical Director (or equivalent). Notification must then be made to the CCG Executive Director followed by NHS England/Improvement or equivalent Directors on call when out of hours and when: ➢ All internal actions have been exhausted by the trust; ➢ System wide support actions have been implemented; ➢ Mutual aid has not relieved the issue; **Then a formal declaration should be made to both NHS England/NHS Improvement**
ED Closure	**<u>Declaration of an Internal Critical Incident Requiring ED Closure</u>** Occasionally the declaration of an internal critical incident may require the closure of the ED (fire/flooding etc.); Agreement to implement this must be made at Executive Director level in conjunction with the Medical Director (or equivalent). Notification must then be made to the CCG Executive Director followed by NHS England/Improvement or equivalent Directors on call when out of hours and when: ➢ A formal dynamic risk assessment indicates that this is the only option viable at that time; ➢ Closure is the safest and most appropriate action to be taken; ➢ A formal plan has been established to address the issue and return the ED to normal functions as soon as possible; ➢ All health and multi-agency partners have been informed.

	Other actions include: ➢ Agree with NHSE to lead the response in close conjunction with the CCG and Acute Trust; ➢ Request that NHSE assist with re directing/diverting of ambulances to other local EDs within an agreed time frame and incident dependant; ➢ Adhere to all the other actions listed below.
Actions	**<u>Providers must also:</u>** ➢ Complete an SBAR report as soon as possible and then in line with the agreed battle rhythm; ➢ Forward to NHS England and the CCGs via the generic ICC email accounts; ➢ Consider invocation of Business Continuity plans; ➢ Ensure quality of care for all patients is maintained at all times; ➢ Ensure the well-being of staff is being considered and reviewed periodically; ➢ Activate all relevant internal plans and action cards; ➢ Ensure command, control, co-ordination and communication are intrinsically managed; ➢ Ensure actions at OPEL 2, 3 and 4/REAP levels are revisited; ➢ Agree a battle rhythm with the NHSE/CCG to manage the incident ➢ Activate agreed reporting arrangements; ➢ Take part in any health system teleconferences; ➢ De-escalate when appropriate; ➢ Inform all relevant system wide partners of escalation and de-escalation; ➢ Hot debrief the incident followed by a formal debrief; ➢ Produce an incident report with a supporting action plan. **<u>CCGs must also:</u>** Ensure that NHSE is informed of any updates/issues via the ICC generic account or first on call out of hours.

SBAR Report form:

Date:	dd/mm/yyyy	**Time:**	hh:mm
Completed by:		**Title:**	
Telephone number:		**Email address:**	
Approved for release by:		**Title:**	

CRITICAL INCIDENT – SBAR REPORT		
SBAR is a structured method for communicating critical information requiring immediate attention and action contributing to effective escalation and increased patient safety. Please note: A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions. *(NHS England EPRR Framework 2015)*		
Incident Declared by: Name of Trust / CCG / NHS England		
1. **S**	**Situation** *Describe situation/incident that has occurred.*	
2. **B**	**Background** *Explain history and impact of incident on services / patient safety.*	
3. **A**	**Assessment** *Confirm your understanding of the issues involved.*	
4. R	**Recommendation** *Explain what you need, clarify expectations and what you would like to happen.*	
Send to: *NOTE - If reporting an incident prior to formal request for an SBAR, then return to NHS England (insert local office) via normal incident reporting procedures.*		**NHS England – South East (HTV)** **Incident Manager** (name)**:** **Email:** **@nhs.net** **Contact Telephone No.**