Action Card: OPEL 3

All actions at OPEL 2 must be completed to mitigate pressure prior to (and with the intention of avoiding) further escalation to OPEL 3:	
COMMISSIONERS	
C5	CCG to continue to chair daily teleconference calls. Ensure all actions listed in OPEL 2 have been completed
C6	Utilise actions from organisational business continuity plans to ensure continuity of service across the system
C7	Notify CCG On-call Director to ensure appropriate operational actions are taken to relieve the pressure as appropriate
C8	Escalation information to be cascaded to all community care providers,, nursing homes and residential care homes with the intention of alerting
C9	Cascade current system-wide status to GPs and OOH providers and advise to recommend alternative care pathways.
C10	Notify local Directory of Services (DoS) Lead and ensure NHS111 Provider is informed. Review NHS 111 advice strategy with local DoS lead and update Interactive Voice Response (IVR) to warn/inform/signpost patients away from ED as appropriate. Agree options with NHS 111 provider how DoS can be flexed to reduce impact
C11	Consider Continuing Healthcare funding to be agreed outside panel
C12	Ensure that liaison between and within PTS services is robust and functioning well, especially where provided other than by the Ambulance Service
C13	Utilise all other available assets e.g. Fire Service
C14	Ensure all OPEL 3 actions are allocated, monitored and completed in a timely manner
ACUTE TRUST	
AC16	ED consultant to be present in ED 24/7, where possible
AC17	Contact on-take and ED on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly
AC18	Senior Physician to be present in ED 24/7 to monitor all admissions and expedite discharges, where possible
AC19	Reschedule appropriate elective admissions. The Acute Trust must remain mindful of the need to maintain planned care targets and take on-going action as necessary to ensure that there is no slippage against these wherever possible
AC20	Enact process of cancelling day cases and staffing day beds overnight if appropriate
AC21	Place NHS patients on private patient ward(s) if there are empty nursed beds as appropriate
AC22	Ensure reverse triage has been implemented to support rapid discharge of all patients in the green category

AC23	Open additional beds on specific wards, where staffing allows and it is safe to do so
AC24	ED to open an overflow area for emergency referrals, where staffing allows
AC25	Review and reschedule plans for scheduled maintenance where work is likely to impact on capacity or patient flow
AC26	Consider extra staffing in ED (GP, Emergency Care Practitioner / Advanced Nurse Practitioner, Specialist Nurses and other hospital staff, such as ITU or CCU staff, paediatrics staff)
AC27	Liaise with Ambulance Service to ensure risk assessment and agreed clinical plan for any patients awaiting handover
AC28	Bring in extra staff to radiology, pathology, pharmacy, occupational therapy etc. If appropriate deploy staff from other areas of service to relieve key pressure points
AC29	Assign clinical staff to care for any ambulance patients waiting for space (in ED, Assessment Units and other admission areas etc.)
AC30	Senior clinicians to actively scrutinise all GP requests for admission
AC31	Alert Social Care in conjunction with the CCG to expedite care packages
AC32	Notify CCG On-call Director so that appropriate operational actions as above can be taken to relieve the pressure when appropriate
AC33	Liaise with voluntary and independent sector for the availability and use of private beds and other services/assets
AC34	With ward sisters, nurse in charge & therapies; consider the risk of discharging patients who are medically fit, but not ready for discharge for other reasons, subject to appropriate support at home in place.
AC35	Ensure senior decision making and Registrar/Consultant availability in A&E, AMU and SAU
COMMUNITY CARE PROVIDERS	
CC7	All community care teams to review all patients awaiting assessments (with single point of access) in order to expedite discharge or transfer – this to include In-reach teams and community hospitals
CC8	Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible
CC9	Community providers to expand capacity wherever possible through additional staffing and services, including primary care
CC10	Community providers to consider the use of wider group of agencies (e.g. higher cost agencies) to increase staffing capacity
CC11	Patients waiting at home for admission to be referred to Community Teams (by In-reach nurses) and/or single point of access and Emergency Medical Unit (EMU)
SOCIAL CARE	
SC5	Social Care On-call managers to have oversight and support staff to expedite care packages e.g. make immediate funding decisions. Social Care to review all re-ablement packages and re-ablement placements to improve flow

SC6	Social Care to review all assessments in pipeline to expedite discharges in line with Onward Care Procedure
SC7	Increase domiciliary support to service users at home and residential and care homes in order to prevent admission
SC8	Ensure close communication with Acute Trust, including on site presence where possible
SC9	Actively support all Onward Care referrals
PRIMARY CARE	
PC4	OOH services to identify and implement alternative care pathways to avoid attendance at ED. This will include the ambulance admission avoidance line, better use of the A&E voucher scheme
PC5	In hours GP services to identify and implement alternative care pathways to avoid attendance at ED
PC6	Review staffing level of GP OOH service. This will include calling on the Care UK wider network to move resource around if applicable
MENTAL HEALTH	
MH5	To review all discharges currently referred and assist with whole system's agreed actions to accelerate discharges from acute and non-acute facilities wherever possible
MH6	Increase support to service users at home in order to prevent admissions
MH7	Are home treatment/crisis interventions being delivered appropriately to support people at home and avoid a/e attendance
MH8	Escalation to relevant on call manager
MH9	Liaison with Social Care if delays relate to arranging MH Act Assessment
MH10	Liaison/joint working with Social Care and Housing to identify appropriate accommodation/care packages
AMBULANCE TRUST	
A2	Review and reallocate resources to meet current emergency workload
A3	Ensure effective use of managers/officers and staff and community responders is maximised in response to pressures being faced within the system
A4	Ensure (in conjunction with other PTS providers if commissioned) current PTS capacity is prioritised for patient discharge and transfer
A5	Maintain communication with GP and OOH services to review potential delays to patient transport to ED and consider alternative transport arrangements
A6	Ensure all duty officers and directors are aware of current status levels and attend daily teleconference calls
A7	Liaise with acute trust to risk assess and utilise a hospital queue nurse to support any patients delayed in being handed over to ED staff

A8	Target Specialist Practitioners and primary care to use alternative care pathways whenever possible to avoid ED attendances and retain patients within the community. Raise with Commissioners/Duty Directors to cascade amongst providers
A9	Utilise actions from REAP plan to create capacity where possible
A10	Ambulance Trust to liaise with Acute Trust to ensure that ambulance handover is maintained with minimal impact on Ambulance Trust delivery
A11	If handover delays are continuing, with increasing resource impact, consideration for deployment of appropriate HALO to Acute Trust must be made. Role of the HALO is to liaise with ED to ensure priority is maintained in turning ambulance resources around to be able to provide service to community. The HALO is not to manage patients in queue, but to support relationship with Acute Trust and liaise with senior Managers/Officers within Ambulance Trust
A12	Consideration for any level of Immediate Handover Procedure utilised by Ambulance Trust to be reviewed and considered if ability to deliver ambulance provision to community is deemed to be increasingly compromised
PTS SERVICE PROVIDERS	
PT2	Ensure that capacity is fully utilised for patient discharge and transfer, and that liaison between different PTS providers and the Ambulance Trust is functioning well
111 Provider	
111 1	Ensure that Call Centre staff are aware of and act on information about organisational capacity and changes to service provision
111 2	Agree NHS 111 advice strategy with local Directory of Services (DoS) lead and update Interactive Voice Response (IVR) to warn/inform/signpost patients away from ED