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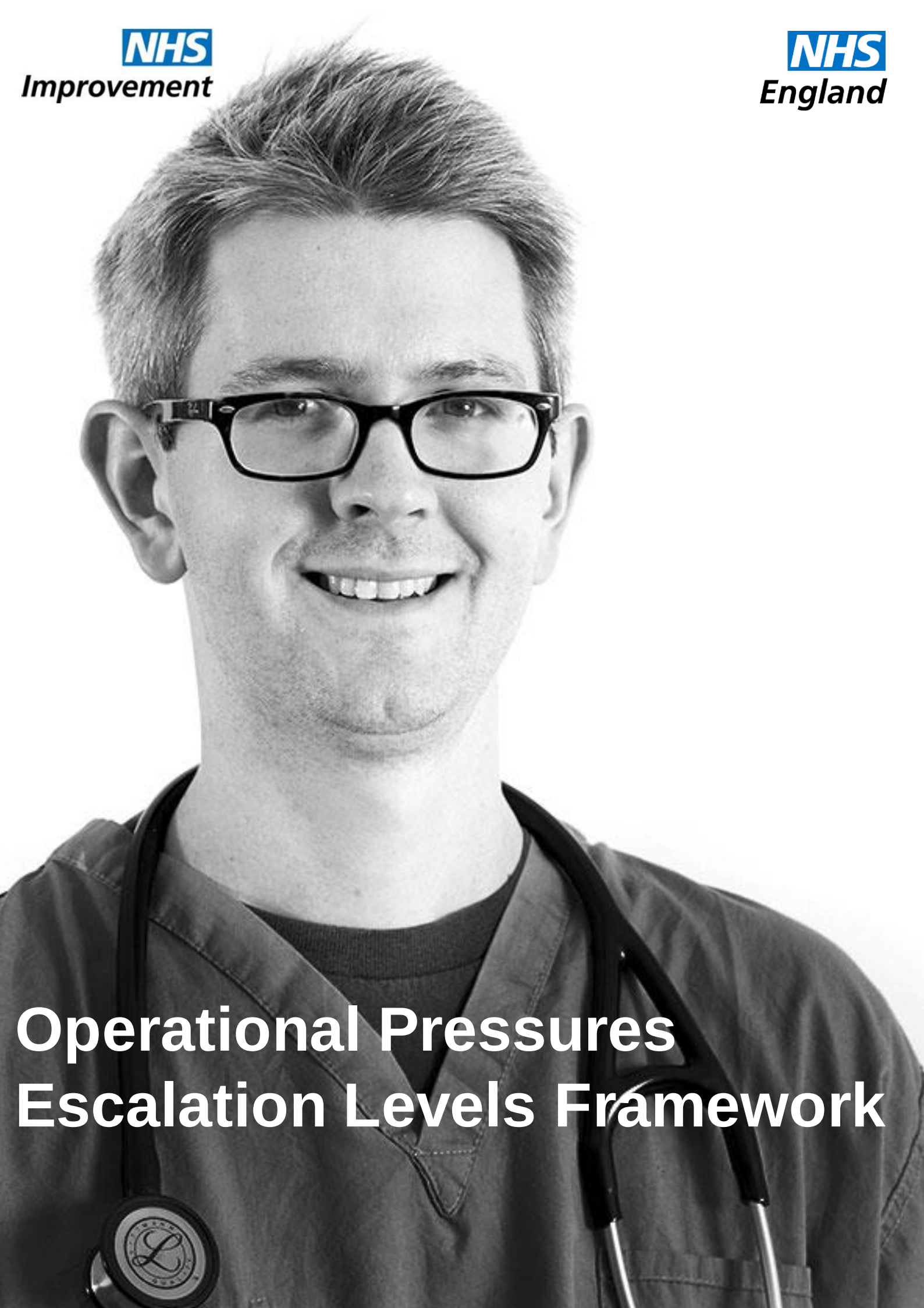

Operational Pressures Escalation Levels Framework

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Operational Pressures Escalation Levels Framework

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Glossary

OPEL	Operational Pressures Escalation Level
EPRR	Emergency Preparedness, Resilience and Response
REAP	Resource Escalation Action Plan, used by ambulance services
ALBs	Arms-Length Bodies (NHS England, NHS Improvement etc)
PICU Beds	Paediatric Intensive Care Unit Beds
NICU Beds	Neo-natal Intensive Care Unit Beds
ECMO Beds	Beds specifically for Extracorporeal Membrane Oxygenation - equipment similar to that used in heart-lung bypass operations – used in treatment of acute respiratory failure
DCO team	The teams that work for NHS England Directors of Commissioning Operations, which operate on a sub-regional footprint
ED	Emergency Department
DTA	Decision to admit
OOHs	Out of Hours services
DoS	Directory of Services
CCG	Clinical Commissioning Group
A&E	Accident & Emergency
CSU	Commissioning Support Unit
GP	General Practice

1 Introduction

1.1.1 Context

Operational escalation systems and protocols vary considerably from one local health economy to another. Whilst flexibility at local level is necessary, the absence of an overarching framework means variation between different systems creates inefficiencies and is unhelpful in several ways including:

i. Preventing effective cross-system working if terminology and protocols aren't aligned
ii. Making regional and national monitoring of operational pressures and winter surge difficult
iii. Creating confusion with the EPRR escalation framework
iv. Slower wider system response leading to spikes in waiting times.

A single national system will bring consistency to local approaches, improve management of system-wide escalation, encourage wider cooperation, and make regional and national oversight more effective and less burdensome.

1.1.2 Scope of this policy

The Operational Pressures Escalation Framework shares common actions with the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework[1], however they are not interchangeable. **EPRR escalation should therefore be considered separate to this framework.**

This framework has been developed for operational pressures and is applicable all year round, not just in response to winter pressures.

1.1.3 Aims and Objectives

The aims of this policy framework are to provide a consistent approach in times of pressure, specifically by:

i. Enabling local systems to maintain quality and patient safety
ii. Providing a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards to align with their existing escalation processes
iii. Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level (providers, commissioners and local authorities), by Directors of Commissioning Operations (DCO) and NHS Improvement sub-regional team level, regional level and national level
iv. Setting consistent terminology

[1] https://www.england.nhs.uk/ourwork/eprr/gf/

2 Benefits of a national framework

2.1 Benefits at local level

This framework does not seek to remove or override local management of operational pressures and escalation. Escalation planning at the local level should not take place in isolation, and a national framework will support and improve local and regional level planning by:

- Drawing on (and sharing) best practice in use across the country
- Providing a series of standardised triggers, actions and language which could enable a better understanding of:
    - Roles and responsibilities within an A&E Delivery Board footprint
    - Pressures being encountered in neighbouring A&E Delivery Board footprints
- Reducing the frequency and burden of reporting detailed information during periods of heightened pressure

Another benefit of a national framework to local systems is that it promotes transparent and fair responses from local providers, and a mechanism for local A&E Delivery Board leadership to challenge. For example, if provider A decides unilaterally to 'divert' and provider B (who is also encountering similar pressures) is cancelling elective activity to respond internally to manage their pressures, then this is unfair and the local A&E Delivery Board needs to use the escalation policy to moderate and ensure that all local system partners are operating consistently.

2.2 Benefits at regional and national level

Regional teams across NHS England and NHS Improvement have a crucial role to play in monitoring and managing escalation in response to surge pressures, particularly during winter.

Standardising the approach to escalation planning will enable regions to:

- Compare levels of pressure in different A&E Delivery Board footprints against the same criteria
- Facilitate better dialogue between different A&E Delivery Boards, especially in relation to any potential mutual aid and cross-regional boundary working
- Present a more coherent picture of operational pressures when aggregating up to a national level

2.3 Improved communications planning and handling

There are instances when operational pressures need to be communicated to the public to help reassure and manage demand. It is crucial that nationally consistent protocols and terminology be followed to ensure messages to the public are consistent and widely understood, with all local partners involved in the decision making process.

More detail on this is given in section 5.

3 Principles

3.1 Overview of the national framework

To enable local A&E Delivery Boards to align their escalation protocols to a standardised process, the national framework has been built on work already done across the four regions.

The levels mirror systems already in use around the country, and aligns with the national Resource Escalation Action Plan[2] (REAP) used by Ambulance trusts.

Operational Pressures Escalation Levels	
OPEL 1	**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 2	**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 sub-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 3	**The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms**
OPEL 4	**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. 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 4 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 individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

[2] http://naru.org.uk/documents/resource-escalation-action-plan-reap/

4 The national escalation framework

Good surge management happens when health and social care partners come together to resolve pressure system-wide. Health and social care organisations have been working more closely in recent years to solve short term surge in parts of their system for the benefit of their whole population. This system partnership should continue.

A&E Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An A&E department could be experiencing isolated difficulties but the rest of the system is coping well; there are sufficient beds available and there is good flow through the system. Alternatively, an A&E could be managing well whilst the rest of the hospital, and the wider system; community beds, community services and social care are experiencing high pressures due to a lack of capacity.

4.1 Escalation triggers at each level

- Local A&E Delivery Boards should align their existing systems to the escalation triggers and terminology used below, and add to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.**
- Local A&E Delivery Boards should be able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.
- **National terminology (OPEL) should be adopted by all systems.**
- **Local specific triggers and actions should then be shared and agreed with DCO/sub-regional teams during assurance.**

Escalation level	Acute Trust (s)	Community Care	Social care	Primary care	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 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 2 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 Hospitals 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 can't 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 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	• Actions at OPEL 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • 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 • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Infectious illness, Norovirus, Severe weather, and other pressures in Acute Trusts (including A&E handover breaches) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 4 hours	• 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 • 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	

4.2 Mitigating actions at each level

The following list of actions for each level of escalation are not exhaustive, and should be added to at the local level as needed. When a decision is taken to move to a higher level of escalation, the following actions (and any additional locally determined actions), should be implemented or considered.

Escalation level	Whole system	Acute trust	Commissioner	Community Care	Social care	Primary care	Mental Health
OPEL One	• Named individuals across Local A&E Delivery Board to maintain whole system coordination with actions determined locally in response to operational pressures, which should be in line with business as usual expectations at this level • Maintain whole system staffing capacity assessment • Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases • Active monitoring of infection control issues • Maintain timely updating of local information systems • Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken • Proactive public communication strategy eg. Stay Well messages, Cold Weather alerts • Maintain routine active monitoring of external risk factors including Flu, Weather.						
OPEL Two	•All actions above done or considered •Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate	•Undertake additional ward rounds to maximise rapid discharge of patients • Clinicians to prioritise discharges and accept outliers from any ward as appropriate •Implement measures in line with Trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place • Notify CCG on-call Director to ensure that appropriate operational actions are taken to • Maximise use of nurse led wards and nurse led discharges • Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	• Expedite additional available capacity in primary care, out of hours, independent sector and community capacity • Co-ordinate the redirection of patients towards alternative care pathways as appropriate •Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers)	• Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. • Maximise use of re-ablement/intermediate care beds •Task community hospitals to bring forward discharges to allow transfers in as appropriate. • Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals.	• Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements • Ensure all patients waiting within another service are provided with appropriate service • Where possible, increase support and/or communication to patients at home to prevent admission. Maximise use of re-ablement/intermediate care beds	• Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community • In reach activity to ED departments to be maximised • Alert GPs to escalation and consider alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service • Where possible, increase support and/or communication to patients at home to prevent admission

OPEL Three	•All actions above done or considered •Utilise all actions from local escalation plans • CEOs / Lead Directors have been involved in discussion and agree with escalation to OPEL 4 if needed	• ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff • Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Enact process of cancelling day cases and staffing day beds overnight if appropriate. • Open additional beds on specific wards, where staffing allows. • ED to open an overflow area for emergency referrals, where staffing allows. • Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	• Local regional office notified of alert status and involved in discussions • CCG to co-ordinate communication and co-ordinate escalation response across the whole system including chairing the daily teleconferences • Notify CCG on-call Director who ensures appropriate operational actions are taken to relieve the pressure • Notify local DoS Lead and ensure NHS111 Provider is informed. • Cascade current system-wide status to GPs and OOH providers and advise to recommend alternative care pathways.	• Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible • Community providers to expand capacity wherever possible through additional staffing and services, including primary care	• Social Services on-call managers to expedite care packages • Increase domiciliary support to service users at home in order to prevent admission. •Ensure close communication with Acute Trust, including on site presence where possible	• OOH services to recommend alternative care pathways • Engage GP services and inform them of rising operational pressures and to plan for recommending alternative care pathways where feasible • Review staffing level of GP OOH service	• To review all discharges currently referred and assist with whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission

OPEL Four	• All actions above done or considered •Contribute to system-wide communications to update regularly on status of organisations (as per local communications plans) • Provide mutual aid of staff and services across the local health economy • Stand-down of level 4 once review suggests pressure is alleviating • **Post escalation:** Contribute to the Root Cause Analysis and lessons learned process	• All actions from previous levels stood up • ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff •Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical senior clinical decision makers to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7, where possible • **An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG and neighbouring trusts to agree a divert.**	• Local regional office notified of alert status and involved in decisions around support from beyond local boundaries • The CCGs will act as the hub of communication for all parties involved • **Post escalation:** Complete Root Cause Analysis and lessons learned process	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible capacity has been freed and redeployed to ease systems pressures	• Senior Management team involved in decision making regarding use of additional resources from out of county if necessary • Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including supporting ED re prevention of admission & turn around. Identification via board rounds and links with discharge team & therapists. • Hospital Service Manager/Deputy Director to monitor escalation status, taking part in teleconferences as required.	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible actions are being taken on-going to alleviate system pressures	• Ensure all actions from previous stages enacted and all other options explored and utilised • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible

4.3 Reporting arrangements

All year round, reporting should be on an exception basis only, with reporting processes agreed between local systems and the relevant NHS England DCO team and NHS Improvement sub-regional team. For the winter period (commencing 01 December and ending, at the earliest, on 28 February), there will be daily escalation status reporting processes in place (by exception).

A&E Delivery Boards should notify NHS England DCO/NHS Improvement sub-regional teams if escalation status is raised to OPEL 2 (if agreed locally), and should provide a full report if escalation is raised to OPEL 3 (details of specific reporting requirements to be agreed locally), with daily updates on the situation until escalation has been stood down.

If an A&E Delivery Board escalates to OPEL 4, updates to DCO/NHS Improvement sub-regional teams should be agreed as frequently as necessary between the board and the DCO/sub-regional teams, this is to ensure all support and interventions are available to facilitate standing down escalation as soon as it is appropriate to do so.

Escalation status should be discussed in conjunction with relevant information from the NHS Improvement dashboard which will contain daily activity data. For OPEL 3 and OPEL 4, there will be a yes/no reporting field in the daily sitrep collection, for trusts to signal if their system has been in that level of escalation in the past 24 hours.

4.4 Roles and responsibilities

4.4.1 Local, regional and national level

Organisation	Role/ Responsibility
Local A&E Delivery Board	• All providers should: ○ Maintain timely updating of local information systems that monitor pressures in their patch ○ Ensure all trust level pressures are communicated regularly to all local partner organisations, and communicate all trust level escalation actions taken (e.g. opening escalation beds) • Acute providers should: ○ Investigate at a senior (executive or nominated deputy) level the reasons for diverts (last resorts) and identify and apply the lessons to prevent reoccurrence. ○ Liaise with local ambulance services over pressure levels affecting EDs and address issues including increased ambulance handover times etc.
	• CCGs should: ○ Keep in touch with the day to day situation across the patch and be aware of any developing issues. This includes information on community services, mental health etc. ○ Maintain oversight of the A&E Delivery Board area (including social care system) and monitor receipt of hot weather / cold weather / flooding alerts and ensure appropriate actions are taken in response. ○ Agree the measures taken by commissioned partners to address increased demand for NHS services. ○ Broker agreements across the patch and ensure mutual aid is available if required to re-balance pressures (e.g. acute and community services). If there is protracted failure to reach a conclusion favourable to patient care, ALBs may intervene to help reach a resolution. ○ Liaise with bordering CCG/ CSUs on any issues which may impact upon their own pressures, and advise ALBs if there are any actions that cannot be taken locally in partnership. ○ Commission additional resources (beds, staff etc.) and ensure local CCG demand management initiatives are working during times of surge. ○ Ensure the NHS 111 Directory of Services (DoS) is kept up to date in respect of any changes to community capacity. ○ Ensure a full investigation and debrief takes place following a system-wide escalation to level 4, share findings with all A&E Delivery Board partners, and ensure actions are implemented to prevent reoccurrence.

Joint NHS England/NHS Improvement teams (DCO and sub-regional footprint)	• Maintain arrangements to review daily pressure across the NHS. • Put a process in place to inform providers of relevant alerts. • Provide advice and guidance to CCGs on the handling of escalating situations. • Where applicable locally, ALBs to be informed of any agreed diverts. • Agree reporting requirements at a local level. • Ensure that communication protocols are followed if pressures affecting Trusts outside of the local area are likely to impact across boundaries. • Implement coordination arrangements as pressure levels increase across agreed thresholds. • Ensure that 'lessons learned' events are held locally and updated plans reflect the actions identified and agreed. • Inform ALB regional operations and communications colleagues of system pressures. • Inform ALB regional teams regarding system-wide escalation to OPEL 3 or 4 and actions being taken.
Joint NHS England/NHS Improvement teams (Regional A&E Delivery Boards)	• Provide oversight and coordination to local ALB teams where system-wide level 4 applies across a number of areas in the region. • Proactively brief and liaise other ALB regions and central team as appropriate. • Support local ALB teams as required.
Joint NHS England/NHS Improvement teams (National A&E Delivery Board)	• Coordinate routine reporting arrangements e.g. winter sit rep • Provide oversight and coordination to regional ALB teams where system-wide OPEL 4 applies. Support cross-regional boundary working where required • Identify and implement National actions if required. • Ensure comms support is available and comms responses are coordinated between local, regional and national comms teams

In areas where DCO and regional teams are co-located, roles and responsibilities can be interchangeable with actions taken jointly in support of a response.

4.4.2 Expectations of local A&E Delivery Boards

Individual A&E Delivery Boards are expected to identify named senior individuals to lead on and manage the escalation and de-escalation processes at local level (this framework does not seek to prescribe the detail of escalation processes and management).

Regular whole system teleconferences are a 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 system wide meetings can be part of local 'business as usual' systems resilience processes or arranged when deemed necessary. The following points should be addressed as part of system resilience and escalation framework planning processes and are seen as a good practice checklist:

1. Each A&E Delivery Board partner organisation must have a robust, up-to-date local escalation plan signed off at Board level which dovetails into up-to-date overarching Delivery Board wide plans and focuses on early warning triggers;
2. Each acute trust is required to have, and comply with, an ambulance services handover plan;
3. Escalation planning must form an integral part of system resilience and winter planning of all partner organisations in the local A&E Delivery Board, throughout all community and hospital care settings, with due regard for emergency, elective and on-going patient / service user care;
4. It is expected that all local escalation plans will have clearly defined escalation triggers including (but not limited to) the triggers included in section 4.1 of this framework**;**
5. Special action will be required where an Emergency Department (ED) has to close (as opposed to not being able to receive new attenders) as it will not be able to offer resuscitation facilities. **This must go through NHS England DCO teams in conjunction with the relevant CCGs;**
6. There must be clear identification of the system leaders (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 raised their escalation status it is expected that the executive directors of the lead commissioners shall lead the de-escalation process once review shows suitably 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
- Executive level director in each partner organisation should hold the responsibility for ensuring that escalation plans are actioned and reviewed;

- All escalation plans relating to a given A&E Delivery Board should be readily available to all relevant managers and clinicians. All should have a clear, current understanding of the processes;
- The impact on ED facilities due to the knock on effect of another local system must be considered;
- A stringent response to all ambulance handover delays is essential.

5 Communications

The variation of terminology, triggers and actions across the country has been known to lead to local confusion and can hinder effective responses to escalation.

There have been instances of escalation alerts being declared by Trusts before local, regional and national partners have been notified and given the opportunity to input and offer support. This should be avoided wherever possible.

5.1 Communications with local partners

It is expected that all local A&E Delivery Boards will follow agreed steps in terms of communications with partner organisations regarding escalation.

The list of required steps is not exhaustive and should be added to at the discretion of local leaders, but the decision to escalate should always involve:

- Discussion with all local partners involved in urgent and emergency care (providers and commissioners), to ensure there is agreement the escalation is necessary and appropriate
- Alerting local authorities to ensure social services are aware and prepared
- Ensuring the formal decision to escalate comes from named individuals in the local A&E Delivery Board footprint with the appropriate seniority
- Discussion with NHS England and NHS Improvement sub-regional teams to ensure neighbouring systems can be notified and proper support can be considered (as appropriate dependent on the level of escalation)

5.2 Protocols for reporting to NHS England and NHS Improvement

A key step in standardising processes across the country is for local A&E Delivery Boards to report pressures and escalation steps in a manner consistent with the national framework.

Therefore, all local A&E Delivery Boards must do the following when reporting their escalation status to the ALBs:

1. Communicate their official escalation status using the terminology in the national framework. In practice this means using OPEL 1 to 4.
2. When communicating their formal escalation status to ALBs, be prepared to demonstrate that they:
    a. Have met the relevant criteria to warrant escalation to the reported level, as set out in the national framework

   b. Have taken, or at least considered and can provide a rationale for not taking, all appropriate action associated with each level of escalation as set out in the national framework
   c. Have discussed escalation with all relevant local partner organisations, to ensure everyone is primed for upcoming actions
3. When all relevant steps have been followed and the collective decision to escalate has been made, this must be communicated to local NHS England and NHS Improvement colleagues before any wider communication (with the press and public).

5.3 Communications with the public

In a similar way to communications with ALBs, it is important that communication with the public is done in a way that is consistent with the national framework.

By conducting external and public facing communications in a clear and consistent manner, local A&E Delivery Boards can:

1. Communicate operational pressures and actions taken in response more coherently and efficiently to reassure patients and the public
2. Portray an accurate picture of operational pressures to the staff and the public, which will potentially reduce the amount of queries received, freeing up system leaders to focus on management of pressures
3. Accurately inform the public of the pressures on services in their local area, and advise on any actions or response required of them.

5.4 Using public communication of escalation and operational pressures to manage demand

It is recognised that at times of severe operational pressure, it may be necessary to communicate these pressures to the public to help manage demand and bring stability to the situation.

Service disruptions are more likely to occur during winter, and when this happens there is a recognised need for local health and care leaders to communicate this via the press, to ensure local populations are well informed of pressures in their area and how they can access the care they need even during times of pressure.

Local A&E Delivery Boards (and constituent member organisations) are therefore strongly encouraged to engage with local media ahead of winter to set out and explain the issues and processes to support effective communication with the public.

When doing so, all organisations in the local A&E Delivery Board area should take the following steps:

1. Ensure all partner organisations are made aware of any public facing communications being issued in relation to operational pressures and escalation, and should be sighted on these communications ahead of time if possible

2. Ensure terminology consistent with the national framework is used when describing the operational pressures and escalation status within the local area
3. Ensure the description of the operational pressures and escalation status is accurate and responses being taken are proportionate
4. If the decision is taken by organisations within an A&E Delivery Board area to communicate to the public that A&E pressures are severe, and advise them to consider alternative places to seek treatment, then detailed information on all appropriate alternatives must be provided

6 Next steps

6.1 Actions required

Escalation systems used at a local level will vary considerably from one health economy to another, to reflect circumstances unique to each local area.

Local A&E Delivery Boards do not necessarily need to discard any existing protocols, triggers and agreed actions that are in place across local partners and may well be embedded into local planning arrangements. However, all local arrangements must be aligned to the national framework, and there are a number of changes that need to be adopted, and actions taken by all local A&E Delivery Boards which are set out in the following sections.

6.1.1 Aligning local escalation systems to the national framework

There are a number of actions that all local A&E Delivery Boards must take in response to this policy:

1. **Ensure that all escalation levels used locally are aligned to the levels described in the national framework.**
2. Whilst the list of triggers, actions and protocols included in the national framework is not exhaustive and does not exclude local systems adding to these in their own escalation protocols, **all triggers, actions and protocols included in the national framework should be considered at local level.**
3. As escalation levels rise, **there are defined actions required in the national framework regarding how escalation is communicated to local partners and upwards to ALBs.** The expectation is that all health economies will build this into their own escalation systems used locally.

6.1.2 Involvement of DCO and regional teams

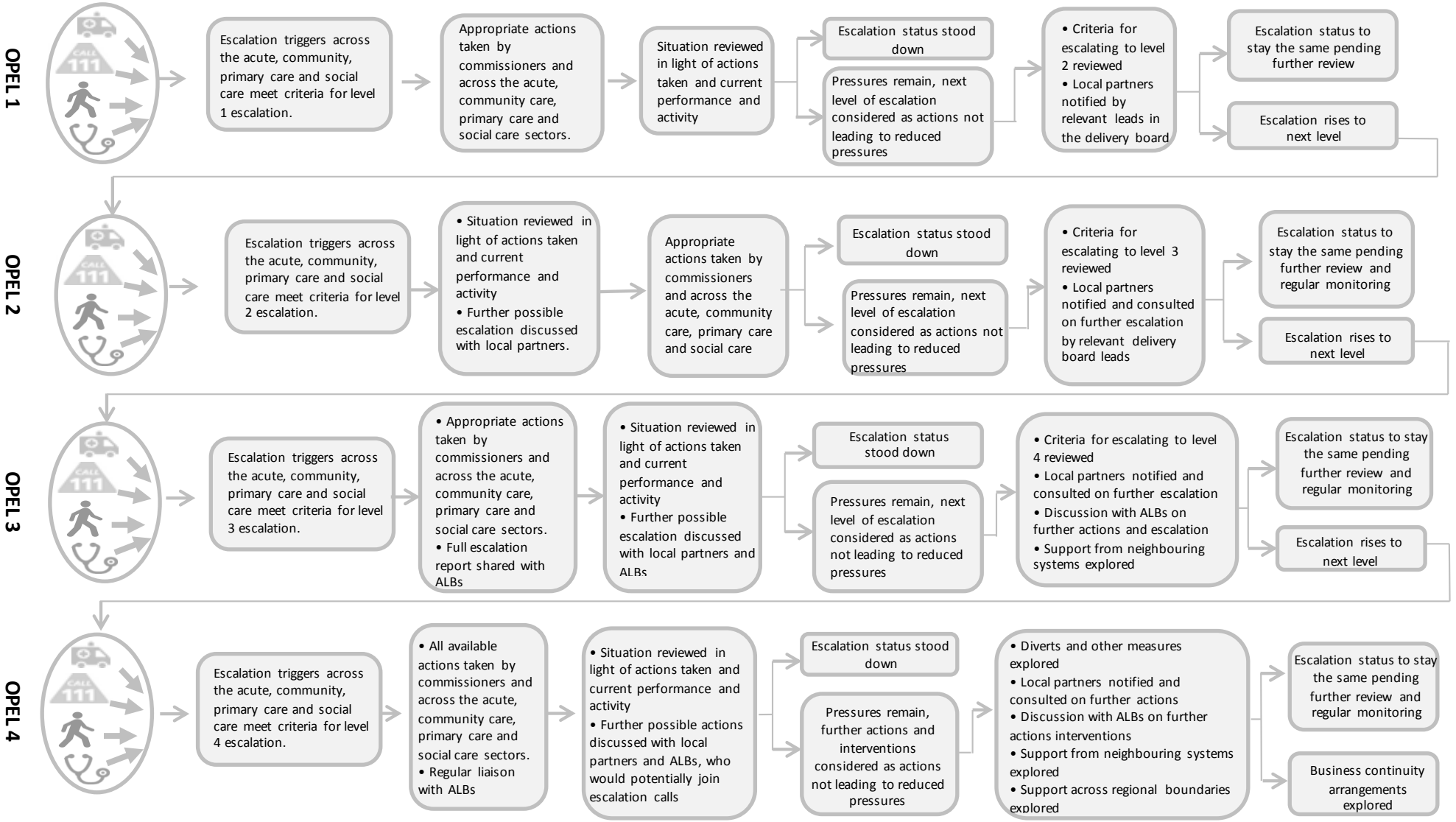
NHS England DCO and NHS Improvement sub-regional teams will work with local A&E Delivery Boards to migrate to revised escalation systems, in line with the national framework.

6.1.3 On-going review

This framework will be reviewed and refreshed as needed on an annual basis.

6.2 Annex – The escalation process

6.2.1 Local escalation processes



6.2.2 Escalation and protocols with local partners, NHS England and NHS Improvement