Classification: Official

Operational Pressures Escalation Levels (OPEL) Framework 2023/24

Version 2.0

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Contents

1 Introduction

1.1 NHS England (NHSE) introduced the national Operational Pressures Escalation Levels (OPEL) Framework in 2016 to bring consistency to local and system escalation. It provided guidance to encourage wider cooperation and make regional, and national, oversight more effective. The framework was last reviewed in 2018, and since the revised framework was released in 2019, considerable variation in its application and utilisation has been seen. In addition, the introduction of the new NHSE Operating Framework alongside the response to the COVID-19 pandemic has changed clinical pathways.

1.2 The OPEL Framework 2023/24 replaces all previous versions of the NHS OPEL Framework. The current framework aims to:

- Provide a unified, systematic and structured approach to detection and assessment of acute hospital Urgent and Emergency care (UEC) operating pressures – achieved through standardisation of parameters and assessment within acute NHS trusts. These parameters have been identified through consultation and collaboration with operational and clinical leaders from across the country. The parameters are designed to reflect the key drivers of operational pressures.
- Provide a consistent framework for the proportional representation of each acute trust hospital's OPEL score toward the corresponding Integrated Care System (ICS), NHSE Regions, and NHSE Nationally.
- Provide guidance to acute hospital trusts, ICS and NHSE regions that that supports an effective, integrated and coordinated response to acute trust operational pressures.
- Provide guidance on the alignment of, and interaction between, the OPEL Framework 2023/24 and the national Emergency Preparedness, Resilience and Response (EPRR) framework.

1.3 Patients – their safety, quality of care, and overall outcomes and experience – must come first in everything we do. The welfare of staff providing and supporting the provision of this care should also be given priority. The NHS Constitution of England establishes the principles and values of the NHS in England. It sets out the rights to which patients, the public and staff are entitled. Through the application of the OPEL Framework, we can strive to provide the safest possible access to UEC, along with

provision of compassionate and considerate leadership to colleagues, across the NHS.

2 Scope, limitations, and future iterations

2.1 This framework focuses on operational pressures within acute hospitals and how this pressure at each hospital is proportionately reflected and reported through to NHSE at a national level. The focus is on acute hospitals as the area of system health provision that often carries the highest risk from operational pressure.

2.2 The OPEL Framework 2023/24 will be reviewed regularly. These iterations will expand upon the contribution of providers beyond acute trusts and will aim to provide similar consistency of the parameters and actions for other providers.

2.3 **The OPEL Framework 2023/24 is an adjunct and must be read alongside local full capacity protocol (FCP), surge policies, or equivalent.** However, these local policies should be updated to reflect the **core** parameters and actions outlined in this policy.

2.4 The principles of the OPEL Framework 2023/24 should also be read in conjunction with the NHSE EPRR Framework, see Appendix A. However, the two are not interchangeable. Both frameworks can be implemented in parallel, for example an incident can be declared under the EPRR framework at any OPEL level. Equally, both can also be considered as a continuum, for example where the actions outlined within the OPEL Framework 2023/24 are not able to meet the operational pressure being experienced.

3 Benefits of a national OPEL framework

3.1 OPEL is the widely recognised term for the measurement of, and response to, operational pressures. The benefits of using a consistent and unified OPEL framework across all acute NHS trusts and ICSs include:

- **Improved patient safety:** The OPEL Framework aims to improve patient safety across the system pathway – through identification of, and consistent response to, address actual and potential risks to patient care.

- **Increased efficiency:** By optimising the use of resources and enabling clinical and operational teams, the OPEL Framework can benefit patients by helping increase efficiency across the UEC pathway.
- **Improved communication:** By providing a common framework for communicating operational pressures, the OPEL Framework can improve communication through standardisation of escalation processes across teams. This will improve the speed of system response.
- **Enhanced decision-making:** By providing a clear and consistent overview of operational pressures and a framework to consider and implement responses consistently, patient-centred decision-making across the UEC pathway is enhanced.

4 OPEL Framework 2023/24 procedure

4.1 The OPEL Framework 2023/24 focuses on assessment of an acute hospitals' operational pressures and how this assessment contributes to the OPEL score of their corresponding NHS trust, ICS and NHSE region, and NHSE nationally.

4.2 **Each acute hospital with a Type 1 emergency department (ED) is required to complete an OPEL assessment.** This generates an OPEL score, as outlined in Section 6. The score from each acute hospital contributes to the acute trust's OPEL score.

4.3 A Type 1 ED is a consultant-led, 24-hour, 7-day service, with full resuscitation facilities, and designated accommodation for the reception of patients receiving 'emergency care' – Emergency care department type (datadictionary.nhs.uk)

The OPEL score must be calculated at a hospital level. Acute trusts with multiple hospitals must use the current proportionate contribution calculations published in the technical guidance issued by NHSE.

4.4 **Subsequently, the acute trust OPEL scores are proportionately aggregated to give the ICS OPEL score**. The ICS OPEL scores are aggregated to provide the NHSE region's OPEL score. In turn, the regional scores are aggregated to produce the national OPEL score and trend analysis.

4.5 It is important to note that the assessment of the acute hospital's OPEL score, not the corresponding level, is used within for the proportional representation throughout every organisational grouping of hospitals, trusts, ICS, and regions.

5 OPEL parameters

5.1 The following **core** parameters make up the OPEL assessment for each submission. Each acute hospital with a type 1 ED must complete their own OPEL assessment based on these parameters. Full descriptions and definitions of these parameters can be found within Appendix BAppendix B:

1. Mean ambulance handover time
2. ED all-type 4-hour performance
3. ED all-type attendances
4. Majors and resuscitation occupancy
5. Time to treatment (TTT)
6. Percentage of patients spending >12 hours in ED
7. G&A bed occupancy as a percentage
8. Percentage of open beds that are escalation beds
9. Percentage of beds occupied by patients no longer meeting the criteria to reside (NCTR)

5.2 **Only the core parameters listed above should contribute toward the OPEL score and level for an acute hospital reported through to NHSE.**

5.3 The reported OPEL score for each acute trust, ICS, NHSE region and NHSE nationally is to be based solely on the scores produced for each acute hospital within it.

5.4 Acute trusts, ICSs and NHSE regions must update local documentation and procedures to reflect the core parameters. Such documentation could extend but is not limited to those relating to surge and escalation and those pertaining to the measurement, reporting and escalation of operating pressures. The ICS will support individual trusts to achieve this in preparation for winter 2023.

5.5 The parameters above can be supplemented with other parameters for use within locally agreed process by the acute trust, ICS and NHSE regions. However, to foster consistent comparison, measurement and parity of response, only the OPEL parameters listed above can be used when escalating OPEL assessment and when comparing parity of response.

5.6 This does not mean that providers cannot utilise escalation or OPEL systems from other non-acute [hospital] providers of health and social care. At this moment, systems are encouraged to continue localised escalation and response using these tools in daily operations with non-acute providers.

6 How the OPEL 2023/24 score works

Table 1 outlines the core OPEL parameters in Appendix B, their thresholds and the scores attributed to each threshold. Assessments should be time-cycled as per the OPEL action cards; this calculation should be digitally automated where possible. Scores range from 0 to 44 – with the lowest pressure assessment being 0 and the highest pressure assessment being 44.

Table 1: OPEL parameters and scoring range

OPEL parameter	Score						
	0	1	2	3	4	5	6
Mean ambulance handover time previous 180 minutes.	<15 min		15–30 min		>30–60 min		>60 min
ED all-type 4-hour performance	>95%	>76–95%	>60–76%		≤60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120%		>120%
Median time to treatment since midnight.	≤60 min	>60–90 min	>90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2–4%	>4–6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

6.1 As a minimum, an OPEL assessment must be completed once per 24-hour period **or** in response to changes in OPEL status (see action cards). The first assessment must be completed no later than 1000 hrs, 7 days per week.

6.2 **The system should be digitally automated to provide a continually or scheduled review of the OPEL score and provide the 'real-time' score to the ICS via the System Co-ordination Centre (SCC).**

6.3 OPEL parameters outlined in Appendix B have been assigned scores within the ranges 0–4 and 0–6, with the score reflecting how far that parameter deviates from the expected standard. The ranges indicate the weighting of those parameters that contribute to the overall OPEL for that acute hospital. The sum of the score assigned to the nine parameters gives the **OPEL score**. Table 2 indicates the OPEL that is attributed to each range of OPEL score; the indicated risk is also denoted.

Table 2: OPEL score and corresponding level

Aggregated OPEL Score	OPEL	Clinical Risk	Response
0–11	OPEL 1	Low	**See OPEL action card** (and local policy/ protocols)
12–22	OPEL 2	Medium	
23–33	OPEL 3	High	
34–44	OPEL 4	Very High	

6.4 The acute hospital's OPEL assessment (per parameter) and overall OPEL score must be submitted to the ICS which will aggregate all trust scores within its geographical boundary. ICS must, in turn, submit this to NHSE regions to establish the NHSE regional OPEL score.

7 OPEL actions in response to risk and operating pressures

7.1 The OPEL Framework will recognise operational pressures, while supporting a system response to aid with stabilisation or recovery using core actions. The OPEL Framework 2023/24, particularly the core actions outlined in Appendix E through

Appendix N, should supplement and be applied in conjunction with local policies and surge and escalation documentation.

7.2 These core actions, and any additional actions taken, should follow the below guiding principles:

- **OPEL actions are grounded by the acute trust's OPEL assessment:** This means the ICS and NHSE region are expected to take OPEL 3 and 4 actions if an acute trust's OPEL assessment within their boundary is 3 or 4. This is regardless of the aggregated OPEL score for that ICS or region.
- **Making decisions in extremis for crowding and delays will involve risk:** It is recognised that actions within this framework would not routinely be taken. Choosing to enact them should reduce a more significant patient risk in another part of the pathway.
- **Risk is dynamic and everyone sees it in different ways:** For this reason, a more considered safety decision will result from involving those who can articulate and share insights about the risks and courses of action.
- **Decisions about the actions taken should always be recorded:** Along with documentation of any anticipated risks, a consideration of how these might be identified and measured to determine the scale of potential harm must be recorded. This also provides an opportunity for learning and evaluation going forward.

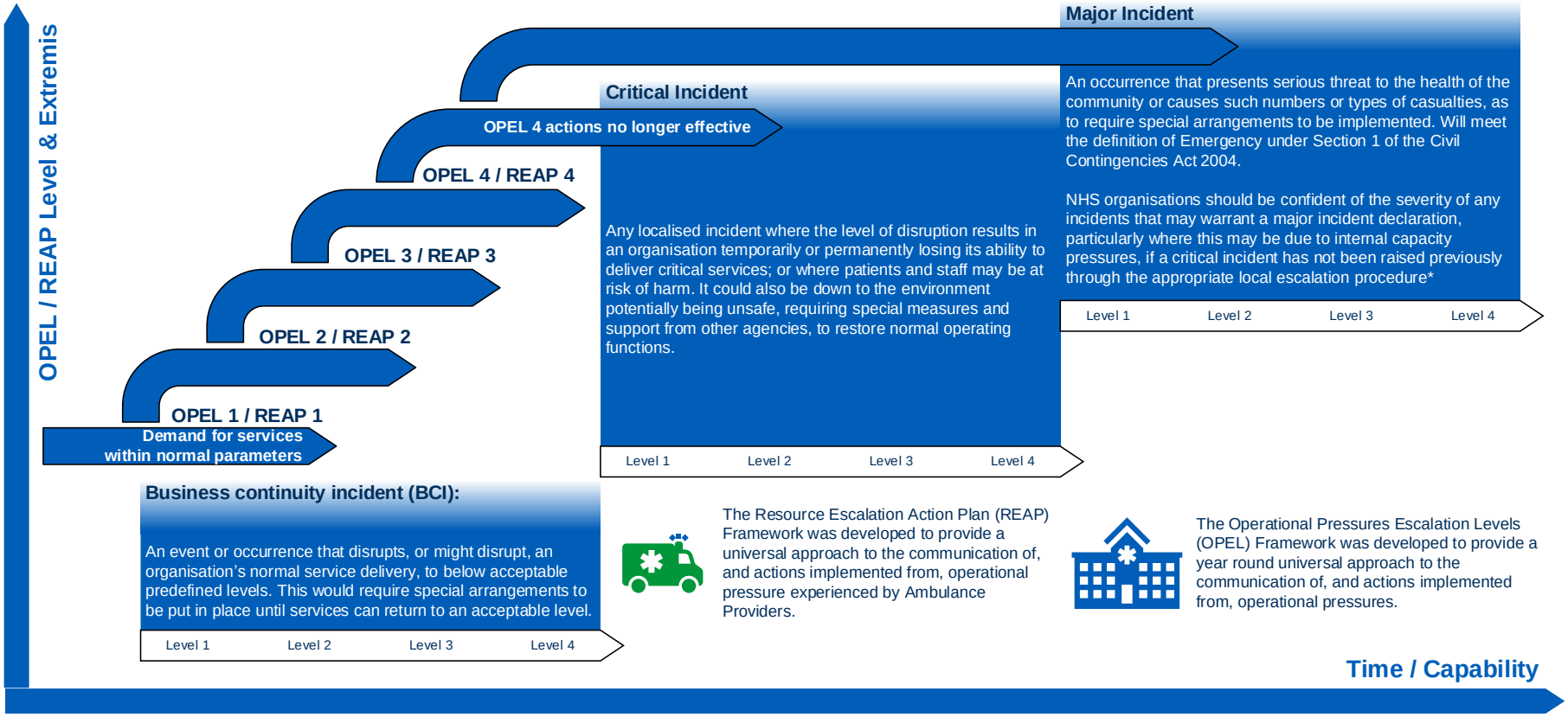
7.3 An overview for navigation of the OPEL action cards, ICS and NHSE region algorithms can be found in Appendix D. Actions card for each level of the OPEL are provided starting at Appendix E through N; they clearly outline roles and responsibilities for the acute trust, ICS and NHSE regions. These actions are mandated in their entirety to ensure there is parity of escalation and risk is shared equally between organisations.

7.4 **Local policy and procedures must be updated to reflect the OPEL 2023/24 action cards and escalation algorithms.**

7.5 Special note should be taken of the **tripartite actions** found in Appendix N. These actions are considered higher risk and require joint ICS and NHSE region awareness and response to support the acute trust.

7.6 The actions cards do not outline when an action should not be taken as this is for local discretion. However, should an action at any level of escalation be deemed undeliverable through choice or circumstance, this should be reported to the ICS (via the SCC) and NHSE region, by exception.

Appendix A OPEL to EPRR diagram



With thanks to the NHS England East of England Regional Operations Centre (EPRR and UEC Operations) for this infographic.

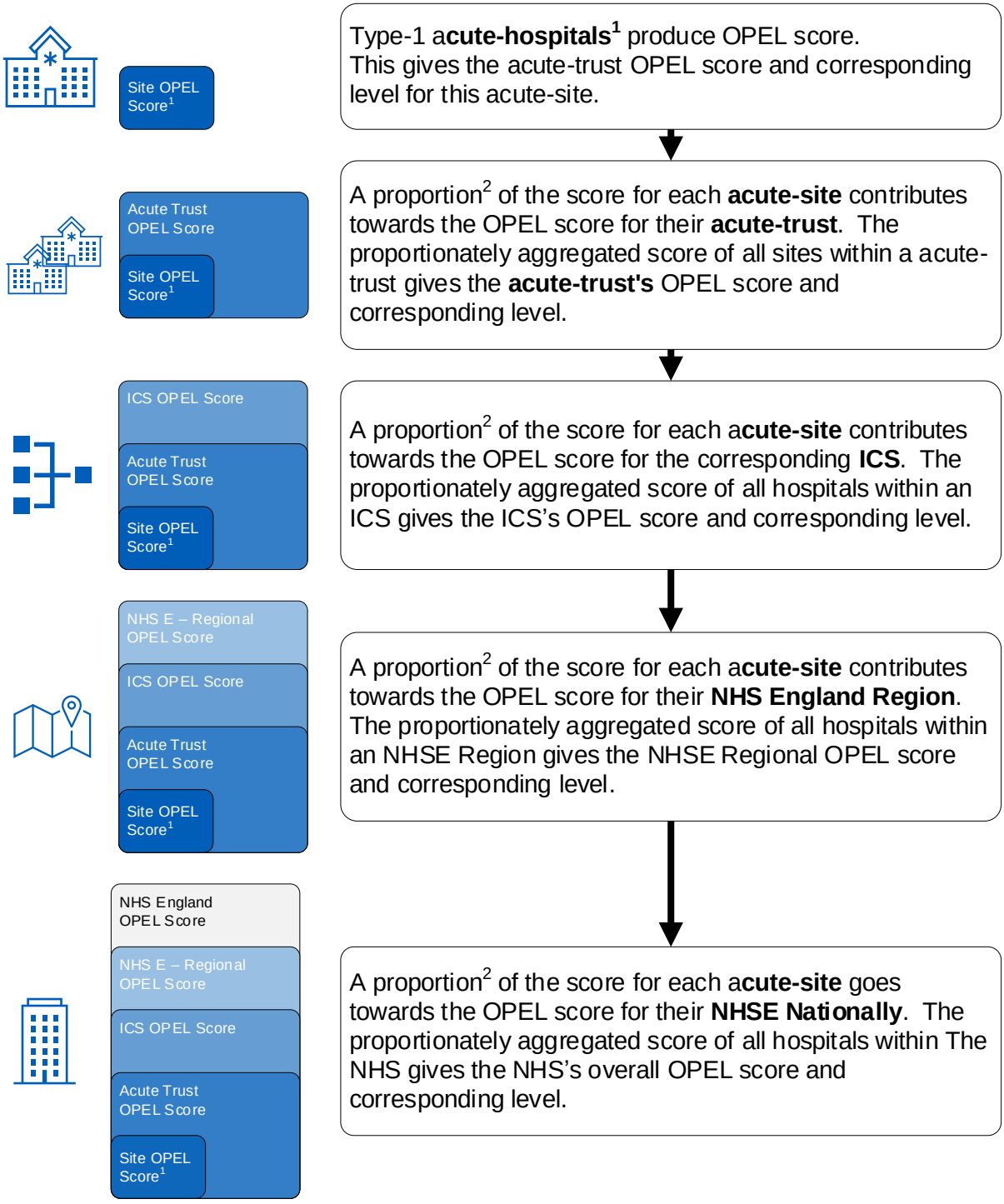
Appendix B Core OPEL parameter definitions

1. Mean ambulance handover time previous 180 minutes		
Mean time, expressed in minutes, considering all completed ambulance patient arrival to handovers completed within the last 180 minutes. Numerator: Sum of total number of minutes between arrival and handover, for handovers within the last 180 minutes. Denominator: Total number of ambulance handovers within the last 180 minutes.	<15 min	0 points
	15–30 min	2 points
	>30–60 min	4 points
	>60 min	6 points
2. ED all-type 4-hour performance		
Percentage of all type attendances admitted, discharged or transferred within 4-hours since midnight. This is excluding booked appointments. Patient journeys that span midnight should be counted in the subsequent day performance in line with UEC sitrep guidance. Numerator: (Number of all-type attendances admitted, discharged or transferred within four hours of arrival since midnight) + (Number of all-type attendances currently in the department waiting for less than four hours since arrival). Denominator: (Number of all-type attendances since midnight) + (Number of all-type attendances in the department at midnight).	>95%	0 points
	>76–95%	1 point
	>60–76%	2 points
	≤60%	4 points
3. ED all-type attendances		
The number of all-type attendances at the hospital within the past 60 minutes. This should be compared to the expected or anticipated number of attendances, which must be established and agreed locally based on historical demand. This can be a consistent hourly average or an average that considers varying attendances throughout a 24-hour period. Numerator: Variation between the expected and actual all-type attendances within the past 60 minutes. Denominator: Expected number of all-type attendances within the past 60 minutes.	≤2%	0 points
	>2–10%	1 point
	>10–20%	2 points
	>20%	4 points

4. Majors and resuscitation occupancy (adult)		
Percentage occupancy of adult majors and resus at time of assessment. Numerator: Sum of all patients who are the clinical responsibility of the ED and who require a majors space (regardless of whether they are receiving care in a traditional space, ambulance cohorting or escalation area). Denominator: Maximum number of patients who can be cared for in major and resus areas, as stated in the acute hospital OPEL statement	≤80%	0 points
	>80–100%	2 points
	>100–120%	4 points
	>120%	6 points
5. Median time to treatment since midnight.		
Median time of all times between patient arrival at ED (defined as post ambulance handover or self-presenting at reception) and time patient is seen by a clinical decision-maker. For all patients who have been seen since midnight. Clinical decision-maker is a care professional who can define the management plan and discharge the patient **or** diagnose the problem and arrange or start definitive treatment as necessary.	≤60 min	0 points
	>60–90 min	1 point
	>90–120 min	2 points
	>120 min	4 points
6. % of patients spending >12 hours in ED		
Total number of patients spending over 12 hours in ED from time of arrival to time of review as a percentage of total number of patients in ED at time of review. Numerator: Total number of patients spending over 12 hours in ED from time of arrival (handover/reception). Denominator: Total number of patients in ED.	≤2%	0 points
	>2–5%	1 point
	>5–10%	2 points
	>10%	4 points

7. % G&A bed occupancy		
Percentage bed occupancy of hospital at time of OPEL assessment. Bed occupancy should be calculated as the sum of patients occupying all open general and acute beds (including assessment units) Numerator: Number of adult G&A beds currently occupied by a patient Denominator: Total number of defined core adult G&A beds. NB: For paediatric hospitals, this metric applies to paediatric beds, not adult. Below 92% occupancy should not be considered as a target, the correct level will vary locally. This should be considered alongside the other metrics.	≤92%	0 points
	>92–95%	2 points
	>95–98%	4 points
	>98%	6 points
8. % open beds that are escalation beds		
Percentage of escalation beds as a proportion of the general and acute bed base open at the time of OPEL assessment. Escalation beds are those considered in line with A&E SitRep definitions. The denominator should be the G&A beds in the acute hospital SitRep. Numerator: Number of adult escalation beds open. Denominator: Total number of adult G&A beds per the daily Sitrep definition (SUM of core beds AND escalation beds). NB: For paediatric hospitals, this metric applies to paediatric beds, not adult.	≤2%	0 points
	>2–4%	1 point
	>4–6%	2 points
	>6%	4 points
9. % of beds occupied by patients no longer meeting the criteria to reside (NCTR)		
Percentage of open beds occupied by patients NCTR at time of OPEL assessment. Numerator: Patients no longer meeting criteria to reside. Denominator: Total number of adult G&A beds per the daily Sitrep definition (SUM of core beds AND escalation beds).	≤10%	0 points
	>10–13%	2 points
	>13–15%	4 points
	>15%	6 points

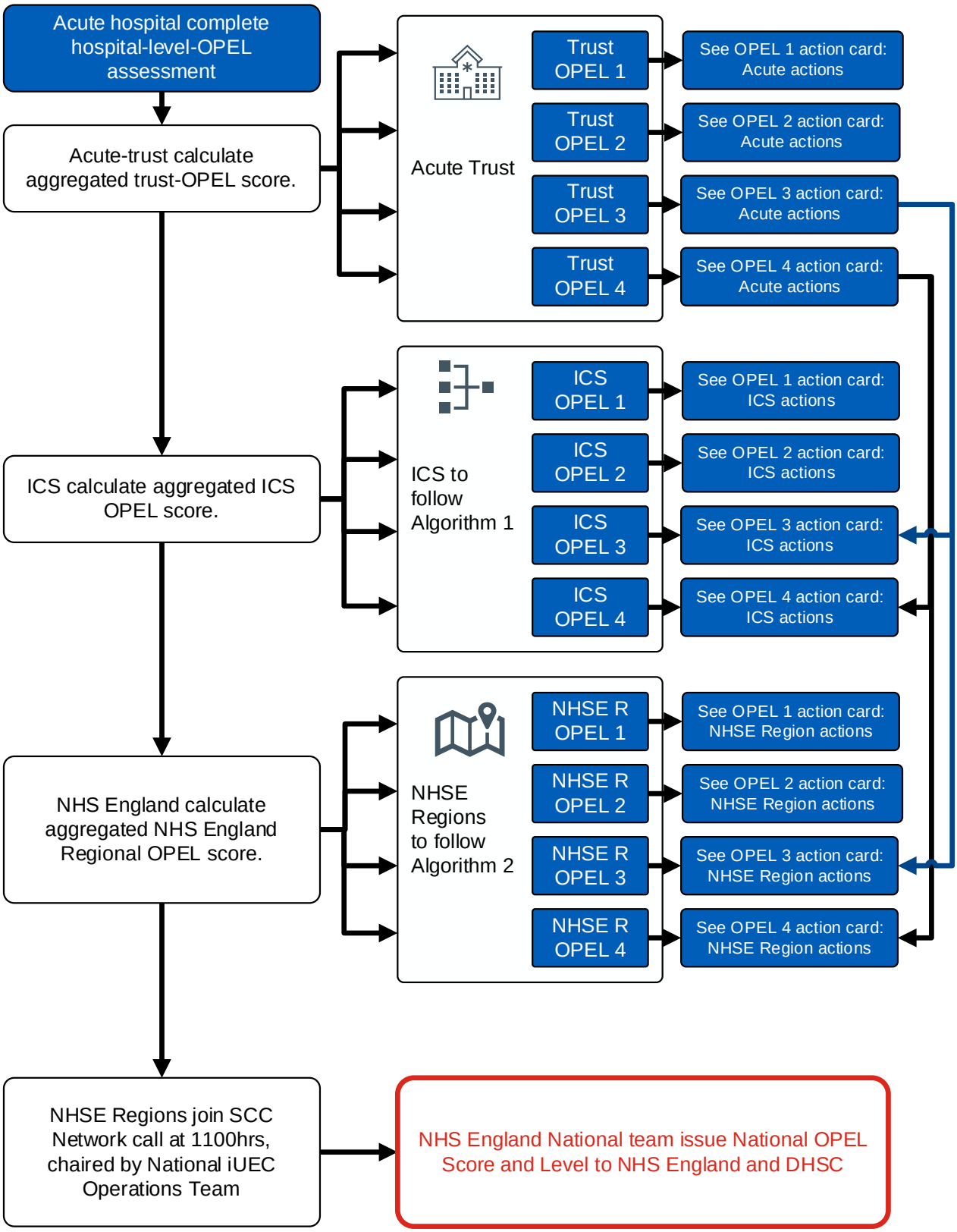
Appendix C Acute trust contribution



[1] Each acute-site classed with a Type 1 must complete an OPEL assessment (A Type 1 ED is consultant-led, 24-hour, 7-day service, with full resuscitation facilities, and designated accommodation for the reception of patients receiving 'emergency care')
[2] Proportions shown are for illustrative purpose only – a list of proportions for each site will be made available separately and are based upon average all type attendances at type-1 hospital sites.

Appendix D OPEL action card overview

OPEL escalation algorithm and action card overview



Appendix E Acute Trust OPEL 1 action card

ACUTE TRUST OPEL 1 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O1AT-01:** Site Operations to review all OPEL actions with hospital teams that require specific oversight or intervention as per local escalation or surge policy. Site Operations to set hospital objectives, and ensure these are understood by all hospital teams and reviewed at an agreed meeting cadence. Site operations team(s) will calculate in-patient bed position, ensuring support for assessment units for the next 24hrs.
- ❑ **O1AT-02:** Follow Rapid Assessment and Treatment (RAT) protocol (or equivalent) to ensure high-risk patients are prioritised for ambulance to hospital handover.
- ❑ **O1AT-03:** Maintain plan that ensures initial assessment is completed within 15 minutes of patient arrival. Diagnostic access at this point should be optimised to ensure results are available or pending for the clinical decision-maker. Provide continual re-assessment of initial assessment waiting times to maintain safe access to emergency care.
- ❑ **O1AT-04:** Ensure waiting times for all pathways within ED is deemed safe by ED nurse and doctor-in-charge and aim to escalate any operational concerns to Site Operations.
- ❑ **O1AT-05:** Aim to have patients referred to specialty, transferred to assessment units for clerking within 30 minutes of referral. Patients should not be clerked in ED by a specialty team unless it is indicated by local policy, require organ support or specific clinical intervention.
- ❑ **O1AT-06:** Site Operations will identify patients overnight who wish to leave or can leave the hospital via the discharge lounge* before 0900hrs. The Site Operations team will monitor the discharge lounge to ensure maximal utilisation and flow throughout the day.
- ❑ **O1AT-07:** As a minimum update OPEL by 1000hrs daily.
- ❑ **O1AT-08:** maintain agreed thresholds of contact with SCC and other providers with the intention of receiving system support in event of rising pressure.

*or equivalent / available

Appendix F ICS and NHS England Region OPEL 1 action card

ICS OPEL 1 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O1S-01:** Ensure acute trust OPEL submissions are received by 1000hrs. Ensure OPEL actions are being implemented and ensure escalation algorithms are followed. This may require further OPEL submissions throughout the 24 hour period.
- ❑ **O1S-02:** Review Ambulance Clinical Safety Plan with ambulance service commander. Maintain plan to ensure ambulance response standards are being met.
- ❑ **O1S-03**: Monitor utilisation of Virtual Ward capacity and flow through all virtual ward pathways.
- ❑ **O1S-04:** Monitor Urgent Community Response caseload size and ensure response times are being met. Confirm in-patient bed position for community providers and maintain plan to support early patient transfers.
- ❑ **O1S-05:** Monitor acute and ambulance provider interface with mental health to ensure patients receive access to assessment and treatment 24/7. Liaise with mental-health bed managers to assess in-patient bed position and aim to facilitate admission as early as possible.
- ❑ **O1S-06:** Monitor NHS111 activity levels and maintain plan to ensure call answer performance is being met.
- ❑ **O1S-07:** Real-time information systems are reviewed at agreed intervals to facilitate horizon scanning for escalating operational pressure. The ICS will ensure OPEL status is updated to the national platform as per OPEL assessment timelines dictated at OPEL 1 through to 4.
- ❑ **O1S-08:** Review actions with ICS provider operational teams requiring system oversight or intervention as per local policy. ISC SCC room lead to set system objectives and ensure these are understood by all system partners and reviewed at an agreed interval.

NHS ENGLAND REGION OPEL 1 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O1R-01:** Maintain SCC cadence of submissions to National iUEC for National Coordination Centre (NCC) Call.
- ❑ **O1R-02:** Agreed monitoring of system performance and thresholds for communications.
- ❑ **O1R-03:** Co-ordinate across NHSE regions the repatriation or delayed specialised intervention for patients >72hrs

Appendix G Acute Trust OPEL 2 action card

ACUTE TRUST OPEL 2 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O2AT-01: Review and ensure OPEL 1 actions are followed.**

- ❑ **O2AT-02:** On-site presence of ambulance commander has been considered by the SCC to work in tandem with the Rapid Assessment and Treatment (RAT) protocol (or equivalent).

- ❑ **O2AT-03:** Patients who have been delayed in the handover process will be jointly assessed between the RAT team and the ambulance service. Patients who are not able to offload from an ambulance trolley within 30 minutes of arrival will be escalated to the SCC who will initiate joint tracking with the ambulance service.

- ❑ **O2AT-04:** Site Operations will work with hospital teams to ensure that all referred patients not able to move to assessment units (DTA's) are reviewed by specialty within 30 mins of referral. Patients requiring organ support or specific intervention will be pre-allocated to a suitable ward and where possible an agreed time for admission set between the ED and the admitting team.

- ❑ **O2AT-05:** Update OPEL every 6 hours and maintain agreed thresholds of contact with SCC and other providers with the intention of receiving system support in event of rising pressure. Ensure Chief Operating Officer (COO) is briefed on hospital position.

- ❑ **O2AT-06:** Initiate non-use of discharge lounge by exception by supporting ward teams to transfer all clinically suitable patients waiting to go home to the discharge lounge (or equivalent). Site Operations should consider requesting that completion of take-home medication and discharge information are completed by specialty teams in the lounge setting.

Appendix H ICS and NHS England Region OPEL 2 action card

ICS OPEL 2 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O1S-01:Review and ensure OPEL 1 actions are followed.**
- ❑ **O1S-02:** Contact the ambulance service to maintain plan for ambulance to hospital handover. This may require the SCC to request ambulance officer on-site presence to support both ambulance and ED with patient risk assessment. Prepare to initiate joint tracking with hospital of each patient who is delayed >30 mins.
- ❑ **O1S-03:** Undertake review of hospital OPEL with Site Operations and ambulance Clinical Safety Plan actions with ambulance service. Review local policy and formulate joint plan to stabilise, recover or make-ready for an increase in operational pressure. This is likely to include re-assessment of system capacity to reduce non-CTR patients in acute beds and focused utilisation of vacant Virtual Ward capacity.
- ❑ **O1S-04:** Ensure CRISIS / CAMHS team are meeting performance standards for mental health care in the ED. Formulate joint plan to ensure patients that are 'ready to transfer' from ED are pre-allocated to a bed within 1 hour. The patients journey should be tracked by the SCC in collaboration with the mental health provider and agreed escalation thresholds maintained for each patient.

NHS ENGLAND REGION OPEL 2 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O2R-01: Review and ensure OPEL 1 actions are followed.**
- ❑ **O2R-02**: Support objective setting on system capacity and response in readiness for increased operational pressure or to maintain OPEL 2.

Appendix I Acute Trust OPEL 3 action card

Acute Trust OPEL 3 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O3AT-01: Review and ensure OPEL 2 actions are followed.**
- ❑ **O3AT-02:** The senior doctor and senior nurse within the RAT alongside the Site Operations team will initiate a huddle with the ambulance officer to make-ready for patient cohort as per agreed Trust policy. If cohort is initiated then please follow actions outlined in the OPEL 4 section.
- ❑ **O3AT-03:** Site Operations will update OPEL every 4 hours and maintain agreed thresholds of contact with SCC and other providers. Ensure COO is briefed on hospital position and a nominated deputy is attending the flow meetings to provide leadership of hospital objectives. This will now include a re-assessment of hospital capacity to make-ready escalation beds and deployment of local surge plans to increase pace and volume of patient discharge.
- ❑ **O3AT-04:** Ensure most senior specialty clinical decision-maker present in ED to support alternatives to admission where possible (SDEC, planned hot-clinics). The specialty teams will be supported by the specialty operations teams to ensure there is adequate clinical resources to meet both demand and patient acuity.
- ❑ **O3AT-05:** Site Operations will seek permission from the Chief Pharmacist and Medical Director to enact completion of take-home medication and discharge information by specialty teams in the lounge setting.
- ❑ **O3AT-06:** Hospital Site Operations should assess emergency care demand. in collaboration with the SCC, consider whether updating the Directory of Services benefit patient flow. The SCC will ensure the DoS is updated in accordance with local procedure.
- ❑ **O3AT-07:** Maintain flow through hospital ambulatory care or SDEC areas by ensuring patients requiring in-patient admission are done so within 30 minutes of request. Hospitals should take all steps to ensure these areas are not occupied by patients requiring in-patient care, including escalation to a Director or above if at risk of ‘bedding’.

Appendix J ICS OPEL 3 action card

ICS OPEL 3 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O3S-01: Review and ensure OPEL 2 actions are followed.**
- ❑ **O3S-02:** On-site presence of ambulance officer has been actioned by the SCC and will work in tandem with the Rapid Assessment and Treatment (RAT) protocol (or equivalent). Patients who have been delayed in the handover process will be jointly assessed between the RAT team and the ambulance commander to ensure offloading sequence is commensurate with clinical priority.
- ❑ **O3S-03:** Increase frequency of SCC call cadence (4 hourly) with providers, now including Local Authority, to increase situational awareness and system oversight of actual and potential provider risks. Director level (or above) present with SCC. SCC will ensure the Director's strategic assessment of the ICS position is acknowledged by the ICS with stabilisation / recovery objectives being monitored for impact.
- ❑ **O3S-04:** Where possible, SCC to seek extension or amendment of hours of UCR and intermediate care teams to meet demand and consider senior community presence on specified clinical areas to pull referred patients into community. The action will also ensure that patients who meet the potential for referral are considered alongside the clinical teams for selection into community care.
- ❑ **O3S-05:** SCC to support services to flex criteria for admission to community, rehabilitation or residential home settings and consider temporary increase in capacity. All actions should be risk assessed by the provider organisation, and where the request has been specified by the SCC, exception reported where the action is not completed.
- ❑ **O3S-06:** SCC to request local authority contribute to system objective setting with regards to social care provision
- ❑ **O3S-07:** ICB communications should support the SCC with public facing communications to raise awareness of rising operational pressure. Inform and enable the public to utilise NHS111 and/or to dial 999 for an emergency. Work with NHSE communications to consider a region wide plan.
- ❑ **O3S-08:** If the SCC has assessed the risk of the hospital entering OPEL 4 or delayed ambulance handover as likely then inform regional NHSE team to jointly assess the operational position and mitigating plan. The region will facilitate a discussion on the requirement for ongoing mutual aid which may alter ambulance disposition.

Appendix K NHS England Region OPEL 3 action card

NHS ENGLAND REGION OPEL 3 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O3R-01: Review and ensure OPEL 2 actions are followed.**
- ❑ **O3R-02:** Prompt supportive regional communications with the ICS to raise awareness of heightened operational pressure across the region.
- ❑ **O3R-03:** Facilitate discussions on system capacity and collaborative objective setting in readiness for OPEL 4. Assess all ICSs within region to receive or provide mutual aid as per ongoing regional risk assessment. Mutual-aid is non-exhaustive, however the NHSE regional team must be aware of any SCC-led augmentation of UEC patient pathways in response to operational pressures.
- ❑ **O3R-04:** Establish need for post 1800hrs call cadence with SCC team and ensure Director on-call is briefed on risks and subsequent mitigation.
- ❑ **O3R-05:** If the ICS is at risk of entering OPEL 4, then inform the National IUEC team (or Director on-call) and agree a cadence of regional to national calls to jointly review ICS objectives, interventions and recovery timeline.

Appendix L Acute Trust OPEL 4 action card

Acute Trust OPEL 4 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O4AT-01 Review and ensure OPEL 3 actions are followed - Review tripartite action card**

- ❑ **O4AT-02:** Patient cohort initiated as per agreed local protocol. The RAT team, alongside the on-site ambulance officer, should dynamically assess patients at risk of deterioration. The RAT team may enact RAT assessment on ambulances. **Cohorting or on-ambulance RAT assessment will prompt the Hospital and System to enact the Tripartite OPEL 4 action card.**

- ❑ **O4AT-03:** Site Operations will update OPEL every 2 hours and maintain agreed thresholds of contact and participation with SCC. Ensure COO (Supported by DoN and/or MD) is attending the flow meetings to provide direct leadership of hospital objectives. **The Tripartite OPEL 4 action card must be reviewed in readiness for SCC engagement.**

- ❑ **O4AT-04:** Where there is an unmitigated capacity deficit that would result in anticipated ED overcrowding / prolonged patient stays in ED / ambulance handover delays then Site Operations should facilitate a discussion on opening up temporary escalation capacity as per local surge plans or full capacity protocol (FCP).

- ❑ **O4AT-05:** Review of planned elective activity in OPEL 4 should be completed by a hospital team consisting of operational and senior clinical personnel. **Hospital planned elective activity and/or cancer treatments should only be rescheduled under COO, or above, direction and will trigger the Tripartite OPEL 4 action card with the SCC.**

See additional Tripartite action card
for Acute Trust / ICS / NHS England joint actions

Appendix M ICS and NHS England OPEL 4 action card

ICS OPEL 4 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O4S-01 Review and ensure OPEL 3 actions are followed - Review Tripartite action card**
- ❑ **O4S-02:** Tactical system control enacted by the SCC to safeguard the integrity of clinical services within the affected hospital. The SCC should consider extending the operating hours to replicate the regional operations centre (ROC) with OPEL reported at 2 hourly intervals between 0800hrs to 2000hrs.
- ❑ **O4S-03:** ICS Director (or above) chairing SCC call cadence with ICS providers who will field a Director or above to agree stabilisation and recovery objectives. **This will include a mandated review of all actions contained within the Tripartite action card as well as reviewing any mutual aid discussions assessed by region as part of OPEL 3.**
- ❑ **O4S-04:** In the event of the hospital opening up additional escalation capacity, the SCC will request that community and intermediate care providers re-assess their own capacity to maintain flow from the hospital. The ICS Director (or above) will request an options appraisal via the SCC based on community and intermediate care providers response. Assessment should include real-time information on current acuity within these settings, exceptional demand patterns, and non-CTR profile.
- ❑ **O4S-05:** SCC will brief ICS EPRR of OPEL 4 status. Only in consultation, and with EPRR primacy, consider enacting EPRR framework in response to operational pressures. Ensure NHS England Region are briefed on likelihood of EPRR enactment and involved in decisions on threshold for mutual aid and further communications.

See additional Tripartite action card
for Acute Trust / ICS / NHS England joint actions

NHS ENGLAND REGION OPEL 4 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

- ❑ **O4R-01 Review and ensure OPEL 3 actions are followed - Review Tripartite action card**
- ❑ **O4R-02:** ROC to consider amending or extending operating hours in support of SCCs and to support regional participation in agreed SCC call cadence.
- ❑ **O4R-03:** Regional NHS England (UEC) to establish daily calls with ICS to assess system for recovery to OPEL 3 within 24hrs and outline collaborative objectives, and timeline. This will also include consideration of the mutual aid assessment detailed in OPEL 3.
- ❑ **O4R-04:** Regional NHS England (UEC) to liaise with National NHS England (IUEC) to provide assurance on system recovery or request access to further national support.
- ❑ **O4R-05:** If the ICS is at risk of activating the EPRR Framework due to operational pressures, the NHS England region must ensure that the regional EPRR team have primacy of any briefing arrangements. This is to make-ready for deployment of local EPRR policy that stipulates the requirement of a tripartite actions plan to maintain the integrity of clinical services for patients.

See additional Tripartite action card
for Acute Trust / ICS / NHS England joint actions

Appendix N OPEL 4 Tripartite action card

TRIPARTITE ACTION CARD OPEL 4 ACTION CARD

Actions must be considered as core actions but should enacted in conjunction with local, system, and regional operating policy.
For each level ensure all actions at subsequent level have been completed.

READ IN ADDITION TO OPEL 4 ACUTE TRUST, ICS AND NHS ENGLAND REGION ACTION CARD

Acute Trust	ICS & SCC	NHS England Region

- ❑ **O4TRI-A:** Hospital executive team to consider increasing clinical staff availability through review of non-clinical commitments / redeployment of staff where possible to maintain safe care ratios in the ED and/or expedite patient discharge from in-patient areas and/or deployment of +1 protocol[1] on hospital wards. **The initiation of +1 protocol will require the ICS Director (or DoC) to set a system capacity objective that aims to restore OPEL 3 within 24hrs.**
- ❑ **O4TRI-B:** Once +1 protocol has been reviewed, consider initiating reverse boarding protocol[1] in the ED to maintain the handover of ambulances to the RAT team. Consider use of areas not usually used for clinical care in the ED or adjacent areas for lowest acuity patients and augment environment to maintain oxygen, suction and other emergency equipment. **The initiation of reverse boarding protocol in ED will require the ICS Director (or DoC) to set a system objective to immediately reduce both ambulance and walk-in attendance to the affected ED for a mutually agreed period of time.**
- ❑ **O4TRI-C:** Once reverse boarding has been reviewed, consider initiating cohorting protocol[2] of ambulance patients. If no further offloading space, then on-ambulance RAT assessment should be considered. **In the event of ambulance cohorting and/or on-ambulance RAT assessment being initiated, the ICS Director (or DoC) will review options for further escalation capacity at the affected site and across all community and acute providers within the ICS.**
- ❑ **O4TRI-D:** The potential to reschedule planned elective activity and/or cancer treatments will be reviewed by the Senior Operational team at the hospital provider[1]. **The rescheduling of planned activity will require the ICS Director (or DoC) to set a system objective that ensures the risk of cancellation is fully mitigated through ICS or regional network arrangements (including the option for further independent sector support).**
- ❑ **O4TRI-E: If the risk of OPEL 4, or enactment of EPRR Framework due to operational pressures, remains for >48hrs then the ICS Director (or DoC) must agree with the region the escalation steps to the national iUEC team.**

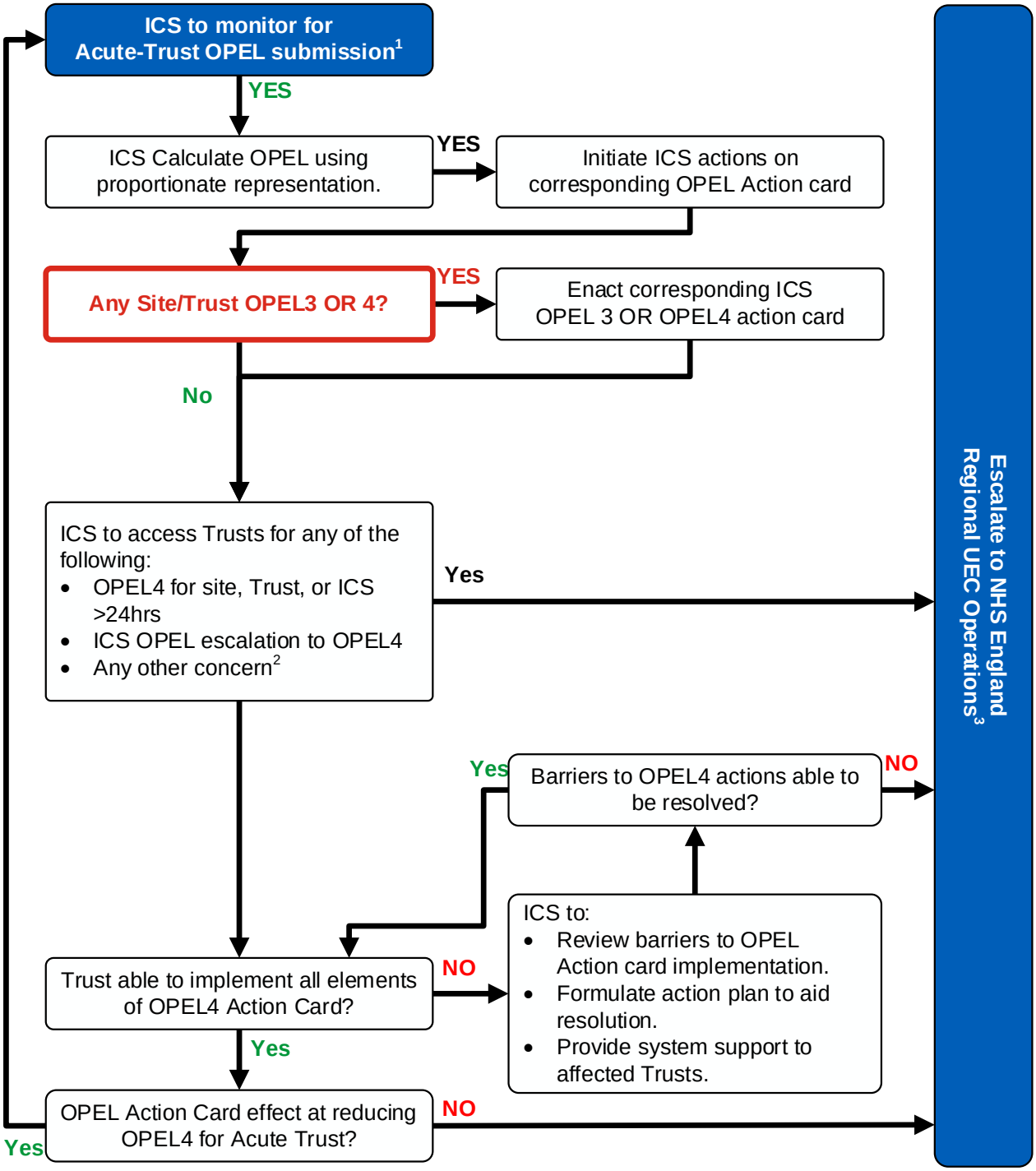
WHEN THESE ACTIONS ARE ENACTED ICS AND NHS REGIONS MUST ENACT THE FOLLOWING TRIPARTITE ACTIONS.

- ❑ **04TRI-F: ICS Executive oversight –** required to ensure these actions are in place and assessed for clinical impact and/or safety risk.
- ❑ **O4TRI-H: System Calls -** Increase cadence of calls and seek additional support from NHS England national iUEC team.
- ❑ **O4TRI-I: Mutual aid –** review need and review possibilities for mutual aid across NHS England regional boundaries.

[1]Each hospital Trust is required to have an executive approved policy or protocol in place.
[2]Typically a joint agreement between ambulance trust and hospital.

Appendix O Algorithm 1: ICS to NHS England region escalation

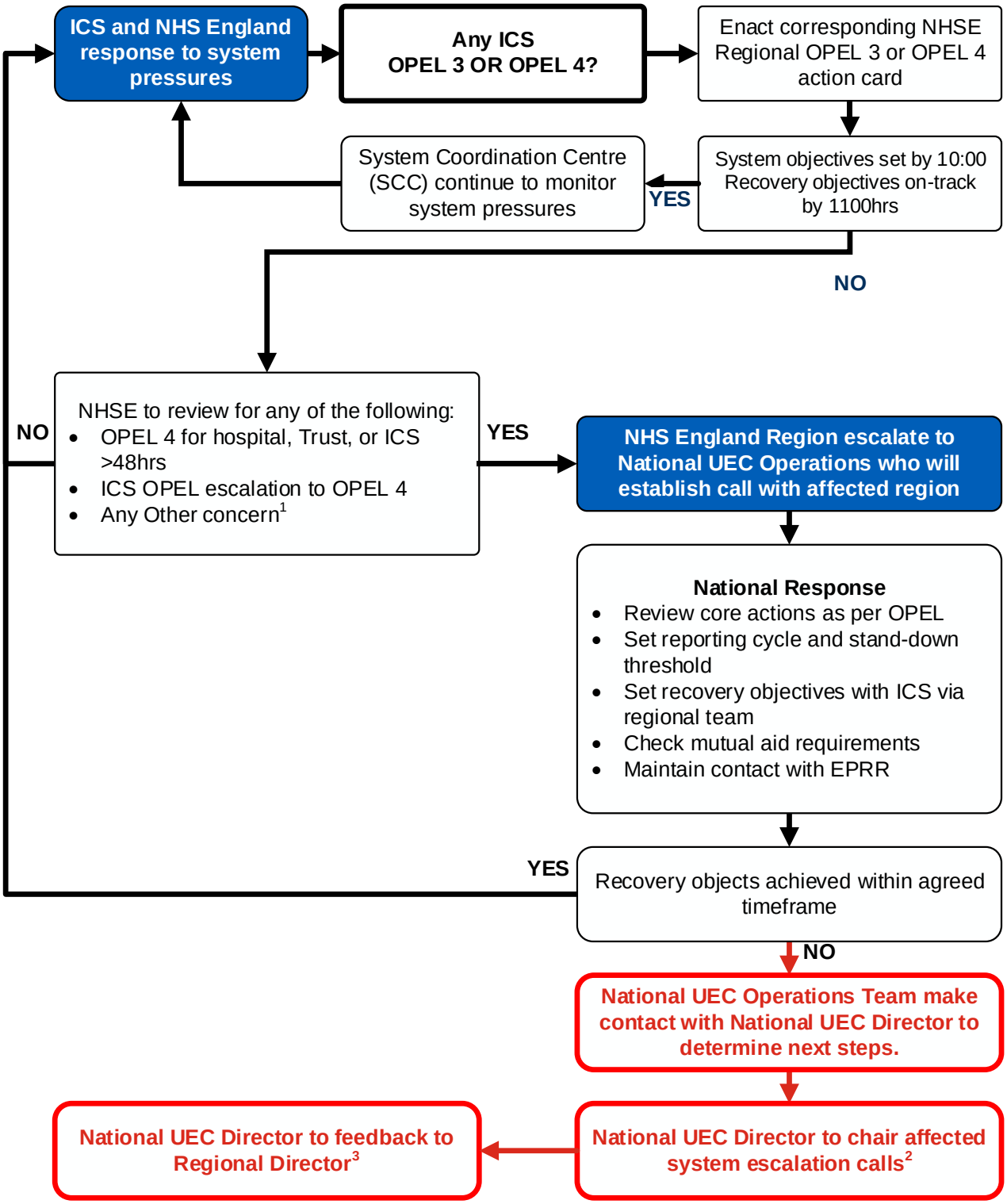
Algorithm 1: ICS SCC to NHS England Region Escalation:



[1]Late or missing OPEL submissions should be escalated by 1030hrs daily and must include the named ICS personnel accountable for resolution, reason for late submission, and timeframe for resolution.
[2]This includes but is not limited to clinical, reputational, or workforce related concerns.

Appendix P Algorithm 2: NHS England regions to NHS England national

Algorithm 2: NHS England Regions to NHS England National



[1]This includes but is not limited to clinical, reputational, or workforce related concerns.
[2]Out of office hours to be chaired by on-call National UEC Director
[3]Contact will be made via director-to-director.

Glossary

A&E SitRep	Accident and Emergency situation report
BCI	Business Continuity Incident
CAG	Clinical Advisory Group
CAMHS	Children and Adolescent Mental Health Service
CEO	Chief Executive Officer
CI	Critical Incident
COO	Chief Operating Officer
CSP	Clinical Safety Plan
CSU	Commissioning Support Unit
DoC	Director on-call
DoN	Director of Nursing
DOS	Directory of Services
DTA	Decision to Admit
ECIST	Emergency Care Intensive Support Team
ED	Emergency Department
EHIA	Equality and Health Inequalities Impact Assessment
EPRR	Emergency Preparedness, Resilience and Response
FCP	Full Capacity Protocol
G&A	General and Acute (bed occupancy)
ICS	Integrated Care System
IPC	Infection Prevention and Control
IUC	Integrated Urgent Care
iUEC	Integrated Urgent and Emergency Care
MD	Medical Director
MI	Major Incident
NACC	National Ambulance Co-ordination Centre
NHSE	NHS England
NCTR	No Criteria to Reside
OPEL	Operational Pressures Escalation Level
RAT	Rapid Assessment and Treatment
SCC	System Co-ordination Centre
SDEC	Same Day Emergency Care

SRO	Senior Responsible Officer
RD	Regional Director
REAP	Resource Escalation Action Plan
ROC	Regional Operations Centre
TTO	To Take Out (medication on discharge)
TTT	Time to Treatment
UEC	Urgent and Emergency Care
VW	Virtual Ward

Further information and contact

For queries relating to this document please contact the iUEC National Team at NHS England:

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