# Appendix F: OPEL 2024 to 2026 Acute actions V1.0

This document outlines the actions NHS acute trusts should take through the 4 operational pressure escalation levels (OPEL).

Please note that it must be read in conjunction with the Integrated OPEL Framework 2024 to 2026, which provides the overarching structure and context within which these actions need to be taken.

For queries relating to these actions, please contact the iUEC national team at england.uec-operations@nhs.net

## OPEL 1 Acute trust actions

1. Hospital site operations team to undertake OPEL assessment by reviewing specific contributing parameters in addition to any other locally agreed parameters. Any rising pressures to be addressed by taking a tailored approach to the actions relating to the specific drivers identified within the OPEL parameters. Submit data for each OPEL parameter to the system co-ordination centre (SCC) no later than 10:00, or more frequently as per local trust/ICS policy or if digital enablement allows.
2. Maintain compliance with regional and national reporting mechanisms and escalation thresholds that have been agreed with the SCC and other providers. Report current position, challenges and agreed actions to ensure support during periods of rising pressure and to maintain oversight in preparedness for any escalation.
3. Emergency department (ED) to monitor the effectiveness of ambulance handovers and critical patient assessments and identify personnel/process that would help maintain effectiveness.
4. Nurse in charge and emergency physician in charge in ED to assess waiting times for all pathways and escalate operational concerns to hospital site operations as needed to maintain safe and efficient patient flow within the ED.
5. Directorate operational lead (or similar) to assess waiting times and constraints for all respective pathways. Operational and patient safety concerns to be escalated to hospital site operations and senior clinical leadership to maintain safe and efficient pathway flow across the hospital.
6. Aim to refer patients to specialty and transfer them to assessment units in line with locally defined protocols, [GIRFT principles](https://gettingitrightfirsttime.co.uk/wp-content/uploads/2019/12/Getting-it-right-in-emergency-care-Aug18.pdf) and any internal professional standards. Specialty teams should not clerk patients in ED unless local policy, organ support or specific clinical needs dictate this, to expedite appropriate care pathways.
7. Identify patients to be discharged to the discharge lounge before 09:00 to maximise discharge lounge utilisation and maintain patient flow.
8. Inform minors patients in ED of pressures and potential delays and of alternative care pathways where appropriate, and ensure navigation is in place at the front door to redirect to MIUs (minor injury units), WICs (walk in centres), UTCs (urgent treatment centres), pharmacies or out of hours (OOH) services.
9. Hospital site operations team to continuously oversee the critical care status (CritCon) and ensure patients are stepped down from critical care within 4 hours of a decision to refer them to an appropriate specialty ward.

OPEL 2 Acute trust actions

1. Ensure OPEL 1 actions are completed.
2. Deputy chief operating officer to be briefed and made aware of hospital capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources.
3. Consider request via integrated care system’s (ICS’s) SCC for on-site input from ambulance trust clinical leadership to work alongside the RAT (rapid assessment and treatment) team or equivalent, to enhance co-ordination during ambulance handovers and critical patient assessments.
4. Hospital site operations team to work with ED teams to review all referred patients who cannot be transferred to assessment units within 60 minutes of their referral to a specialty. Patients requiring organ support or specific intervention will be pre-allocated to a suitable ward and, where possible, an agreed time for admission will be set between the ED and the admitting team to ensure timely transition of care or transfer. Review all DTAs (decisions to admit)/referrals and assist with whole systems agreed actions to accelerate safe discharges from ED.
5. Increase the frequency of monitoring critical care capacity and patient flow. Start planning for potential delays in step-downs. Begin closer monitoring of resus capacity and waiting times in the ED for critical care. Ensure that any emerging delays are identified early and addressed promptly to prevent escalation, reporting emerging pressures to the critical care network.

OPEL 3 Acute trust actions

1. Ensure OPEL 2 actions are completed.
2. Increase OPEL assessment frequency to every 4 hours minimum. Chief operating officer (COO) to nominate a deputy to work with hospital site operations team to maintain effective flow. Focus activities to reduce OPEL and ensure efficient management of resources.
3. Ensure the oversight of patient safety within queue of patients waiting to be handed over from ambulance service to acute hospital staff, with input from ambulance trust clinical leadership. Where this input is available on site, ambulance trust clinical leadership to work in tandem with the RAT team or equivalent.
4. ED to jointly assess those patients delayed in the handover process between the RAT team. Ambulance leadership to co-ordinate assessment and prioritisation of patients delayed in the handover process, ensuring the offloading sequence is commensurate with clinical priority.
5. Hospital site operations team to initiate conversation with the nurse in charge in and emergency physician in charge in ED and ambulance leadership present to prepare for patient cohort management as per local trust policies. If cohorting is enacted, follow OPEL 4 actions to efficiently organise resources for anticipated further delays and patient surges.
6. Ensure all patients waiting for assessment/treatment are prioritised and managed based on risk. This includes taking appropriate actions to review and ensure safety of patients waiting for handover from ambulance to acute site.
7. Where ED crowding, prolonged patient stays or ambulance handover delays occur, as evidenced through high scoring in OPEL parameters, hospital site operations team to facilitate a discussion on opening temporary escalation capacity.
8. Consider enacting, or prepare to enact, full capacity protocols (FCPs) to mitigate forecast G&A capacity deficit.
9. Ensure joint huddles between ED and medical team to agree flow objectives such as single clerking and hot clinic follow-up, and the threshold for same day emergency care (SDEC) flow. Support alternatives to admission where feasible (for example, SDEC and planned hot clinics).
10. Specialty teams, supported by the hospital site operations team, should ensure adequate clinical resources to meet demand or patient acuity; these should balance clinical needs while avoiding unnecessary admissions. Seek all opportunities to safely discharge from ED, including by considering alternative care pathways and follow-up.
11. Ensure patients in hospital ambulatory care or SDEC areas requiring inpatient admission are transferred within 60 minutes of request. Escalate to a named specialty director or equivalent, or higher if these areas risk being occupied by patients awaiting inpatient care (bedded).
12. Hospital site operations team to ensure patients’ ‘take home medication’ is prepared and ‘discharge information’ is completed within the discharge lounge setting, where a lounge is available. Consent and support should be sought from the chief pharmacist, medical director and chief nurse (or nominated deputies).
13. Consider requesting a change to the trust’s entry in the Directory of Services (DoS) if this will benefit patient flow. The ICS’s SCC will ensure the DoS is updated in accordance with local procedure to optimise patient pathways and resource utilisation.
14. Consider additional multidisciplinary team ward rounds to ensure any delays (for example, in diagnostics and therapy) in the patient journey are identified and escalated to the specialty operations team for urgent action.
15. Increase discharge lounge capacity where estate and resourcing allow.
16. Proactively manage critical care capacity, review CritCon level and ensure step-downs are achieved within 4 hours. Any escalation to CritCon 2 should involve the ICU team agreeing and updating objectives with hospital site operations to maintain flow. This may involve discussions with the critical care network.

OPEL 4 Acute trust actions

1. Ensure all OPEL 3 actions are completed. Increase OPEL assessment frequency to every 2 hours to monitor effectiveness of actions on OPEL score. OPEL 4 actions may remain in place even if the OPEL score is reducing.
2. Ensure COO is briefed of the OPEL status. The COO, supported by the director of nursing and/or medical director, to attend operational flow meetings and provide on-site direct leadership presence for hospital recovery objectives. Consider on-site presence out of hours as per local on-call and working arrangements.
3. Prepare to implement OPEL actions across multiple agencies to stay consistent with the OPEL framework.
4. Initiate local surge plans/FCPs to mitigate capacity challenges.
5. In the event of delays in patient arrival to handover, via ICS’s SCC request on-site presence of ambulance trust clinical leadership or other support from ambulance trust (for example, HALO), to maintain the safety of patients waiting to be handed over.
6. Stand down all non-essential services, for example routine bloods and minimal risk follow-up outpatient appointments.
7. Hospital teams (including operations and senior clinical personnel) should review planned elective activity. Reschedule pathway 2 elective surgery or cancer treatments under the direction of the COO or higher, triggering the OPEL multi-partner actions with the ICS’s SCC to balance urgent care needs with planned procedures.
8. Stand down low priority meetings, training and activities that are not part of the clinical response, to improve clinical staffing availability. Review overtime authorisation and consider voluntary cancellation of annual leave.