# Appendix G: OPEL 2024 to 2026 Community Health Service actions V1.0

This document outlines the actions community health service (CHS) providers 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 should be taken.

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

OPEL 1 CHS provider actions

1. Undertake OPEL assessment, reviewing specific contributing parameters in addition to any locally agreed parameters. Taking tailored approach to actions relating to specific drivers identified within OPEL parameters. Submit data for each OPEL parameter to System Coordination Centre (SCC) no later than 1000hrs, or more frequently as per local trust/ICS policy, or if digital enablement allows.
2. Review patients daily to identify those that can move to a more appropriate place for their onward treatment, and care.
3. CHS provider to maintain dialogue with care transfer hubs, to set dynamic objectives for discharge and to understand the demand for community hospital beds and/or community services to aid flow.
4. Ensure patients referred by the acute trust or stepped up from urgent care response (UCR), virtual wards (also known as hospital at home), NHS 111, general practitioners or community nurses are accepted within 24 hours of referral.
5. Ensure plans are available for the urgent procurement of additional beds should the need for these arise but note that they should not be enacted at this level.
6. Monitoring to include capacity and utilisation of virtual wards, intravenous IV pathways, and UCR caseload and response times. Ensure capacity, capability and utilisation of virtual wards are optimised to meet UEC demand, working to deliver the core components of the virtual wards operational framework [NHS England » Virtual wards operational framework](https://www.england.nhs.uk/long-read/virtual-wards-operational-framework/). Consider using the virtual wards self-assessment tool and occupancy checklist.

OPEL 2 CHS provider actions

1. Ensure OPEL 1 actions are completed.
2. Deputy chief operating officer or equivalent to be briefed and made aware of CHS provider capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources.
3. Prioritise the optimal use of reablement and intermediate care beds by implementing flexible admission criteria. This approach ensures that these resources are fully utilised, enhancing patient flow and providing timely care for those in need.
4. All bedded services to deploy proactive reviews of discharge plans, with discharge waits to be escalated through local governance and escalation processes.
5. Establish and maintain daily reporting by the transfer of care hub. This reporting should detail the status, identify challenges and outline agreed actions, to ensure transparency, facilitate problem-solving, and promote co-ordinated efforts to improve patient care and resource management.
6. Ensure virtual wards link with Single Point of Access (SPoA), Same Day Emergency Care (SDEC), UCR, 999/111, care homes, and consider in-reach initiatives in both ED and inpatient wards to identify patients who could benefit from virtual ward care.
7. Increase the frequency of ward rounds and in-reach activities to identify patients in community beds who can be discharged with comprehensive wrap-around support. Highlight and escalate any social care capacity issues and blockages to ensure timely resolution and improve patient flow.
8. Ensure senior level oversight of virtual ward and UCR utilisation, with objectives for utilisation established by the ICS SCC.

OPEL 3 CHS provider actions

1. Ensure OPEL 2 actions are completed.
2. Chief operating officer (COO) to be briefed and made aware of CHS provider capacity and OPEL position. The COO or nominated deputy to focus activities to reduce OPEL and ensure efficient management of resources. They should attend flow meetings to provide executive leadership on CHS provider objectives.
3. Verify the status of all community bedded and non-bedded positions, ensuring that all beds are operational. Develop and maintain a comprehensive plan to facilitate early patient transfers.
4. Enact predetermined plans to procure additional step-up beds.
5. Ensure all partners from whom referrals are accepted are aware of heightened pressure and request that they prioritise any referrals appropriately, seek guidance for using alternative pathways and consider seeking coordinated support from the SCC
6. CHS providers should consistently conduct additional ward rounds and rigorously review admission and treatment thresholds, to identify and create capacity wherever feasible.
7. Community nursing and community therapy teams should begin flexing admission for discharge to access (D2A) and rehab capacity. This includes reviewing the caseload, prioritising patients according to clinical need and referring to the internal silver command for next steps. Consider additional step-up beds and packages of care.
8. Maximise the efficiency of triage processes and prioritise admission based on urgency and clinical need for pathways 1 to 3.
9. Where possible seek extension or amendment of the hours of UCR and intermediate care teams to meet demand. Consider senior community presence in specified clinical areas to ‘pull’ referred patients into the community.
10. CHS director in liaison with director of site operations or equivalent to instigate review of all patients with no criteria to reside (NCTR) to reduce delay for patients ready to leave.
11. The operations team, reporting to the service clinical lead, should consider diverting resource from non-urgent activity to pathways that can improve the OPEL score.
12. Increase clinical/therapy review, considering how this resource can be utilised effectively, potentially over multiple sites.
13. Consider utilising specialist nursing services, therapy or carer support to assist other community teams.
14. Stand down low priority meetings, training and activities that are not part of the clinical response, to improve availability of clinical staff. Review overtime authorisation and consider voluntary cancellation of annual leave.

OPEL 4 CHS provider actions

1. Ensure OPEL 3 actions are completed.
2. COO to be briefed on CHS provider capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources. Provide on-site leadership presence for provider recovery objectives. Consider on-site presence out of hours as per local on-call arrangements and working arrangements.
3. Redeploy staff to support home-based intermediate care and discharge as part of the reablement process. Pool community resources across the area to ensure they are used where most needed.
4. Review rotas within hospital and community teams and consider their impact on reviews and assessments.
5. Ensure staffing levels are adequate and patient care is not compromised. Ensure additional workforce resource to focus on supporting existing teams and structures, ensuring patient flow.
6. 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.