# Appendix H: OPEL 2024 to 2026 Mental Health actions V1.0

This document outlines the actions required of NHS mental health providers through the 4 levels of operational pressure escalation levels.

Please note that this document must be read in conjunction with the Integrated OPEL Framework 2024-2026. The integrated framework provides the overarching structure and context within which these parameters operate, ensuring alignment with the framework’s strategic goals and objectives.

For queries relating to this document please contact the iUEC National Team at NHS England: **england.uec-operations@nhs.net** Version Control for editing purpose only (to be removed):

OPEL 1 MH provider actions

1. Trust bed management team to undertake OPEL assessment by reviewing specific contributing parameters in addition to any other locally agreed parameters. Address any rising pressures by take a tailored approach to the actions related 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. Undertake demand and capacity mapping at trust level and escalate to the integrated care board (ICB) where gaps are identified.
3. Escalate daily patients clinically ready for discharge (CRfD) within bed base but waiting for social support to the ICB and local authority chief executives.
4. 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.
5. Co-ordinate flow management and review inpatient admissions and discharges in line with baseline activity for bed management. Identify and mitigate any increasing risks that could impact on patient flow, with escalation of barriers to a named individual.
6. MH flow team daily to review, co-ordinate and expedite the return of patients in inappropriate out-of-area placements to their local services. Escalate any delays to the SCC.
7. Review community teams (general and crisis teams) caseload daily, to assess clinical need for patients to remain on their caseload, and step down or reduce contacts if clinically appropriate, creating capacity within those teams.
8. Prioritise community-based care and home treatment team capacity through proactive management of at-risk MH patients at home and facilitating return home for others. Maximise the utilisation of community-based services such as step-down provision and crisis houses.
9. CRfD/long length of stay meetings to use multi-agency discharge event (MADE) principles; regularly reviewing cases with extended lengths of stay.

OPEL 2 MH provider actions

1. Review OPEL 1 actions.
2. Deputy chief operating officer to be briefed and made aware of trust capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources.
3. Review the use of [leave beds](https://archive.datadictionary.nhs.uk/DD%20Release%20July%202024/classes/leave.html) and ensure contingency plans are put in place for their use, and that these plans are clearly communicated to all those supporting patient flow.
4. Review all estimated discharge dates (EDD) that are within the next 72 hours, ensuring all internal and external actions are taken to enable the discharge to proceed.
5. Highlight to the ward consultant any newly admitted people who have not had a review within 24 hours of admission and a purpose for admission identified.
6. Inform MH community teams about increasing pressures. Enhance contingency plans to support patients at home, to help prevent hospital admissions and ensure continuous care.

OPEL 3 MH provider actions

1. Ensure OPEL 2 actions are completed.
2. Chief operating officer (COO) to be briefed and made aware of trust capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources.
3. Increase frequency of capacity and demand review meetings with senior managers. Focus on expediting discharges, increasing bed capacity and addressing barriers with leadership. Explore options to open more beds to ensure ED and community safety. The COO’s deputy will attend flow meetings to lead on MH provider objectives. Senior clinicians should provide increased support to wards and be included in early discharge reviews.
4. Senior clinicians will support informal admission bed requests, review cases and provide in-reach interventions when needed. They will prioritise the least restrictive alternatives to admission.
5. Review options to reopen temporarily closed beds.
6. Review options to maximise staffing across all appropriate teams by cancelling non-essential training, meetings and activities that impact on clinical staffing levels. Review voluntary review of annual leave, secure temporary staffing, and consider offering voluntarily extra hours, overtime to help patient care needs to be met across inpatient, crisis and community teams.
7. Service managers should assess the risk of needing to extend community team’s demand and extend working hours where possible.

OPEL 4 MH provider actions

1. Ensure OPEL 3 actions are completed
2. Escalate further actions as needed. Maintain review of OPEL to monitor effectiveness of actions on OPEL score. OPEL 4 actions may remain in place despite a falling OPEL score.
3. Ensure COO is briefed on trust capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources. Executive clinical leads should maintain a visible presence in high-priority areas.
4. Increase operational bed flow meetings cadence to twice daily, with meetings to be led by the director of nursing and/or medical director or nominated deputies.
5. Ensure the presence of key personnel on the hospital site. Members of in-reach, hospital discharge teams, bed management and discharge co-ordinators (and relevant managers) should be present on the hospital site to facilitate efficient co-ordination and communication between key personnel, helping to manage patient flow and discharges effectively.
6. MH operational teams should review the provider’s ability to implement surge plans that create temporary capacity where there is an unmitigated capacity deficit and increased risk through prolonged delays in all pathways. Consider any practicable additional measures to reduce OPEL.
7. Proactively identify discharge opportunities and expedite in-reach processes. Communicate this information to bed capacity teams. Regularly review the list of upcoming discharges from the wards, and strategies to accelerating in-reach. This approach aims to enhance patient flow, optimise bed management and make best use of available resources.
8. Consider deploying non-clinical staff to alleviate the non-clinical workloads of clinical staff wherever possible, to improve efficiency and allow clinical staff to focus on patient care.
9. Cancel non-essential community activity to focus community and crisis resources on admission avoidance where possible.
10. Increase the frequency of review of CRfD patients, with review including their EDD, to identify any delays and escalate these to the SCC for system response.