# Appendix I: OPEL 2024 to 2026 NHS 111 actions V1.0

This document outlines the actions required of NHS 111 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 to 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****.**

## NHS 111 call routing options

There are four types of dynamic call routing available for the routing of calls between NHS 111 providers across various geographical locations.

It is recognised that the establishment of systems, processes and workforce at ICB and NHS England regional level may preclude the enactment of the call routine at a regional level therefore these actions are written as an aspirational for ICBs and NHS England regions to work towards and enact where possible. As outlined in the main Integrated OPEL Framework 2024 – 2026 document variance from the ability to meet these actions must be accounted for within local governance.

The following are the 4 levels of call routing available:

* **BAU operation:** existing telephony routing already established within NHS 111 providers. This may include an element of networking calls across a provider’s footprint and/or region via regional call management.
* **Base regional call management:** the technical capability to deploy an agreed set of telephony routing rules that allow some regional networking of calls to be applied in BAU operation or during low levels of escalation if appropriate.
* **Enhanced regional call management:** the technical capability to deploy an agreed regional set of telephony routing rules that allow an increased amount of regional networking of calls to be applied at higher levels of escalation if appropriate.
* **National routing of calls:** the technical capability to network calls nationally based on an agreed set of telephony routing rules, if appropriate when OPEL 4 is reached nationally.

## NHS 111 ICS OPEL

This table shows the actions available to the national team with regions when reporting OPEL. This is dependent on the establishment of subsidiary within ICB and NHS England regional telephony systems and organisational processes.

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| **OPEL Level** | **Possible actions** |
| OPEL 1 | * Accept any requests for national contingency from providers that are in OPEL 4.
* National contingency will be activated on a case-by-case basis. The factors that can be found in the guidelines that support OPEL reporting will be used to decide if national contingency is used.
* The on call integrated urgent care (IUC)/urgent and emergency care (UEC) team makes this decision about national contingency activation.
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| OPEL 2 | * Where available, accept any requests for national contingency from providers that are in OPEL Level 4, as long as more than 50% of providers are in OPEL Level 1 or 2. Accept any requests for national contingency from providers that are in OPEL 4, as long as >50% of providers nationally are in OPEL 1 or 2.
* National contingency will be activated on a case-by-case basis. The factors that can be found in the guidelines that support OPEL reporting will be used to decide if national contingency is used.
* The on-call IUC/UEC team makes this decision about national contingency activation.
* Consider the temporary introduction of busy message at local, regional or national level if performance is deteriorating.
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| OPEL 3 | * Review existing and any further requests for national contingency arrangements.
* Consider temporary introduction of regional or national busy message and remove immediately once national OPEL level returns to Level 1.
* Consideration must be given to how the service has performed through the last period and what expected performance would be for the next period.
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| OPEL 4 | * Consider removing any national contingency arrangements currently in place.
* Review whether alternative telephony routing strategies including but not limited to regional call management or national call routing are appropriate.
* Consider continuous use of national busy message, with a sustained 2-week period at lower OPEL level required before this can be switch off.
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## Provider and ICS NHS 111 actions

The following are considerations for the management of NHS 111 actions at corresponding OPEL levels. These actions are partially dependent on the establishment of subsidiary within ICB and NHS England regional telephony systems and organisational processes.

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| OPEL 1 | * Should be managed at NHS 111 provider level with ICS oversight, locally agreed plans should direct where and when the commissioner/system co-ordination centre is involved.
* Managed at provider or regional level using the regional capability to distribute calls more evenly around the region in the most efficient manner and as suits the escalation at the time and agreed with the lead ICB.
* The NHS 111 provider will be expected to manage their own demand and have the staff numbers to meet KPIs and ensure clinical queues are manageable.
* Normalised OPEL scores, with standardised thresholds for OPEL across providers and ICBs, will providers to indicate current OPEL, and score and also track increases in operating pressure.
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| OPEL 2 | * Ensure all OPEL 1 actions have been enacted/considered as above.
* If a provider escalates from OPEL 1 to 2 as determined by the thresholds, the system control centres (SCCs) should report to the region. Once aware, the region should consider turning on Regional Call Management (RCM) and Single Virtual Contact Centre (SVCC) so that all providers are taking a share of the load in the region, if not already set as automatic overflow in the background.
* The RCM/SVCC provides region with the ability to share patient demand to make best use of capacity available. The RCM/SVCC gives the region the ability to share patient demand to make best use of available capacity. At the same time, clinical capacity can be maximised in the region by giving all remote tele-triage clinicians access to clinical queues across NHS 111 providers and implementing clinical queue system management plans.
* Regions may need to consider technical requirements to deliver shared clinical queue management.
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| OPEL 3 | * Ensure all OPEL 2 actions have been enacted/considered
* To be managed at regional and/or national level in conjunction with the provider(s), and/or regions’ ICBs.
* Provider/region – escalate with proposed action being taken whilst in OPEL 3
* National team to record actions and oversee
* ICB/Region to make RCM changes
* National Telephony Team to make changes depending on circumstances
* Managed at provider or regional level using the regional capability distribute calls around the region in the most efficient manner and as suits the escalation at the time and agreed with the lead ICB.
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| OPEL 4  | * Managed at regional and/or national level in conjunction with the provider(s) and/or regions’ ICBs.
* It is possible that a single provider is at this OPEL and all other providers across the country are at a lower level.
* For NHS 111 providers requiring national contingency, we would deem the NHS 111 provider to need OPEL 4 support, involving the iUEC national team to manage call flow.
* The iUEC national team will determine the use of national contingency/ resilience as needed. Triggering OPEL 4 will not automatically invoke contingency. If a provider requests this, its activation will be considered in relation to the pressure in other providers, performance levels and system pressures across the country.
* The region will be maximising the capacity and providers where it is still under pressure, and it should escalate so that where possible the pressured provider can be supported.
* The on-call IUC/UEC senior responsible officer (SRO) will determine the best course of action based on reported levels at the time. This action may be a combination of use of national contingency messaging and maximised capacity using SVCC.
* Depending on the clinical pressure, providers and regions may decide to close low priority calls in the clinical queue and instead send these callers worsening instructions via SMS.
* There is also capability in the pathways product to consult and complete certain call types (pathways cut off). Providers/regions will agree how they use this as a tool for escalation in extremis and they will determine the use of this option with/without national agreement.
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