# Appendix J: OPEL 2024 to 2026 ICS and NHS England actions V2.0

This document outlines the actions required of Integrated Care Systems Regions 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.**

## ICS OPEL 1 actions

The ICS should enact the following actions when it is operating at OPEL 1:

1. Review and assess current OPEL, score and specific contributing parameters. Address any rising pressures by taking a tailored approach to the actions relating to the specific drivers identified within the OPEL parameters.
2. Maintain the frequency with which all providers make their OPEL submissions. These should be received by 10:00 daily, to ensure OPEL status can be updated on the national platform as per OPEL assessment timelines. Ensure all providers comply with their respective OPEL frameworks, including with OPEL submission and deployment of respective actions in accordance with the Integrated OPEL Framework 2024 to 2026 and local governance.
3. Maintain oversight of and compliance with reporting to all NHS England escalation and reporting mechanisms: the urgent and emergency care (UEC) SitRep and other reporting mechanisms cascaded by NHS England and other regulatory bodies among others.
4. The system co-ordination centre (SCC) will oversee system-level operations via OPEL monitoring, consistently communicating pressures to local partners and anticipating challenges to foster transparency, collaboration and co-ordinated responses. Provide advance warnings and timely escalation of system pressures. Provide and promote seamless communication channels across the local health economy, bridging communication boundaries between providers to enable agile responses and swift escalation/de-escalation as required.
5. SCC to ensure it and providers comply with non-OPEL national and regional reporting requirements, and it maintains review of real-time information systems and contact with providers and NHS England regions at agreed intervals. Undertake horizon scanning for information sources to identify escalating operational pressure within specific metrics.
6. Promote alternatives to patients attending and remaining in the emergency department (ED) through joined up working between system partners, and ensure all alternative pathways are optimised and ED waits for admission have senior clinical oversight.

### ICS actions for acute trusts at OPEL 1

The ICS should enact the following action when an acute trust is operating at OPEL 1:

1. SCC to ensure ongoing engagement with ambulance and acute trusts to support plans for ambulance-to-hospital handover to ensure efficient and timely transitions from pre-hospital care to hospital services.

### ICS actions for mental health service providers at OPEL 1

The ICS should enact the following action(s) when a mental health (MH) service provider is operating at OPEL 1:

1. Provide support to acute ED sites. Ensure they can support patients who have been under their care for extended periods and require MH admission, as the prospect of timely transfer to a MH bed may be limited.
2. Ensure NHS 111 MH Option 2 services are promoted so patients can speak directly to MH professionals.
3. Monitor MH service providers’ in-day operational responses to demand for early indication of potential issues, and ensure they prioritise responses to urgent/crisis presentations.
4. Monitor all system partners’ operational interface with MH services, ensuring patients have access to assessment and treatment 24/7. Liaise with MH flow managers to assess inpatient bed position and facilitate early admission.
5. Support resolution of delays to MH inpatient setting admissions by providing co-ordination through the SCC and addressing bottlenecks promptly.
6. Develop local escalation protocols for patients waiting to be admitted to MH beds and undertake daily escalation for long waits in EDs via SCC calls with regions.
7. Consider creating a MH compact for all stakeholders/partners, to ensure timely access to a health-based place of safety and MH inpatient care and treatment when those in a MH crisis need it.
8. Ensure MH crisis alternatives are commissioned and listed in the Directory of Services and monitor and promote the use of these services.
9. Lead bed brokerage across the system, for all people waiting for a MH bed. Source an out-of-area provider if no local/mutual aid is available and all other options have been exhausted, but with a view to the patient’s repatriation as soon as possible. Escalate to the region where demand for a bed exceeds capacity, including planned discharges.
10. Collaborate with system partners and consider shared objective setting to ensure comprehensive planning and support, especially for social care requirements. For example, invite local authorities to contribute to system objective setting to ensure full utilisation of social care provision and an increase in provision where required.

### ICS actions for community health service providers at OPEL 1

The ICS should enact the following action when a community health service (CHS) provider is operating at OPEL 1:

1. Monitor and ensure full utilisation of all services to optimise patient flow in all clinical services and pathways. SCC-level dynamic risk assessment of capacity versus demand should be ongoing.
2. To maximise the impact of virtual wards, virtual ward capacity should be strategically co-ordinated and delivered at a place and system level alongside existing out-of-hospital and physical hospital capacity, ensuring it is used as efficiently and productively as possible.
3. ICBs should develop a consistent offer of virtual wards and pathways across the system, in line with the functions and core components outlined in this framework.
4. ICBs, providers, services and all relevant system partners should work together locally to improve the flow of referrals to virtual wards.
5. Where possible, ICBs should encourage utilisation of a single point of access (SPoA) to maximise the use of virtual wards along with other services across a system (for example, UCR, respiratory infection hubs, SDEC, acute frailty and falls services), and align with UCR pathways.

### ICS actions for NHS 111 provider(s) at OPEL 1

The ICS should enact the following action(s) when an NHS 111 provider is operating at OPEL 1:

1. SCC to monitor NHS 111 activity levels and maintain a plan to ensure call answer performance standards are met.
2. Any perceived requirement for national contingency activation outside OPEL should be escalated to the integrated urgent care (IUC)/UEC on-call team for consideration and activation.
3. Consider implementing base regional call management if appropriate.
4. Ensure NHS 111 providers are adhering to C3/C4 validations and admission avoidance where appropriate and are providing sufficient out-of-hours cover to meet demand.

## ICS OPEL 2 actions

The ICS should enact the following actions when it escalates to OPEL 2:

1. Review the OPEL score for each provider to identify the parameters that are triggering the increase in OPEL.
2. Review local policy in collaboration with all providers and formulate a joint plan to stabilise operational pressure and recover or prepare for a further increase in operational pressure.
3. Consider reassessing system capacity to reduce the number of patients in acute beds who no longer meet the criteria to reside. Focus on utilising all vacant out-of-hospital capacity, including, but not limited to, community beds and virtual ward.
4. ICS communications should support the SCC with communications to the public about rising operational pressure. Inform the public about and enable them to utilise NHS 111, especially NHS 111 MH Option 2, and/or dial 999 for emergencies. Co-ordinate with NHS England communications to develop a region-wide communications plan.

### ICS actions for acute trusts at OPEL 2

1. The ICS should enact the following action when an acute trust is operating at OPEL 2:
2. SCC to consider requirements for on-acute-site presence of clinical leadership from the ambulance trust, or other support, to help maintain safety of patients waiting to be handed over. This support should work in tandem with the rapid assessment and treatment (RAT) teams (or equivalent), to ensure the assessment and prioritisation of patients delayed in the handover process is co-ordinated.

### ICS actions for mental health service providers at OPEL 2

1. The ICS should enact the following action when a MH service provider is operating at OPEL 2:
2. Ensure any outliers for CAMHS or adult performance are highlighted to the MH service provider for early action and intervention. Collaborate with the SCC to track each patient’s journey and maintain agreed escalation thresholds in line with local and national policy.

### ICS actions for community health service at OPEL 2

No specified actions for ICS at this level.

### ICS actions for NHS 111 providers at OPEL 2

1. The ICS should enact the following action when an NHS 111 provider is operating at OPEL 2:
2. Consider implementing base regional call management if appropriate.

OPEL 3 actions

The ICS should enact the following actions when it escalates to OPEL 3:

1. Review OPEL 2 actions and utilise all actions from local escalation plans.
2. Instigate additional SCC call touchpoints as required with representatives from all providers who have appropriate authority from ICS and providers. Cascade current system-wide operational pressure status to all stakeholders. Monitor the effectiveness of actions in stabilising operational pressures, set and monitor recovery objectives, and strengthen communication, alignment and oversight across the system.
3. At any time of day, where there is any concern for patient safety or a significant level of unmitigated OPEL escalation, SCC to consider convening a director-level escalation call to take focused mitigation.
4. Provide a nominated contact to maintain regular communication with the NHS England region, ensuring timely updates around escalation, collaboration and alignment between the local system and regional oversight.
5. Alert ICS communications team of escalation. If required their support and guidance can be sought for communicating messages regarding heightened escalation status to the public.
6. SCC to assess and maintain oversight of OPEL scores across the system and escalate to the NHS England region in line with the escalation algorithms.
7. Collaborate with system partners and consider shared objective setting to ensure comprehensive planning and support, especially for social care requirements. For example, invite local authorities to contribute to system objective setting to ensure full utilisation of social care provision and an increase in provision where required. Additionally, the ICS should support the expedited delivery of social care packages to avoid unnecessary admissions and support early or prompt discharge, promoting patient wellbeing.
8. Increase liaison with other system partners to explore the availability of additional resource to support system response and recovery. For example, NHS 111 could increase revalidation capacity or a CHS provider could increase capacity.
9. Enact pre-prepared contingency plans to commission additional resources/services to boost system capacity and with this enhance access to care for patients.

### ICS actions for acute trusts at OPEL 3

The ICS should enact the following actions when an acute trust is operating at OPEL 3:

1. SCC tojointly assess plans for reduction of delays in handing over patients’ arrival by ambulance. Consider the need for on-site clinical leadership from the ambulance service to help maintain safety of patients waiting to be handed over to the acute trust, and co-ordinate this arrangement between the acute and ambulance trusts. Consider existing arrangements, procedures and protocols for the oversight of the clinical safety of patients waiting to be handed over.
2. SCC to facilitate discussion on the requirement for ambulance conveyance mutual aid, both within the ICS and beyond, for patients with physical health needs. Monitor and mitigate arrival to handover delays and ensure such ambulance resource is available.

### ICS actions for mental health service providers at OPEL 3

The ICS should enact the following actions when an MH service provider is operating at OPEL 3:

1. Explore opportunities for mental health trust mutual aid within the same ICS area where multiple providers, and with neighbouring ICBs and providers.
2. Undertake a dynamic review led by the chief nursing officer and chief medical officer at trust and system level that puts long stay patients in a ward with place compliance.
3. Evaluate funding requests within the same working day and explore options for mutual aid with neighbouring ICSs, including out-of-area providers.
4. ICS to collaborate with local authorities and third-sector partners to utilise available capacity within the voluntary and independent sectors. Secure additional social care and/or housing support and optimise voluntary and independent sector capacity for out-of-area placements, supporting efficient admissions.

### ICS actions for community health service providers at OPEL 3

The ICS should enact the following actions when a CHS provider is operating at OPEL 3:

1. Advocate for extending or amending urgent care response (UCR) and intermediate care team hours whenever feasible. Collaborate with clinical teams to prioritise patient selection for community-based services and with this enhance community-based care capacity and responsiveness.
2. Deploy senior community staff to specific clinical areas, facilitating the transition of referred patients into community care.
3. ICS to support services to flex admission criteria for community, rehabilitation and residential home settings. Additionally, explore the feasibility of these settings temporarily increasing their capacity. Commissioned providers should conduct clinical risk assessments before taking these actions. Where the SCC specifically requests action and the action is not completed, exceptions should be reported to optimise resource allocation within the context of maintaining safety and quality standards.
4. ICS to collaborate with local authority in reviewing and potentially expanding social care capacity to expedite discharges.
5. Explore all opportunities to maximise use of social care and voluntary sector provision, to reduce clinical risk of through discharge from community to home.

### ICS actions for NHS 111 providers at OPEL 3

The ICS should enact the following action when an NHS 111 provider is operating at OPEL 3:

1. If required, escalate to the NHS England region the need for regional NHS 111 call management.

ICS OPEL 4 actions

The ICS should enact the following actions when it escalates to OPEL 4:

1. Review OPEL 3 actions and prepare to enact OPEL multi-partner ICS actions.
2. SCC to undertake regular dynamic risk assessments with leaders for managing system pressures.
3. Contribute to system-wide communications that provide regular updates on system pressure status or pressure within organisations (as per local communications plan).
4. Use digitally enabled systems to increase cadence of OPEL score assessment to every 2 hours, to ensure continuous oversight and management of clinical services during periods of heightened operational pressure. Ensure system capacity objectives are set for restoration to OPEL 3 within 24 hours.
5. Ensure ICS emergency preparedness, resilience and response (EPRR) team are aware of OPEL 4 position. In consultation with EPRR primacy, consider enacting the [EPRR framework](https://www.england.nhs.uk/publication/nhs-emergency-preparedness-resilience-and-response-framework/) in response to operational pressures. Ensure the NHS England region is briefed on the likelihood of EPRR framework enactment and is involved in decisions on mutual aid and further communications.
6. SCC to enact tactical system control to safeguard the integrity of clinical services across the system.
7. Increase SCC oversight call cadence; ICS director (or above) to chair the SCC call with ICS providers and agree the stabilisation and recovery objectives.
8. Provide support for co-ordinated communication strategies that cover external communications. Ensure clear and consistent communication on position across the system.
9. Provide regular updates to the NHS England region in line with the escalation algorithms.
10. Review and, if appropriate, stand down non-urgent meetings that are impacting on urgent care capacity and discharges, and support all providers to do the same where required.

### ICS actions for acute trusts at OPEL 4

The ICS should enact the following actions when an acute trust is operating at OPEL 4:

1. SCC to request that community and intermediate care providers reassess their capacity to maintain flow from the hospital. Assessment should include looking at real-time information on current acuity within these settings, exceptional demand patterns and NCTR profile. Based on response from these providers, the ICS director (or above) may request an options appraisal via the SCC.
2. SCC in collaboration with ambulance service to instigate and support load balancing between ED sites in line with local procedures. This is sometimes referred to as intelligent conveyance or dynamic conveyancing.

### ICS actions for mental health service providers at OPEL 4

No specified actions at this level for ICS.

### ICS actions for community health service providers at OPEL 4

No specified actions at this level for ICS.

### ICS actions for NHS 111 provider(s) at OPEL 4

1. The ICS should enact the following action when an NHS 111 provider is operating at OPEL 4. If required, escalate need for NHS 111 national contingency call management to NHS England.

## NHS England region actions

The NHS England region should enact the following actions for the relevant OPEL when an ICS within its geography and/or the region escalates to that OPEL.

### NHS England region OPEL 1 actions

1. Ensure compliance with SCC cadence of OPEL review and submission to the iUEC national team so that the National Co-ordination Centre call can provide regular and timely communication and escalation of rising OPEL.
2. Provide support and facilitate communication between ICSs where out-of-area patients are not being repatriated at the earliest opportunity, with NHS England arbitrating where necessary.

### OPEL 1 NHS England national actions for NHS 111

1. Accept any requests for national contingency from providers that are in OPEL 4.
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.
3. The on call integrated urgent care (IUC)/urgent and emergency care (UEC) team makes this decision about national contingency activation.

### NHS England region OPEL 2 actions

1. Review and ensure OPEL 1 actions have been enacted. Set objectives for system capacity and response to mitigate further escalation, such as the monitoring of specific key performance metrics/OPEL parameters and the impact of actions.

### OPEL 2 NHS England national actions for NHS 111

1. 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, if >50% of providers nationally are in OPEL 1 or 2.
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.
3. The on-call IUC/UEC team makes this decision about national contingency activation.
4. Consider the temporary introduction of busy message at local, regional or national level if performance is deteriorating.

### NHS England region OPEL 3 actions

1. Review and ensure OPEL 2 actions have been enacted.
2. Provide regional communications to raise awareness of heightened operational pressure across the region and ensure all stakeholders are kept informed.
3. Assess need for increased regional out-of-hours operational monitoring. Review current risk and establish the need for increased out-of-hours monitoring with more frequent out-of-hours with the region’s ICSs. Ensure the on-call NHS England regional director is briefed on risks, additional calls frequency and mitigation plans, to maintain continuous oversight and risk management when one on-call director hands over to another and outside regular hours.
4. Escalate risk of OPEL 4, if the region or any ICS within it is at risk of entering OPEL 4 to the iUEC national team (or director on-call) and agree the cadence of regional to national calls for joint review of the ICS objectives based on agreed trigger thresholds, interventions and recovery timeline.
5. Consider request to NHS 111 providers requested to escalate, based ICS review, and enhanced regional NHS 111 call management.

### OPEL 3 NHS England national actions for NHS 111

1. Review existing and any further requests for national contingency arrangements.
2. Consider temporary introduction of regional or national busy message and remove immediately once national OPEL Level returns to level 1.
3. Consideration must be given to how the service has performed through the last period and what expected performance would be for the next period.

### NHS England region OPEL 4 actions

1. Review and ensure OPEL 3 actions have been enacted.
2. Based on assessment of current and anticipated regional operating pressure, consider augmentation of the NHS England region UEC operating model. This may include provision of more on-call support or extension of operating hours as deemed appropriate and based on local arrangements and governance, as well as considering working time regulation and available staffing.
3. Ensure a co-ordinated response and mutual aid across the region. Assess each ICS within the region for need to receive mutual aid or ability to this as per ongoing objective regional risk assessment.
4. NHS England region UEC team to establish daily operational calls with ICSs to outline collaborative objectives and timeline for recovery.
5. NHS England region UEC team to liaise with iUEC national team or request further national support and provide assurance on system recovery and patient safety.
6. On escalation of NHS 111, consider requests for national support (but only where these are for operational reasons) via national contingency.

### OPEL 4 NHS England national actions for NHS 111

1. Consider removing any national contingency arrangements currently in place.
2. Review whether alternative telephony routing strategies including but not limited to regional call management or national call routing are appropriate.
3. 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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## Multi-partner system OPEL 4 actions

These multi-partner system actions must be considered as core actions, but they should be enacted in accordance with local, system and regional operating policy. For each OPEL, ensure all the actions at the preceding level have been completed. If such actions are deployed, ICB and NHS England need to be notified.

1. Acute trust: staff deployment and +1 protocol

**Hospital action:** Maximise clinical staff availability by reviewing non-clinical commitments. Redeploy staff to maintain safe care ratios in any areas under pressure and expedite patient discharges, and/or acute trust to deploy ‘+1 protocol’ on hospital wards.

**ICS support:** Initiating +1 protocol requires the ICS director to set a system capacity objective to restore OPEL 3 within 24 hours.

1. Reverse boarding

**Acute trust action:** After reviewing +1 protocol, consider implementing reverse boarding for which each acute trust is required to have a policy or protocol in place that has been approved by an executive. in the ED to ensure ambulance staff handover the lowest acuity patients to the RAT team. Reverse boarding should only be used for these patients, ensuring necessary emergency equipment is available. Where this is implemented, site operations team to ensure patients are regularly assessed to always maintain their clinical safety. Reverse boarding should be in place for as short a time as possible and its use should be regularly reviewed.

**ICS support:** The ICS director sets a system objective to immediately reduce both ambulance and walk-in attendances at the affected ED for a planned period.

1. Ambulance cohorting and escalation capacity

**Acute trust action:** If ED is too crowded and space is limited, initiate the cohorting protocol, typically, a joint agreement between the ambulance trust and hospital, for ambulance patients. Consider ‘ambulance platform assessment’.

**ICS support:** If cohorting is insufficient to free sufficient ambulance crews, the ICS director to assess whether providers within the ICS can open additional escalation capacity.

1. Planned care rescheduling

**Acute trust action:** Senior operational team to review potential for rescheduling of electives or outpatient appointments.

**ICS support:** ICS director ensures risk mitigation through ICS or regional network arrangements, including by harnessing independent sector support if needed.

1. Long length of stay review

Acute trust action: Each acute trust to urgently undertake a long length of stay review. This should be chaired by a director and attended by community and local authority representatives. Aim for a 10% increase in discharges.

ICS support: Director-level support across all organisations to enable additional discharge actions to be taken. Patient choice should be suspended as a collective ICS action to support rapid discharge via discharge to assess (D2A) pathways.

When the above actions are deployed ICSs and NHS England regions must enact the following multi-partner actions:

1. Executive oversight – ICS action: Executive oversight – required to ensure these actions are in place and assessed for clinical impact and/or safety risk.
2. System calls – NHS England region action: Increase call cadence and seek additional support from the iUEC national team.
3. Mutual aid – NHS England region action: review need and any options for mutual aid across NHS England regional boundaries.