Bromley A&E Delivery Board

2016/17 Escalation Meeting Plan

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1. Overview

This report contains subsets of the Bromley Winter Plan 2016/17 and incorporates information from the PRUH Urgent Care Improvement Plan. The report is separated into three sections for clarity and ease of read, these areas are;

Section A – Performance. This includes information on the:

1) A recovery trajectory
2) An action plan to deliver against this.
3) The resources required to implement the plan

Section B - Delivery against 5 national initiatives

4) Progress to date

Section C – Winter surges

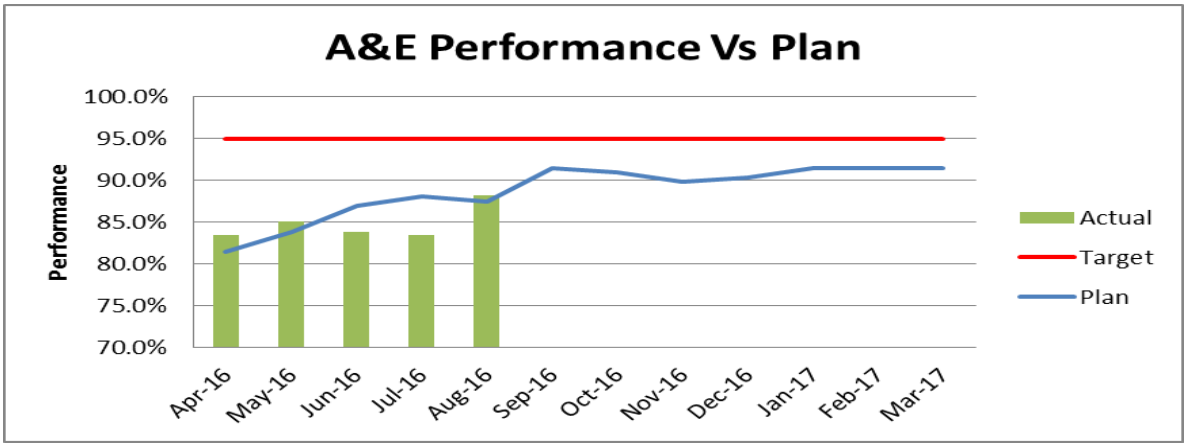
5) Winter schemes identified
6) Escalation procedures

The report has been written with the contribution and support from key partners in the Bromley Urgent Care system and Local A&E Delivery Board.

2. Section A - Performance

2.1 Performance

The performance at the PRUH has been varied over the last 6 months, and has not met the planned trajectory or the 4 hour 95% A&E target consistently.



In April 2016 Transformation Nous was commissioned to help identify through a robust and comprehensive diagnostic, reasons for poor performance.

The results showed there was not one key reason for failure but several smaller areas that required addressing. One of the areas assessed and identified were breaches and time to be seen.

The following table showing breach analysis over a 5 week period

		Week ending					
		11/09/2016	18/09/2016	25/09/2016	02/10/2016	09/10/2016	16/10/2016
Bed Management		150	83	125	167	149	125
Waiting for Diagnostics		16	10	8	8	18	11
Waiting for Specialist	Acute Trust	69	63	100	85	85	69
	MH Trust	13	11	7	7	12	7
Wait for First Clinician (not triage)		105	91	82	91	69	49
A&E Triage		1	0	2	2	0	0
Clinical		23	10	19	15	13	12
UCC breach		55	64	71	56	69	57
Transport (hospital Provided)		2	3	2	0	0	3
Others		17	38	19	13	10	14
Total Breaches		451	373	435	444	425	347
Total Attendances		2334	2373	2480	2361	2439	2420

The highest attributor to breaches consistently is the bed management and waits for first clinician, both areas have been allocated as key workstreams in the Urgent Care Improvement Plan (see Appendix 1). Work has undertaken with the UCC provider to address late handovers and ensure appropriate referrals into ED or bypass ED through alternative pathways.

2.2 Key actions identified to deliver the trajectory with timelines

2.2.1 Capacity

the Trust undertook a bed modelling exercise to assess the Trust's bed gap by site, based on historic seasonality and bed occupancy information, assumed growth, a do nothing productivity and efficiency assumption and a range of a range of bed occupancy scenarios.

2.2.2 Bed Management

40 beds additional beds have been commissioned in Orpington Hospital, 20 of the beds will be utilised to close the PRUH bed gap and 20 to provide elective capacity for the Denmark Hill service moves

2.2.3 Frailty Pathway

40 bed Frailty Unit at Orpington as part of overall frailty pathway development - the Orpington unit will act as a catalyst for overall pathway and outcome improvement, noting the very significant current frailty workload at the PRUH. It is anticipated this unit will open in January 2017

2.2.4 Discharge

Continued development of the Transfer of Care Bureau - enhanced leadership and capacity to drive and optimise impact and benefits, pending procurement of the service and the development of new longer term contractual arrangements to underpin an integrated, multi agency transfer of care bureau. More detailed actions can be found in the section B (Progress against 5 national initiatives)

2.2.5 Front Door Improvements

- Action to address and optimise the pathway from ED to assessment and admission, differentiating between admitted and non-admitted pathways and between adult and children's services – a key focus is improving flow in and out of AMU and ASU

- Review of rota's to match demand including redesign of hospital at night team
- Action to improve LAS handover delays and queues.
- Clean sheet redesign to focus on first 72 hours processes and pathways - key focus is ambulatory care offer, including new ambulatory care pathways and hot clinics

2.2.6 In-Hospital Plan

- Action to improve and maximise in-hospital ward based processes – to improve length of stay, reduce MFFD patients and improve discharge planning
- Implementation of a 23/12 surgical unit
- Improved bed allocation policy and bed management processes
- Improved infection control planning to mitigate norovirus risks

2.3 Resources required, and key risks and issues identified

Significant resource, in terms of both management and clinical capacity and transformation funding has been focused on the short and medium term work taking place on the emergency care pathway, recognising that the Clean Sheet Redesign Programme represents a three year emergency pathway transformation programme and the Recovery Plan a range of more immediate short term recovery actions.

KCH is in the process of a significant internal reorganisation – this will provide enhanced site based leadership and capacity and introduce a streamlined directorate structure, with clear clinical, nursing and operational leadership in place for each directorate. The corporate performance and planning functions have also been strengthened. These changes have not yet come in to effect but will do so over the remainder of Q3 and 4. They will take time to embed.

3. Section B – Delivery against 5 national initiatives

In August 2015 new guidance was issued by NHS Improvement and NHS England on a series of 'must dos' in relation to A&E performance improvement. This guidance was split into 5 domains which are:

3.1 Progress on delivering ED streaming

A&E Streaming at the Front Door:

A&E departments need to be able to access the most appropriate services for patients in a timely fashion to prevent delays and crowding of the department. This can be achieved by identifying the main services required and designing them around patient needs. There are several streaming paths for patients including primary care, ambulatory emergency care, out-patient referral, transfer to an assessment unit and transfer to a frailty service.

KCH operate a range of specialty advice lines for primary care including general medicine, paediatrics and geriatrics. These advice lines offer support, guidance and advice to primary care and help avoid unnecessary ED attendances, allow patients to be streamed to hot clinics and ensure that referrals are made appropriately. ED also has access to all specialties 24 hours a day.

A well designed streaming service delivered by Greenbrooks Urgent Care Centre (UCC) is supported by the availability of each of the streams during periods of high demand can reduce crowding and pressure on ED staff leading to an improved patient experience. The UCC operates 24 hours and day, 7 days a week.

Psychiatric liaison services are in place 24 hours a day 7 days a week at the PRUH

As part of winter management Greenbrook will need to assure the CCG they are able to fill all required GP slots. To provide assurance we have met with Greenbrook to evaluate their rota filling procedure. Recruitment for winter was circulated to their current GP list in August 2016 to obtain early take up. Slots that remain outstanding are then sourced through their internal staff bank across other Greenbrook sites. If slots are still unable to be filled they will offer an incentivized rate for those currently already on shift.

Greenbrook also have a contingency GP that works between several sites as additional capacity.

The final contingency is being outlined with the ED through a standard operating procedure that allows ED to pull patients from the UCC into the ED department at an early stage of the process.

3.2 NHS 111 calls transferred to clinicians

111 – Increasing the percentage of calls transferred to a clinical advisor

The Integrated Urgent Care Commissioning Standards outline a new model of care which will result in improved outcomes for patients. A key part of this new model is to increase the amount of clinical input into calls to the NHS 111 number thereby enhancing patient assessment and ensuring the patient is directed or referred to the most appropriate point of care. The IUC model has 8 key elements which commissioners are expected to achieve, these elements will to greater and lesser degrees contribute to increasing clinical input and ensure patients are directed appropriately.

Call volumes are predicted as a result of analysis of both historic and recent patterns of demand. Rotas are planned in line with the predicted call volumes, taking account of known activity peaks. LAS have a rolling recruitment programme to ensure sufficient staff to fill the rotas throughout the year.

Additionally LAS have in place a demand management plan that can be enacted when demand goes beyond predicted levels and mutual aid arrangements in place with SEL GPOOH providers.

It is anticipated that national timescales will be met; LAS 111 intend to take a pan-CCG approach initially and incorporate the following actions - Enhanced Clinical Assessment of Green Ambulance dispositions - increase transfer to clinician rate. Critical thinking and Probing skills workshops for Clinical Advisors - extend roll out to all Clinical Advisors. Identify referral outliers (Call Handlers and Clinical Advisors) and support to improve clinical outcomes. Frequent Callers - work has commenced - cross reference to 999 database, additional activity to review call activity and referral patterns (objective to increase SPN and appropriate supporting information to reduce 999 referrals where appropriate). Review data for Care homes with highest LAS 999 incidents (3 of top 4 are in Bexley CCG) to identify trends to 111 contacts and any potential interventions to support.

3.3 Ambulance Response Programme

The Ambulance Response Programme (ARP) is a national programme led by NHS England to improve the outcomes and experience of patients contacting the 999 ambulance service. The ARP aims to achieve:

- a more equitable and clinically focussed response from the ambulance service, that meets patient needs in an appropriate time frame
- Better allocation and distribution of resources in the face of rising demand
- Response standards that encourage the best possible patient outcomes
- An improved experience for all patients

Regular meetings are taking place between LAS and the ED department to address the handover issues that are occurring – Additional details of this can be found in the Urgent Care Improvement Plan – Appendix 1

There are a number of initiatives in place to support LAS across Bromley including:

3.3.1 Care Homes

The following is in place to reduce calls to LAS from Care Homes:

By pass numbers have been given to care home managers in order that they can directly access the GP.

- GP surgeries have joint protocols in place with the homes for management of UTIs & falls.
- A new VMO and care homes scheme is being developed and introduced in care homes across Bromley where gaps of provision have been identified. This will be procured substantively in the longer term but a pilot will run over this coming winter.
- Providers with large care homes have been asked to review their policy on when to call an ambulance.
- All care homes complete falls risk assessments and have fall prevention plans in place.
- A single Bromley wide policy has been developed and agreed in BROMLEY. For people who are at end of life, DNARS are in place and where appropriate the palliative team is involved.

3.3.2 Community Treatment Scheme

- Bromley Healthcare are focusing specifically on care home which have been identified as high users of both A&E and ambulances
- Bromley Healthcare are re-promoting the current ACP in place to help reduce ambulance callouts and admissions
- Discharge to Assess programme is being developed in the Transfer of Care Bureau to allow patients to be discharged into their place of residence whilst awaiting ongoing assessment

3.3.3 Frequent Users Forum

- There is an established forum covering PRUH, the current membership is being reviewed
- In addition Bromley CCG review frequent attenders at the Local A&E Delivery Board

3.4 Improving Patient Flow

SAFER bundle:

KCH has embedded the SAFER bundle to help improve flow, in line with ECIP best practice guidance. They currently use the SAFER bundle on acute admissions and medical wards, and plan to roll out across all wards. A programme to embed within all remaining wards is underway, alongside KCH's ward accreditation programme. They currently use ward round checklists as standard.

Baseline assessments of EDDs and Clinical Criteria for Discharge:

KCH – As part of a local CQUIN KCH have significantly increased the percentage of patients that have an EDD set, with in excess of 90% of patients in Q2 having an EDD set within 24 hours of admission. Further improvements are expected by the end of the year. KCH are also implementing a Clinical Utilisation Review system as part of the national CQUIN. The CUR supports clinicians to make evidence based decisions and improve operational efficiency by ensuring that discharges can be better targeted and length of stay reduced. A Project Manager has been engaged who is overseeing the implementation over Q3 and Q4.

3.5 Improving Discharge Processes

3.5.1 Transfer of Care Bureau

We have implemented elements of the safer bundle as part of the Kings way and this includes green days, red days, daily ward and board rounds etc.

Over the past 12 months the TOCB has reviewed its practices and developed new ways of working by **creating a multi-agency team based approach** with colleagues including Therapy, TOCB, Medics and Nurses - final agreement regarding the overall management of this team will be agreed and the performance monitored as a KPI will be set to reflect a minimum of 3 patients being discharged per day with this teams involvement.

This was agreed the Urgent Care Improvement Group.

Extensive conversations have already taken place about this team based approach and it has been agreed that (Community Matron) will be based within the TOCB and will utilise the existing resources and skills of the TOCB team that include LBB and Discharge co- ordinations to ensure that we are maximising the opportunities that the additional winter monies provide.

This work is mirroring the work on the wards to create a single list of patients with a team based approach on the wards

This will be linked to **new ways of working within the ED department** that have recently started in the PRUH,
We will have a senior SW supervising and supporting the work of two other social workers to ensure that rapid decision making can take place

LBB have agreed in principle that additional POC can be purchased and will be available via the TOCB to facilitate rapid decision making and expedite discharge.

The TOCB have recently completed a piece of pathway work with London Borough of Bexley around rapid response services and Bexley now has Social Workers on site and located in the Bureau to help facilitate the patients identified for Bexley borough.

4. Section C – Winter surges

Bromley Urgent Care providers met as a system to develop a collaborated approach for the management of surges over winter. An initial mapping exercise took place to:

- Evaluate last year's winter plan
- Identify and gaps in provision
- Develop scheme to address those gaps

Partners that met were Bromley Healthcare, Oxleas, Bromley Alliance, London Borough of Bromley, Kings College Hospital, Bromley CCG, and London Ambulance Service, all key contributors to the Local A&E Delivery Board.

Areas identified for addressing were

- Admission avoidance – pre-front door and inappropriate attendances
- Expedited discharges – from the PRUH into community services
- Improved discharge processes – between providers
- Additional capacity in primary care – to manage discharge or prevent admissions

4.1 Admission avoidance

The following admission avoidance schemes will be implemented as part of winter:

- BHC Medical Response In-reach
- Rapid Response ACP for care homes
- Social Care Manager at the front door
- Increase of Mental Health Patient Liaison Nurses

Working with community providers to avoid admission into an acute setting. Bromley Health Care (BHC) currently provides a step up admissions avoidance service for Primary Care, Care homes and LAS via ACP to access via its MRT service.

This was very successful last winter and BHC was routinely providing additional clinical support to patients referred from the other services with a view to preventing admission. The number of referrals significantly increased over the months of December to March (see below.)

Average	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Average number of referrals received (weekdays)	100	107	124	118	128	138
Average number of referrals	42	40	49	62	43	59

received (weekend)							

Number of Referrals	Column Labels						
Row Labels	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Grand Total
Monday	83	128	97	128	143	120	699
Tuesday	99	86	144	127	112	149	717
Wednesday	89	103	152	109	120	140	713
Thursday	107	88	125	94	110	143	667
Friday	124	131	103	133	159	141	791
Saturday	58	43	53	65	48	71	338
Sunday	26	37	45	59	38	47	252
Grand Total	**586**	**616**	**719**	**715**	**730**	**811**	**4177**

The scheme will also link with the emerging ICN network based in the three ICN hubs - the ICN networks aim is to provide proactive care to those frail and risk stratified pts via a hub with GP and Geriatrician support. This will provide links into the hospitals frailty pathway relating to the provision of additional beds on the Orpington Hospital site.

BHC provided a Medical Response Team In-reach service at the front door last year. Over the months of November 2015 – March 2016 In-reach assessed 701 patients and expedited and supports the discharge of 392 patients from ED, AMU and front end wards by assessing patient needs and ensuring that services were co-ordinated to facilitate the discharge as soon as possible.

Approximately 40% of patients identified and accepted were taken out by the team within 24 hrs with a further 38% within 48hrs and 12% within 72hrs.

For patients who were not suitable, for example if those patients lived outside Bromley, the in reach team signposted patients to other services and offered advice to the PRUH staff to assist navigating them to the right service. Tracking patients who could not be discharged straight from ED enabled the team to form a relationship with the patient, family and hospital staff to make sure the discharge happened as soon as possible once the patient was fit to go home.

It was challenging to discharge patients within 4 hours from ED or UCC. There were few patients identified/referred from ED or UCC. Patients were often awaiting investigations that medical staff required to enable them to declare the patient medically safe for discharge and these could not be undertaken within a 4hr timeframe, hence patients were admitted to CDU or AMU. Even when patients were identified within ED/UCC it was often not possible to discharge them straight from ED/UCC. BHC have undertaken

analysis of this and identified the following themes of explanations for delays:

- Faller with head injury needs CT head not able to be done within 4 hours
- Acute Coronary Syndrome needed monitoring and troponin result not achievable in 4 hours
- Dehydrated needing IV fluids - not achievable in 4 hours – BHC are exploring how to offer more rehydration in community
- Attended late evening or overnight to ED and were not seen by in reach until ANP came on duty,COPD needing therapy and stabilisation

To enable a multi-disciplinary approach at the front door, additional funding was given to Oxleas to provide 24 hours 7 day week coverage for mental health assessment. Additional social care staff was also employed to access social care services quicker at the hospital front door.

4.2 Redirection

Part of admission avoidance will also include patient redirection; we have commissioned as part of winter the following schemes to manage this:

- UCC champion
- Dressing's service
- Additional appointments in Primary Care Hubs

The UCC champion will redirect patients (after an initial stream) to a more appropriate place of treatment. For those minor illnesses or injuries that can be best seen in primary care, additional appointments have been secured to absorb this activity.

A dressing's service has also been commissioned following an audit by the UCC which reported between 5-10 dressing requests a day, particularly at the weekend. These patients will be redirected to these additional clinics.

The UCC champion will help manage throughout the winter surge on both UCC sites in Bromley and will work as part of the wider front door team.

4.2.1 Discharges

To enable quicker discharge process between providers and out of the hospital we have commissioned over winter an additional

- Discharge Co-coordinator
- Community Matron
- GP based in the Transfer of Care Bureau

- Day and Night Sitting

The additional resources will be managed and located in the Transfer of Care Bureau.

The TOCB has recently refreshed its role and has identified a number of key priorities for the winter period including:

- Clarity about the role and scope of the Bureau
- Governance arrangements to the TOCB board and System Leaders group
- Creation of new SOP and pathways
- Creation of new metrics for performance improvement
- Development of system wide metrics
- Three times weekly MFFD teleconference calls to reduce DTOCs and MFD delays and has seen a rapid reduction in delays, this has been mirrored by the following on the wards
- LOS work per ward
- Creation of one list per ward with oversight from Matron, TOCB and
- Therapy to drive through improvements in patient flow

We are utilising winter funding to purchase the skills of community matrons 5 days per week and GP 5 days per week (4 hrs per day) based within the TOCB and pulling patients from the "back end" of the hospital as part of an initiate to facilitate earlier discharges.
This is a new development at the PRUH and will help develop stronger links into the community, create additional support within the Frailty pathway and link into the ICN network.

It was identified that patients with relative small needs and support through day or night sitting could leave hospital sooner or avoids an admission all together. This will be done in partnership with the Geriatricians

4.2 Outcomes

The progress of the winter schemes will be monitored monthly at an operational meeting with key providers. These meetings will be in addition to the Local A&E Delivery Board.

Operational dates are;

- 23 November 2016
- 7st December 2016
- 8th February 2017

- 1st March 2017

Providers attending

- Bromley Healthcare – Operation Director
- PRUH – Managing Director
- GP Alliance- Director
- Bromley CCG, Clinical Lead (Chair) and Head of Contracts
- Greenbrooks UCC – Service Director
- Transfer of Care Bureau – Director
- London Borough of Bromley – Director, Health Integration Programme

Schemes will be monitored by outcomes and a set of key performance indicators and will be aligned to the PRUH Urgent Care Improvement Plan to measure the impact on the 4 hour target.

4.3 Escalation

Escalation and Winter Plans

Escalation in Bromley will be in-line with SE London escalation plans which have been co-created by, shared with and acted upon by all stakeholders within SE London including CCGs, Acute Trusts, Community Services, Social Services and Mental Health providers.

Below are the pre-defined triggers for, and actions in response to, each level of operational escalation in response to winter pressures. These levels mirror many of the systems already in use around the country, as well as the system that National Ambulance Resilience Unit (NARU) has recently developed.

In general, it is envisaged that local A&E Delivery Board areas will operate Operational Pressures Escalation Level (OPEL) One when operating within normal conditions.

OPEL One	Low levels of pressure across A&E Delivery Board area, relevant actions taken in response if deemed necessary,

	no support required
OPEL Two	Moderate pressure across A&E Delivery Board area, performance deterioration, escalation actions taken in response, support required
OPEL Three	Severe pressure across A&E Delivery Board area, significant deterioration in performance and quality, majority of escalation actions available are taken in response, increased support required
OPEL Four	Extreme pressure across A&E Delivery Board area, risk of service failure, all available escalation actions taken and potentially exhausted, extensive support and intervention required

Escalation Level	Acute Trusts	Community Care	Social Care	Primary Care	Other issues
OPEL One	• Demand for services above the established 'normal' level but capacity available to meet expected demand • Good patient flow through ED and other access points • Anticipated pressure on maintaining ED 4 hour target	Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings	• Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand	NHS 111 call volume within expected levels
OPEL Two	• Anticipated pressure in facilitating ambulance handovers • within 15 minutes • Discharges below expected norm • Slow patient flow through ED • Infection control issues emerging • Lack of beds across the Trust • Predicted discharges < expected admissions • ED patients with DTAs and no plan • Capacity pressures on PICU, NICU, and other intensive • Weather warnings suggest a significant care and specialist beds (possibly including ECMO)	• Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues Emerging	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	• GP attendances higher than expected levels • OOH service demand is above expected levels • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	Rising NHS 111 call volume above normal levels Surveillance information suggests an increase in demand Weather warnings suggest a significant increase in demand

OPEL Three	• Actions at level 2 failed to deliver capacity • Significant failure of ED 4 hour target • Significant ambulance handover delays • Patients awaiting handover from ambulance service within 15 minutes significantly compromised • Patient flow significantly compromised • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Weather warnings suggest a significant care and specialist beds (possibly including ECMO)	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50%(due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Pressure on OOH/GP services resulting in pressure on acute sector • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests an significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services Infection control issues resulting in significant pressure on services
OPEL Four	• Actions at level 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 30 minutes • ED patients with DTAs >8 hrs. • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds including ECMO	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Acute trust unable to admit GP referrals • Inability to see all OOH/GP urgent patients • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision	• Surveillance information suggests an significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services Infection control issues resulting in significant pressure on services

Escalation Level	Whole System	Acute Trusts	Commissioner	Community Care	Social Care	Primary Care	Other issues
OPEL One	Business as usual – actions determined locally in response to operational pressures, which should be in line with expectations at this level						
OPEL Two	Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate	• Undertake additional ward rounds to maximise rapid discharge of patients • Clinicians to prioritise discharges and accept outliers from any ward as appropriate implement measures in line with trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place • Notify CCG on-call Director to ensure that appropriate operational • actions are taken to • Maximise use of nurse led wards and nurse led discharges	• Expedite additional available capacity in primary care, out of hours, independent sector and community capacity • Co-ordinate the redirection of patients towards alternative care pathways as appropriate • Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers)	• Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. • Maximise use of re-ablement/interme diate care beds • Task community hospitals to bring forward discharges to allow transfers in as appropriate. • Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals.	• Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements • Ensure all patients waiting within another service are provided with appropriate service • Where possible, increase support and/or communication to patients at home to prevent admission. • Maximise use of reablement/interm ediate care beds	• Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community • In reach activity to ED departments to be maximised • Alert GPs to escalation and request alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service • Where possible, increase support and/or communicatio n to patients at home to prevent admission
OPEL 3	• All actions above done or considered	• ED consultant to be present in ED department 24/7, where possible • Contact on-take and ED	• Local regional office notified of alert status and involved in	• Community providers to continue to undertake	• Social Services on-call managers to expedite care packages	• OOH services to Recommend alternative care pathways	• To review all discharges currently referred and

	• Utilise all actions from local escalation plans • CEOs / Lead Directors have been involved in discussion and agree with escalation to black if needed	on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly • Enact process of cancelling day cases and staffing day beds overnight if appropriate. • Open additional beds on specific wards, where staffing allows. • ED to open an overflow area for emergency referrals, where staffing allows • Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages	discussions • CCG to co-ordinate communication and co- ordinate escalation response across the whole system including chairing the daily teleconferences • Notify CCG on-call Director who ensures appropriate operational actions are taken to relieve the pressure • Notify local DoS Lead and ensure NHS111 Provider is informed. • Cascade current system- wide status to GPs and OOH providers and advise	additional ward rounds and review admission and treatment thresholds to create capacity where possible • Community providers to expand capacity wherever possible through additional staffing and services, including primary care	• Increase domiciliary support to service users at home in order to prevent admission. • Ensure close communication with Acute Trust, including on site presence where possible	• In hours GP services to recommend alternative care pathways • Review staffing level of GP OOH service	assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission
OPEL Four	• Contribute to system-wide communications to update	• All actions from previous levels stood up • ED consultant to be present in ED department 24/7, where possible • Contact on-take and ED	• Local regional office notified of alert status and involved in decisions around support from	• Ensure all actions from previous stages enacted and all other options explored and utilised	• Senior Management team and cabinet member involved in decision making regarding use of	• Ensure all actions from previous stages enacted and all other options explored and	• Ensure all actions from previous stages enacted and all other options

	regularly on status of organisations (as per local communications plans) Provide mutual aid of staff and services across the local health economy • Stand-down of level 4 once review suggests pressure is alleviating • Post escalation: Contribute to the Root Cause Analysis and lessons learnt process through the SI investigation	on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical consultants to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7, where possible • An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG to request authorisation to explore a divert to neighbouring trusts whether these are in or out of the region.	beyond local boundaries • The CCGs will act as the hub of communication for all parties involved • Post escalation: Complete Root Cause Analysis and lessons learnt process in accordance with SI process	• Ensure all possible capacity has been freed and redeployed to ease systems pressures	additional resources from out of county if necessary • Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including supporting ED re prevention of admission & turn around. Identification via board rounds and links with Discharge team &therapists. • Hospital Service Manager/Deputy Director to monitor escalation status, taking part in teleconferences as required.	utilised • Ensure all possible actions are being taken on-going to alleviate system pressures	explored and utilised • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible

Local Escalation Diagram