WIRRAL

HEALTH AND WELLBEING BOARD

16TH NOVEMBER 2016

REPORT TITLE	*The Establishment of the Wirral Health Economy A&E Delivery Board*
REPORT OF	

REPORT SUMMARY

The following report provides the Wirral Health & Wellbeing Board with an update on the formation of the Wirral Health Economy A&E Delivery Board. It confirms the Terms of Reference including Health Economy Partners roles in sustained delivery of A&E performance and recommendations for both reporting and ongoing visibility across the Health economy for services which impact on emergency patient flows. It provides an update on the health economy assessment of its state of readiness to deliver the national service improvements outlined in the A&E Rapid Implementation guidance.

Establishment of the A&E Delivery Board

Earlier in the year following continued poor performance nationally against the 4 hour standard of 95% of patients to be seen, treated and either admitted or discharged from A&E a directive was issued by NHS England supported by NHS Improvement to establish both local (Wirral) and system wide (Wirral & West Cheshire) A&E delivery boards. These were to replace the previous CCG led System Resilience Groups (SRG) and to be chaired by the provider organization focused specifically on improving performance against the 4 hour standard. The expectation is that the members of the group are at executive / senior management level with the authority to make decisions on behalf of their organisation at the Board.

Whilst accountability for the delivery of the 4 hour standard sits within A&E and therefore the acute provider it is recognized that reliability of delivery is based on whole health economy patient flow and as such needs to be owned by all health and social care commissioners and providers. This is because any changes to capacity or demand across the health & social care economy have a direct impact on patient flow into ED, through the hospital and back home. Because of this accepted interdependency it is critical that there is a clear line of sight & transparency of all services which support urgent care and patient flow across the whole system.

On the 29th September 2016 the inaugural meeting of the Board was held. At the meeting the Terms of Reference **(Appendix1)** were agreed by all health & social care partners.

As part of the refresh two pieces of work were expected from each health economy and reported nationally these were:

- To undertake a baseline assessment of current service provision across all points of delivery against nationally agreed best practice outlined in the 'A&E Rapid Implementation Guidance' **(Appendix 2)**
- To align health economy escalation plans and expected response using the nationally agreed OPEL system **(Appendix3)**

Baseline Assessment Outcome

The self-assessment for the Wirral Health Economy was undertaken in partnership with all health economy providers including the North West Ambulance Service (NWAS). The results are detailed in **(Appendix 4)**.

As a health economy Wirral already had an overarching action plan to improve patient flow & ED performance developed & monitored by the Urgent Care Recovery Group. Therefore the key service improvement actions required as a result of the assessment were included in the health economy plan.

OPEL Implementation

Again, health economy partners are in the process of reviewing & aligning the new OPEL system to our existing system so that at any given time the health economy has a OPEL score (1 -4) but more importantly that the expected actions to support de-escalation are undertaken by each partner. It is worth recognising that some of these expected actions may /will have a resource implication for partner's e.g. opening additional capacity

Next Steps

Recognising the agency interdependencies it is equally important that the A&E delivery board have a full overview of the systems in place across Wirral which support patient flow. This needs to include:

- What services have been commissioned and their current capacity to include Primary, community, secondary & adult social care. The agreed contracts & provision including the services commissioned within the 'Better Care Fund'
- Performance against agreed KPI's or improvement KPI's for the commissioned services
- Where new services have been commissioned to support patient flow through the 'better care fund' that there is defined tracking of expected outcomes to monitor return on investment
- Any proposed changes to capacity (decommissioning of services)
- Any unplanned changes to capacity (loss of a care provision)

This will enable the system to understand the impact on performance of any changes to current capacity & demand and support the decision making process for any future investments in services

Reporting

The Wirral A&E Delivery Board reports directly through to the Wirral & West Cheshire A&E Delivery Board. However, each provider will need to agree how the reporting from the Board is fed into their existing governance arrangements.

It is recommended that the outputs from the Wirral A&E Delivery Board are reported to the Wirral Health & Wellbeing Board going forward so that there is clear line of sight at Health Economy level

RECOMMENDATION/S

The Health & Wellbeing Board is asked to:

- Note the progress to date on the establishment of the Wirral A&E Delivery Board.
- Give any feedback on the Terms of Reference
- Recognise the interdependencies of all health economy partners to the reliable delivery of the 4 Hour standard
- Understand that that the new national escalation system (OPEL) actions may result in a resource implication for providers
- Include Wirral ED Delivery Board update as a standing item on the Health & Wellbeing Board

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Appendix 1

Wirral A & E DELIVERY BOARD

TERMS OF REFERENCE

Scope

The focus of the local A & E Delivery Board is to be entirely focused on the delivery of the A&E 4 hour standard. Initially this will be all about recovery of the 4 hour standard but in the longer term working with STP leaders on the future delivery of the Urgent and Emergency Care Review.

The Delivery Board will also consider as part of its longer term planning whether it should span a wider geographical boundary.

Accountability and Core Responsibilities

It is important that every statutory body has a seat on the A & E Delivery Board at Executive Level with authority to commit to decisions on behalf of their organisation.

Their needs to be a mutual holding to account for systems to work effectively, as demonstrated in the Sustainability and Transformation Plan STP groupings.

Although leadership of the BCF will continue at WCCG and WMBC level the Delivery Board will have an important role in helping to implement action plans, particularly in the case of BCF DTOC plans where it can help align discharge elements of A & E plans and DTOC plans.

Core Responsibilities include:

- Leading A & E Recovery
- Developing plans for winter resilience and ensuring effective system wide surge and escalation processes exist
- Supporting whole-system planning (including with local authorities) and ownership of the discharge process
- Participating in the planning and operations of NHS111 services including oversight of local DOS development
- Agreeing deployment of any winter monies
- Agreeing how money in the STP footprints (& UEC Networks) deliver the UEC strategy locally with specific focus to be given to
    1. Expanded access to primary care
    2. Creating an out of hospital hub combing NHS 111 and OOH services
    3. Delivering on the 4 key UEC hospital standards
- Supporting the work started as part of the Vanguard model to ensure good outcomes and supporting spread

Work Programme

The Delivery Board work programme will be framed around the five mandated initiatives as part of the national A & E Improvement Plan. These being:

Appendix 1

1. Streaming at the front door – to ambulatory and primary care
2. NHS111 – Increasing the number of calls transferred for clinical advice
3. Ambulances – DoD and code review pilots: HEE increasing workforce
4. Improved flow – must do's that each Trust should implement to enhance patient flow
5. Discharge – mandating "Discharge to Assess" and "trusted assessor" type models

Membership

An Executive member from each of the following statutory organisations together with the Chairs of each of the two GP federations will form the membership of the Delivery Board:

- Wirral University Teaching Hospital NHS Foundation Trust
- Wirral Clinical Commissioning Group
- Wirral Community NHS Foundation Trust
- Wirral Metropolitan Borough Council
- Cheshire and Wirral Partnership NHS Foundation Trust
- North West Ambulance Service NHS Trust
- NHS Improvement
- NHS England
- Chairs of Primary Care Wirral and General Practice Wirral
- ECIP

The Chair of the Delivery Board will be the Chief Executive of Wirral University Teaching Hospital NHS Foundation Trust.

Quorum

A quorum of 75%, including either the Chair or Vice Chair, must be present to constitute a valid meeting. Deputies below Executive level will not count towards the quorum in view of the need to make decisions on behalf of the organisation.

Frequency of Meetings

The A & E Delivery Board will meet on a monthly basis although this will be subject to regular review. An Extraordinary Delivery Board may be called if the Chair in consultation with members determine that this is required.

Reporting

The Delivery Board will report to the Regional Delivery Board via the minutes and the Chair. The Board will be supported and receive reports from:

Conduct of the meeting

Minutes and action log will be kept by the secretary to the Delivery Board on behalf of the Chair. An annual work plan reflecting the Delivery Board's business will be prepared and agreed for the forthcoming year.

The agenda and supporting papers will be sent out 4 working days prior to the Delivery Board, unless there are exceptional circumstances authorised by the Chair.

NHS Improvement

NHS England

A&E Improvement in 2016/17

Rapid Implementation Guidance for local systems

August 2016

Introduction

Last month's reset letter and subsequent regional communications outlined our plans to restore A&E performance to 95%. This document sets out the 'must dos' for each of the five initiatives in the A&E Plan. It includes milestones, reporting requirements and how progress should be measured.

Most of these initiatives are not new. They are proven and effective good practice that can help improve performance, patient safety and reduce waste. However, implementation is at different stages of maturity across the country. The aim of the A&E Plan is to reduce this variation. All systems need to take stock, establish where the gaps are in depth and breadth of implementation and move rapidly to address these. Where local systems are delivering equally effective alternative approaches that are working this should continue. In short, systems are expected to 'comply or explain', particularly where performance is poor or below trajectory.

Each of the 5 areas for focus are set out in table format on the following slides. The technical guidance contains, milestones, timelines and a list of links that provide a range of support materials such as, case studies or best practice guidelines that are available online to help you. You will also have your own local experts – consultants, nurses, managers, therapists – who will be familiar with the initiatives and eager to implement them.
We have included in the technical guidance some baseline questions to help you with your gap analysis.

We are developing a baseline assessment tool to help you track progress using the BRAG rating system. This, and the reporting requirements from regional to national level, will be provided in the near future.

If you have any questions regarding this document please send your query to the email address provided at the end.

Priorities for making it happen

The actions below cut across all of the initiatives. They are the building blocks on which systems can facilitate real and sustained change. This is not an exhaustive list. If there are good processes already in place, the list below may be complementary.

	Key actions	Further information	Milestones	Timelines for delivery of milestones	Baseline questions
A1	Transforming SRGs into Local A&E Delivery Boards		• Executive representation • Representation from all statutory bodies for UEC • Local geographies reviewed and agreed • Agreed oversight of each initiative in the plan	Sep 2016	• Do you have an executive representation for each core organisation involved in your A&E Delivery Board? • Is the nominated chair agreed by members and supported to drive forward plans?
A2	All providers must develop an adequately resourced and dedicated team experienced in improvement methodologies ,to support delivery of the priorities in their A&E improvement plans.	*Guidance Reference A2*	• Where there is no current improvement team, a budget and recruitment plan should be in place • Improvement team in place	Sep 2016 Dec 2016	• Do providers have dedicated improvement teams? • Have these teams sufficient experience and staff to support implementation of complex clinical change programmes?
A3	Systems must formally assess their capacity and capability to deliver and sustain change using a recognised evaluation tool.	This exercise should take no longer than 2-3 days *Guidance Reference A3*	• Carry out a formal assessment using a recognised tool • Develop a plan to address significant gaps surfaced by the audit	Oct 2016 Nov 2016	• Have all organisations formally assessed their capacity, capability and readiness to affect change within the last year? • Have previous results been acted upon?

A4	**Identify an executive lead within partner organisations responsible for ensuring robust interrogation and action in response to intelligence**	**Identify an executive lead within partner organisations responsible for ensuring robust interrogation and action in response to intelligence** **Where an executive lead covers multiple geographies a delegate may be nominated to attend who is able to act on the their behalf.**	• **Identify (or confirm) an executive lead(s) and their responsibilities** • **Agree local process for interrogating and responding to intelligence**	**Aug 2016** **Aug 2016**	• **Do you have an executive lead within each organisation for the work streams?** • **Do you have a diagnosis of the underlying causes of barriers within your local health economy that is jointly-agreed with all organisations involved in the A&E Delivery Board?**
A5	The Regional Delivery Board has a joint winter plan	The plan should be agreed and signed off by the regional Delivery Board members	• Plan the design of the plan in collaboration with members • Locally and regionally test the plan	End of Sept 2016 End of Oct 2016	• Is the winter plan considered to be robust by all members? • Does the plan have wide coverage of winter pressures? • Are responsibilities of each organisation clear?

Guidance

A2

- 'Improvement teams' (US Health HR site) - http://www.hrsa.gov/quality/toolbox/methodology/improvementteams/part3.html
- 'The Health Foundation – Building the Foundations for Improvement' - http://www.health.org.uk/publication/building-foundations-improvement
- 'Reforming the NHS from within' - http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf

A3

- 'NHS Innovation and Improvement Sustainability Guide' - http://www.nhsiq.nhs.uk/download.ashx?mid=8863&nid=8862
- 'NHS IQ spread and adoption' - http://www.institute.nhs.uk/option,com_spread_and_adoption/Itemid,6946.html
- 'Sustainability Webinar' - http://www.institute.nhs.uk/option,com_spread_and_adoption/Itemid,6946.html

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 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.

A well designed streaming service 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.

Key actions	Technical Guidance
Processes should be in place to allow general practice and emergency departments immediate telephone access to discuss urgent referrals with senior doctors from all major admitting specialities.	 Streaming
Hospitals should consider developing a primary care stream in the emergency department where this can be justified following a review of patient arrival volumes by type, time/day, 4-hour breach patterns and cost effectiveness. This could be supported by on-site pharmacy services	
24/7 liaison mental health services for people of all ages should be available at all times within one hour of referral by an emergency department to navigate patients swiftly to appropriate physical or mental health services.	
Ambulatory Emergency Care for the major medical & surgical specialties should be available at least 12 hours a day, seven days a week to receive patients directly from primary care or the emergency department	
Processes should be in place to enable patients requiring urgent specialist assessment to be streamed directly to an appropriate assessment unit. This applies to patients referred for assessment by general practitioners as well as from emergency departments	
Trusts should have processes systematically to identify people with frailty syndromes and provide them with comprehensive geriatric assessment (CGA) within 24 hours of admission. An acute frailty service should be established to receive patients directly from streaming.	
Protocols should exist for specialty wards to receive agreed patients directly following referral from GPs and emergency departments. Local protocols should support the identification of these patients, initial assessment, investigation & management	
Rapid response community/intermediate care services should be available that can accept a patient within two hours of referral with a primary aim of supporting people at home	

Increase the % 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. The Integrated Urgent Care part of the A&E plan is focussed on the following specific requirements:

- **To increase nationally from 22% to an interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017**
- **To monitor A&E disposition rates to demonstrate a reduction in recommendations to attend**
- **To ensure accuracy and development of the local DoS to ensure callers are streamed to the most appropriate service, and only to A&E when clinically appropriate**

NHS England will ensure that actions which are best undertaken centrally (e.g. technical changes to NHS Pathways) are appropriately commissioned.

Key actions	Technical Guidance
Commissioners and Providers should ensure access to a range of clinical staff who have the necessary skills in specific areas of practice, these skill sets include mental health; pharmacy; dental; and independent prescribing	NHS 111
Commissioners and Providers should ensure additional clinical assessment of: NHS111 A&E dispositions and NHS111 Green Ambulance dispositions	
Commissioners should consider sharing care planning with all NHS 111 services via a flagging mechanism to allow Call Handler to recognise Special Patient Need and transfer to Clinician as appropriate	
Providers should consider tagging callers from Care Homes and direct these numbers directly to a Clinician	
Providers should consider the use of Interactive Voice Response (IVR) to transfer Dental and/or Pharmacy Calls more speedily to an appropriate clinician	
Commissioners should work closely with DoS Leads and NHS 111 call handling providers to ensure A&E services are appropriately ranked, so that alternative services (e.g. clinical hub, urgent care centre) are offered in preference to A&E where available.	
Commissioners should work closely with DoS Leads and urgent care providers to ensure alternatives to A&E have the widest clinical profile available and that there is always an alternate service to A&E.	
Commissioners should consider baselining of investment in clinical services	

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The 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**

Key actions	Technical Guidance
Implementation of Nature of Call (NoC) as a best practise early identifier of cardiac arrest and peri-arrest in-line with nationally agreed timetables	 Ambulance Services
Increase the number of ambulance service interventions where the most clinically appropriate resource is allocated to a 999 call first time through the use of Dispatch on Disposition (DoD) in line with nationally agreed timetables for local adoption.	
Adoption of clinical call categorisation based on robust evaluation of the clinical disposition of actual 999 calls in line with nationally agree timetables. This will help the system to support A&E performance through implementation of key activities identified through the Urgent & Emergency Care Review such as Hear and Treat and See and Treat where clinically appropriate.	
Seek local opportunities to increase Hear and Treat rates for 999 calls where clinically appropriate by making trained clinicians available to deal with 999 calls, particularly at times of peak demand (e.g. evenings and weekends).	
Seek local opportunities to increase See and Treat rates where clinically appropriate by making use of suitably trained ambulance clinicians responding to 999 calls to assess patients, complete management at scene, discharge and/or refer into alternative care pathways.	

Patient Flow

The following initiatives are the fundamental building blocks of good patient flow in Trusts. Effective implementation will reduce bed occupancy, improve performance, enhance patient safety and reduce costs.

Key actions	Technical Guidance
The **SAFER patient flow bundle** summarises a small number of key actions that if implemented systematically, will significantly improve patient flow. As a minimum, all acute trusts must **ensure that SAFER is implemented on assessment and medical wards.**	 Patient Flow
The 'red and green day' approach (a 'red day' is of no value to a patient while a 'green day' is of value) compliments SAFER and should be considered for all acute and community hospital inpatient wards.	
All inpatients must have a **written care plan that includes clinical criteria for discharge (CCDs) and an expected date of discharge (EDD)** so that multidisciplinary teams have clear goals for each patient. The care plan must be determined and signed off by the consultant within 14 hours of a patient's admission.	
The use of **ward round checklists** is essential to patient safety and should be mandatory	
Implement 'Internal Professional Standards' It is important within health care organisations, that all departments work together to agree response standards ('or 'internal professional standards'). Such standards should be agreed 'bottom up' through discussion between senior clinicians. Standards should be measureable, auditable and transparent so that everyone is clear about what to expect when making referrals or requesting tests and procedures. Trust boards should have evidence of the implementation of a wide range of locally agreed response standards ('internal professional standards') that are regularly audited and feature in board reports.	
Respond rapidly to requests for home visits Early and effective assessment of frail and vulnerable adults can enable general practice to plan alternatives to hospital admissions or arrange for early specialist hospital review. Where specialist assessment is needed, early conveyance ensures that patients attend hospital early enough to avoid a default admission, which is typical where patients arrive after 2pm. **General practices** should have processes in place to respond to and prioritise requests for urgent home visits, usually through early telephone assessment and a duty doctor rota.	
Commissioners of ambulance services should ensure that ambulance services respond rapidly to general practice requests relating to patients who may need an urgent ambulance service response and potential conveyance to hospital. This standard must be met at the time the response standard LES becomes operational.	

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Improving Discharge Processes

One of the major themes from the review of winter 2015/16 is the problems created by hospital discharge delays, caused by poor internal processes and external constraints. To combat this, all systems should implement best practice models to support their discharge processes and optimise patient flow.

Key actions	Technical Guidance
Embed 'home first: discharge to assess' ways of working	 Discharge
Embed 'trusted assessor' ways of working	
Implement policy on supporting patients' choices to avoid long hospital stays (if existing policy not in use)	
Reduce the number of NHS CHC screenings and full assessments taking place in an acute location	
Increase proportion of patients receiving RRR (rehabilitation, recovery and reablement) care in home or community settings	
Focus on simple discharge. Expediting routine (simple) discharges can be more effective in releasing beds than only concentrating on complex discharges.	

Contact Us

If you have any questions regarding this document or its contents, please email:

england.aeimplementationpmo@nhs.net

As well as responding to individual queries, we will produce a set of ‘frequently asked questions’ to support implementation

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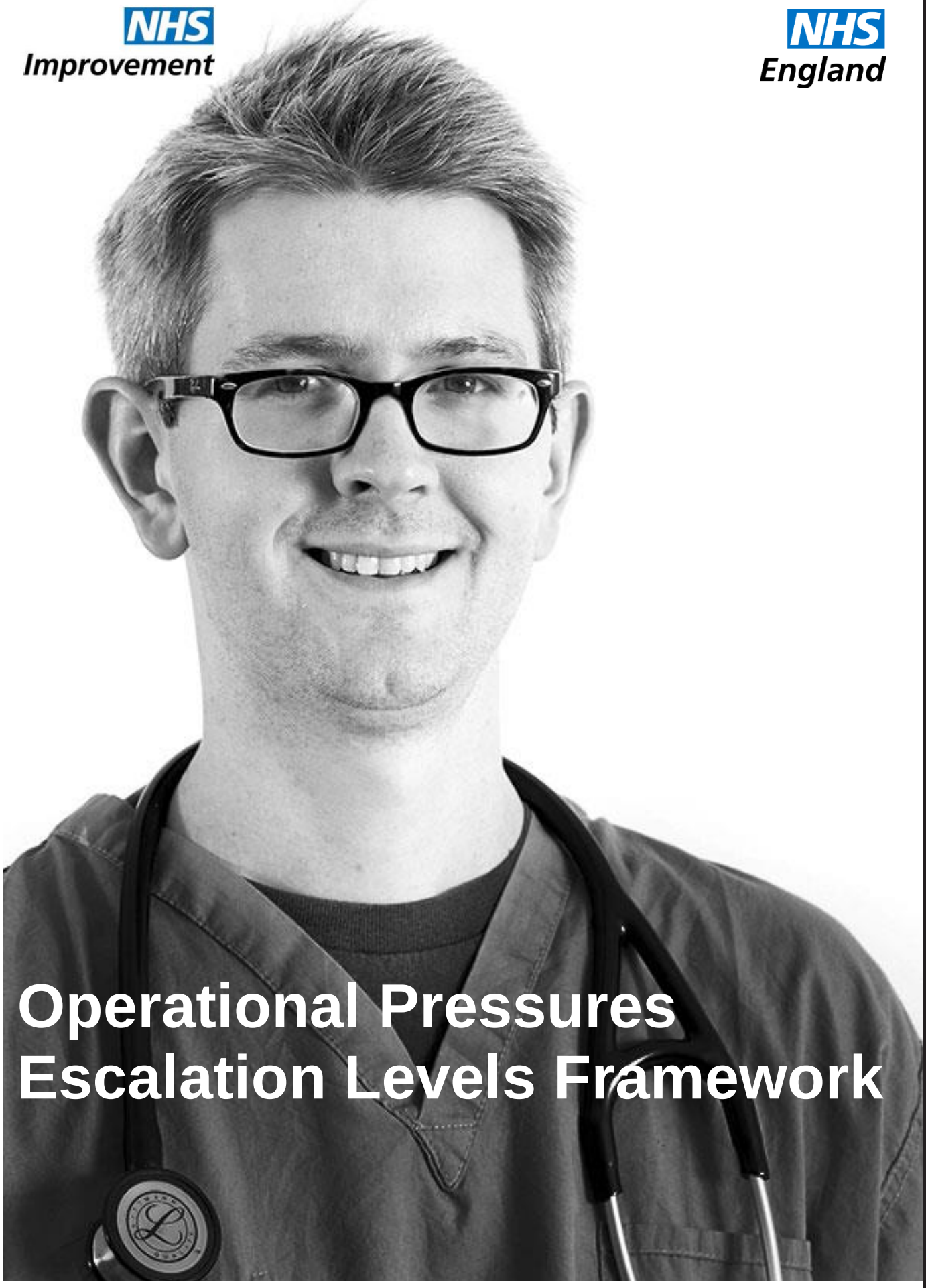

Operational Pressures Escalation Levels Framework

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Operational Pressures Escalation Levels Framework

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Contents

Glossary

OPEL	Operational Pressures Escalation Level
EPRR	Emergency Preparedness, Resilience and Response
REAP	Resource Escalation Action Plan, used by ambulance services
ALBs	Arms-Length Bodies (NHS England, NHS Improvement etc)
PICU Beds	Paediatric Intensive Care Unit Beds
NICU Beds	Neo-natal Intensive Care Unit Beds
ECMO Beds	Beds specifically for Extracorporeal Membrane Oxygenation - equipment similar to that used in heart-lung bypass operations – used in treatment of acute respiratory failure
DCO team	The teams that work for NHS England Directors of Commissioning Operations, which operate on a sub-regional footprint
ED	Emergency Department
DTA	Decision to admit
OOHs	Out of Hours services
DoS	Directory of Services
CCG	Clinical Commissioning Group
A&E	Accident & Emergency
CSU	Commissioning Support Unit
GP	General Practice

1 Introduction

1.1.1 Context

Operational escalation systems and protocols vary considerably from one local health economy to another. Whilst flexibility at local level is necessary, the absence of an overarching framework means variation between different systems creates inefficiencies and is unhelpful in several ways including:

i. Preventing effective cross-system working if terminology and protocols aren't aligned
ii. Making regional and national monitoring of operational pressures and winter surge difficult
iii. Creating confusion with the EPRR escalation framework
iv. Slower wider system response leading to spikes in waiting times.

A single national system will bring consistency to local approaches, improve management of system-wide escalation, encourage wider cooperation, and make regional and national oversight more effective and less burdensome.

1.1.2 Scope of this policy

The Operational Pressures Escalation Framework shares common actions with the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework[1], however they are not interchangeable. **EPRR escalation should therefore be considered separate to this framework.**

This framework has been developed for operational pressures and is applicable all year round, not just in response to winter pressures.

1.1.3 Aims and Objectives

The aims of this policy framework are to provide a consistent approach in times of pressure, specifically by:

i. Enabling local systems to maintain quality and patient safety
ii. Providing a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards to align with their existing escalation processes
iii. Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level (providers, commissioners and local authorities), by Directors of Commissioning Operations (DCO) and NHS Improvement sub-regional team level, regional level and national level
iv. Setting consistent terminology

[1] https://www.england.nhs.uk/ourwork/eprr/gf/

2 Benefits of a national framework

2.1 Benefits at local level

This framework does not seek to remove or override local management of operational pressures and escalation. Escalation planning at the local level should not take place in isolation, and a national framework will support and improve local and regional level planning by:

- Drawing on (and sharing) best practice in use across the country
- Providing a series of standardised triggers, actions and language which could enable a better understanding of:
    - Roles and responsibilities within an A&E Delivery Board footprint
    - Pressures being encountered in neighbouring A&E Delivery Board footprints
- Reducing the frequency and burden of reporting detailed information during periods of heightened pressure

Another benefit of a national framework to local systems is that it promotes transparent and fair responses from local providers, and a mechanism for local A&E Delivery Board leadership to challenge. For example, if provider A decides unilaterally to 'divert' and provider B (who is also encountering similar pressures) is cancelling elective activity to respond internally to manage their pressures, then this is unfair and the local A&E Delivery Board needs to use the escalation policy to moderate and ensure that all local system partners are operating consistently.

2.2 Benefits at regional and national level

Regional teams across NHS England and NHS Improvement have a crucial role to play in monitoring and managing escalation in response to surge pressures, particularly during winter.

Standardising the approach to escalation planning will enable regions to:

- Compare levels of pressure in different A&E Delivery Board footprints against the same criteria
- Facilitate better dialogue between different A&E Delivery Boards, especially in relation to any potential mutual aid and cross-regional boundary working
- Present a more coherent picture of operational pressures when aggregating up to a national level

2.3 Improved communications planning and handling

There are instances when operational pressures need to be communicated to the public to help reassure and manage demand. It is crucial that nationally consistent protocols and terminology be followed to ensure messages to the public are consistent and widely understood, with all local partners involved in the decision making process.

More detail on this is given in section 5.

3 Principles

3.1 Overview of the national framework

To enable local A&E Delivery Boards to align their escalation protocols to a standardised process, the national framework has been built on work already done across the four regions.

The levels mirror systems already in use around the country, and aligns with the national Resource Escalation Action Plan[2] (REAP) used by Ambulance trusts.

Operational Pressures Escalation Levels	
OPEL 1	**The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.**
OPEL 2	**The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.**
OPEL 3	**The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms**
OPEL 4	**Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.**

Local A&E Delivery Board areas will operate Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the A&E Delivery Board, as agreed locally.

[2] http://naru.org.uk/documents/resource-escalation-action-plan-reap/

4 The national escalation framework

Good surge management happens when health and social care partners come together to resolve pressure system-wide. Health and social care organisations have been working more closely in recent years to solve short term surge in parts of their system for the benefit of their whole population. This system partnership should continue.

A&E Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An A&E department could be experiencing isolated difficulties but the rest of the system is coping well; there are sufficient beds available and there is good flow through the system. Alternatively, an A&E could be managing well whilst the rest of the hospital, and the wider system; community beds, community services and social care are experiencing high pressures due to a lack of capacity.

4.1 Escalation triggers at each level

- Local A&E Delivery Boards should align their existing systems to the escalation triggers and terminology used below, and add to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.**
- Local A&E Delivery Boards should be able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.
- **National terminology (OPEL) should be adopted by all systems.**
- **Local specific triggers and actions should then be shared and agreed with DCO/sub-regional teams during assurance.**

Escalation level	Acute Trust (s)	Community Care	Social care	Primary care	Other issues
OPEL One	• Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. No staffing issues identified • No technological difficulties impacting on patient care • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. Pressure on maintaining ED 4 hour target • Infection control issues monitored and deemed within normal parameters	• 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 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services • Lack of beds across the Trust • ED patients with DTAs and no action plan • Capacity pressures on PICU, NICU, and other intensive 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 • Lower levels of staff available, but are sufficient to maintain services	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services	• 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) • Lower levels of staff available, but are sufficient to maintain services	• 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 OPEL 2 failed to deliver capacity • Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Hospitals within 48 hour timeframe • Awaiting equipment causing delays for a number of other patients • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 2 hours	• 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 OPEL 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • 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 (possibly including ECMO) • Infectious illness, Norovirus, Severe weather, and other pressures in Acute Trusts (including A&E handover breaches) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 4 hours	• 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 / patient safety	

4.2 Mitigating actions at each level

The following list of actions for each level of escalation are not exhaustive, and should be added to at the local level as needed. When a decision is taken to move to a higher level of escalation, the following actions (and any additional locally determined actions), should be implemented or considered.

Escalation level	Whole system	Acute trust	Commissioner	Community Care	Social care	Primary care	Mental Health
OPEL One	• Named individuals across Local A&E Delivery Board to maintain whole system coordination with actions determined locally in response to operational pressures, which should be in line with business as usual expectations at this level • Maintain whole system staffing capacity assessment • Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases • Active monitoring of infection control issues • Maintain timely updating of local information systems • Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken • Proactive public communication strategy eg. Stay Well messages, Cold Weather alerts • Maintain routine active monitoring of external risk factors including Flu, Weather.						
OPEL Two	•All actions above done or considered •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 • Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	• 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/intermediate 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 re-ablement/intermediate 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 consider alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service • Where possible, increase support and/or communication to patients at home to prevent admission
OPEL Three	•All actions above done or considered •Utilise all actions from local escalation plans • CEOs / Lead Directors have been involved in discussion and	• ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff • Senior clinical decision makers 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.	• Local regional office notified of alert status and involved in 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	• Community providers to continue to undertake 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,	• Social Services on-call managers to expedite care packages • 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	• OOH services to recommend alternative care pathways • Engage GP services and inform them of rising operational pressures and to plan for recommending	• To review all discharges currently referred and assist with whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible

	agree with escalation to OPEL 4 if needed	• 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 Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	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 to recommend alternative care pathways.	including primary care		alternative care pathways where feasible • Review staffing level of GP OOH service	• Increase support to service users at home in order to prevent admission
OPEL Four	• All actions above done or considered •Contribute to system-wide communications to update 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 learned process	• All actions from previous levels stood up • ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff •Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical senior clinical decision makers 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 and neighbouring trusts to agree a divert.**	• Local regional office notified of alert status and involved in decisions around support from beyond local boundaries • The CCGs will act as the hub of communication for all parties involved • **Post escalation:** Complete Root Cause Analysis and lessons learned process	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible capacity has been freed and redeployed to ease systems pressures	• Senior Management team involved in decision making regarding use of 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.	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible actions are being taken on-going to alleviate system pressures	• Ensure all actions from previous stages enacted and all other options explored and utilised • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible

4.3 Reporting arrangements

All year round, reporting should be on an exception basis only, with reporting processes agreed between local systems and the relevant NHS England DCO team and NHS Improvement sub-regional team. For the winter period (commencing 01 December and ending, at the earliest, on 28 February), there will be daily escalation status reporting processes in place (by exception).

A&E Delivery Boards should notify NHS England DCO/NHS Improvement sub-regional teams if escalation status is raised to OPEL 2 (if agreed locally), and should provide a full report if escalation is raised to OPEL 3 (details of specific reporting requirements to be agreed locally), with daily updates on the situation until escalation has been stood down.

If an A&E Delivery Board escalates to OPEL 4, updates to DCO/NHS Improvement sub-regional teams should be agreed as frequently as necessary between the board and the DCO/sub-regional teams, this is to ensure all support and interventions are available to facilitate standing down escalation as soon as it is appropriate to do so.

Escalation status should be discussed in conjunction with relevant information from the NHS Improvement dashboard which will contain daily activity data. For OPEL 3 and OPEL 4, there will be a yes/no reporting field in the daily sitrep collection, for trusts to signal if their system has been in that level of escalation in the past 24 hours.

4.4 Roles and responsibilities

4.4.1 Local, regional and national level

Organisation	Role/ Responsibility
Local A&E Delivery Board	• All providers should: ○ Maintain timely updating of local information systems that monitor pressures in their patch ○ Ensure all trust level pressures are communicated regularly to all local partner organisations, and communicate all trust level escalation actions taken (e.g. opening escalation beds) • Acute providers should: ○ Investigate at a senior (executive or nominated deputy) level the reasons for diverts (last resorts) and identify and apply the lessons to prevent reoccurrence. ○ Liaise with local ambulance services over pressure levels affecting EDs and address issues including increased ambulance handover times etc.
	• CCGs should: ○ Keep in touch with the day to day situation across the patch and be aware of any developing issues. This includes information on community services, mental health etc. ○ Maintain oversight of the A&E Delivery Board area (including social care system) and monitor receipt of hot weather / cold weather / flooding alerts and ensure appropriate actions are taken in response. ○ Agree the measures taken by commissioned partners to address increased demand for NHS services. ○ Broker agreements across the patch and ensure mutual aid is available if required to re-balance pressures (e.g. acute and community services). If there is protracted failure to reach a conclusion favourable to patient care, ALBs may intervene to help reach a resolution. ○ Liaise with bordering CCG/ CSUs on any issues which may impact upon their own pressures, and advise ALBs if there are any actions that cannot be taken locally in partnership. ○ Commission additional resources (beds, staff etc.) and ensure local CCG demand management initiatives are working during times of surge. ○ Ensure the NHS 111 Directory of Services (DoS) is kept up to date in respect of any changes to community capacity. ○ Ensure a full investigation and debrief takes place following a system-wide escalation to level 4, share findings with all A&E Delivery Board partners, and ensure actions are implemented to prevent reoccurrence.

Joint NHS England/NHS Improvement teams (DCO and sub-regional footprint)	• Maintain arrangements to review daily pressure across the NHS. • Put a process in place to inform providers of relevant alerts. • Provide advice and guidance to CCGs on the handling of escalating situations. • Where applicable locally, ALBs to be informed of any agreed diverts. • Agree reporting requirements at a local level. • Ensure that communication protocols are followed if pressures affecting Trusts outside of the local area are likely to impact across boundaries. • Implement coordination arrangements as pressure levels increase across agreed thresholds. • Ensure that 'lessons learned' events are held locally and updated plans reflect the actions identified and agreed. • Inform ALB regional operations and communications colleagues of system pressures. • Inform ALB regional teams regarding system-wide escalation to OPEL 3 or 4 and actions being taken.
Joint NHS England/NHS Improvement teams (Regional A&E Delivery Boards)	• Provide oversight and coordination to local ALB teams where system-wide level 4 applies across a number of areas in the region. • Proactively brief and liaise other ALB regions and central team as appropriate. • Support local ALB teams as required.
Joint NHS England/NHS Improvement teams (National A&E Delivery Board)	• Coordinate routine reporting arrangements e.g. winter sit rep • Provide oversight and coordination to regional ALB teams where system-wide OPEL 4 applies. Support cross-regional boundary working where required • Identify and implement National actions if required. • Ensure comms support is available and comms responses are coordinated between local, regional and national comms teams

In areas where DCO and regional teams are co-located, roles and responsibilities can be interchangeable with actions taken jointly in support of a response.

4.4.2 Expectations of local A&E Delivery Boards

Individual A&E Delivery Boards are expected to identify named senior individuals to lead on and manage the escalation and de-escalation processes at local level (this framework does not seek to prescribe the detail of escalation processes and management).

Regular whole system teleconferences are a useful way to co-ordinate a response to an escalating or de-escalating situation and can be managed at the discretion of individual organisations. The scheduling of system wide meetings can be part of local 'business as usual' systems resilience processes or arranged when deemed necessary. The following points should be addressed as part of system resilience and escalation framework planning processes and are seen as a good practice checklist:

1. Each A&E Delivery Board partner organisation must have a robust, up-to-date local escalation plan signed off at Board level which dovetails into up-to-date overarching Delivery Board wide plans and focuses on early warning triggers;
2. Each acute trust is required to have, and comply with, an ambulance services handover plan;
3. Escalation planning must form an integral part of system resilience and winter planning of all partner organisations in the local A&E Delivery Board, throughout all community and hospital care settings, with due regard for emergency, elective and on-going patient / service user care;
4. It is expected that all local escalation plans will have clearly defined escalation triggers including (but not limited to) the triggers included in section 4.1 of this framework**;**
5. Special action will be required where an Emergency Department (ED) has to close (as opposed to not being able to receive new attenders) as it will not be able to offer resuscitation facilities. **This must go through NHS England DCO teams in conjunction with the relevant CCGs;**
6. There must be clear identification of the system leaders (including identification of organisation, role/s and responsibilities) who will oversee all levels of escalation, especially those where whole A&E Delivery Board action is needed to avoid or mitigate pressure, and where external support might be required;
7. Where an organisation and / or an A&E Delivery Board have raised their escalation status it is expected that the executive directors of the lead commissioners shall lead the de-escalation process once review shows suitably reduced pressure.

Additional points for consideration:

- Timely and fit for purpose information is crucial to the management of the escalation and de-escalation process;
- Consideration must be given to the onward care of patients transferred or initially taken to a receiving organisation
- Executive level director in each partner organisation should hold the responsibility for ensuring that escalation plans are actioned and reviewed;

- All escalation plans relating to a given A&E Delivery Board should be readily available to all relevant managers and clinicians. All should have a clear, current understanding of the processes;
- The impact on ED facilities due to the knock on effect of another local system must be considered;
- A stringent response to all ambulance handover delays is essential.

5 Communications

The variation of terminology, triggers and actions across the country has been known to lead to local confusion and can hinder effective responses to escalation.

There have been instances of escalation alerts being declared by Trusts before local, regional and national partners have been notified and given the opportunity to input and offer support. This should be avoided wherever possible.

5.1 Communications with local partners

It is expected that all local A&E Delivery Boards will follow agreed steps in terms of communications with partner organisations regarding escalation.

The list of required steps is not exhaustive and should be added to at the discretion of local leaders, but the decision to escalate should always involve:

- Discussion with all local partners involved in urgent and emergency care (providers and commissioners), to ensure there is agreement the escalation is necessary and appropriate
- Alerting local authorities to ensure social services are aware and prepared
- Ensuring the formal decision to escalate comes from named individuals in the local A&E Delivery Board footprint with the appropriate seniority
- Discussion with NHS England and NHS Improvement sub-regional teams to ensure neighbouring systems can be notified and proper support can be considered (as appropriate dependent on the level of escalation)

5.2 Protocols for reporting to NHS England and NHS Improvement

A key step in standardising processes across the country is for local A&E Delivery Boards to report pressures and escalation steps in a manner consistent with the national framework.

Therefore, all local A&E Delivery Boards must do the following when reporting their escalation status to the ALBs:

1. Communicate their official escalation status using the terminology in the national framework. In practice this means using OPEL 1 to 4.
2. When communicating their formal escalation status to ALBs, be prepared to demonstrate that they:
    a. Have met the relevant criteria to warrant escalation to the reported level, as set out in the national framework

   b. Have taken, or at least considered and can provide a rationale for not taking, all appropriate action associated with each level of escalation as set out in the national framework
   c. Have discussed escalation with all relevant local partner organisations, to ensure everyone is primed for upcoming actions
3. When all relevant steps have been followed and the collective decision to escalate has been made, this must be communicated to local NHS England and NHS Improvement colleagues before any wider communication (with the press and public).

5.3 Communications with the public

In a similar way to communications with ALBs, it is important that communication with the public is done in a way that is consistent with the national framework.

By conducting external and public facing communications in a clear and consistent manner, local A&E Delivery Boards can:

1. Communicate operational pressures and actions taken in response more coherently and efficiently to reassure patients and the public
2. Portray an accurate picture of operational pressures to the staff and the public, which will potentially reduce the amount of queries received, freeing up system leaders to focus on management of pressures
3. Accurately inform the public of the pressures on services in their local area, and advise on any actions or response required of them.

5.4 Using public communication of escalation and operational pressures to manage demand

It is recognised that at times of severe operational pressure, it may be necessary to communicate these pressures to the public to help manage demand and bring stability to the situation.

Service disruptions are more likely to occur during winter, and when this happens there is a recognised need for local health and care leaders to communicate this via the press, to ensure local populations are well informed of pressures in their area and how they can access the care they need even during times of pressure.

Local A&E Delivery Boards (and constituent member organisations) are therefore strongly encouraged to engage with local media ahead of winter to set out and explain the issues and processes to support effective communication with the public.

When doing so, all organisations in the local A&E Delivery Board area should take the following steps:

1. Ensure all partner organisations are made aware of any public facing communications being issued in relation to operational pressures and escalation, and should be sighted on these communications ahead of time if possible

2. Ensure terminology consistent with the national framework is used when describing the operational pressures and escalation status within the local area
3. Ensure the description of the operational pressures and escalation status is accurate and responses being taken are proportionate
4. If the decision is taken by organisations within an A&E Delivery Board area to communicate to the public that A&E pressures are severe, and advise them to consider alternative places to seek treatment, then detailed information on all appropriate alternatives must be provided

6 Next steps

6.1 Actions required

Escalation systems used at a local level will vary considerably from one health economy to another, to reflect circumstances unique to each local area.

Local A&E Delivery Boards do not necessarily need to discard any existing protocols, triggers and agreed actions that are in place across local partners and may well be embedded into local planning arrangements. However, all local arrangements must be aligned to the national framework, and there are a number of changes that need to be adopted, and actions taken by all local A&E Delivery Boards which are set out in the following sections.

6.1.1 Aligning local escalation systems to the national framework

There are a number of actions that all local A&E Delivery Boards must take in response to this policy:

1. **Ensure that all escalation levels used locally are aligned to the levels described in the national framework.**
2. Whilst the list of triggers, actions and protocols included in the national framework is not exhaustive and does not exclude local systems adding to these in their own escalation protocols, **all triggers, actions and protocols included in the national framework should be considered at local level.**
3. As escalation levels rise, **there are defined actions required in the national framework regarding how escalation is communicated to local partners and upwards to ALBs.** The expectation is that all health economies will build this into their own escalation systems used locally.

6.1.2 Involvement of DCO and regional teams

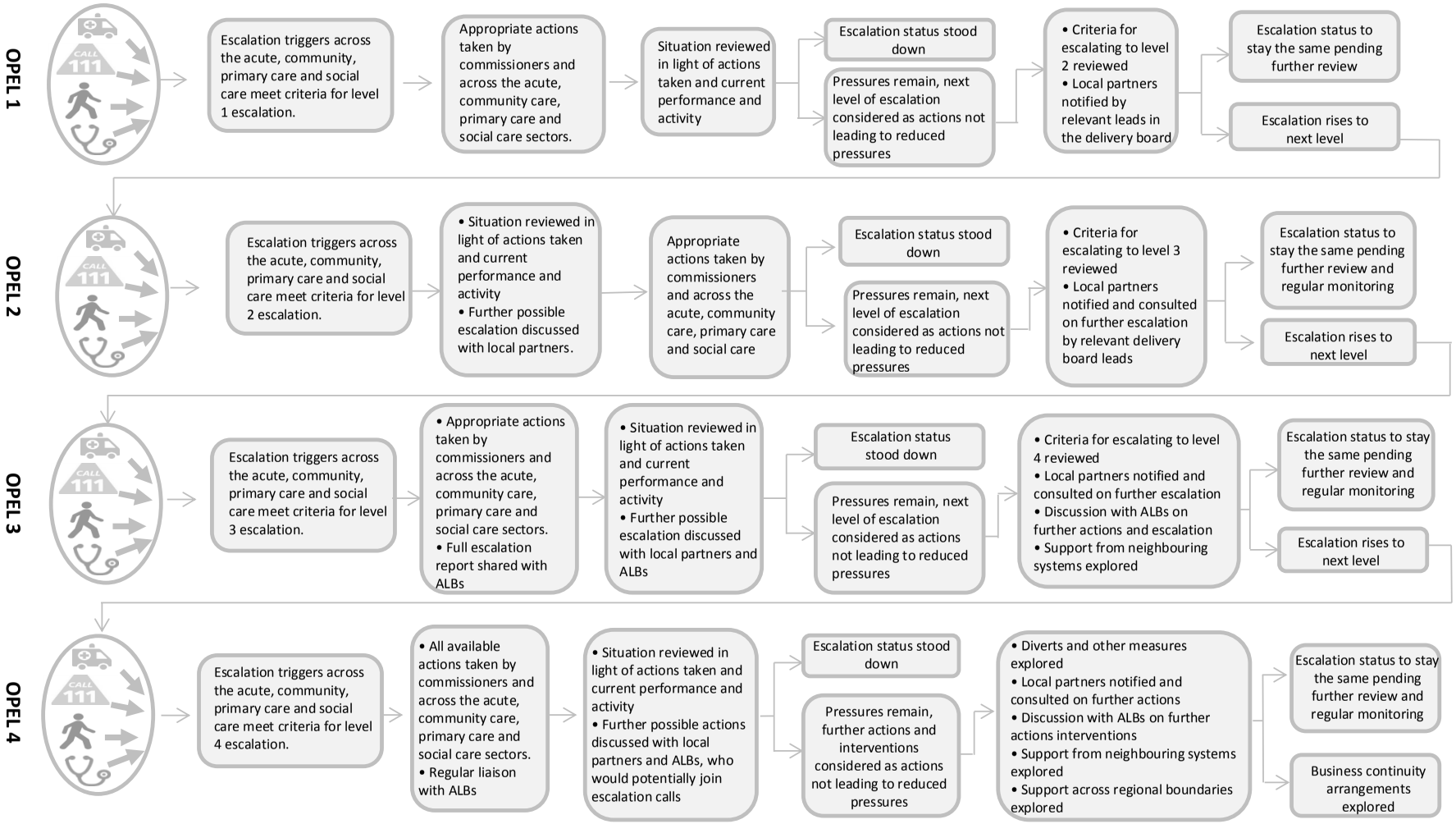
NHS England DCO and NHS Improvement sub-regional teams will work with local A&E Delivery Boards to migrate to revised escalation systems, in line with the national framework.

6.1.3 On-going review

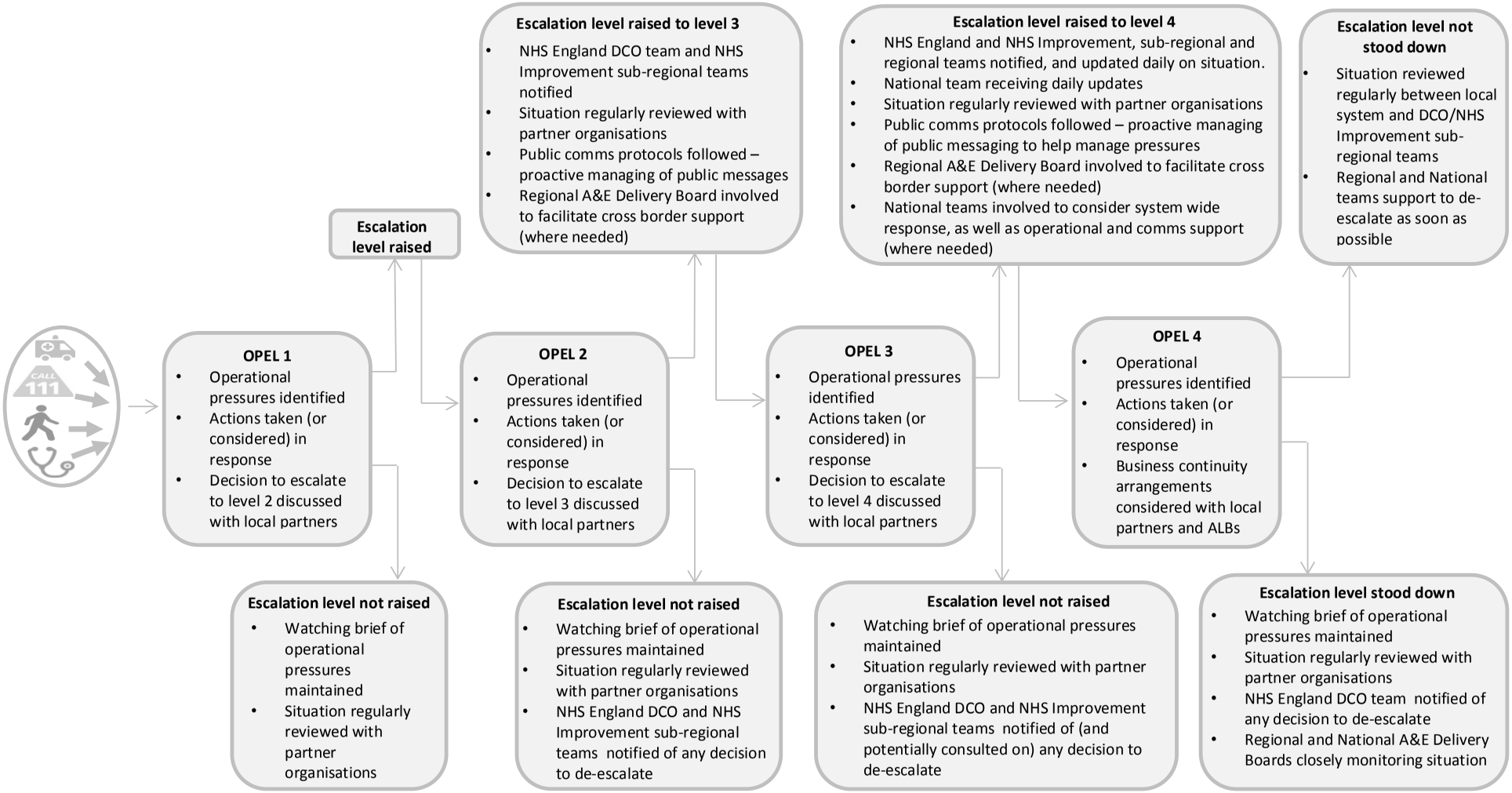
This framework will be reviewed and refreshed as needed on an annual basis.

6.2 Annex – The escalation process

6.2.1 Local escalation processes



6.2.2 Escalation and protocols with local partners, NHS England and NHS Improvement



A&E DELIVERY BOARD	
Agenda Item	2.1
Title of Report	Accident & Emergency (A&E) Rapid Implementation Guidance - Baseline Assessment
Date of Meeting	29th September 2016
Author	Janelle Holmes Chief Operating Officer
Purpose of the Paper	To provide an overview of the health economy baseline assessment & agree the mechanism for ongoing monitoring of the required service improvement to be compliant with the recommendations

1. Background

Earlier in the year following continued poor performance nationally against the 4 hour standard of 95% of patients to be seen ,treated and either admitted or discharged from A&E a directive was issued by NHS England supported by NHS Improvement to establish both local and system wide A&E delivery boards. These were to replace the previous CCG led System Resilience Groups (SRG) and to be chaired by the provider organization focused specifically on improving performance against the 4 hour standard. Whilst accountability for the delivery of the 4 hour standard sits within A&E it is recognized that reliability of delivery is based on whole health economy patient flow and as such needs to be owned by all health and social care providers.

As part of this change and following the publication of 'The A&E Rapid Implementation Guidance' each health economy and wider system had to submit a baseline assessment of the current service provision which supports patient flow and ultimately ED performance. The self-assessment for the Wirral Health Economy was undertaken in partnership with all health economy providers including the North West Ambulance Service. The results are detailed in the attached spread sheet.

2. Baseline Assessment Outcome

The baseline assessment was separated into 5 sections and asked providers to grade a number of work streams based on availability within the economy as described below

Blue = Scheme already in place/alternative in place (Please provide details in commentary)
Green = actions in place and on track for initiative to be implemented within rapid implementation guidance timeframes
Amber = in plans, but risks associated with delivery (Please provide details in commentary)
Red = no evidence of existing implementation or in system plans .

Section 1- ED Streaming

Of the six recommended service areas five were assessed as green and blue with one red.

Red

- Primary Care Stream available for ED

Section 2 - Improved Flow

Of the five recommendations all five were assessed as green or blue.

Section 3 - Improved Discharge
Of the seven recommendations there were two blue, four amber and one red.

Amber

- System in place to review inpatient stays of greater than six days.
- First home – Discharge to Assess Pathway.
- Trusted assessor arrangements in place.
- Responsible Director in the Trust to monitor DTOC situation daily and provide reports to the Board on the issue.

Red

- 90% of Continuing Health Care screenings are conducted outside of the acute setting.

Section 4 - NWAS / 111
Of the six standards there were three green/blue and three amber.

Amber

- Lead in place starting to integrate 111 with local OOHs hospital provision.
- Alternative services in place which can accept and manage patients outsideof the ED.
- ED Board has visibility of demographics of the area and where demand is generated, OOHs specifically in the elderly population.

Section 5 - Ambulances
Of the five standards two assessed as green, two amber and one red.

Amber

- There are working definitions and pathways for 'Hear and Treat' and 'See and Treat'.
- There are alternative services for ambulance dispositions mapped across the Health Economy.

Red

- The ED Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions.

3. Recommendations

It is recognized that there is a significant amount of improvement work being scoped and/or implemented across the Wirral Health economy led by all providers in response to prior ECIP recommendations. This improvement work is being monitored through the health economy Urgent Care Recovery Group (UCRG)

It is recommended that

- the UCRG review the baseline assessment and ensure that all the recommendations assessed as amber or red are reflected in the current work programme with appropriate timescales for delivery and service lead identified. In addition that green schemes are tracked through for completion.

- a progress report is provided monthly at the Wirral A&E delivery board as a standard agenda item.

Delivery against improvement plan
Delivery against Winter Resilience

Sub-Region	A&E Delivery Board	Chair	CCG(s)	Acute Providers(s)	Overall Assessment	ED streaming	Increase in NHS 111 calls	Ambulance Response Programme	Improving Flow	Discharge	Governance & Leadership	Capacity, Demand & Data Analysis	Non Acute Demand (Out of Hospital Care)	Winter Readiness	2016/17 Apr	2016/17 May	2016/17 Jun	2016/17 Jul	Q1	QTD	STF Trajectory	DTOC Rate Current	Key Risks and issues identified	Key Actions	Expected timescale for moving to "Assured"
Sub-Region	A&E Delivery Board	Chair	CCG(s)	Acute Providers(s)	Overall Assessment	ED streaming	Increase in NHS 111 calls	Ambulance Response Programme	Improving Flow	Discharge	Governance & Leadership	Capacity, Demand & Data Analysis	Non Acute Demand (Out of Hospital Care)	Winter Readiness	2016/17 Apr	2016/17 May	2016/17 Jun	2016/17 Jul	Q1	QTD	STF Trajectory	DTOC Rate Current	Key Risks and issues identified	Key Actions	Expected timescale for moving to "Assured"
	West Cheshire and Wirral	David Allison (CEO at Wirral University Teaching Hospital).	Western Cheshire	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	Partially Assured	Partially Assured	Partially Assured	Partially Assured	Partially Assured	Partially Assured	Partially Assured	Partially Assured	Partially Assured	Partially Assured									Overall, WUTH winter plan & associated documents appear to be good. **ED Streaming:** Baseline assessment = in place/plans to deliver. **Ambulance and Patient flow:** Wirral has service & plan. **Patient Flow:** ECIP has been working WUTH to implement SAFER & plans appear robust to embed this way of working. WUTH have also identified additional bed capacity to manage winter pressures. **Discharge:** WUTH is funding community beds, which are, in effect, D2A. There have been issues with domiciliary care provision in Wirral & it is not clear as to whether these have been resolved. **Governance & Leadership:** The board is established with sub-boards in Wirral & West Cheshire.		Not known until a resilient CoCH plan is produced
			Wirral	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST											85.3%	83.4%	87.6%	88.5%	85.4%	88.5%	85.0%	5.5%			
Sub-Region	A&E Delivery Board	Chair	CCG(s)	Acute Providers(s)	Overall Assessment	ED streaming	Increase in NHS 111 calls	Ambulance Response Programme	Improving Flow	Discharge	Governance & Leadership	Capacity, Demand & Data Analysis	Non Acute Demand (Out of Hospital Care)	Winter Readiness	2016/17 Apr	2016/17 May	2016/17 Jun	2016/17 Jul	Q1	QTD	STF Trajectory	DTOC Rate Current	Key Risks and issues identified	Key Actions	Expected timescale for moving to "Assured"