Livewell Southwest

Patient Flow and Escalation Management Policy (Operational Pressures Escalation Framework)

Version 1

Review: December 2017

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Community Urgent Care Services Manager**

Asset Number: **942**

Reader Information

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Author	Sarah Pearce, Community Urgent Care Services Manager
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Is the Equality and Diversity Policy referenced	[NA]
Is the Equality Act 2010 referenced	[NA]
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Associated documentation	N/A
Supersedes document	Escalation Policy
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New Policy to replace Escalation Policy	November 2016	NHS England revised guidance.	Old policy replaced in line with revised national guidance.
1	Minor amends	December 2016	PRG	Minor amends

Patient Flow and Escalation Management Policy (Operational Pressures Escalation Framework)

1 Introduction

1.1 Livewell Southwest (LSW) is committed to supporting the health and social care system to manage patient flow in and out of hospital. This document describes a series of schemes to support the patient flow across the whole system, and outlines the escalation process for the system.

2 Purpose

2.1 This policy sets out LSW response to escalation and resilience planning and managing capacity across the system. It contains business as usual actions to maintain flow and our resilience plan to use in times of escalation across the system.
This policy brings all resilience and escalation planning actions into one document.

3 Definitions

3.1 LSW: Livewell Southwest

3.2 IHDT: Integrated Hospital Discharge Team

3.3 UC-CCC: Urgent Care-Commissioning Control Centre

3.4 CCG: Clinical Commissioning Group

4 Duties & responsibilities

4.1 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

4.2 The Board of **Director(s)** have overall responsibility and accountability for ensuring resilience and capacity arrangements described in this policy are in place and effective within the organisation. The Devon A+E Delivery Board is represented at Director Level.

4.3 Responsibility of **line managers**
All members of the organisation's Senior Management Team are responsible for the operational implementation and maintenance of resilience management arrangements in their individual areas of responsibility.

4.4 Responsibility of all **staff**
To work within the requirements of the policy.

5 Business as Usual Schemes and actions in OPEL that support Resilience across the system

5.1 LSW has a range of teams that support patient flow across the system. Each team has set out business as usual actions to maintain flow, and those they would take at OPEL levels as a response to operational pressures escalation levels across the system. (See Appendix A).

6 The Operational Pressures Escalation (OPEL) Framework

6.1 The purpose of this escalation framework is to describe the arrangements in place to enable LSW to manage day to day variations in demand across its services as well as the procedures for managing significant surges in demand across the system. The plan follows NHS England Operational Pressures Escalation (OPEL) Framework, October 2016. (See Appendix B).

6.2 All communications within and across organisations will adhere strictly to four levels of escalation as set out in the National Guidance:

Operational Pressures Escalation Levels	
OPEL one	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 two	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 three	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 four	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.

6.3 The OPEL levels replace the previous escalation descriptor levels of Green (OPEL 1), Amber (OPEL 2), Red (OPEL 3) and Black (OPEL 4).

7. Escalation Management and Process

7.1 Each organisation is responsible for defining their triggers and actions within the organisational framework in terms of their internal responses at each level of escalation. If their escalation plans seek or require mutual-aid or recognised assistance from another organisation this must be formally agreed with that organisation and set up with trigger levels and communication channels and signed-off by the relevant A+E board.
NHS England guidance to define escalation levels and triggers is described in Appendix C and D.

7.2 **LSW Local Triggers to define OPEL Status**:

Overall Position (to calculate add scores across all services): Green= 1, Amber=2, Red=3
OPEL 1 = Maximum score 10
OPEL 2 = Score between 10-19
OPEL 3 = Score 20-30
OPEL 4 = Score 31+
In-patient and patient flow services:
Delays (across LSW community beds) *Green = <10 Amber =10-20 Red = >20*
Medically Fit Waiting list - PNRU (Green = <3, Amber = 3-5, Red 6>)
Medically Fit Waiting list – Community Bed (LCC/Tavistock and Kingsbridge) (Green = <5, Amber = >5-10, Red 10>)
Medically Fit Waiting list - Stroke (Green = <3, Amber = >3-8, Red 8>)
Total Discharges expected from LSW community beds (Green = <3, Amber <2, Red <1)
Integrated Hospital Discharge Team: Green= Able to allocate new referrals same day Amber= Reduced capacity to allocate new referrals Red= No capacity to allocate new referrals
Early Supported Discharge Team (Stroke): Green= Capacity to take same day referrals onto caseload Amber= Reduced capacity to take new referrals on same day Red= Caseload full with no capacity
Alternatives to attendance/admission teams:
MIUs: Green= Planned to be open until 21.00hrs and fully staffed Amber = Reduced staffing that may impact on ability to open until 21.00hrs Red = Reduced staffing that will impact on opening times

Community Crisis Response Team: Green = Fully staffed and able to respond within 2hrs, access to packages and placements Amber = Reduced access to placements and packages Red = No access to placements and packages
Robin CAH: Green = planned to be open until 19.00rs and fully staffed Amber = Reduced MDT staffing, Kingfisher beds full, X-ray capacity limited Red= No x-ray, no flow from Kingfisher beds and reduced staffing
Acute GP's: Green= AGPs and ACU fully staffed and space available in ACU for treatment Amber= reduced staffing across AGP/ACU Red= No space in ACU and no nursing support in ACU. Reduced staffing
Acute Care @ Home: Green = Capacity to take same day referrals Amber= reduced staffing impacting on ability to take BD and/or TDS referrals Red=no capacity to take any new referrals
Infection Control:
DN's: Green= 0 Outbreaks across LSW Amber= 1 Outbreak across LSW Red = >1 Outbreak across LSW

Each organisation will submit a **self-declared OPEL Status** based on their organisational triggers to the Urgent Care-Commissioning Control Centre D-CCG.urgentcare-control@nhs.net by 10am each day.

7.3 Each A+E Board is responsible for setting the locality triggers for the locality, so that there is a clear equivalency and understanding between organisations for communication purposes. The Chair of the A+E Board will assure the CCG that there are robust plans agreed by organisations and will delegate responsibility to named officers (and deputies) for examining OPEL self-declared reports from organisations and set the OPEL for the Locality. Previous guidance states this should be based on triggers across at least two organisations for the locality. The Locality OPEL must be confirmed to the UC-CCC by 10.30am.

7.4 The UC-CCC will publish, by 11am a Monday to Friday a daily dashboard with the Locality declared OPEL status. On the basis of these three locality OPELs the UC-CCC will declare a CCG-wide OPEL communicating this clearly to CCG on-call directors and NHS E along with the planned Escalation Management.

8. Business Continuity and Major Incidents

8.1 Out of Hours Escalation:
LSW Director on Call to be contacted through switchboard: 01752 268011.

8.2 Bank Holiday actions:
Communications are agreed with the CCG and providers, and released to

encourage patients to access their health and social care providers before bank holidays to reduce demand during the holiday period.

Communications via CCG to include options for patients to “Choose Well”. Before each set of bank holidays the CUCs management team collates BH availability for LSW services and submit to the UC-CCC when requested.

8.3 Please follow the link to healthnet for LSW:
Business Continuity and Service Recovery Policy and
Major Incident and Business Continuity Response Plan
http://LSWnet.derriford.phnt.swest.nhs.uk/Documents/Policies,PGDsandProtocols.aspx

9. Training implications

Staff should familiarise themselves with this policy on induction to post and read key documents included in this policy.

10. Monitoring compliance

There are no audit or compliance requirements for this policy. It will require annual update as escalation protocols are updated annually.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed:

Date:

Appendix A: Business as Usual and Actions in OPEL

Team	Business as Usual Actions (OPEL Level 1)	OPEL Level 2 (amber)	OPEL level 3 (Red)	OPEL Level 4 (Black)
All Teams	• See individual team actions	• Cancel non-essential meetings	• Cancel non-essential training • Communicate with Professional Training and Development	• Cancel mandatory training • Communicate with Professional Training and Development • Offer additional/overtime if agreed with Director
Discharge to Assess and ICR Team	• Caseload management of intermediate care funded cases • Use of extension process for people needing longer than 6 weeks IC	• Review caseload and prioritise cases that could be extended	• Consider internal moves of staff to support in the acute hospital to "Pull" people out	• As per all team actions
Recovery at Home Team	• Referrals into R@H (PHNT base) between 8.30-16.00 7 days a week. Requests for service via telephone, Salus, email or pop into office. • Referrers are required to complete agreement forms - with a plan following their assessments and estimated discharge date from service. • Team working hours are 07.00-22.00; outside of office hours telephone line is diverted to late on call. • Outside of hours the service is covered by Out of hours DNs. • Once agreement form completed by referrer patients are followed up on ward by R@H Co-ordinator, here agreement form is finalised.	• As per all teams actions	• Review caseload where possible and with patient consent re-schedule visit • Review caseload consider discharges where safe and appropriate • Cancel non-daily visits and reschedule informing patients of this • Co-ordinators to support clinical workload	• Manager and Matron to work clinically • Off duty staff called to see if could work • Request support of other community teams

	• Ward is responsible for the patients discharge. • Patient takes yellow folder home with them which contains copy of agreement form, patient information leaflet, care plan for Bridging package of Care. • Patient accepted on Salus and also admitted onto caseload via SystmOne; visits for patients allocated by Co-ordinators • Clients seen in their own homes currently under pathways for 1. Bridging package of care 2. Therapy -medically fit patients who do not need to be seen daily. Once treatment is completed discharge letter is required for their GP. 3. Patients for Recovery at home under Consultant – seen at least daily. One treatment completed discharge letter to ward to go in medical records and copy to GP. 4. Patients who require nursing care / assessments. • Patients have clinical records maintained on SystmOne • Patients informed of planned discharge from service and asked to complete patient survey on last visit • Patient safety brief 8.30 and handover on shared drive updated by team through the shift • Rota completed in timely manner to plan study days and annual leave.			

Acute Care at Home	• Robust referral taking including discharge planning • Daily patient safety brief • Working closely with GP's and referrers to maintain patients at home • Shift system that maximises numbers of patients that can be seen OD, BD and TDS • Explore treatment options with referrers and microbiology when TDS/BD capacity is full • Hold stock of drugs with Community Assessment Hub so that treatment starts are not delayed waiting for drug availability • Working with local pharmacy about drugs held in stock and fast delivery of FP10 items • Bringing patients into and working with Community Assessment Hub for intermittent vascular line management • Advanced planning of Annual leave • Geographical planning of visits to minimise travel time	• As per all teams actions	• Manager increasing clinical role • As per all teams actions	• As per all teams actions
Therapy Unit	• Regular caseload management with all staff, reviewing all patients seen for longer than 6 weeks • Waiting lists are reviewed weekly by OT/PT • All incoming referrals are triaged by registered therapists and prioritised or directed elsewhere if not appropriate and any queries raised with team lead • Triage is reviewed and modified regularly to be maximally efficient	• As per all teams actions	• Explore adjustments to triage and urgency criteria to ensure urgent patients are prioritised • Reduce home visits to free up clinic appointment slots • Band 7 team lead will increase caseload	• As per all teams actions

	• Line management with all staff • Joint Ax and Rx sessions for complex patients (with junior/senior therapist or OT/PT) • Developing a method within system 1 for our admin person to regularly identify any records which have not been accessed recently (previously done with paper records and put in individual actions by staff) • Regular communication with Plym NRU and ESDT to support timely and efficient handover of high priority patients • Stats collected in relation to number of home visits completed and impact on time use			
Community Crisis Response Team (CCRT)	• Professionals triaging in coming community referrals and dealing with over the phone to de-escalate crisis as much as possible to minimise duplicating work and time spent on responder visits. • Identified CCRT Daily Duty manager • Daily MDT morning meeting for MDT working, review high cost 1:1 pocs and ensure clients are being followed up. • Monthly supervision and case load reviews, clinical reasoning regarding 6 week breaches. • ICEADMIN message process for MDT working and referrals from DGH Rapid Response Team. • Coordinator support with sourcing care and contracts.	• Draw on senior therapy staff currently doing intermediate care role to responder role if referrals increase significant • Daily updates to senior management/commissioning re staffing availability • Closer working with s-Rapid Response Team and IHDT to identify clients CCRT can support with discharge • Ensure processes for authorisation and contracting pocs and	• Band 7 SW and Team manager as responder/referral taker • Escalate clients awaiting ASC/CHC to response times for reviews to free up resource under intermediate care • Offer additional shifts out to team • Whole MDT rostered for responder duties	• Consider benefit of staff being based in the hospital to pull rather than prevent admission

	• Therapy and social work support for Robin CAU.	placements are as efficient as possible		
Kingfisher	• Daily whiteboard meetings and update of board. • Daily review of bed state and waiting list including new referrals. Liaison with discharge team re: waiting list and not medically fit patients. • Weekly MDT and TCC overview • Access to equipment on the day and authorisation for this • Daily overview of DToCs with oversight from TCC •	• Matron to re-screen and prioritise patients fit for discharge, update of whiteboards. • Support of matron around conversations re: reluctant discharge/choice • Daily delays escalated and reasons for this to TCC • Request priority pharmacy with TTA's	• Consider reallocation of adult social care workers in terms of SW's for assessment purposes, and access to care packages • Consider releasing OT to carry out rapid assessment of home situation; this will impact on planned work but might free up capacity • Extend times that patients are transferred from PHNT	• Request support from Red Cross to support discharge
SRU/ Skylark	• Daily whiteboard meetings and update of board. • Daily review of bed state and waiting list including new referrals. Liaison with discharge team re: waiting list and not medically fit patients. • Weekly general MDT and TCC overview • Access to equipment on the day and authorisation for this. • Weekly SRU MDT. • Close liaison with ESD Team. • Consultant Ward rounds for both teams. • Progress & goal setting meetings for	• Consider releasing OT to carry out rapid assessment of home situation; this will impact on planned work but might free up capacity • Support of matron/ management in conversations re: reluctant discharge/choice. • Use TCC for escalation of delays • Extend times that	• Consider reallocation of adult social care workers in terms of SW's for assessment purposes, and access to care packages. • Matron/TCC to re-screen and prioritise patients fit for discharge, update of whiteboards.	• Consider flex beds from usual mix of 15/15 to increase stroke capacity • Request support from Red Cross to support discharge

	stroke team within 1 week. • EDD set at first MDT following admission; this is reviewed and brought forward when possible. • Identify new admissions as discharges occur to maintain flow • Daily overview of DToCs with oversight from TCC	patients are transferred from PHNT. • Request priority pharmacy with TTA's • Liaison with ESD Team re stroke patients • The potential to prioritise PHT patients over out of area • Increase TCC whiteboards		
Early Supported Discharge Team (ESDT Stroke)	• Plan and timetable on Thurs for the week ahead – patient therapy need, geographical distance to be travelled, staffing, training, AL all factored in to caseload management • Visit MDT Acute Stroke Unit Derriford Hospital Tues and Fri at 0900hrs • Telephone Acute Stroke Unit Mon, Weds, Thurs and Sat am @ 1030hrs • Visit MDT Stroke Rehab Unit LCC Weds • Telephone Bodmin Stroke Unit Cornwall, Newton Abbott Stroke Unit, Devon and George Earle Acute Stroke Unit, Torbay once a week for any potential referrals • ESD MDT Thurs am at 0845-1000 discuss all patients on board • Daily update from ESD Team with Team Manager re current caseload for AHP's and Nurses, those pending discharge from board, referred patients and potential referrals out over weekend • Triage and prioritise new referrals with Team	• Liaise closely with Hospital Discharge Teams re pending referrals from ASU & SRU and Packages of Care • Triage and prioritise new referrals with Team	• Increase visits to MDT Acute Stroke Unit Derriford Hospital to four times a week • Increase telephone communication with Acute Stroke Unit to twice daily • Increase visits to Stroke Rehab Unit to attend lunchtime whiteboard meetings • Triage caseload with aim to discharge patients timely and safely	• Utilise Community Stroke co-ordinator role • If ESD staffing allows support ASU/SRU locally with Home visits/Therapy Assessments
Plym Neuro Rehab Unit	• Daily MDT whiteboard meeting • Consultant / unit doctor / MDT	• Increase grand round	• Prioritise PHT patients	• Consider outliers if no neuro patient waiting

(PNRU)	member attend PHT Neuro meeting every Monday to review / assess PHT referrals (PHT recently have instigated the practise of repatriation so some assessments need to be out of area) • Consultant ward round on PNRU every Monday • Weekly MDT every Tuesday, review of EDDs • Weekly Grand Round via TCC • Key worker identified to oversee patient admission episode • EDD set at first MDT following admission; this is reviewed and brought forward when possible. • Identify new admissions as discharges are planned to maintain flow. • Progress / goal planning meetings held throughout patient admission episode (inclusive of family /carers/community services/funders) • Appropriate staffing reviewed daily (recognition of need for 1-2-1 patient care also factored) and reported • If unit carrying sickness / absence other unit staff regularly work extra hours / shifts. Night Coordinators also work flexibly to support ward staffing. • Use of Discharge Coordinator to help flow.		• Implement Therapy staff supporting nursing staff re: sickness / absence	
Neuropsychology	• Regular caseload management with staff. • Waiting lists reviewed twice weekly • Incoming referrals triaged by service	• As per all teams actions	• Prioritise new assessments for patients with long waiting times	• As per all teams actions

	lead and directed elsewhere if not appropriate • Regular line management with all staff • Close liaison with other professionals involved to enhance input with complex patients.		• Minimise home visits	
Out of Hours District Nursing (Twilight and Overnight)	• Undertaking DN regular visits which fall into OOH category due to frequency of medication required or need for evening visit for routine care. • Undertaking of DN capacity visits which cannot be met during in hours as a result of increased workload and priority • Triage calls via D Doc with assessment and planning skills to ascertain if appropriate visit required Out of Hours • Undertake Urgent calls within triage service spec New Out of Hours SOP. Referral Triage Guidance. • Undertake mandatory training and completion of competencies out of normal working hours, staff thus requiring TOIL for this to prevent additional payment • Monthly team meetings – TOIL also required • Cover areas of Plymouth 17:00- 08:00 • Cover South Hams and West Devon 19:00-07:00	• Implement Robust prioritisation of need in line with logistical location. • Communication with MDT teams OOH to establish support available. E.g. Crisis team CCRT.	• Reduce / liaise with regard to non-essential regular visits, moving days or sourcing emergency family support to assist with delivery of care if able. • Pull band 6 and 7 non clinical hours to assist with clinical shifts. • Utilise longer Twilight shift hours if able to support capacity into night referrals • Communication with D Doc to inform patients/ referrals of extended waiting time	• Liaise with DN service to reduce capacity referrals/ priorities capacity referrals • In exceptional circumstances escalated to director on call and implement Out of Hours service closure pathway.
Integrated Hospital Discharge	• Screening new referrals • Bronze template completion • Bronze call and daily escalation	• Provide information for Silver escalation calls • Increase discharge rate	• Cascade escalation to the communities • If extra capacity put	• Use community capacity

Team	• Allocations and case review • Coding against DTOC • Review all patients over 21 days • Front door presence to triage and discharge • Aim to achieve a minimum of 15 discharges daily • Investigate SG on admission • Provide discharge details to Site Team • Provide Site Team with patient level detail of patients within the complex pathway • Move resource to areas of pressure within the acute trust • Review needs of LCC waiters and look at alternative discharge routes • Receive bed capacity in the Community Hospitals, Care Home capacity and Dom/ HSG • Arrange discharge planning meetings for complex discharges • Communicate with patients and relatives • Complete MCAs and BI meetings • Communicate with voluntary sector • Quality assurance of assessments through clinical supervision • Daily review of SALUS green and Amber crosses	to a minimum of 20 • Uplift support to front door • Plan workforce for next 48 hrs to aid recovery • Additional caseload review with TCC	in system then coordinate use • Attend Site Meetings as per escalation plan • Prioritise cases that will give same day discharge	
Minor Injuries Unit **Kingsbridge MIU:** 09.00	• Staff on duty promptly with computers logged onto System1 ready to receive 1st patients at 08.30 • Booking in patients via reception in a timely manner	• Communication between ourselves or MIUs and ED •	• Manager to work clinically • A designated NP to triage and signpost patients	• Call in extra staff not on duty where possible • Extend the opening hours of MIU to 08.00

to 17.00, 7 days **Cumberland MIU:** 08.30 to 21.00 Open 365 days/year **Tavistock MIU:** 08.00 to 22.00hrs 7 days	• Ist contact by healthcare assistant in a timely manner, possibly sent for x ray at this point after quick review by NP • Assessment and plan by nurse practitioner • Constant overview by Manager and if patient numbers are too great manager to go and help clinically • Notes written in a timely manner and discharge home or to another speciality i.e. Derriford ED or GP • Plan all mandatory training in Winter as surge in Summer time • AL management in line with surge		• Staff to work across units	– 22.00
Acute GPs	• AGPs provide clinical advice and support via acute referral hub telephone to community teams, mainly Community GPs and SWAST in relation to acute medical problems • Challenge and discuss with referrer the best pathway for the current issue • Consider patient and family choice around their healthcare • Advise community teams, GPs and SWAST staff on clinical matters to prevent requiring acute hospital care • Maximise use of urgent speciality outpatient clinics • Maximise and administrate use of Rheumatology TIA clinics, neuro ACU and ACU • Maximise use of urgent diagnostic pathways • Support referral to community teams	• Provide information for Silver escalation calls • Ensure that all 'hub' phone are logged in (including Robin CAH) and that Admin staff are available to take demographics • Interrogate ED screen with ACU nurse to 'pull' ACU type patients direct from ED	• Cascade escalation to referrers • Have a nominated person to attend site escalation meetings daily • Cascade to CAH staff • Provide liaison with community teams regarding escalation status • Consider use of Robin CAH for ambulatory patients out of normal pathway	• Consider use of Band 7 time for operational support at Derriford • Consider use of locum GP staff to increase number of ACU patients seen • Consider use of overflow areas such as Short stay for treatment and clinical examination

	as an alternative to admission e.g. acute care @home, community hospitals, Robin CAH, CCRT • Flag patients on referral who may require support for discharge • Interrogate Systm one in regards to current community input for patients • Provide diagnostics and diagnosis for patients within the ACU • Provide prescriptions for ongoing needs • Provide up to date information on PHNT pathways for admission • Liaise with Derriford doctors regarding specialist advice • Liaise with radiologist regarding opinion • Patients have access to urgent specialist opinion • Provide hospital staff with full patient history and summary of care given if this is the patients appropriate pathway • Provide patients own GP with timely discharge from service summary • Recommend further diagnostics from patients own GP • Request that diagnostic results be sent to patients own GP • Monthly governance and team meetings • Include capacity in resilience dashboard			
Robin Community Assessment Hub	• AGPs on CAH provide clinical advice and support via acute referral hub telephone to community teams, mainly community GPs and SWAST in relation to acute frailty issues that may require	• Ensure that all 'hub' phone are logged in and that Admin staff are available to take patient demographics	• Cascade escalation to referrers • Provide information for Silver escalation calls	• Utilise Therapy room as extra space for patient couches • Consider use of Robin CAH for ambulatory

	admission to hospital. • Challenge and discuss with referrer the best pathway for the current issue • Request patient history summary from patients own GP • Interrogate Systm one in regards to current community input for patients • Consider patient and family choice around their healthcare • Advise community teams, GPs and SWAST staff on clinical matters to prevent requiring acute hospital care • Maximise use of urgent speciality outpatient clinics • Maximise use of Rheumatology TIA clinics, neuro ACU and ACU • Support referral to community teams as to alternatives to admission e.g. acute care @home, community hospitals, ACU, CCRT • Flag patients on referral who may require support for discharge • Provide diagnostics and diagnosis • Provide prescriptions for ongoing needs Liaise with radiologist regarding opinion • Provide referrer with real time information regarding the hospital capacity and most appropriate front door • Provide up to date information on PHNT pathways for admission • Provide full nursing assessment and care • Provide IV therapy including infusions • Provide therapy and social work		• Have a nominated person to receive updated information re escalation from AGPS • Consider temporary use of increased diagnostics e.g. ultrasound	patients out of normal pathway. • Consider use of Band 7 time for operational support at Derriford • Consider use of locum GP staff to increase number of patients seen

	support through CCRT • Provide resuscitation provision • Provide on-site prescription drugs • Provide onsite prescribing pharmacist availability • Provide medication review • Access to inpatient beds to continue care requirements up to 72 hrs • Provide therapy space for patients requiring assessment • Provide access to point of care testing • Provide full MDT assessment of patient need on site • Provide patients own GP with timely discharge from service summary • Provide hospital staff with full patient history and summary of care given if this is the patients pathway • Recommend further diagnostics from patients own GP • Request that diagnostic results be sent to patients own GP • Patients have access to urgent specialist opinion (through AGPS) • Monthly governance and team meetings			
Liaison Psychiatry Adults and complex care/older people)	• Meet / liaise with night SHO on call to discuss workload undertaken that night and pending referrals for the day. • Adult mental health practitioners make contact with ED/CDU to obtain a sit rep. • Check Salus for any new referrals • Daily morning meeting including mental health practitioners, medics,	• Team manager can become clinical if required •	• Clinical focus is urgent so all training and meetings will be rescheduled according to this response. • Triage current caseload to determine whether	• Contact staff off duty to check availability to come into work and offer overtime as appropriate; permission to be sought from DLM or LM • Liaison with HTT, CCRT

	consultant, admin to review new referrals and any ongoing cases and then allocate work accordingly. • Review information already known to the team and make contact with any local teams for pertinent clinical information when relevant. • Contact the relevant Wards /ED/CDU To arrange when appropriate to assess • Priorities patients according to flow paying attention to the pressures on the ED & CDU Ward & Lounge to free up flow. • Same approach may apply to ITU though direct discharge is very rare. • MAU patients including Tamar, Thrushel and Tavy (more likely a priority than ITU) • red top referrals are reviewed as a team to determine the most appropriate response (note it is more appropriate to call the team directly with a referral or use SALUS and call the team to alert to referral • Review workload priority at mid-day to reassess focus as needed. • End of shift handover to SHO at night. • All of this depends on staff availability. • For inpatient referrals e.g. complex care all referrals will be reviewed in the morning meeting – however this service is only active Monday – Friday and over the weekend direct referrals will be taken by the on-call SHO. • Response to gateways and rapid		priorities could be changed.	and Hospital Discharge Team to consider a joined up approach in managing flow to avoid duplication and waste of resources. Need agreement with locality senior managers if this is the case in how this will be managed. • Ask other medical staff to provide support, if available. • Request support of On-call SHO, if available.

	moving areas of hospital to facilitate early discharge. • Daily review of all referrals and other patients on current team caseload. • Shift system with service from 0830 to 1900 – five days weekly. • Out of hours referrals dealt with by On-call Psychiatric SHO. • Regular meetings with Derriford Mental Health leads. • Notes written as contemporaneously as possible and within SystmOne recordkeeping guidelines. • Weekly clinical supervision with Consultant to discuss all new referrals. • Daily peer group supervision to discuss current team caseload. • Timely signposting and referring on to internal services through SystmOne. • Timely signposting and referrals to external agencies in accordance with their referral systems. This includes out of area patients. • Liaise with appropriate care/discharge teams for Devon and Cornwall. • Liaise with Plymouth Integrated Care Teams. • Provide telephone advice as requested to wards and departments within the acute hospital. • Offer help and support to the acute general hospital in relation to Mental Health Act issues. • Offer help and support to the acute general hospital in relation to Mental			

	Capacity Act and DOLs.			
District Nursing Teams (Plymouth)	• Routine DN visits as per assessed need to housebound patients and meeting referral criteria as set in service specification • Working closely with GP's and referrers to maintain patients at home • Attendance at GP MDT meetings • Respond to urgent calls and referrals from varying sources e.g. GPs, Devon Doctors, Patients and families • Daily peer group supervision to discuss current team caseload and handover • Timely signposting and referring on to internal services through SystmOne. • Advanced planning of annual leave and safe staffing numbers through E-roster • Regular team meetings • Monthly team managers' meetings and weekly operational support to consider capacity and demand across the whole service • Use additional staffing from NHSP and internal Clinical Support Team to cover vacancies/maternity leave/absence and prioritises this across the 4 locality team	• As per all teams actions	• Manager increasing clinical role • Review activity and undertake essential patient activity only •	• As per all teams actions
Long Term Conditions Matrons (Plymouth)	• Routine planned visits based on assessment of individual needs • Allocated 2 hour slots for new patient visits and one hour slots for routine support • Working closely with GP's and referrers to maintain patients at home	• As per all teams actions	• Review of all visits and urgent/essential visits undertaken	• As per all teams actions

	• Attendance at GP surgeries for MDT • All referrals come to a central point for initial triage • All patients not considered appropriate for the service have a second clinical triage and signposting/feedback given to referrer. • Through central calendar management, the wider LTC staff are supported to cover vacancies and increased demand and referrals if needed • In reach where appropriate •			
The HUB (Ivybridge and South Hams)	• The HUB will receive referrals from GPs on a daily basis. Currently operational Monday – Friday 9-5 and 4.30 close on Friday. • It serves the patient populations from the following Health Centres :- Ivybridge Health Centre(Beacon Medical Group), Highlands Health Centre, Yealm Medical Centre, Modbury Health Centre, South Brent Health Centre and Wembury Surgery. • The Hub also co-ordinates 5 virtual wards held every month • The Hub also links directly with the ACS Complex Care team (currently co-located) and is able to offer support to urgent/complex cases not referred by the health community.	• Should the HUB (Hayloft & Byre) be inaccessible due to flooding/snow then the team relocate pre-arranged health centres in Ivybridge, process follows is that the person(s) who lives close by will go to Ivybridge so they have access to a health computer, making sure that the other practices have a mobile number link. • The other members of the HUB may work from home on a laptop just completing My Assessments on the DCC system. • For the CCT , staff will go	• As per all teams actions	• As per all teams actions

		to the Kingsbridge site or work from nearest local office or home with a laptop. Care Direct Plus, Health Centres. Colleagues , will all be kept updated.		
South Hams Hospital	• 12 beds around 20 admissions a month Average Loss 11 days over August ranges from 10-15 days on average. Supported with 1 Physiotherapist and Occupational Therapist and Rehab Supporter as well as Social Care/CCW. We currently work early and lates with 2 RGN and 2 HCA, 2 RGN and 1 HCA for the night shift. • Dr Support – Ward rounds x 3 weekly and twice weekly with clerking support. Delivers rehab, medical support and end of life care to individuals within the local and surrounding areas. • Nurse lead unit with GP support • 24/7 The Hospital allows access to a number of professionals for instance intermediate care, District Nurses, Community Matrons, School Nurses, Midwives etc. • The local population we serve is around 18000 but this fluctuates due to large influx of visitors in the summer period. The local geographical area is from Salcombe, to Chillington, to Ivybridge, and the edge of Modbury. Most of the residents are of the older age group with a large proportion being retired. It	• Draw on senior therapy staff currently doing intermediate care role to responder role if referrals increase significant. • Daily delays escalated and reasons for this. • Liaise with staff if in the event of bad weather 48hrs pre to ensure cover possible. • In the event of adverse weather staff if unable to drive to turn up to their nearest hospital on foot where possible and offer support. • Data base held locally with staff details re 4 wheel drives, who can walk to work etc. • MIU nurse to support ward area if no attendances • Request priority with TTA's from local	• Consider reallocation of adult social care workers in terms of SW's for assessment purposes, and increase access to POC, Interim placements or placements. • Matron to re-screen and prioritise patients fit for discharge, update of whiteboards. • Matron to support clinical as much as possible to ward area. • Consider releasing OT to carry out rapid assessment of home situation; this will impact on planned work but might free up capacity. • Support of matron/	• Possible 13th bed available if the patient mix (M/F) allows with executive and CCG approval • On a case by case basis consider patients who not normally fit the acceptance criteria

	is an affluent area.	pharmacy	management in conversations re reluctant discharge/choice. • Extend times that patients are transferred from PHNT. • Conduct ward to ward and verbal handovers at this time to expedite the movement of patients •	
Tavistock Hospital Ward	• Daily whiteboard meetings with ward nurses and therapists and update of board. • Daily review of bed state and waiting list including new referrals. Liaison with onward care team re: waiting list and not medically fit patients. • Weekly MDT with ward nurses, therapists, social services and volunteer sector representative • Access to equipment on the day and authorisation for this • Daily overview of DToCs • Medical assessment on admission and throughout week as clinical need requires • EDDs reviewed daily • Direct admissions from the community accepted in collaboration with Onward Care to ensure clinical prioritisation	• Ward Manager/Matron to re-screen and prioritise patients fit for discharge, update of whiteboards. • Support of matron around conversations re: reluctant discharge/choice • Daily delays escalated and reasons for this to TCC	• As Level 2 plus: • Request allocated social worker to be on the ward for daily MDT review of requirements. • Consider releasing OT to carry out rapid assessment of home situation; this will impact on planned work but might free up capacity • Extend times that patients are transferred from PHNT • Matron/Ward Manager to review all patients on	• As Level 2 & 3 plus: • On a case by case basis consider patients who not normally fit the acceptance criteria • Request volunteer representative to be on the ward to support rapid discharges • Ask local pharmacies to provide same day blister packs and to prioritise any medication requests from the ward

			waiting list with Onward Care to identify if any other options are available	
South Hams and West Devon Community Nursing	• Manage and delegate referrals • Add patients to ongoing caseload s/caseload holders (Band 5) • Identify Risks. • Prioritise complex patients, allocate visits and commence patient centred care planning. • Liaise with GP and relevant health professionals. • Initiate referrals if risks or specialised treatment is indicated. • Attend surgery meetings. • Carry out assessments such as CHC, DAT, and HNA. • Pick up one off unplanned visits. • Produce work rota and duty cover for the 08.30-19.00hrs service with the correct skill mix and competencies available to carry out the service. • Log and investigate any incidences • Geographical planning to minimise travel. • Record daily activity. • Supervision and PDP's for staff. • Manage training and educational competency requirements. • Recruitment and selection. • HR issues • Managing Sickness absence.	• Ensure safety of patients and staff. • Rearrange visits if possible. • Utilise staff from the larger team to provide backup for unexpected sickness and /or excess referrals. • Quesst to highlight and escalate staffing and work related issues. • Incident reporting. • Use of management escalation tool to identify what may be required to lessen risk and maintain safety. • High light any extreme weather issues that would affect patients and nurses, Flooding, Snow & ice and Extreme heat. • Escalate contingency plan for assistants from ambulance vehicles and local police and farmers. • Plan for nurses to work near where they live	• Reviews of caseload and prioritise work load. • Utilise staff from the larger team to provide backup for unexpected sickness and /or excess referrals. • Record any unmet needs I.E. Equipment not turning up, Lack of Dom care help to maintain palliative patients at home.	• As per all teams actions

		instead of travelling. • Ensure lone worker plans are robust and communication is kept open at all times. • Constantly review risk and record actions.		
South Hams and West Devon Community Therapy	• Manage and delegate referrals • Daily Intermediate Care triage meeting to prioritise caseload • Daily duty worker for new IC1 referrals received during the hours 0900 – 1700. • Attend daily board rounds in Community Hospitals • Source intermediate care placements (temporary suspension) for those deemed suitable for up to 6 six weeks. • Produce work rotas for teams working 0900 – 1700. • Support the Rapid Response Care Service • Record daily activity • Manage training and education requirements • Manage vacancies and recruitment	• Escalate delays within the community hospitals to MDT • Utilise SHH for I/C placements if beds (up to 2) are available. • Review IC2 caseload and prioritise IC1 patients • Source alternate placements by escalating to locality team.	• Move staff across bases to meet demand of caseload i.e. from hospital to community and vice versa.	• Review skill mix of teams to support community hospital discharge •
System-wide support (TCC)	• Daily bronze call • Daily Alamac lighthouse report • Work with QAIT team to match care homes	• Amber cross review with RAH and therapists on wards • Ask all community	• Escalate to silver and ask for CCG chaired call • Ask discharge teams	• Consider asking LSW staff to work at PHT; involve governance in this

	• Daily green cross updates • Over 10 days' work • Grand rounds at PHT and at MGH site • Daily brokerage review • Attend Ops meetings • Daily SLM meetings • Review green crosses over 5 days • Daily meeting with IHDT • Community hospital matron in-reach	hospitals to complete an additional board round • Review community hospital waiting lists and identify alternative pathways	to prioritise discharges that will achieve same day • Set up additional board rounds • Call in additional LSW TCC staff to support • Request additional community capacity from CCG if needed • Consider moving staff from review teams	• Consider planned outpatient activity from PHT being carried out at alternatives sites in LSW such as Robin CAH • Red Cross • Consider use of OPMH beds on the MGH site • Consider outliers in community hospitals

Appendix B: NHS England Operational Pressures Escalation (OPEL) Framework, October 2016

Operational Pressures Escalation Levels Frar

Appendix C: Escalation Level Definitions

Escalation Definitions:

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 the decision is being 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 on-take and ED on-call • 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 within 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 learnt process through the SI investigation	• All actions from previous levels stood up • ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact on-take and ED on-call 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 learnt process in accordance with SI 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 and cabinet member 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