

**NHS England and NHS Improvement
North East and Yorkshire Region – Incident Management**

Escalation and mutual aid plan to support local systems across the Region

December 2020

1.0. Purpose

This document sets out the principles and processes that NHS England and NHS Improvement's North East and Yorkshire Region (NEY) will use to support the coordination of mutual aid across the NHS to minimise risk and optimise outcomes for patients and reduce burden on staff. The principles and processes will apply in all current and future situations where mutual aid is required in response to any serious incident.

Currently, the ongoing management of COVID-19 presents a significant challenge to the NHS. All providers will most likely need to seek mutual aid at some point and will also be able to offer it at other times. It is only by working together and flexing their collective assets collaboratively that we can get the best outcomes for our patients and staff.

Mutual Aid is defined by the Cabinet Office as:

An arrangement between Category One and Two responders and other organisations not covered by the Civil Contingency Act, within the same sector, or across sectors and across boundaries, to provide assistance with additional resources during an emergency, which may overwhelm the resources of an individual organisation.

2.0. Scope

The principles and process outlined in this paper will be applied during a Level 3 and/or Level 4 incident as part of NHS England And NHS Improvement's North East and Yorkshire regions response. The paper outlines:

- Actions that are expected at an Integrated Care System (ICS) level in order to manage escalation and mutual aid within the ICS boundary.
- Actions that are expected through the North East and Yorkshire Joint Regional Operations Centre (JROC) to support escalation and mutual aid between ICS's where that is required.

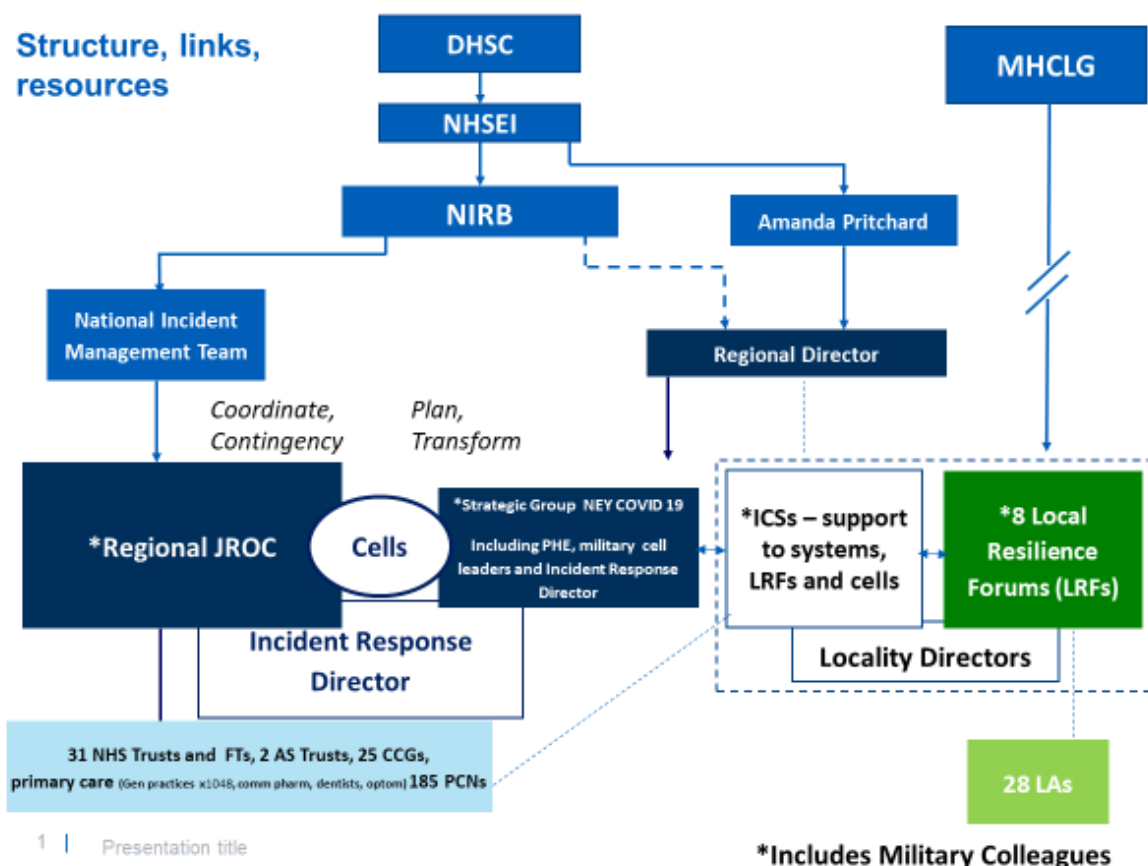
This paper does not intend to replace existing processes that are already in place, to support mutual aid, when these are working effectively.

3.0. Incident Management - Decision Making and Governance Arrangements

In a national level 3 and/or level 4 incident, the regional day to day governance of this process, and responsibility for overseeing the application of agreed principles, rests solely with the North East and Yorkshire JROC, led by the Incident Director. This group is directly accountable to the National Incident Centre led by the National Incident Director. The JROC is responsible for the day to day coordination of the incident and for the development of a contingency response.

Decision making in the JROC will be supported by the Regional Covid Strategy Group (CSG) and Covid Response Cells. This group and cells will provide advice and guidance to the JROC so that any decisions JROC make consider the wider strategic and clinical context in which the Region operates. The CSG, with Cell support, is responsible for planning post incident recovery and wider service transformation in response to lessons identified.

Governance Structure for NHS England and NHS Improvement North East and Yorkshire Region Incident Management



Integrated Care Systems (ICS) are integral to supporting the local incident response and in co-ordinating a system wide approach. NHSEI Locality Teams are represented at the regional CSG supporting decision making through the JROC. As part of the recent stress testing exercises with the ICS's across the Region, facilitated by military colleagues, it was noted that there was a weakness in some plans based on localities all turning to mutual aid as their means of managing immediate pressures. Feedback at this time was that mutual aid within ICS' clearly has a limit in terms of effectiveness if all localities/trusts were equally pressured. As a result of this, NEY and the ICS's have undertaken a review of escalation plans and developed a shared approach to effect mutual aid. This paper is a response to the risks identified.

4.0. Operating Principles

Through collaborative working across localities and cells, the following principles have been developed. These principles underpin the way NEY will approach the management of escalation and the consideration of mutual aid. It is important that our four local ICS's are working to similar levels of escalation when managing urgent and elective activity across local trusts. This is to ensure that:

- Principle 1:** No trust or system is placed under disproportionate pressure compared with others across the North East and Yorkshire when there is an ability to mitigate potential risks to patient outcomes.
- Principle 2:** All capacity in the region is mobilised to deliver surge capacity that maintains optimum access to urgent and emergency care to all patients who require it.
- Principle 3:** Patients have equitable access to urgent planned care and are not disadvantaged by significant differences between Trusts and systems in local availability of beds, critical care, staff and other resources.
- Principle 4:** As much planned care, for those in greatest need, should be delivered and when capacity is limited this should be used as equitably as possible so that no patient population is disadvantaged.
- Principle 5:** Staff are not placed under sustained, high levels of strain disproportionately between systems or trusts.

5.0. ICS Level Structures and Processes

To deliver the principles outlined above, understanding that there will be times when urgent access to mutual aid is required, it is expected that:

1. Each ICS will have locally agreed, detailed escalation plan in place for urgent (immediate support that needs to be in place within the next 24 hours) and ongoing incidents. These will build upon arrangements within existing Business Continuity Plans in line with responsibilities under EPRR and will adhere to the principles and processes outlined in this plan to ensure consistency.
2. Each ICS will have a clear governance and accountability framework in place to oversee, record and support the operational delivery of agreed escalation plans and management of mutual aid. This will be led by relevant Executive Officers.
3. Each ICS will be using a locally agreed proactive 7-10 day forward mutual aid planning system and process that uses projections of activity and capacity to support pre-emptive mutual aid or to escalate where reasonable projections suggest that within and between ICS mutual aid will be required.
4. All requests for mutual aid will be managed, in the first instance, at a locality level, as part of a shared escalation process but is considerate of the impact on organisations that cover wider geographies (ambulance services and tertiary service providers).
5. Each ICS will ask all trusts in a system to mobilise and respond equally to support a local trust requiring mutual aid to restore patient safety. Mutual aid must be provided and can take the form of transfer of staff, equipment, services and supplies or the transfer of patients where

clinically appropriate and safe to do. This may include all trusts scaling back activity equitably to provide that mutual aid to maintain patient safety.

6. Where it is not possible to deliver mutual aid locally, sufficient to maintain access / quality of non-elective and more urgent elective care, as all trusts are working to the same level of escalation, this is reported by the ICS through the Joint Regional Operations Centre (JROC) through the daily Tactical Coordination Group (TCG). They will involve the relevant regional cells to support further assessment of the situation in the ICS and across the region and action to optimise delivery of care within and across systems.
7. All requests and decision-making regarding escalation and mutual aid are managed transparently, recorded appropriately and reported through the JROC as part of its incident management responsibilities. This includes any agreements and decisions for mutual aid made within locality for that locality.

6.0. Managing escalation

As demand across each ICS increases and before any request for mutual aid is made, it is assumed that each ICS (including Local Authority partners) will be using their formal operational oversight processes and be demonstrating that:

1. All inpatients who are ready for discharge are being discharged swiftly and appropriately, supported by a positive risk-taking approach.
2. Appropriate and effective admission avoidance pathways are in place so that all care that can be undertaken outside of a hospital setting is optimised.
3. Use of the local Independent Sector is being maximised to deliver agreed planned care pathways and has been reviewed to consider changes in use of capacity that could be triggered when necessary in response to increased 'surge' demand.
4. Active flow management of urgent and emergency care is in place.
5. Active management of theatre and critical care capacity is in place.
6. Available workforce is deployed efficiently and effectively, taking account of staffing guidelines.

In addition, guidance on the appropriate timing of surgical procedures is given in the document '*Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic*' (**See Appendix 1**). The most recent version of this document is at https://fssa.org.uk/covid-19_documents.aspx Note that not every procedure has been listed, and the aim is to avoid patient harm and distress. Clinicians should use their clinical judgement within their Trust's agreed governance process to assess individual patient need and urgency for treatment.

Low volume, high priority services that are carried out in few centres across the region (high priority specialised services) require consideration. ICS escalation plans must align to and support the maintenance of prioritised specialised elective services, where they will often support populations beyond the ICS catchment. Tertiary centres should also scale back lower priority activity to provide mutual aid but recognise it is more difficult to scale back tertiary services. This highlights the importance of effective forward planning in order to allow enough time for changes in specialised services to be made and capacity for mutual aid released.

In addition to the above, all ICS's must support their local systems to regularly undertake a clinical review of all patients on a patient pathway and clinically validate and reprioritise based on clinical assessment.

7.0. Data and intelligence to inform escalation

It is acknowledged that there will be different approaches between ICS's to calculate when escalation steps are implemented and mutual aid is required, based on each system's needs and operating context. However, the point at which systems will meet the criteria for region-wide mutual aid will be consistent.

Several data and intelligence points will need to be considered to determine the level of escalation within a system and to indicate the need for mutual aid. This data and intelligence will need to be considered at system and where appropriate trust level and will change based on the nature of the incident, however this will include but not be limited to:

1. Community prevalence data as required.
2. Number of G&A beds in use, by trust, currently split by non Covid and Covid patients and therefore hospital occupancy rates.
3. OPEL level
4. CRITCON status, surge capacity and critical care bed occupancy.
5. 7-10 day forecast community and care home prevalence data.
6. 7-10 day forecast hospital and critical care bed demand and occupancy data.
7. Level of surge reached in each trust against the agreed locality surge escalation plans.
8. Workforce availability – including vacancies, staff absences due to Covid, ability to meet safe staffing ratios and availability of and access to additional staff.
9. Status of theatre list availability, elective activity and cancellations of P3 and P4 work and rescheduling of P2 work.
10. Critical equipment or infrastructure risks or failures.

8.0. Requesting Mutual Aid

All NHS commissioners and providers are required to have in place agreed mutual aid arrangements, outlining the process for requesting, coordinating and maintaining mutual aid resources in line with NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2019.

Mutual aid is likely to be needed in situations of escalating demand or dwindling resources that require a coordination of assets and external support. Mutual aid agreements may include staff, equipment, the transfer of patients where clinically appropriate and safe to do, services and supplies. This may include the equitable scaling back of activity to provide mutual aid that maintains patient safety. Mutual aid can also include support within an ICS boundary and across ICS boundaries and support across sectors such as community, primary care, mental health and acute care.

In order to maximise capacity before any mutual aid is considered, it is expected that all acute trusts in line with their ICS escalation plans and section 6 above, will be able to demonstrate and record that they have enacted the following sequential steps in response to their escalating position:

1. Accelerated discharge of patients supported by positive risk taking.
2. Increased their own capacity by opening any closed wards with available staffing and equipment.
3. Postponed non-urgent elective care (P3 and P4) including outpatients to enable the release of staff and to create bed capacity to support both themselves and partner trusts in their system.
4. Re-deployed clinical staff from non-patient facing roles to support wards and stood down where possible any non-clinical time in job plans and training.
5. Reduced staffing ratios to open all on site beds following appropriate risk assessments.
6. Reopened beds on COVID wards closed due to social distancing.

It is important to consider further available intelligence to support informed decision making. Any decision to trigger a mutual aid request will be made based on a collective consideration of all these factors rather than driven by a specific measure.

If ICS discussions have exhausted all options for mutual aid to be delivered locally, the standard process for the management of escalation and securing mutual aid is through the JROC daily process led by the Incident Director, as follows:

	Action	Time/Frequency	Purpose	Responsibility
1.	Data will be presented to the Tactical Coordination Group (TCG) every day on identified key incident metrics. <i>(points 1-8 in section 6.2 above)</i>	10.30am daily	<ul style="list-style-type: none"> To inform TCG of current pressures across the system. To identify any escalating trends To review the forecast position. To act as an indicator for further analysis and local discussions. 	Analytics Team
2.	NHSEI Locality Directors will bring further intelligence to the TCG daily about operational pressures being experienced.	10.30am daily	<ul style="list-style-type: none"> To support the hard data presented above. To report on local support activity. To share any immediate learning or identified risks. 	Locality Directors (or nominated deputy) Specialised Commissioners
3.	Covid Cell Leads will brief TCG daily, by exception, on operational issues for escalation.	10.30am daily	<ul style="list-style-type: none"> To support both the hard data analysis and locality information. To report on any cell actions. To feed in national information from respective national cells. 	Cell SRO (or nominated deputy)

4.	TCG will decide, based on the information presented, whether to recommend to the Incident Director activation of a Regional Mutual Aid Panel. (See Appendix 2 for Terms of reference)	10.30am daily	<ul style="list-style-type: none"> To support further analysis of the situation. To engage relevant Accountable Officers and appropriate clinical advice To secure clinician to clinician discussion where appropriate. . 	Incident Director through the Incident Manager
5.	Regional Mutual Aid Panel will meet on the same day, if a request is received or the data indicates need.	Before 3.00pm on the day called.	<ul style="list-style-type: none"> To review the situation in more detail. To agree options for mutual aid To support Locality Directors in securing mutual aid from within their ICS trusts. To invoke to activation of the Nightingale Cell should that be required. 	Incident Director
6.	Mutual aid agreed and delivery timescales identified.	Before 10.30am the following day	<ul style="list-style-type: none"> To identify a timely response to support patient and staff safety To ensure full engagement of stakeholders involved in the delivery of and receiving of mutual aid including patients and carers where appropriate. 	Locality Directors with JROC support
7.	Briefing on Mutual Aid status given to TCG	10.30am the following day	<ul style="list-style-type: none"> To close the loop on problem identification, solution implementation and resolution. To share learning 	Locality Director (or nominated deputy)
8.	Formal record of mutual aid made following EPRR guidelines.	Prepared for the JROC daily report.	<ul style="list-style-type: none"> To comply with record keeping guidance. To share learning 	Incident Manager

9.0. Nightingale Hospitals

The Nightingale Hospitals are part of a regional mutual aid response to ensure we continue our ability to minimise risk and optimise outcomes for patients by providing safe and effective care. The Nightingale Hospitals also provide wider system resilience in the event of any further incidents on top of the current pandemic management. However, it is acknowledged that the use of either Nightingale Hospital in the North East and Yorkshire Region, as centres to support care of Covid-19 positive patients requiring hospital inpatient care, is overwhelmingly seen as a last resort option by our ICS's, trusts and partners. The primary aim is to deliver all inpatient care in local hospital facilities wherever possible.

Any decision to trigger the activation of either of the two Nightingale Hospitals in the North East and Yorkshire Region will be taken based on a collective consideration of all the factors outlined in sections 7.0 and 8.0 above.

10.0. Thresholds for Escalation

In addition to the information highlighted in section 7 above, specifically that data linked to a 7-10 day forward view to support proactive planning to anticipate the need for mutual aid, escalation plans across the NEY are required to operate against the nationally prescribed OPEL (Operational Pressure Escalation Level) framework. The framework aims to standardise escalation thresholds and provides examples of trigger and actions for partners at each OPEL level (**See Appendix 3**).

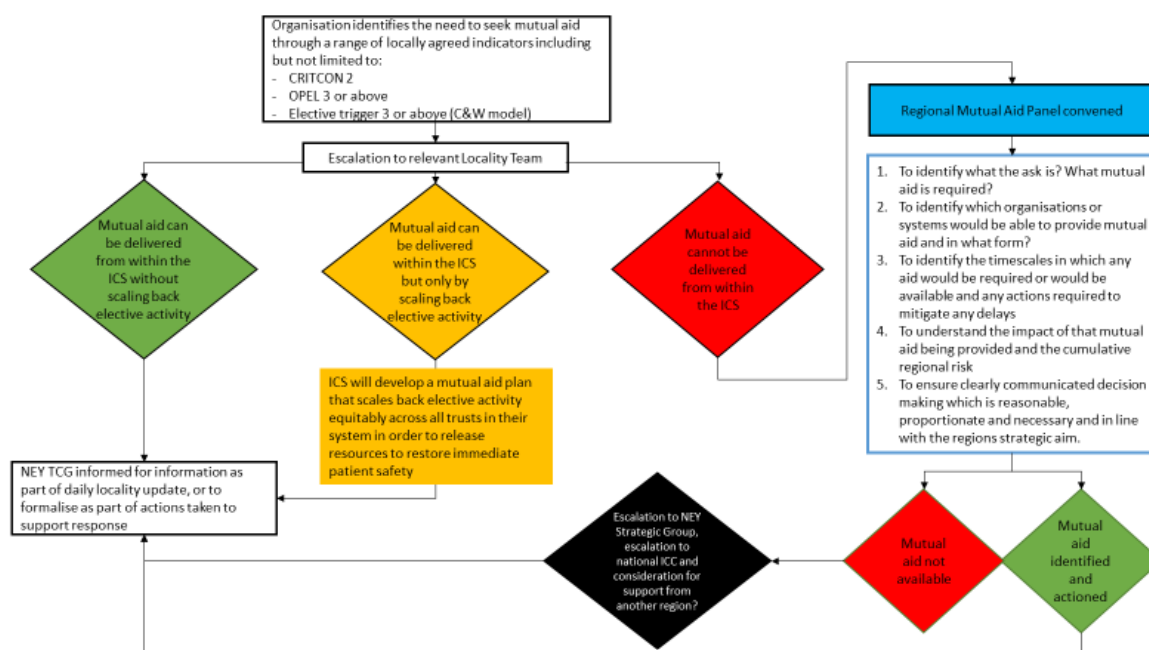
In addition, regular Directory of Services (DOS) information is provided at a system and regional level for critical care. This provides oversight on availability of all adult critical care beds and identifies CRITCON (surge) levels across all critical care units (**See Appendix 4**).

These frameworks can also be supported by deploying a best practice tool for escalation management, the University Hospitals Coventry and Warwickshire NHS Trust Alert Status and Elective response Tool (**See Appendix 5**).

These frameworks give an indication of operational pressures across trusts and ICS's and can be used, along with other indicators, to prompt a discussion about elective response and the need for mutual aid.

Once the escalation level within a local system reaches OPEL 3 and CRITCON 2, and there is no ability to manage the offer of mutual aid within an ICS, JROC will be informed by the Locality Director, through the TCG that there may be a request for regional mutual aid. This will start the process for standing up the formal Regional Mutual Aid Panel

A flow diagram outlines the escalation process is below: (**also attached at Appendix 6**)



Each ICS has developed a process and stages for escalation and mutual aid within their system. Specific details of each process can be found in **Appendix 7**.

The escalation process for Critical Care is managed through the Critical Care Operational Delivery Networks (ODN's) with each ICS having its own aligned ODN. The ICS escalation processes include the ODN clinical leads with discussions partially informed by the CRITCON process.

Publications approval reference: 001559

Specialty guides for patient management during the coronavirus pandemic

Clinical guide to surgical prioritisation during the coronavirus pandemic

11 April 2020 Version 1

This guidance describes levels of surgical priority, covering all surgical specialties with the exception of obstetrics and gynaecology and ophthalmology. Prioritisation for these disciplines will follow.

Patients requiring surgery during the COVID-19 crisis have been classified in the following groups:

Priority level 1a Emergency - operation needed within 24 hours

Priority level 1b Urgent - operation needed with 72 hours

Priority level 2 Surgery that can be deferred for up to 4 weeks

Priority level 3 Surgery that can be delayed for up to 3 months

Priority level 4 Surgery that can be delayed for more than 3 months

These time intervals may vary from usual practice and may possibly result in greater risk of an adverse outcome due to progression or worsening of the condition, but we have to work within the resources available locally and nationally during the crisis.

For those involved in the planning and delivery of cancer services, specific guidance is available: www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/#cancer

For guidance on organ transplantation services please refer to www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/

The current guidance is designed primarily to assist a variety of professionals involved in the care of surgical patients. This categorisation will help:

- managers to plan the allocation of surgical resources
- individual surgical specialties to appreciate the needs of other specialties when resources are stretched
- facilitate the development of regional surgical networks to sustain the delivery of surgery in a timely fashion.

It is imperative that patients do not get lost in the system. Clear records of patients whose care is deferred must be held and co-ordinated.

In time, understanding the extent of work that has been deferred will help with planning the measures that need to be taken to reduce the inevitable increase in waiting times and the size of waiting lists that will occur in all surgical specialties.

Please note: Any delay in treatment, especially of cancers, trauma and life-threatening conditions, may lead to adverse outcomes.

Numbers sheet name	Numbers table name	Excel worksheet name
1a) Emergency		
	Table 1	1a) Emergency
1a) Emergency		
	Table 1	1a) Emergency
1a) urgent 72 hrs		
	Table 1	1b) urgent 72hrs
2) up to 1/12		
	Table 1	2) up to 1_12
3) up to 3/12		
	Table 1	3) up to 3_12
4) over 3/12		
	Table 1	4) over 3_12

Emergency (24hrs) - Table 1a														
General surgery (oesophago- gastric, HPB, coloproctology, breast, endocrine)	Emergency laparotomy (peritonitis/ perforation/ ischaemia/ Necrotising fasciitis)	Emergency laparotomy - bleeding not responding to endoscopic / interventio nal radiology	Appendicectomy - complicated/ unresponsive to conservative Rx appendicitis	Intra-abdominal trauma which cannot be managed conservatively	Laparotomy for post operative complications (eg anastomotic leaks/ bleeding)	Drainage of localised sepsis/ necrosis if not responding to conservative Rx (antibiotics/ Interventional radiology)	Benign Perforated oesophagus/ stomach - with survivable mediastinitis/ peritonitis	Acute airway obstruction - thyroid						
Oral and faciomaxillary surgery	Haemorrhage from maxillary/mandib ular trauma not responsive to conservative Rx (reduction and IR)	Dental Sepsis - not responding to conservative Rx and threatening life/ airway/sight/ brain.	Orbital Compartment Syndrome/Mus cle Entrapment - threatening sight	Jaw Dislocation - not responding to conservative Rx										
Reconstructive plastic surgery including burns and hands	Major burns - Airway management/ resuscitation/ escharotomies/ amputations/To xic Shock	Chemical burns - especially Eye/ Hydrofluoric acid >2%/	Necrotising Fasciitis - any site	Soft tissue infection - any site (especially closed compartments/ joints) not responding to conservative Rx	Revascularisatio n/ re- implantation/ failing free flap - any site	Washout open wound/fractur es/ infected/grossl y contaminated (human/anima l/ contaminated) wounds - any site	Removal of prosthesis/expa nder for fulminant infection							
Urology	Renal obstruction with infection - not responding to conservative Rx	Renal/ureteric trauma requiring open surgery	Bladder trauma requiring open surgery	Genital trauma/ amputation/ priapism (24hrs)	Fournier's gangrene	Haematuria/ uncontrolled haemorrhage - causing haemodynamic instability and unresponsive to conservative Rx								
Trauma and orthopaedics	Fractures - Open/ Neurovascular compromise/Sk in compromise/ Long Bone/Pelvis/Spi ne/Hip	Septic arthritis - natural/prosth etic joint	Dislocated joints	Compartment syndrome										
ENT	Airway obstruction - Cancer/Foreign body/Sepsis	Neck trauma with vascular/visce ral/ airway injury	Nasal/ear button battery removal	Life threatening middle ear conditions	Orbital cellulitis									
Neurosurgery	Traumatic Brain injury - unsuitable for conservative RX	Traumatic spinal injury - unsuitable for conservative RX	Intra-cranial haemorrhage - not responding to conservative RX	Acute raised Intra cranial pressure/ hydrocephalus (recoverable stroke/ tumour) - not suitable for conservative Rx	Cauda Equina Syndrome - not suitable for conservative Rx	Acute spinal cord compression - not suitable for conservative Rx								
Cardiothoracic surgery	Ruptured bronchus	Myocardial infarction - imminent death	Empyema with sepsis	Aortic dissection	Acute presentation of ventricular septal defect	Acute mitral valve disease	Chest Trauma							
Vascular surgery	Vascular injury/ occlusion (Limb - including compartment syndrome and GIT)	Uncontrolled external haemorrhage - any site/source	Ruptured AAA											
Paediatric general and urological surgery	Neonatal Malformations needing emergency correction (life threatening) - Oesophageal Atresia, Gastroschisis, Anorectal Malformations	Emergency Neonatal Laparotomy - Necrotising Entero- Colitis (NEC), Perforation, Malrotation	Emergency laparotomy (peritonitis/ perforation/ ischaemia/ Necrotising fasciitis)	Emergency laparotomy - bleeding not responding to conservativ e manageme nt	Laparotomy for post operative complications (eg anastomotic leaks/ bleeding)	Appendicectomy - complicated or unresponsive to conservative Rx	Thoracotomy / Chest Drain Insertion / Video Assisted Thorascopic Surgery (VATS) for Empyema	Laparotomy for intussuscept ion	Strangulated inguinal hernia	Acute Scrotal Exploration (suspected Testicular Torsion)	Trauma Thoracotomy	Trauma Laparotomy	Removal of Infected Central Line	Renal Obstruction with infection - not responding to Conservative Rx

[illegible]

Urgent (up to 72 hrs) — Table 1b										
General surgery	Laparotomy - small bowel obstruction not responding to conservative Rx	Laparotomy - colectomy for acute severe ulcerative colitis not responding to conservative Rx	Laparotomy - bowel obstruction not suitable for stenting.	Perianal abscess/ other infection - not responding to conservative Rx.	Urgent enteral nutrition access	Failed conservative management of localised intra peritoneal infection	Breast sepsis - without necrosis unresponsive to conservative Rx	Upper GI endoscopy for foreign body removal		
OMS	Facial fractures - not suitable for conservative Rx									
Reconstructive plastic surgery including burns and hands	Burns - requiring resuscitation.	Burns- full thickness/deep dermal requiring debridement and closure	Burns- mid/deep dermal with exposure of deep structures likely/ infection	Soft tissue infection - any site (especially closed compartments/ joints) not responding to conservative Rx	Delayed primary closure of open wound/fracture- any site	Primary tendon/ nerve repair -all sites.	Unstable closed fractures or joint injuries - unsuitable for conservative Rx	Secondary closure of washed out open wound/ fracture- any site	Finger tip/nail bed repair / terminalisation	Major limb trauma reconstruction unsuitable for conservative Rx
Urology	Upper urinary tract obstruction	Renal stones - pain/ impairment not responsive to conservative Rx	Penile fracture	Infected prosthesis - penile/testicular/ stent						
T & O	Unstable articular fractures that will result in severe disability with conservative Rx	Pelvis fractures- unstable	Tibial fracture - high energy/displaced, unstable shaft.	Fractures - pathological	Lower limb frailty fractures (non-hip) - requiring fixation for early mobilization					
ENT	Uncontrolled epistaxis	Sinus surgery for impending catastrophe	Acute mastoiditis and other middle ear conditions not responding to conservative Rx (eg Cholesteatoma-complicated)	Traumatic/ cholesteotoma related facial nervc palsy	Traumatic injury to the pinna	Lymph node biopsy - lymphoma where core biopsy inadequate.	Head and neck sepsis - not responding to conservative Rx.			
Neurosurgery	Traumatic brain injury - not responding to conservative Rx	Traumatic brain injury - not responding to conservative Rx - neurological compromise	Intracranial haemorrhage - no longer responding to conservative Rx	Acute raised Intra cranial pressure/ hydrocephalus (recoverable stroke/ tumour) - no longer responding to conservative Rx	Cauda Equina Syndrome - no longer responding to conservative Rx	Acute spinal cord compression - no longer responding to conservative Rx	Battery change for spinal/deep brain/ epilepsy stimulators/pumps			
Cardiothoracic surgery	Empyema not responding to Rx	Coronary Artery Disease -Unstable/ Rest ECG changes and not reposing to conservative Rx	Aortic Valve Disease - Deteriorating Symptoms / Haemodynamically unstable	Mitral Valve Disease - Deteriorating Symptoms / Haemodynamically unstable	Myxoma - Emboli/ Haemodynamically unstable	Chest Trauma				
Vascular surgery	Acute on chronic limb ischaemia	Symptomatic carotid disease	Amputation for limb ischamia							
Paediatric general and urological surgery	Neonatal Malformations needing urgent correction - Duodenal Atresia, Small bowel obstruction, Large bowel obstruction, Congenital Diaphragmatic Hernia, Congenital Pulmonary Airway Malformations (CPAMS) - respiratory compromise	Laparotomy - small bowel obstruction not responding to conservative Rx	Laparotomy - Colectomy for colitis (Ulcerative Colitis / Hirschsprung's) not responding to conservative Rx	Soft tissue infection - any site not responding to conservative Rx	Central Venous Line insertion for Oncology/Enteral nutrition/Access for antibiotics/Dialysis	Drainage of obstructed renal tract	Malignant tumour or Lymph node biopsy	Peritoneal Dialysis Catheter Insertion	Resection of Posterior Urethral Valves	Pyloromyotomy
Paediatric Orthopaedic surgery	Slipped Upper Femoral Epiphysis	MDT Directed Suspected bone or soft tissue malignant tumours	Fractures - Displaced articular/ peri-articular/ Forearm/Femoral	Exposed metalwork						
Please note	Any delay in treatment, especially of cancers, trauma and life threatening conditions, may lead to adverse outcomes.	Other Specialist Surgery in Paediatric patients is included in the guidance above.	Safeguarding issues must be considered in all those attending with trauma and acute surgical problems (e.g. NAI/ domestic violence/ abuse of the vulnerable)							

Up to 1 month - Table 2

General surgery	Crohn's disease - stricture/fistula/ optimise medication/nutrition.	MDT Directed hepatobiliary/ pancreatic/ oesophagogastric cancer causing obstruction (biliary/ bowel).	Goitre - mild moderate stridor	MDT Directed thyroid/parathyroid cancer surgery	Thyrotoxicosis - Not responding to conservative Rx. (including orbital surgery for impending sight loss)	Parathyroidectomy - calcium >3.0mmol/l and/or not responding to conservative Rx, especially pregnancy/post-transplant/repeated admission.	MDT Directed adrenal cancer surgery	Adrenalectomy - pathology not responding to medical Rx (eg Cushing's/ phaeochromocytom a)	MDT Directed breast cancer resection - ER negative/Her2+/ pre-menopausal ER+ with adverse biology
OMS	MDT Directed orpphayngeal/tonsil/ tongue cancer resection +/- reconstruction.	Facial Fractures causing diplopia/ occlusal problems	Mandibular/maxillary orthognathic surgery - airway compromise unresponsive to conservative Rx AND unsuitable for tracheostomy - adults and children	Dental extractions - Adult and paediatric if unresponsive to conservative Rx (severe pain/ infection)	Craniofacial - ocular complication/Raised Intracranial Pressure				
Reconstructive plastic surgery including burns and hands	Burns- Mid/deep dermal/otherwise unhealed.	Removal of prosthesis - unresponsive to conservative Rx.	Burns- reconstruction for severe eyelid closure problems/ microstomia/joint and neck contracture	MDT Directed Major soft tissue tumour resection (all sites)	MDT Directed Skin cancer resection - All sites. Melanoma/ Poorly differentiated cancers/nodal disease/compromise of vital structures, including the eye, nose and ear.				
Urology	MDT directed testicular cancer surgery - non-metastatic.	MDT directed penile cancer surgery including inguinal node surgery.	MDT directed bladder cancer surgery - invading bladder muscle.	MDT Directed renal cancer surgery -not bleeding.	MDT directed upper tract transitional cell cancer surgery	MDT directed bladder Cancer surgery -high risk carcinoma-in-situ.	MDT directed inguinoscrotal sarcoma surgery	Acute Urinary Retention - Bladder neck stenosis post RARP.	Partial Nephrectomy - single kidney
T & O	MDT Directed Sarcoma surgery - any site	Solitary metastasis surgery - any site.	MDT Directed destructive bone lesion surgery with risk of fracture (e.g Giant cell tumour)	Fractures - displaced, intra- articular/peri-prosthetic/ osteochondral defect/Ankle/Foot/ olecranon/Not Otherwise Specified	Knee extensor disruption (including fractured, displaced patella)	Tendon rupture - hamstring/displaced Achilles/rotator cuff	Locked joints - any site	Nerve Decompression - any site (pain not responding to conservative Rx)	Arthroplasty - lower limb (where delay will prejudice outcome)
ENT	EUA/biopsy for malignancy - hypopharynx/ larynx	MDT directed nasopharyngeal surgery for malignancy	MDT directed oropharyngeal surgery for malignancy	Cochlear implantation post meningitis.	Baro-trauma perilymph fistula	Organic foreign bodies in the ear.	MDT directed treatment of small, high grade salivary cancers.	MDT directed treatment of sinus cancers. - threatening sight	
Neurosurgery	MDT directed brain tumour surgery (including gamma knife for metasases)	MDT directed spinal tumour surgery	Spinal surgery - degenerative/ progressive spinal syndromes with impending neurological compromise.	Acute/chronic pain syndromes - (e.g.trigeminal neuralgia) - unresponsive to conservative Rx					
Cardiothoracic surgery	MDT directed treatment of resectable Non- Small Cell Lung Cancer	Unstable Non ST elevated MI	Aortic stenosis	Unstable coronary	Any deteriorating heart condition	Pneumothorax not responding to conservative Rx			
Vascular surgery	Chronic severe limb ischaemia - no neurology	AAA >7cms diameter							
Paediatric general and urological surgery	Laparotomy or Stoma Closure to manage intestinal failure with liver disease / complications	Infant with Biliary Atresia - bladder exstrophy	Inguinal hernia under 3/12 of age	MDT Directed surgery for Nephroblastoma/ Neuroblastoma/ Rhabdomyosarcoma	Crohn's Disease - stricture/fistula/ optimise medication/nutrition	Circumcision for severe BXO	Renal transplant	Renal Stent Removal/Exchange	
Paediatric Orthopaedic surgery	MDT Directed Suspected, aggressive benign bone tumour	Meniscal repair							
Please note	Any delay in treatment, especially of cancers, trauma and life threatening conditions, may lead to adverse outcomes.	Other Specialist Surgery in Paediatric patients is included in the guidance above.	Safeguarding issues must be considered in all those attending with trauma and acute surgical problems (e.g. NAI/ domestic violence/ abuse of the vulnerable)						

Up to 3 months - Table 3

General surgery	MDT directed resection of colon cancer	MDT directed resection of rectal cancer	MDT Directed hepatobiliary/ pancreatic/ oesophagogastric/ GI Stromal tumour cancer surgery	MDT Directed thyroid cancer surgery - including diagnostic lobectomy.	Renal stones - symptomatic, including sepsis not responding to conservative Rx	MDT directed adrenal resections - intermediate masses a) >4cm<6cm) with hypersecretion (Cortisol/androgen) b) metastases - progressing on scan at 3/12.	MDT directed breast cancer resection - pre-menopausal ER+ without adverse biology	Cholecystectomy - post acute pancreatitis	Hernia - presenting with complications that have settled with conservative Rx	Parathroidectomy - symptomatic renal stones/Sepsis not responding to conservative Rx .
OMS	MDT directed resection of head and neck skin cancer - moderately/ well differentiates with no metastases.	MDT directed salivary gland tumours (low grade).								
Reconstructive plastic surgery including burns and hands	Burns- reconstruction for eyelid closure/ microstomia/joint and neck contracture	Limb contractures								
Urology	MDT directed prostate cancer surgery - high/ intermediate risk	Stent removal/ exchange	Haematuria - investigation for non-visible	MDT directed bladder cancer surgery (not invading muscle)	MDT Directed penile cancer surgery (low grade and premalignant).					
T & O	Hip Avascular Necrosis (night pain/ collapse of the joint/ going off their feet)	Frozen shoulder - severe and not responding to conservative Rx	Tendon reconstruction/ tenodesis - biceps/ hamstring	Revision surgery for loosening/impending fracture.	MDT Directed Benign bone/soft tissue lesion excision biopsy - not otherwise specified	MDT Directed primary sarcoma plus metastases surgery	Arthroscopic removal of joint loose body (Reversible symptoms preventing work)	Locked Knee - ACL/ other reconstruction		
ENT	CSF fistula repair	Symptomatic mucocoele (eg diplopia/recurrent infection)	Cochlear implant in pre-verbal profound hearing loss where delay will impact on long term outcome.	MDT directed otological cancer surgery.						
Neurosurgery										
Cardiothoracic surgery	Stable Non ST Elevation MI									
Vascular surgery	AAA >5.5cm and <7cmin diameter									
Paediatric general and urological surgery	Congenital Malformations with delayed Management - Hirschsprung's Disease initially managed with washouts.	Inguinal hernia 3-12 mths of age	Gastrostomy for Failure To Thrive (FTT)	Interval appendicectomy for recurrent symptoms	Cholecystectomy					
Paediatric Orthopaedic surgery	Developmental Dislocation of the Hip (DDH) - Primary joint stabilisation	Congential Talipes Equino Varus (CTEV) - Initial management including tenotmies	Limb length discrepancy/ malalignment							
Please note	Any delay in treatment, especially of cancers, trauma and life threatening conditions, may lead to adverse outcomes.	Other Specialist Surgery in Paediatric patients is included in the guidance above.	Safeguarding issues must be considered in all those attending with trauma and acute surgical problems (e.g. NAI/ domestic violence/ abuse of the vulnerable)							

NHS England and NHS Improvement North East and Yorkshire Region

Regional Mutual Aid Panel

DRAFT Terms of Reference

1.0. Introduction.

1.1. This document defines the Terms of Reference for the Regional Mutual Aid Panel, under which NHS England and NHS Improvement North East and Yorkshire Region (NEY) will manage escalation and direction of mutual aid support required to mitigate severe operational pressures being experienced by trusts across local Integrated Care Systems (ICS's).

1.2. This will include the activation of the Nightingale Hospitals where this is seen to be integral to any mutual aid requirements.

1.3. This document must be read in conjunction with the NHS England and NHS Improvement North East and Yorkshire Region - Escalation and Mutual Aid Plan, November 2020.

2.0. Purpose of the Regional Mutual Aid Panel

2.1. Mutual aid is likely to be needed in situations of escalating demand or dwindling resources that require a coordination of assets and external support. Mutual aid agreements may include the transfer of staff, equipment, services, supplies, and patients where this is clinically appropriate and safe to do. Mutual aid can include support between trusts within an ICS boundary and across ICS boundaries. It can also include support across sectors such as community, primary care, mental health and acute care.

2.2. The Panel will meet when a mutual aid request is escalated through Incident Management processes, during a Level 3 or 4 incident.

2.3. The Panel will support the identification and delivery of mutual aid, from across the region, to any NHS organisation and/or ICS where all local ICS mutual aid options have been thoroughly explored in line with the regional Escalation and Mutual Aid Plan – November 2020, and have been exhausted.

2.4. The Panel will adhere to the operating principles of the regional Escalation and Mutual Aid Plan – November 2020 as follows:

- **Principle 1:** No trust or system is placed under disproportionate pressure compared with others across the North East and Yorkshire when there is an ability to mitigate potential risks to patient outcomes.
- **Principle 2:** All capacity in the region is mobilised to deliver surge capacity that maintains optimum access to urgent and emergency care to all patients who require it.
- **Principle 3:** Patients have equitable access to urgent planned care and are not disadvantaged by significant differences between Trusts and systems in local availability of beds, critical care, staff and other resources.
- **Principle 4:** As much planned care, for those in greatest need, should be delivered and when capacity is limited this should be used as equitably as possible so that no patient population is disadvantaged.

- **Principle 5:** Staff are not placed under sustained, high levels of strain disproportionately between systems or trusts.

2.5. Where all options for mutual aid have been exhausted across the region, the Panel will, the Panel will recommend to the Regional Incident Director that the requirement be escalated to the national Incident Control Centre to request support from another region.

2.6. Where required, as part of the mutual aid offer this Panel will be responsible for recommending the activation of the Nightingale Hospital to the Regional Incident Director.

2.7. The Panel will ensure that all discussions and decisions are accurately recorded in line with the requirements of incident management. This will include but not be limited to:

- Specifying the detail of the mutual aid required.
- Identifying which organisations or systems would be able to provide mutual aid and in what form. This will be based on the detail within the regional Escalation and Mutual Aid Plan – November 2020.
- Identify the timescales in which any aid would be required or would be available and any actions required to mitigate any delays.
- Identifying the impact of that mutual aid being provided and the cumulative regional risk and any further mitigation that will be required.
- Clearly communicating and documenting decisions made, identifying named individuals with responsibility for action.

3.0. Membership.

The core membership of the Panel will include the following:

- NHSEI NE&Y Incident Director (Chair)
- NHSEI NE&Y Director of Nursing
- NHSEI NE&Y Medical Director
- NHSEI Director of Performance and Improvement
- NHSEI Locality Directors
- ICS Chief Executive/Chairs
- ICS Medical/Nursing Leads
- Regional Head of EPRR
- Lead Executive for Nightingale Hospitals

In attendance would be:

- Director NEY Public Health England
- Incident Manager for the day
- Specialist support as required, for example, HR, Specialist Commissioning, Clinical Leads, Regional IPC Lead.
- Logist

Deputies may attend if necessary but must be fully briefed and empowered to make decisions on behalf of the area they are representing.

To be quorate, all core members above must be present or represented.

4.0. Responsibilities

4.1. **NHSEI NE&Y Directors** will provide a regional oversight of operational issues and broader contextual information to support any mutual aid request during a Level 3/4 incident. They will facilitate discussions between systems to both understand the mutual aid request and to identify potential options for delivery of mutual aid response.

4.2. **ICS Chief Exec/Chair Leads and ICS Medical/Nursing Leads** will provide a system oversight of operational issues and broader contextual information in support of the mutual aid request. They will support discussions to identify options for delivery of effective mutual aid in order to support patient safety and facilitate discussions with local provider trusts. ICS's will work together to ensure agreed system level actions are delivered.

4.3. **Regional Head of EPRR** will provide advice and guidance in the management of mutual aid during a Level 3/4 incident.

4.4. **Lead Executive for the Nightingale Hospitals** will provide a view of readiness for activation should this be required.

4.5. **Specialists in attendance** will provide specialist advice and guidance relating to the provision of mutual aid, outline any risks and benefits, likely duration and advice on restoration.

5.0. Secretariat

The meeting will be supported by the NHSEI NE&Y Joint Regional Operations Centre (JROC).

6.0. Frequency

The Regional Mutual Aid Panel will stand up when a request for mutual aid is received through JROC, where all local ICS mutual aid options have been thoroughly explored in line with the regional Escalation and Mutual Aid Plan – November 2020 and have been exhausted. It will continue to meet, at a frequency agreed by core members, until the mutual aid is no longer required in order to monitor and manage ongoing risks and mitigations.

7.0. Format

The Panel will be held via MS Teams

8.0. Data

Via the NHSEI Incident Director, the JROC will coordinate the provision of appropriate data and information, in line with the regional Escalation and Mutual Aid Plan – November 2020.

A black and white portrait of a young man with short, light-colored hair, wearing black-rimmed glasses and a dark V-neck scrub top. A stethoscope is draped around his neck. He is smiling at the camera. The background is plain white.

Operational Pressures Escalation Levels Framework

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Medical	Operations and Information	Specialised Commissioning
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Finance		

Publications Gateway Reference:**8760**

Document Purpose	Guidance
Document Name	Operational Pressures Escalation Levels Framework
Author	NHS England
Publication Date	06 December 2018
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Care Trust CEs, Foundation Trust CEs, Medical Directors, Local Authority CEs, Directors of Adult SSs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, Communications Leads, Emergency Care Leads, NHS Trust CEs
Additional Circulation List	
Description	
Cross Reference	
Superseded Docs (if applicable)	Published 31 October 2016
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	ENGLAND.performanceteam@nhs.net

Document Status

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Operational Pressures Escalation Levels Framework

Version number: 2.0

First published: 31st October 2016

Second Edition Published: 21st December 2018

Prepared by: NHS England

Classification: OFFICIAL

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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.

Please note that where the document refers to an A&E Delivery Board (AEDB) if this has been substituted by an Integrated Care System, STP UEC Network or other local System Leadership Forum with a similar remit, then it is imperative that it is formalised and that the Regional Director is able to confirm the same to the National Director for Emergency and Elective Care.

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) framework¹, however they are not interchangeable. **EPRR escalation should therefore be considered separated to this framework.**

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

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/eprp/qf/>

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. This activity will be coordinated by the UEC Operational Teams in each of the 7 Regions.

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

The Framework is intended to support decision making and improve communication of operational pressures within a system, between the partner organisations, system leadership groups, Regional Operation and National Operations.

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 Plan² (REAP) used by Ambulance trusts.

Operational Pressures Escalation Levels	
OPEL 1	Four-hour performance is being delivered. 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	Four-hour performance is at risk. 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	Four-hour performance is being significantly compromised. The local health and social care system is experiencing major pressures compromising patient flow, and these continue 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 including the Regional Director will be made aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. Decisions to move to system level OPEL 4 will be discussed between the Trust CEO, the CCG AO, and System leadership (CCG/STP/ICS Director). This should also be agreed with the Regional Director, or their nominated Deputy. The National UEC Operations team will be immediately informed by the Regional UEC Operational Leads through internal reporting mechanisms.
OPEL 4	Four-hour performance is not being delivered and patients are being cared for in overcrowded and congested department(s). Pressure in the local health and social care system continues and 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. If pressure continues for more than 3 days an extraordinary AEDB meeting should be considered. 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. The Regional UEC Operations Leads will have an ongoing dialogue with the National UEC Ops Room providing assurance of whole system action and progress towards recovery. The key question to be answered is how the safety of the patients in corridors is being addressed, and actions are being taken to enable flow to reduce overcrowding. The expectation is that the situation within the hospital will be being managed by the hospital CEO or appropriate Board Director, and they will be on site. 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.

² <http://naru.org.uk/documents/resource-escalation-action-plan-reap/>

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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 is expected that there will be executive level involvement across the A&E Delivery Board.

4 The national escalation framework

Good surge management happens when health and social care partners come together to resolve pressures taking a system-wide perspective. 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 in Annex 1 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 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.**

4.2 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 further escalation to OPEL 4 as a system (not at trust level) is likely then System lead (CCG/STP/ICS Director) should escalate and agreed with the Regional Director, their nominated Deputy.

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. As mentioned above, the system lead should escalate and should be agreed with the Regional Director, their nominated Deputy with the National Operations Team notified when any system escalates to OPEL 4.

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.

4.2.1 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 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) must close (as opposed to not being able to receive new attenders) as it will not be able to offer resuscitation facilities. This must be reported through NHS England DCO teams, System Leadership and via Regional Operational Leads to the National Operations function. This will need to have been reported to the Regional Directors, or their appointed deputy.
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 local ED facilities due to OPEL escalation of another local system must also 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 Involvement of the Regional Operations Leads

The Regional UEC Operations Team will provide strategic oversight, support and, when necessary, constructive challenge to local system leaders. During periods of surge in demand, or significant operational pressure, they will ensure local escalation plans are robust and there is a collective focus by all system partners to mitigate any harm to patients and recovery plans are being prioritised and implemented effectively

6.1.4 On-going review

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

Annex 1 – The escalation process

Escalation level	Acute Trust (s)	Community Care	Social care	Primary care	Other issues
OPEL One	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination 	<ul style="list-style-type: none"> • Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings 	<ul style="list-style-type: none"> • Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand 	<ul style="list-style-type: none"> • NHS 111 call volume within expected levels
OPEL Two	<ul style="list-style-type: none"> • Four-hour performance is at risk • Anticipated pressure in facilitating ambulance handovers • 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) 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Actions at OPEL 2 failed to deliver capacity • Four-hour performance is significantly compromised • Significant number of handover delays • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Surveillance information suggests a significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals
OPEL Four	<ul style="list-style-type: none"> • 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 / Exceptional increase in ambulance attendances • 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) 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Weather conditions resulting in significant pressure on services • Infection control issues resulting in significant pressure on services

	<ul style="list-style-type: none"> • 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 • Four-hour performance is no longer being delivered, and patients are being cared for in overcrowded and congested emergency departments 	compromises service provision / patient safety	increased pressure on patient flow	service provision / patient safety	
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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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 • Open additional beds on specific wards, where staffing allows • 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 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • All actions above done or considered • Utilise all actions from local escalation plans • Trust CEOs / CCG AO involved in discussion with Regional Director / Deputy / On-Call Director and agree relevant recovery actions and their ongoing tracking. 	<ul style="list-style-type: none"> • 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 • 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 <p>Active management of elective programme including clinical prioritisation of non-urgent elective inpatient cases</p> <p>Active management of elective programme including clinical prioritisation of non-urgent elective inpatient cases</p>	<ul style="list-style-type: none"> • 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 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. 	<ul style="list-style-type: none"> • 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, including primary care 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • OOH services to recommend alternative care pathways • Engage GP services and inform them of rising operational pressures and to plan for recommending alternative care pathways where feasible • Review staffing level of GP OOH service 	<ul style="list-style-type: none"> • To review all discharges currently referred and assist with whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission
OPEL Four	<ul style="list-style-type: none"> • 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 <p>If OPEL 4 continues for more than 3 days consider an Extraordinary AEDB meeting.</p>	<ul style="list-style-type: none"> • 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. • Ambulance service review all referral pathways and ensure all possible alternatives are considered • 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 ambulance divert. 	<ul style="list-style-type: none"> • Local regional office notified of alert status and involved in decisions around support from beyond local boundaries • Regional Operations Lead provides briefing to National Operations Room • The CCGs will act as the hub of communication for all parties involved • Post escalation: Complete Root Cause Analysis and lessons learned process 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • Stand-down of level 4 once review suggests pressure is alleviating • Post escalation: Contribute to the Root Cause Analysis and lessons learned process 						
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Roles and responsibilities - Local, regional and national level

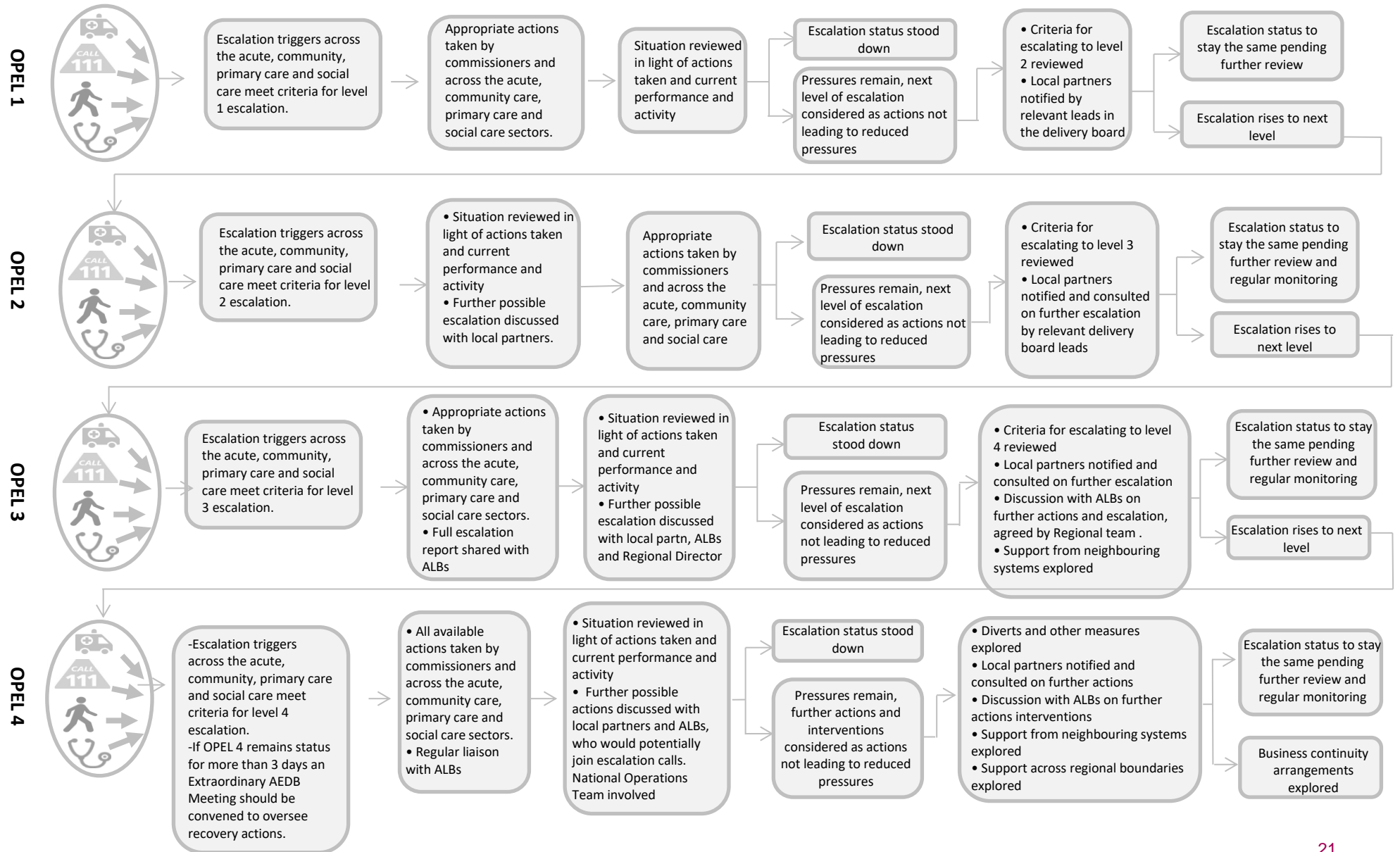
Organisation	Role/ Responsibility
Local A&E Delivery Board	<ul style="list-style-type: none"> • All providers should: <ul style="list-style-type: none"> ○ Maintain timely updating of local information systems that monitor pressures in their patch ○ Ensure all trust level pressures are communicated regularly to all local partner organisations, and communicate all trust level escalation actions taken (e.g. opening escalation beds) • Acute providers should: <ul style="list-style-type: none"> ○ 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.
	<ul style="list-style-type: none"> • CCGs should: <ul style="list-style-type: none"> ○ 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.

	<ul style="list-style-type: none"> ○ 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)	<ul style="list-style-type: none"> • 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. • When the decision to move to OPEL 4 as a system is being considered then the system leadership should escalate and agree with the Regional Director, their nominated Deputy or the Regional On-Call Director and the National Operations Team should be immediately notified of the outcome.
Joint NHS England/NHS Improvement teams (Regional A&E Delivery Boards)	<ul style="list-style-type: none"> • 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 the National Operations Room. • Support local ALB teams as required.

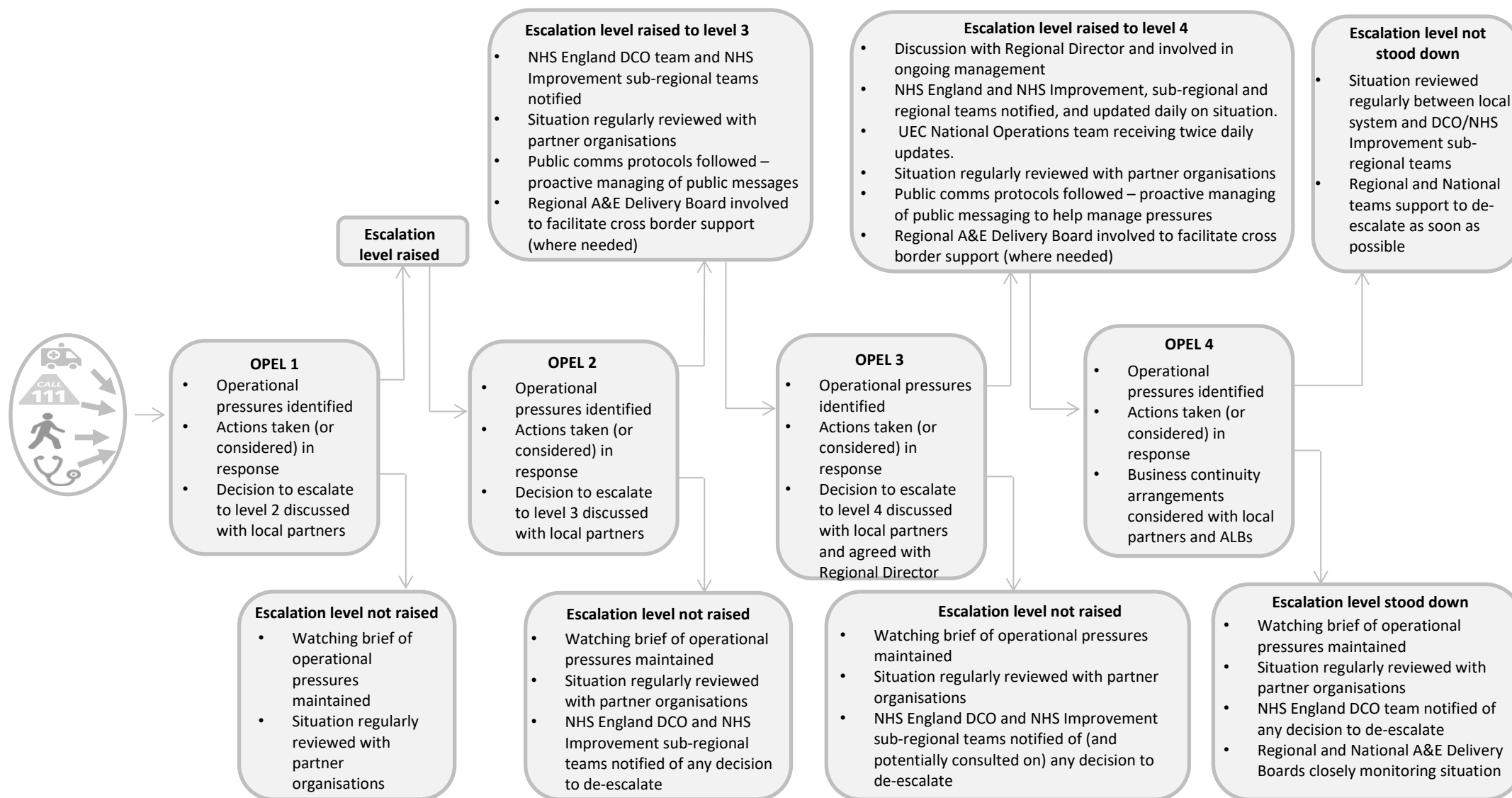
Joint NHS England/NHS Improvement teams (National A&E Delivery Board)	<ul style="list-style-type: none">• Coordinate routine reporting arrangements e.g. winter sit rep• Provide oversight and coordination to regional ALB teams where system-wide OPEL 4 applies. Support cross-regional boundary working where 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
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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.

Annex 2 Local escalation processes



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



COVID-19 Pandemic CRITCON Levels

Please declare CRITCON level and for CRITCON 1, 2 or 3 the staffing level A or B

DEFINITION	STATUS
Normal – ‘Business as usual’	
<ul style="list-style-type: none"> Normal, able to meet all critical care needs, without impact on other services Normal winter levels of non-clinical transfer and other overflow activity. 	CRITCON 0
Low Surge – ‘Bad winter’	
<ul style="list-style-type: none"> Usual funded critical care capacity full. Some non-clinical transfers 	CRITCON 1
Medium Surge – ‘Unprecedented’	
<ul style="list-style-type: none"> Usual funded critical care capacity full – overflow into quasi-critical care areas (theatre recovery, other acute care areas). High level of non-clinical transfers Trusts beginning mutual aid 	CRITCON 2
High Surge – ‘Full stretch’	
<ul style="list-style-type: none"> Expansion into non-critical care areas (e.g. wards) and/or use of paediatric facilities for adult critical care. Trust operating at or near maximum physical capacity. Maximum mutual aid between Trusts, with network and regional NHSE co-ordination. The prime imperative in CRITCON 3 is to prevent any single trust entering CRITCON 4 	CRITCON 3
Triage – ‘Emergency’	
<ul style="list-style-type: none"> Resources overwhelmed. Possibility of triage by resource (non-clinical refusal or withdrawal of critical care due to resource limitation). This must only be implemented on national directive from NHSE and in accordance with national guidance. 	CRITCON 4
Staff Declaration: CRITCON 1,2 & 3 SHOULD BE FURTHER CATEGORISED A OR B	
<ul style="list-style-type: none"> Adhering to BACCN / ICS staffing recommendations or unit norm 	A
<ul style="list-style-type: none"> Staffing below BACCN / ICS staffing recommendations or unit norm 	B

UHCW STP/ICS Surge Escalation

Alert Status & Elective Response

Triggers

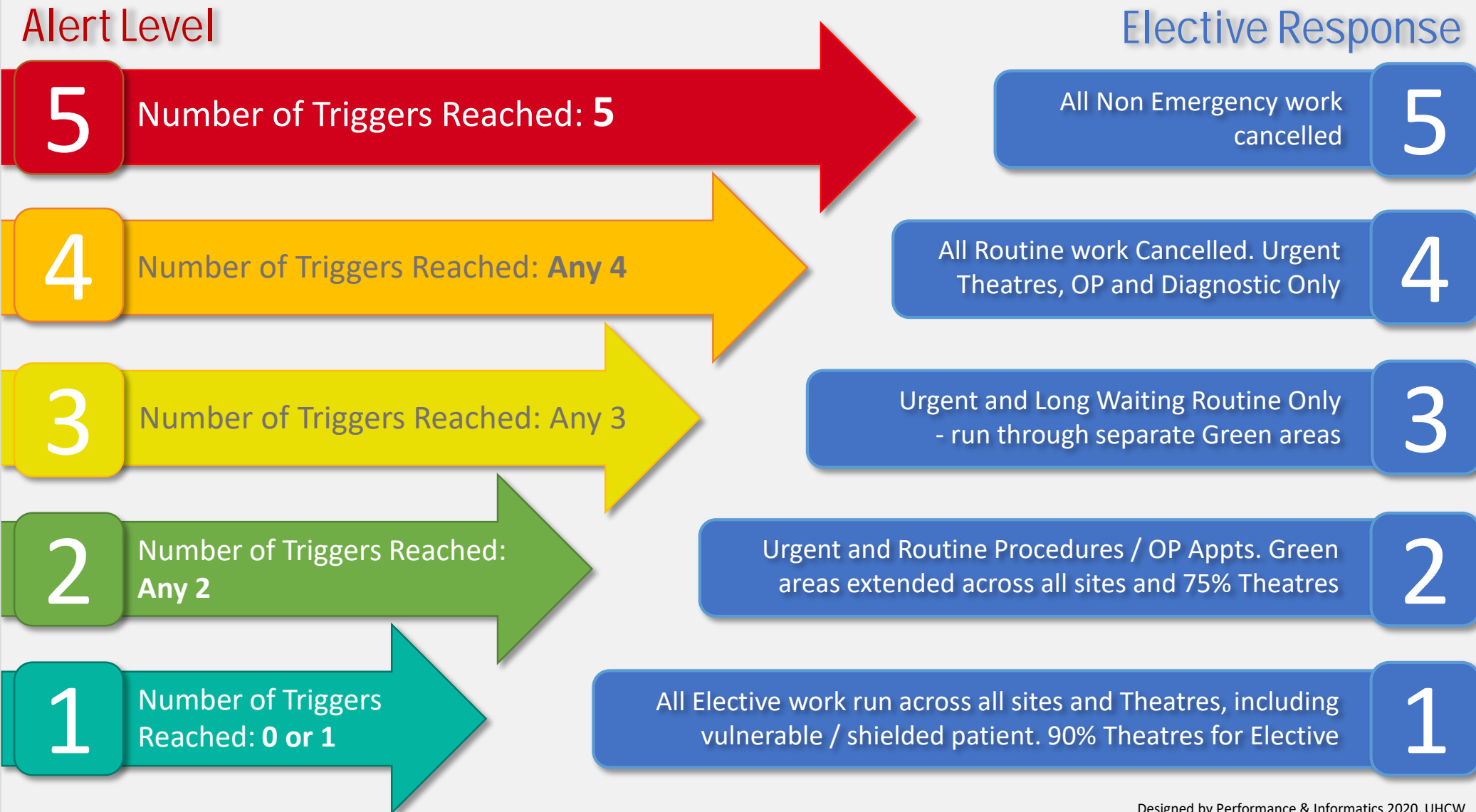
Trigger	Threshold	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Experiencing Increased volumes through ED	>10% Rolling Growth	Zero or one of the triggers	Any two of the triggers	Any three of the triggers	Any four of the triggers	All five of the triggers
Experiencing Limited COVID Critical Care Capacity	>80% Occupancy					
Experiencing Limited General Critical Care Capacity	>80% Occupancy					
Experiencing Limited COVID Cohort Bed Capacity	>80% Occupancy					
Experiencing Limited General and Acute Bed Capacity	>95% Occupancy					

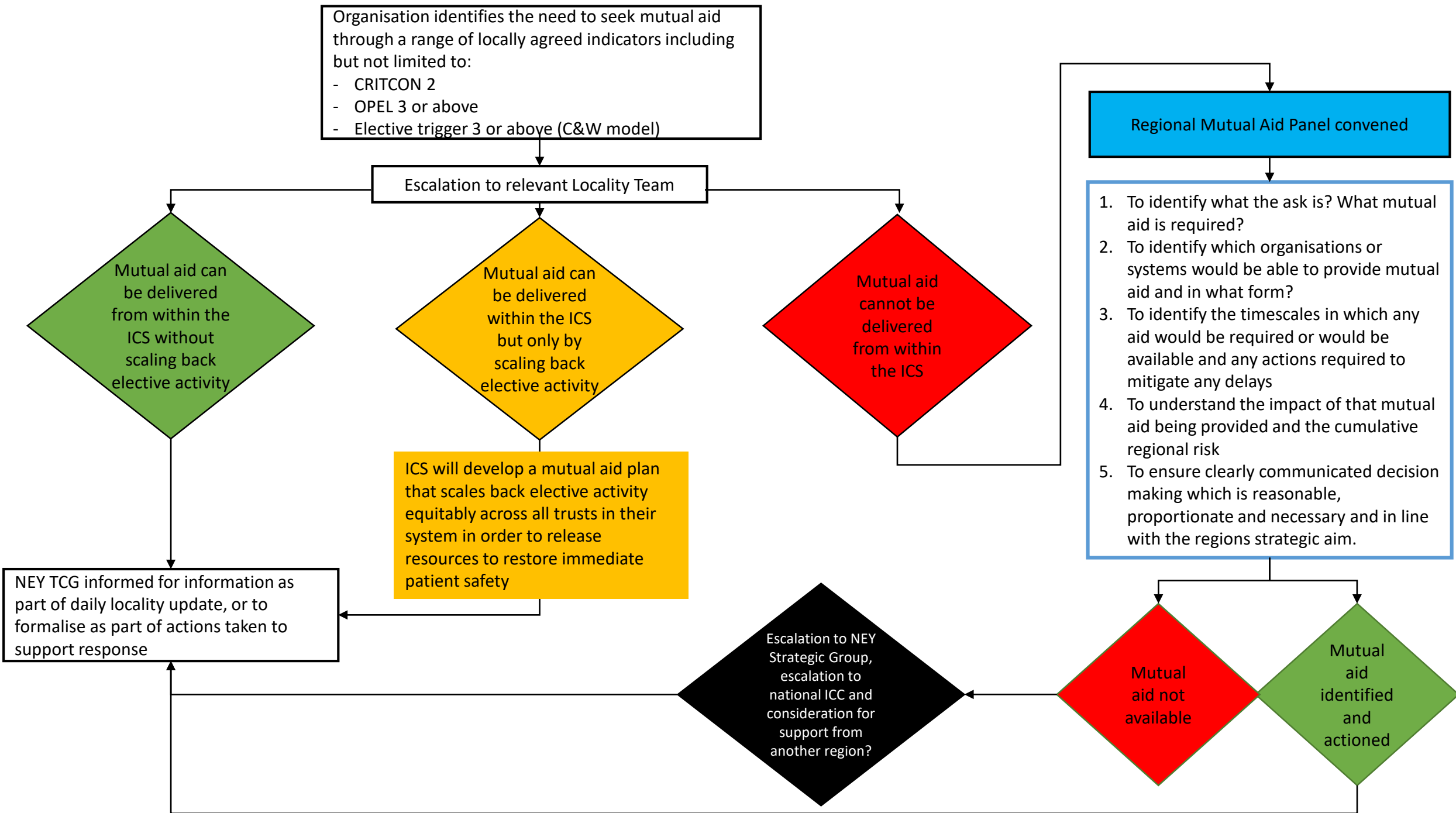
Current Hospital Position

UHCW COVID-19 Alert System and Escalation Triggers			
Trigger	Threshold	Value	Triggered
Experiencing Increased Volumes Through ED Respiratory	>10% Rolling Growth	-4%	N
Experiencing Limited COVID Critical Care Capacity	>80% Occupancy	41%	N
Experiencing Limited General Critical Care Capacity	>80% Occupancy	61%	N
Experiencing Limited COVID Cohort Bed Capacity	>80% Occupancy	22%	N
Experiencing Limited General and Acute Bed Capacity	>95% Occupancy	82%	N
Stage 1			

UHCW STP/ICS Surge Escalation

Alert Status & Elective Response





HCV Covid19 Escalation Plan

6th November 2020



HCV Current Position

All Hospitals across HCV (6th November):

- Number of beds occupied by confirmed covid patients as of 8am = 313 (includes community/mental health)
 - Harrogate 23,
 - HUTH 113 (above wave 1 peak on 21st April)
 - NLAG 98 (above wave 1 peak on 21st April)
 - York 76
- The number of confirmed COVID patients in HDU/ITU as of 8am = 28
 - Harrogate 2
 - HUTH 11
 - NLAG 10
 - York 5



Key Challenges

- Rising number of COVID positive patients impacting on G&A and HDU/ITU bed capacity across the ICS, resulting in the need to open additional COVID capacity and redeploy of staff which is leading to increased cancellation of operations across the ICS
- Pressure on workforce due to staff absence, including need to self isolate (All staff absence 2,674 and of those COVID related absence are 1,160 – 43%), and impact of risk assessments on available clinical staff
- Testing capacity at NLAG – issue with analyser which is causing delays
- Patient flow resulting in breaches of the 4-hour target, 12-hour trolley breaches and ambulance handover delays
- Increase challenges in discharging COVID positive patients into community settings



HCV Escalation Framework

Level	Trigger	Response
5 Very High	Occupancy >95% COVID Occupancy > 30% Critical Care occupancy and % staff sickness, especially in key areas, a key consideration	<ul style="list-style-type: none"> All non-emergency work cancelled Maintain P1 capacity and prioritise P2 patients (including cancer surgery) Critical care capacity escalated in line with agreed framework Triggered IS surge clause and maximising utilisation of 100% of staffed capacity System partners OPEL 4 actions in place
4 High	Occupancy >90% COVID occupancy > 25% Critical Care occupancy and % staff sickness, especially in key areas, a key consideration	<ul style="list-style-type: none"> Maintain P1 & P2, daycase, outpatients and diagnostics Full surge capacity opened across all acute hospitals Cancer Alliance prioritising cancer care across the system Surgical admissions group (Surgical Directors & COOs) prioritising P1 and P2 admissions North Yorkshire and Humber Critical Care Networks managing critical care capacity across the system Engage neighbouring Trusts/Ambulance Service regarding mutual aid – Planned and Unplanned Care Business continuity plans and mutual aid from partners across ICS for ancillary and administrative staff – to support all sectors Maximise utilisation of independent sector and consideration being given to triggering surge clause in National contract to access 100% capacity – with 7 days' notice – at place or ICS level System partners OPEL 3 actions in place
3 Moderate	Occupancy >85% COVID occupancy > 20% Critical Care occupancy and % staff sickness, especially in key areas, a key consideration	<ul style="list-style-type: none"> Maintain P1 & P2, long waiters, daycase, outpatients and diagnostics All available community capacity stood up to support discharge and CCGs working across boundaries to flex discharge capacity Operational group (COOs) reviews scheduling of long waiters to minimise breaches Surge capacity is open in individual Trusts, as required. Daily system call – director level – to agree mutual aid across the local system Consider engaging neighbouring Trusts/Ambulance Service regarding mutual aid Community surge capacity is open across one or more systems to support discharge Maximise utilisation of independent sector
2 Low	Occupancy >85% COVID occupancy >5% but less than 20%	<ul style="list-style-type: none"> Maintain emergency and urgent care services Maintain P1 & P2, long waiters, daycase, outpatients and diagnostics HCV Wave 2 plan operationalised Mutual aid operates within Place and across organisations
1 Minimum	Business as usual	<ul style="list-style-type: none"> Phase 3 plan fully operationalised

Incident Management

- All trusts have individual incident management arrangements in place. Trusts, CCGs and LAs participate in these arrangements to ensure coordination across systems, ensuring escalation of risks and mutual support as appropriate
- HCV ICS has a number of well established regular mechanisms in place to share intelligence, track delivery and respond to anticipated / emerging pressures including:
 - HCV Strategic Health Coordination Group brings together all partners to ensure coordination across the system
 - Humber and North Yorkshire Geographical Partnerships have their respective Gold and Silver arrangements, linked to the work of AEDBs
 - Acute Trust COOs and HCV Locality Team meet twice weekly to discuss surge issues, response and potential for mutual aid
 - Weekly call between HCV ICS lead and all Chief Executives and AOs, including Local Government leads
 - Acute, Community and Mental Health sector Provider Collaboratives meet regularly to provide system support and resilience
 - ICS Communications network are proactively responding to actions agreed from above, including increasing links with Humber and North Yorkshire LRF comms



Mitigations

Underpinning the ICS Escalation Plan are a set of Trust Surge Plans and system escalation plans, with associated triggers and actions depending on various OPEL levels.

Trust Surge Plans include:

- Ward surge plans including staffing models
- Critical Care surge plans
- Elective activity to be protected as long as possible and the identification of lower risk activity to be stepped down to release staff for critical care and red ward areas, based on clinical risk
- Prioritisation of Surgical and Outpatient activity to be protected for as long as possible



System Risks

Themes	Unmitigated risks
Patients first – Quality care – links to safety, governance, social care and IPC	<ul style="list-style-type: none"> • Workforce – in particular CHC, IPC and domiciliary care • Risk of providers unable to comply with IPC due to challenges of restoration and winter and covid concurrently (e.g. potential to breach social distancing in order to meet demand) • Clinical risk of the waiting list backlog not all risk mitigated
Caring for our Staff – Workforce – wellbeing and as a critical enabler	<ul style="list-style-type: none"> • The increased requirement for staff to shield as school aged children are sent home to isolate and/or be tested for Covid-19 will reduce the available workforce. • Support and shared intelligence on absence rates to support opportunities for staff mobility/mutual aid across our ICS area and into other ICS's. This will include learning from the adopt and adapt programme. • Sharing of thinking on health and wellbeing proposals from across the region to identify common themes with further support if appropriate to include mental health support and a wider approach of staff engagement
Demand – links to winter pressures and Urgent & Emergency Care (inc 111 and 999)	<ul style="list-style-type: none"> • Increased non elective demand – Covid and non Covid –with resulting impact on flow, discharge and hospital capacity • Workforce due to self-isolation and associated absenteeism • System approach to discharge in certain parts of HCV
Demand – links to critical Care and capacity planning	<ul style="list-style-type: none"> • Workforce • Required Increased Capacity • Impact on Continued Elective Work-Trust • Overwhelming demand



System Risks

Themes	Unmitigated risks
Critical Functions- Primary Care – links to vaccination plans influenza and COVID-19	<p>Vaccination & Immunisation</p> <ul style="list-style-type: none"> • There is a risk that workforce will be insufficient to deliver programme, this will be caused by staff needing to self-isolate, this would lead to patients not be able to be vaccinated • There is a risk that eligible patients will not be able to be vaccinated. This will be caused by vaccine not being available when needed. This would lead to not meeting the national ambition. Patients left vulnerable. (Mitigation /letter from DH to address this but may be a risk before next vaccines released) • There is a risk we will not have accurate recording and interoperability of performance data across cohorts. This will be caused by new data collection tools being implemented for different cohorts and confusion about national data reporting plans/progress. This would lead to challenge on uptake figures which may be unfounded. <p>Primary Care</p> <ul style="list-style-type: none"> • Flu vaccine supplies have for many pharmacies and practices become the rate limiting step. More central stock now available but not known if this will be sufficient to cover all including 50-64 year olds. • Impact of local lockdowns on vaccination programmes. • Impact of self-isolation on workforce capacity.
Critical Functions – Testing – links to acute flow, discharge flow and workforce	<ul style="list-style-type: none"> • Workforce capacity to support the labs. • Ensuring quick turnaround of test results to support effective discharge and hospital care. • Ability to provide mutual aid across Humber coast and vale given the different pathology networks.



System Risks

Themes	Unmitigated risks
Critical Functions – Procurement, PPE & Logistics	<ul style="list-style-type: none"> Storage capacity and capability – plans to secure a storage unit in Hull Inconsistency of some products – notably FFP3 – with resulting uncertainty and challenges in relation to FIT testing requirements and opportunity cost alongside substantial PPE kit being held that can never be used given its inappropriate quality checks, and space this is taking up. Ensuring PPE supplies through Portal to primary care
Critical Functions – Recovery – links to restoration, maintaining services and independent sectors	<ul style="list-style-type: none"> Maintaining sufficient frontline staffing levels in primary, community and secondary if there is a significant level of Covid-relate absences that may coincide with Covid peaks in the general population/ return to school. Workforce burnout, low resilience, sickness and limited agency nursing staff available in some areas. Confirmation of capital funding to support the implementation of schemes to maintain safe working and 'hot' and 'cold' areas in primary, community and secondary care. Noted that Harrogate FT has assumed that <u>all</u> capital bids submitted will be funded as they have already committed to this expenditure. This includes all retrospective claims of £3.534m plus Phase 3 recovery capital bids of £3.663 a total of 7.017m. Patients not wanting to present to GPs, take up offers of scheduled surgery or treatment, or unable to access treatment and diagnostics (including moving around the wider system to utilise shared capacity if hubs are progressed). Feasibility of mobilising all additional capacity to shift to diversionary pathways to support key transformations, e.g. NHS 111 First.
Resilience – Cyber Preparedness and Digital resilience – links to business continuity and contingencies	<ul style="list-style-type: none"> Funding provided to support HCV digital COVID phase 3 proposal for cyber and security scheme to improve resilience and remove legacy technology. Embed NHS Digital cyber resource in HCV to improve the management of cyber resilience during COVID. Agreement with ISP for homeworking to allow the continued use of VPN and uncapped data usage for Health & Social care staff.



COVID-19 Wave 2 Response and Escalation Plan

4 November 2020



Current Position (4 Nov 2020)

- Hospitals across West Yorkshire now have more covid-19 patients (794) than at April peak (718)
- This number has doubled over the last 13 days
- The number in HDU/ITU (69) has grown less slowly but is now at 55% of April peak
- This increasing level of covid demand has placed significant pressure on hospital capacity and particularly on workforce availability.
- Unlike in the spring, Trusts have reintroduced a wide range of planned operations and appointments over the last few months and are continuing to provide many of them. However, Trusts have had to take difficult decisions to pause some of these planned services so that staff and wards can be available to care for covid patients
- All trusts will continue to maintain as many services as possible, including outpatient appointments, day case procedures, as well as urgent operations and cancer care.
- The surge clause to access 25% additional IS capacity has been activated for West Yorkshire
- Trusts are working together to ensure that any further changes will be made in a planned and consistent way, in line with a WYAAT escalation model
- The Y&H Nightingale is being made ready to help provide additional capacity if it is needed, as part of the escalation framework.



The ICS is implementing a five-point plan to mitigate Covid-19 Wave 2 pressures across WY&H

Aim	Action	Lead
1. To ensure a consistent approach to prediction / forecasting for the future, providing a basis to prepare for expected peak in covid activity.	<ul style="list-style-type: none"> Provide modelling tools and data across WY&H, and collate views of Trusts to achieve a single version of the truth around expected pressures over the next 2-3 weeks 	Locality Director PHE lead
2. To ensure that key interventions are implemented consistently to make a difference to prevalence	<ul style="list-style-type: none"> Support WY-wide implementation of local contact tracing arrangements (i.e. the Bradford and Calderdale model) Preparation for introduction of mass testing Planning for logistic implications of covid vaccine delivery Introduce nudge theory messages (subject to funding) Ensure consistent public messaging 	WY LRF Chair
3. To ensure a greater understanding and oversight of pressures in the system,	<ul style="list-style-type: none"> Introduce regular communication with Trust COOs to understand pressures in system and oversight of impact on elective activity DASSs to ensure consistent assessment of pressures on carme home sector 	Locality Director WYAAT Director SRO for critical care DASSs
4. To ensure that appropriate business continuity and crisis response plans are in place.	<ul style="list-style-type: none"> Ensure clarity around escalation arrangements Critical Care Network and WYAAT to agree principles and triggers for mobilisation of Y&H Nightingale 	Locality Director WYAAT Director SRO for critical care Trust COOs
5. To help build public confidence through collective leadership messaging	<p>Development of a joint leadership statement on behalf of the ICS:</p> <ul style="list-style-type: none"> Where we are How we are working What we're asking of people 	Karen Colman (with core team)



In line with point 4 of the ICS plan the West Yorkshire Association of Acute Trusts (WYAAT) has agreed an escalation framework

	Criteria	Description	Additional inputs required	Data
1	Accelerate discharge of patients supported by positive risk management	<ul style="list-style-type: none"> All trusts will implement good practice from across WYAAT Enact system response (with primary care, community services and social care, and with CQC) 	<ul style="list-style-type: none"> WYAAT agreed admission and discharge criteria (to be set by MDs) 	<ul style="list-style-type: none"> COVID Discharge sit-rep (submitted weekdays only)
2	Trusts increase own capacity by opening any closed wards with available staffing	<ul style="list-style-type: none"> Additional surge capacity in use with current staffing ratios 		<ul style="list-style-type: none"> Trust baseline position 02/11/2020 CCN daily sit rep
3	Reopen beds on COVID wards closed due to social distancing	<ul style="list-style-type: none"> Trusts will increase bed numbers on COVID wards by removing social distancing measures 		<ul style="list-style-type: none"> Trust baseline position 02/11/2020
4	Postpone non-urgent electives	<ul style="list-style-type: none"> All trusts will postpone non-urgent electives including a consistent position on day case, independent sector provision, and tertiary capacity Services stood down where staff can be suitably redeployed to support non-elective demand Mutual aid deployed to manage most urgent patients where service provision retained 		<ul style="list-style-type: none"> Trust baseline position 02/11/2020
5	Open YHN with reduced staffing ratios as per agreed ratios	<ul style="list-style-type: none"> Open some YHN capacity when modelling indicates step 6 will be required to meet demand 	<ul style="list-style-type: none"> WYAAT agreed minimum staffing ratios (to be set by Chief Nurses) Agreed trigger for opening YHN capacity 	<ul style="list-style-type: none"> CCN daily sit rep EPRR Occupancy trajectory
6	Reduce staffing ratios in trusts to open all on site beds	<ul style="list-style-type: none"> Staffing reduced to WYAAT agreed ratios All physical space in base hospitals utilised 	<ul style="list-style-type: none"> WYAAT agreed minimum staffing ratios (to be set by Chief Nurses) 	<ul style="list-style-type: none"> Occupancy trajectory

Actions taken by Trusts in line with level 4 of WYAAT escalation framework

Trust	Current no. of covid Patients (inc HDU/ITU)	Situation update
Airedale Hospital NHS FT	53 (3)	<ul style="list-style-type: none"> For the first two weeks of November the only elective inpatient operations at Airedale are for cancer or urgent pathway, due to overall occupational pressures Currently impacting 10-15 patients per week. Continue to utilise independent sector capacity. Day case activity is continuing for now, working on the basis of clinical priority. Will review this position on a regular basis during the next 2 weeks to inform a decision beyond this.
Bradford Teaching Hospitals NHS FT	138 (9)	<ul style="list-style-type: none"> Pausing non-urgent hospital appointments and operations to allow the hospital to dedicate staff and beds to maintain our high standard of care. Appointments, diagnostic tests and operations for time critical conditions such as cancer and emergency are still taking place. From November reducing elective capacity at the BRI to 1/3 of planned sessions per week. Overall with additional support from the IS anticipate delivery of 56% of our planned elective capacity. The Trust will be treating fewer patients than outlined in the NHSE phase 3 recover plan. When we restart services, we will enact a ramp up plan to increase theatre capacity as staff are returned from redeployment
Leeds Teaching Hospitals NHS Trust	289 (10)	<ul style="list-style-type: none"> The Trust has not closed any full services with the exception of elective overnight activity at Chapel Allerton Hospital (cold site). Still delivering as much outpatient and elective/daycase as possible where capacity allows. Proactively standing down any activity ahead of time (where possible) based on demand and capacity available to continue to deliver these services.

Actions taken by Trusts in line with level 4 of WYAAT escalation framework



Trust	Current no. of covid Patients (inc HDU/ITU)	Situation update
Calderdale & Huddersfield NHS FT	106 (8)	<ul style="list-style-type: none"> 7.5% of clinical staff now absent on top of a high qualified nursing vacancy level of 156 wte All adult beds are full with several patients waiting overnight for access to a bed each morning Critical care capacity is into Phase 2 and full All surge and escalation plans from Wave 1 are being implemented where this was the agreed pathway All theatre activity stopped apart from emergency and cancer cases that cannot be undertaken in the IS Working with IS to ensure full utilisation of additional 25% of capacity. 5 virtual Multidisciplinary accelerated discharge events (MADE) a week are taking place with GPs and therapy teams focussing on the Reason to Reside patients to expedite discharge. This is facilitated by our ability for all colleagues to access both primary and secondary care records The Huddersfield Birth centre is being closed and will be used as a green facility for the small amount of cancer work that cannot be treated in the IS due to clinical complexity Notice has been given to Medical teams on the reintroduction of the COVID Rota A review of outpatients and diagnostic activity will commence on Monday with a view to further reductions Impact on electives is currently 160 patients per week on November phase 3 plans, Once additional IS 25% worked through then this number will reduce 2500 Outpatients appointments per week as a consequence of needing to implement the Medical rota Will review all other Outpatients and diagnostics, including Endoscopy to identify any further reductions. These will only be required should further clinical staff need to be released to support additional beds Overall bed & staffing position will be reviewed weekly and if safe then the decision will be reconsidered.
Mid Yorkshire Hospitals NHS Trust	185 (39)	<ul style="list-style-type: none"> Patients are being cancelled to free staffing to support higher acuity beds. So far 290 planned procedures have been cancelled. 106 Daycase spells at DDH, 137 Daycase at PGH and 47 Inpatients at PGH. Elective services continue to be provided and not all non-urgent cases (P4) have been suspended, however we are operating at a reduced rate due to the operational pressure of having increased proportion of patients requiring higher acuity beds and support. This position will be maintained until the bed position improves. <p>At present we are cancelling (or reducing planned activity) by approximately 100 patients per week (50 on both sites). This rate will remain for the duration of the second wave.</p>

Next Steps

- WYAAT Trusts are working to agree the triggers to move to levels 5 of 6 of the escalation framework.
- This will include preparing to mobilise the 'super surge' opportunity within the IS contract, to enable places to ask the IS to stop elective activity to allow their staff to be redeployed into the NHS to bolster numbers / open more beds.
- Partners in each place are working together to take all possible actions to free-up beds by facilitating discharges. This would be helped by national changes to allow greater flexibility to act (eg in relation to CQC requirements and IPC guidance)

Our Asks

- Regional support for staffing flexibilities required as part of level 6 of WYAAT escalation framework
- National resolution of care homes insurance problem
- Greater flexibility to support primary care resilience (eg on implementation of RCGP red-amber-green guidance)
- Resolution of primary care income guarantee
- Flexibility to use unspent primary care transformation funds to support pressures in primary care
- Greater flexibility to act in relation to care home discharge policies
- Rapid review of self-isolation payment model, linked to Test and Trace
- Consider national extension of IS contract arrangements
- Need for national contract for access to mental health IS capacity

Annex – Wider ICS Wave 2 resilience and response plans

Quality care – links to safety, governance, social care and IPC

- Quality and safety are overseen by WY Clinical Forum and Quality Surveillance group. The Clinical Forum has agreed an ethical principles framework to support prioritisation / guide decision making.
- Weekly chief nurse/quality leads call to share learning, mitigate risk. Collaborative arrangements on safety and safety issues at ICS in place i.e. IPC learning, LeDeR.
- Weekly sector leads meeting supporting the ICS COVID response includes a DASS on behalf of ASC enabling escalation of issues.
- Quality impact assessment approach in place for reset plans, includes consideration of social distancing, IPC arrangements learning from IPC BAFs
- System Flow / Care Homes Support : Led by A&E Boards in Each Place. Place Based Plans Include
 - Purchasing of care home beds, enhanced community support, training.
 - Care home support arrangements established in each place /ICS level group co-ordinate across where necessary.
 - Each Place has local arrangements in place to support sustainability of Care Sector
- Place led Integration and partnership working across ASC, Community and VCS accelerated as a result of Covid supported through range of West Yorkshire Programmes

Risks and Issues

1. **Care Home and ASC sector vulnerability.** Void levels are high and low placement rates significant financial viability risk. Whilst each place has provided IPC support and training embedding and sustaining practice is challenging and represents a risk, particularly if pressures result in high levels of unplanned admissions to care homes.
2. **Workforce** -Scaling up use of Nightingales – Learning from outbreaks demonstrates staff “weariness” with greater risk of poorer adherence to social distancing. Workforce fragility across all sectors including primary care due to increased cases and self isolation
3. **Balancing clinical safety and quality risks** between increasing COVID cases and restart elective in context of high community transmission, increasing hospital admission including critical care.

Workforce – wellbeing and as a critical enabler

- WY ICS has an established Workforce Programme focusing on a **prevention first** approach to enable workforce to stay well, supplemented with recovery and support services when needed
- **WY&H Health and Wellbeing Webpage:** Resources and sign-posting for staff inc tailored support e.g BAME staff
- Two ICS Bids submitted to NHSE/I:
 - **‘Mental Health and Wellbeing Hub’** which will enable *Definition and development of a minimum “standard offer” for mental health and wellbeing Support with Enhanced support offer* for staff in challenging environments
 - **Enhanced Occupational Health Services** building on hub approach to provide targeted support to address:- Burnout, Long-Covid rehabilitation plus access to specialist/complex psychological support
- **Bringing Back Staff** –Work with NHSE/I to identify and deploy staff who want to continue to be considered as part of the BBS through recent stock take

Risks / Issues

1. General Workforce Health and Wellbeing: Mitigation reliant on support for the two bids outlined above –notably those requiring specialist support
2. Staff Shielding and Sickness Absence: Capacity Gaps
3. Sickness and Absence Knock on Effect to Staff Remaining: Impact on annual leave, burnout and accessing support

Demand – links to winter pressures and Urgent & Emergency Care

The ICS has a well-established Urgent Care Programme that works across West Yorkshire to ensure robust winter and covid response plans with following in place:

- All Trusts have measures to ensure **social distancing** in ED, Covid secure seasonal virus cohorting and testing in place for all suspected covid cases that need admission.
- ICS implementation of NHS 111 First in partnership with YAS ahead of 1st December 2020, with increased 111 capacity and clinical capacity) plus availability of alternative dispositions across UEC, particularly improved pathways into primary and community services (56.9% dispositions)
- Implementation of an 111 referral and alert system into EDs including transfer of patient information
- Agreed ICS Wide Communications Narrative re choosing the right service aligned to national 111 First campaign
- Admission and flow Measures: daily consultant ward rounds. community capacity development inc. rehab and community beds.
- Focus on improving ambulance handovers,

Risks / Issues

1. Managing same day demand and social distancing in ED
2. Balancing the restoration of electives with peaks in Covid and demand for inpatient beds
3. Test and Trace Pressures: Access and Timeliness of Results



Critical Care and capacity planning

- WY has an established Critical Care Network that leads on resilience, with strategic leadership by a trust CEO. System has baseline capacity of 76 L3 / 58 L2 beds with escalation plan as follows L3 *2 (surge), L3 *2*2 (max surge) + all other capacity (super surge)
Super surge = 378 L3 Beds
- Triggers for escalation agreed include rising tide, lack of network capacity, lack of isolation or cohort facilities with potential for patients being transferred between hospitals to decompress pressurised units and to ensure equity of access / services
- Principle that BAU / elective work to continue as long as possible recognising surge plans utilise theatre capacity / staff.
- Some capital works planned to improve surge capacity / resilience
- Trust supplied with additional critical care equipment from the National Equipment Loan Scheme
- Reverse Osmosis facilities installed in LTHT and BRI

Risks / Issues

1. **Workforce:** Response to the initial wave of COVID relied heavily on non critical care staff such as theatre / anaesthetic staff , being released, to support ICU. Changes to emphasis on maintaining elective operating and changes in use of IS if maintained will result in less staff being available to support ICU during second wave.
2. **Estate** (capital funding): Allocated capital funding for CC improvement works allocated but not released). Delays to capital schemes likely to occur reducing capacity and resilience. Also some baseline CC capacity may be lost during any building works.
3. **Overwhelming demand:** Whilst the NHS Nightingales' provide some mitigation against overwhelming critical care demand they rely on already overstretched critical care workforce. It is doubtful therefore we have a sustainable solution to overwhelming demand. Including ability to respond to a Major/Mass Casualty Incident
4. **BAU:** Despite imperative to continue elective operating as long as possible any significant surge will impact on elective activity

Primary Care – links to vaccination plans

- WY has an established Primary and Community Programme Board that supports development of PCNs. CCGs and PCNs have established robust arrangement for Covid Hubs. PCNs are increasingly working in partnership with Community Services, ASC and VCS to manage patients including development of pathways alternative pathways for patients at high risk of admission.
- GPs have increased significantly the ability to manage patients through non face to face technology both from within practices and at home to improve resilience. PPE supply chain improvements also improve resilience for practice staff
- The WY ICS has a Flu Board. The Board continues to share approaches to maximising vaccination uptake through local place leads with specific focus targeted approaches to addressing inequalities in uptake for specific population groups.
- WY have undertaken a Validation Exercise, supported by MOD, to test the Flu Plans for each CCG. Plans are being refined as a result of this to ensure robustness
- Task and finish group established to disseminate good practice and practical tools to support collaboration between GPs and pharmacy to make best use of resource and vaccine availability and maximise local uptake
- SOPs and a local dashboard are being developed to show performance data and enable targeted interventions
- LTHT identified as lead provider for **covid19 vaccine**. Work is progressing well to establish the delivery model and the relationship with places and the LRF

Risks / Issues

1. **System Resilience** – Primary care staff fatigue /sickness and absence; access to responsive Test and Trace, Improving resilience of digital technologies to support remote working. Wider System: Impact of pressure on wider Health and Care Services on Primary Care (Community Services, ASC, Mental Health and VCS)
2. **Vaccines** – early demand from at-risks groups for flu vaccine has led to local shortages as practices routinely have phased deliveries. Comms for GPs on how to access national stock. Covid-19 vaccine – need to confirm the scope of lead provider role and roles and responsibilities of other partners
3. **Funding for innovative delivery mechanisms** – supporting CCGs in gaining clarity on funding routes and process for accessing
4. **Data collection** – new National data collection tools are being released which requires support for providers (in particular school age immunisations) to implement.

Testing – links to acute flow, discharge flow and workforce

- The WY ICS and Local Resilience Forum (LRF) have established a joint programme to co-ordinate our approach to testing (including Test and Trace) across system, led by Martin Barkley, CEO of Mid Yorks Trust. Local NHS leads and DsPH are part of this programme, and participate in weekly co-ordination meetings.
- Pillar 1: NHS testing capacity is well co-ordinated through the pathology network, providing effective mutual support between labs.
- Pillar 2: West Yorkshire has good access to testing channels, through effective working with the national programme to open regional testing centres in Leeds and Bradford, plus satellite sites in Wakefield, Halifax, Huddersfield and Keighley, as well as additional walk-in sites and has achieved effective use of mobile units. A number of places have developed satellite sites into locally commissioned testing services, allowing more direct local control and prioritisation of testing.
- As part of wave 2 planning, and in response to the national constraints on pillar 2 testing, plans have been implemented to bring all NHS staff testing into pillar 1, while ensuring that social care will continue to be supported with priority access to testing as well.
- All trusts prioritising pillar 1 capacity to provide testing for patients to support timely admission, discharge and flow through the system and have joined the Elective Care COVID Home Testing Service to support COVID free admissions (CHFT was national pilot)

Risks / Issues

1. Increasing demands on pillar 1 labs (e.g. proposed requirement for regular testing of asymptomatic staff)
2. Continuing constraints on pillar 2 capacity
3. Resource limitations

Pharmacy – links to dual running and EU Exit

- Strong Medicine Management Collaborative Arrangements in Place through WY CCG Meds Management leads with identified Lead for EU exit.
- Engaged with National / Regional Team re processes to support dual running and EU exit. Informed that processes in place and more detail to follow on local plans to sit beside these’.
- Each PCN has an identified lead community pharmacy: We are working through our Local Pharmacy Committee members to ensure that there is an active connection between the Community Pharmacy and PCN CD.
- Each community pharmacy contractor has their own Business Continuity Plan, which includes arrangements for sourcing medication, either from their usual suppliers or others. Where there are any national shortages or supply issues, alerts are sent to all pharmacies, for them to be aware and action accordingly.

Risks / Issues

1. Communication Challenges. Medicines shortages impact on GP prescribing. Risk that communications between practices and pharmacies needs improving to make this a more efficient process.
2. EU exit risk to supply

Critical Functions - Procurement, PPE & Logistics

WY&H PPE Programme Board since April to work on and improve the supply of PPE. A programme has been established, chaired by Mel Pickup as the SRO, and is accountable to the WY&H HCP System Leadership Executive. The NEY Regional cell represented on programme board. To facilitate the work we have a virtual PPE Programme team established, a PPE Clinical Reference Group

The purpose of the PPE Programme is to establish and maintain a resilient supply of PPE for partners in WY&H. The programme team escalates issues as appropriate to the NHS Regional Procurement Advisory Cell

Well-established collaborative approach to PPE coordination across the NHS, local authorities and partners by working closely with the LRF. Throughout the pandemic WY&H trusts Procurement Leads Group (all trusts not just acute and including YAS) has continued to meet weekly and is actively swapping PPE as part of the arrangement we have for mutual aid. Mutual aid is also coordinated through our LRF arrangements. And there has been collaboration across Councils, CCGs and YPO to develop our model.

The Clinical Reference Group provides a clinical voice and expertise required to ensure staff are supplied with appropriate PPE including:

- Undertaking standardised testing of PPE procured by organisations within the WY&H Health Care Partnership as per PHE Guidance
- Providing expert clinical advice on the pre-procurement of PPE, including bespoke manufacture of products for use across WY&H
- Providing & sharing 'good practice' on the use of PPE across the whole partnership
- Horizon scanning & providing a view on alternatives to PPE items in short supply or complete outage i.e. reusable gowns, FFP3 masks
- Developing joint assurance processes for product quality

Risks / Issues

1. Risk that the national offer of PPE does not flow or is enough to supply national and local demand
2. Quality of products is variable and Fit testing is time consuming
3. Other consumables running out

Recovery – links to restoration, maintaining services and independent sector

- WY has established well established programmes including WYAAT, Planned Care Programme and Cancer Alliance Programmes
- Actions to mitigate impact on urgent and cancer electives:
 - Agreement to prioritise patients by clinical urgency across system level,
 - Oversight of waiting times and activity at ICS level through the Planned Care and WY&H Cancer Alliance
 - Creation of “green” elective capacity on sites across system including use of IS as “green” elective capacity
- Actions on diagnostics services
 - Separation of red/green diagnostic facilities
 - Endoscopy: Validation of waiting lists by WY&H endoscopy clinical network. Use of IS (including AQP) endoscopy capacity
- How and when would work be transitioned to the IS (and agreements to that effect)
 - Trusts are already using the full 75% of IS capacity to deliver NHS elective activity
 - Additional 25% capacity available for NHS activity has also now been secured

Risks / Issues

1. **Workforce.** Main constraint on ability to deliver elective activity. Impacts due to staff redeployment to support Covid effort and expected increasing numbers of staff absent as covid levels rise: Expect urgent and cancer elective activity prioritised with outpatient and daycase activity reduced.
2. **Bed Capacity.** The maximum bed capacity which can be opened in WY&H limited by facility and workforce constraints. As Covid (and other NE) demand increases, less bed capacity will be available for electives. Trusts are already seeing DTOC/MOFD patients increase; regional support to keep DTOC/MOFD patients at low levels would help maintain elective capacity.
3. **Limits on use of IS** for inpatient activity. IS rules, e.g. on overnight cover, reduce ability to use the IS for inpatient activity. Regional support to address this would provide additional protected capacity for urgent inpatient elective activity (facilities and staff skills limit use of the IS for the more complex cases)

Cyber Preparedness and Digital resilience – links to business continuity and contingencies

- WY has an established Digital Programme which works with all CIOs across system. The programme has worked with places agree approaches including actions at systems and place level
- At a systems level the ICS will work to
 - Identify the related cyber vectors across the ICS and at Place and put mitigations in place.
 - Provide mutual support where required, in the event of an incident.
- Each Organisation to:
 - Carry out cyber security assessments of remote access facilities provided to staff during Covid-19, as part of their annual mandatory penetration testing.
 - Act upon CareCERT Advisories within required timescales.
 - Review action plans to be compliant with the Cyber Essentials Plus standard by June 2021.
 - Run regular cyber awareness campaigns for staff.
 - Review business continuity and disaster recovery plans.

Risks / Issues

1. **Legacy Windows 7 Systems:** Additional central support and funding required to replace remaining legacy Windows 7 dependant services, systems and devices to facilitate migration to a Windows 10 platform.
2. **Data Resilience:** Additional funding/resource to move and manage 'suitable' data into the Cloud (Office365, Azure, Sharepoint etc) to drive up resilience.
3. **Infrastructure Resilience:** Additional hardware and data centre funding to provision resilient local infrastructure (including Cloud backup services, Data Centres etc) to ensure robust disaster recovery plans, where Cloud cannot be deployed

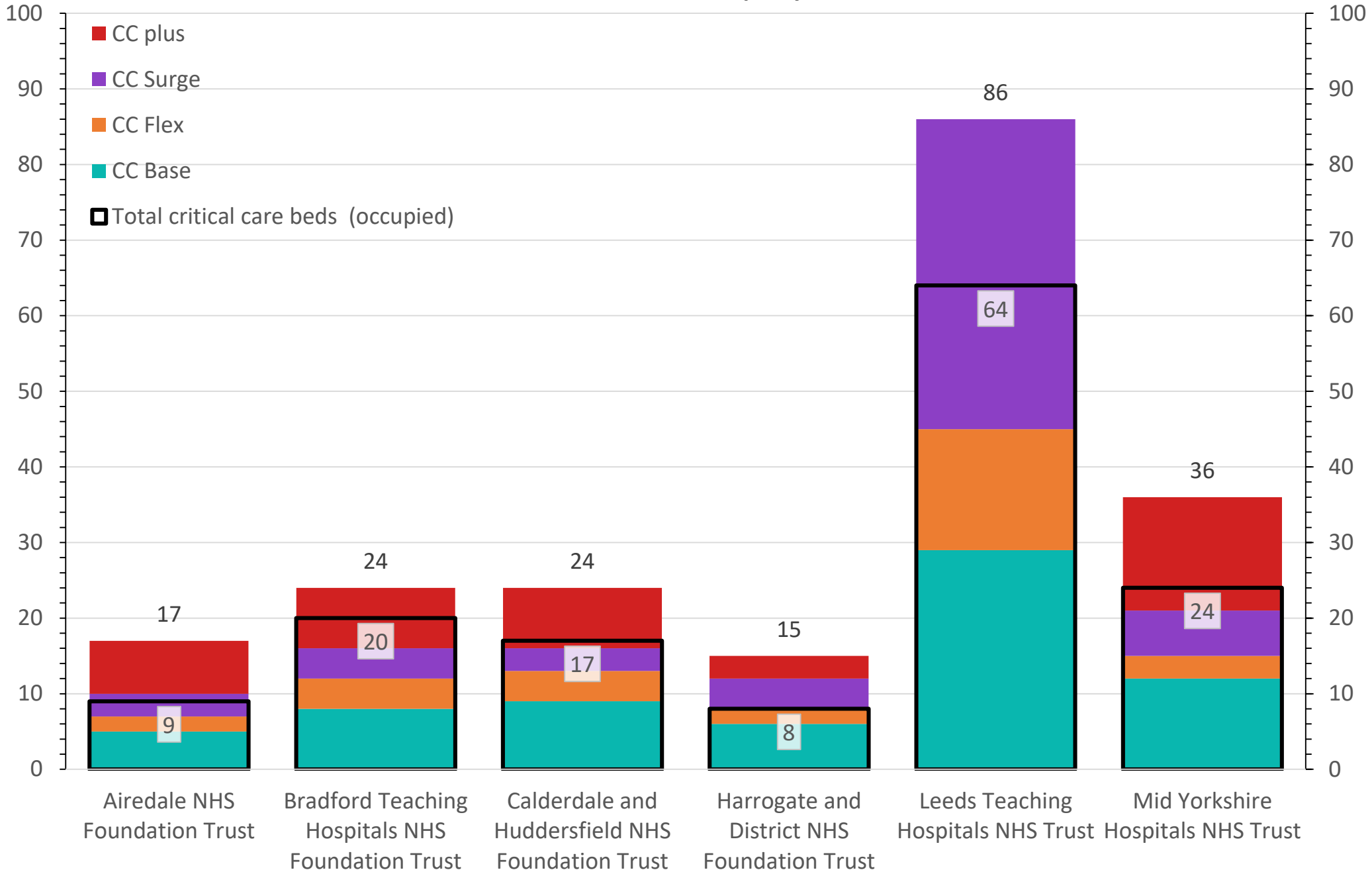
Mental Health, Learning Disability & Autism services

- Through our MHLDA collaborative we have three regular forums for assessing demand impacts on the system, sharing learning and working through collective solutions:
 - Fortnightly, 'crisis pathways' discussions with the collaborative, YAS and WYP to talk through pressures on S136 etc
 - Weekly, 'cohorting' discussions with the collaborative to develop proposals on identifying additional capacity, system resilience testing and sharing of local approaches
 - Weekly, 'mutual aid' conversations between COOs to share common challenges, identify potential areas to work on jointly and taking a collaborative approach to discussions with WYAAT and other colleagues.
- These are on top of specific areas of operational focus, such as weekly operational reconfiguration/support meetings for our ATUs and our formal quarterly governance discussions via the Committees in Common.

Risks / Issues

1. **Inpatient capacity** – there is limited resilience in the system to respond to ward closures arising from IPC or cohorting requirements. Individual organizations are considering whether block purchasing of IS capacity is possibly (to be coordinated collectively), but given the recent funding envelope and a lack of national support for mental health unfunded pressures this remains a significant risk
2. **Staffing** – MHLDA workforce numbers were a challenge prior to the pandemic. Impact of test and trace, sickness, shielding and supporting self-isolation for dependents means we are significantly reliant on bank and agency staff and this provision is starting to become stretched too
3. **Increased acuity** – the impact of lockdown and the pandemic is being felt in the level of acuity presenting to services – which in turn is impacting on the intensity of staffing required. There is a need to ensure that primary care and VCS organizations are supported and enabled to intervene at earlier stages of presentation to prevent escalation

Critical Care occupancy

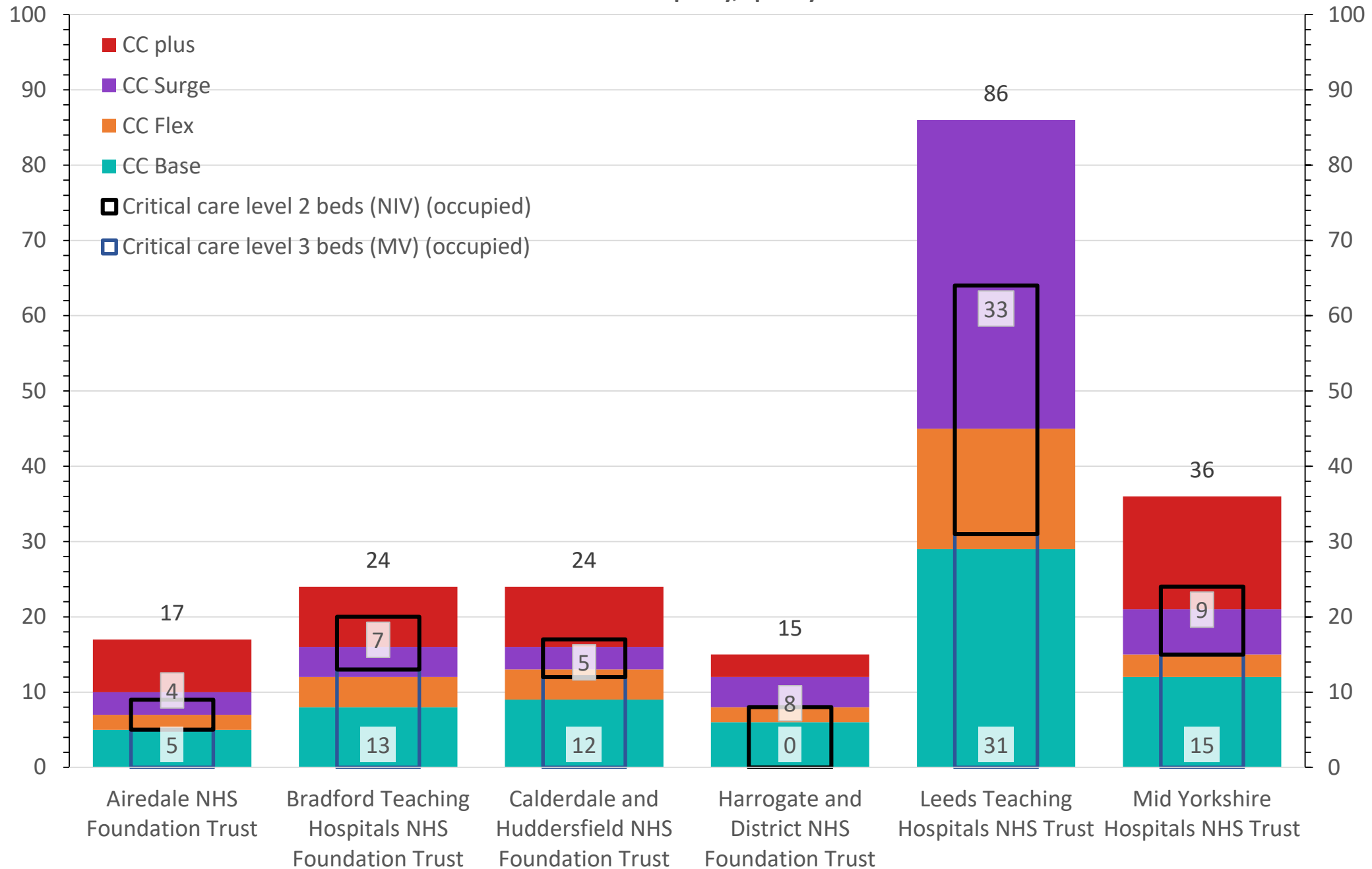


Total occupied Critical Care beds (CC DOS – completed each day by CC unites) (Level 2 + 3), plotted against L3 surge capacity.

All capacity is L3 capable but will flex to support patients requiring L2 and L3 care.

L3 patients will not exceed a 1:2 ratio in surge / surge plus.

Critical Care occupancy, split by L2 L3



Total occupied Critical Care beds (CC DOS – completed each day by CC unites) (Level 2 + 3), plotted against L3 surge capacity.

All capacity is L3 capable but will flex to support patients requiring L2 and L3 care.

L3 patients will not exceed a 1:2 ratio in surge / surge plus.

Non Invasive Ventilation (occupied numbers may include paed)s

■ NIV TOTAL Surge plus

■ NIV TOTAL Surge

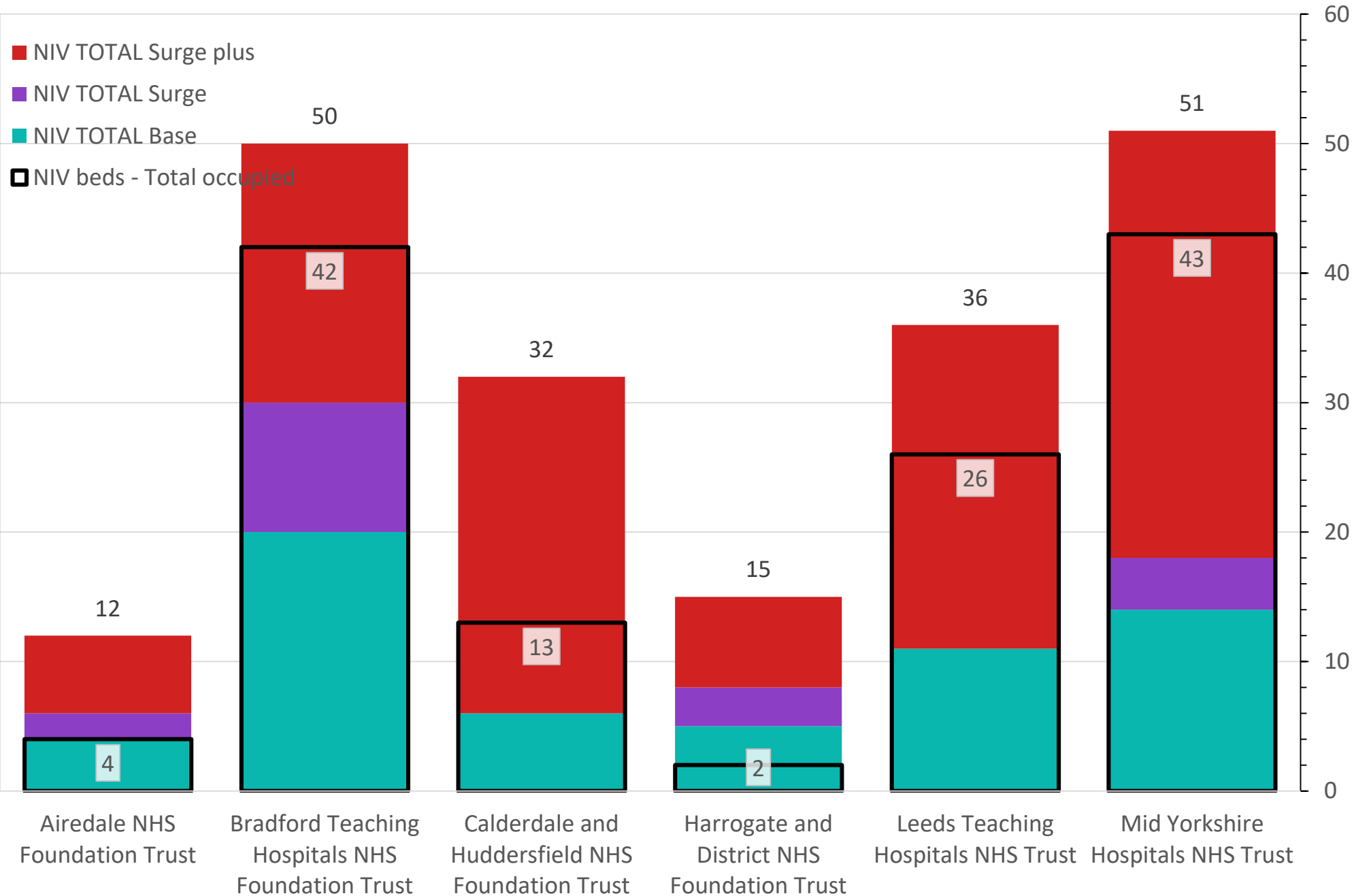
■ NIV TOTAL Base

■ NIV beds - Total occupied

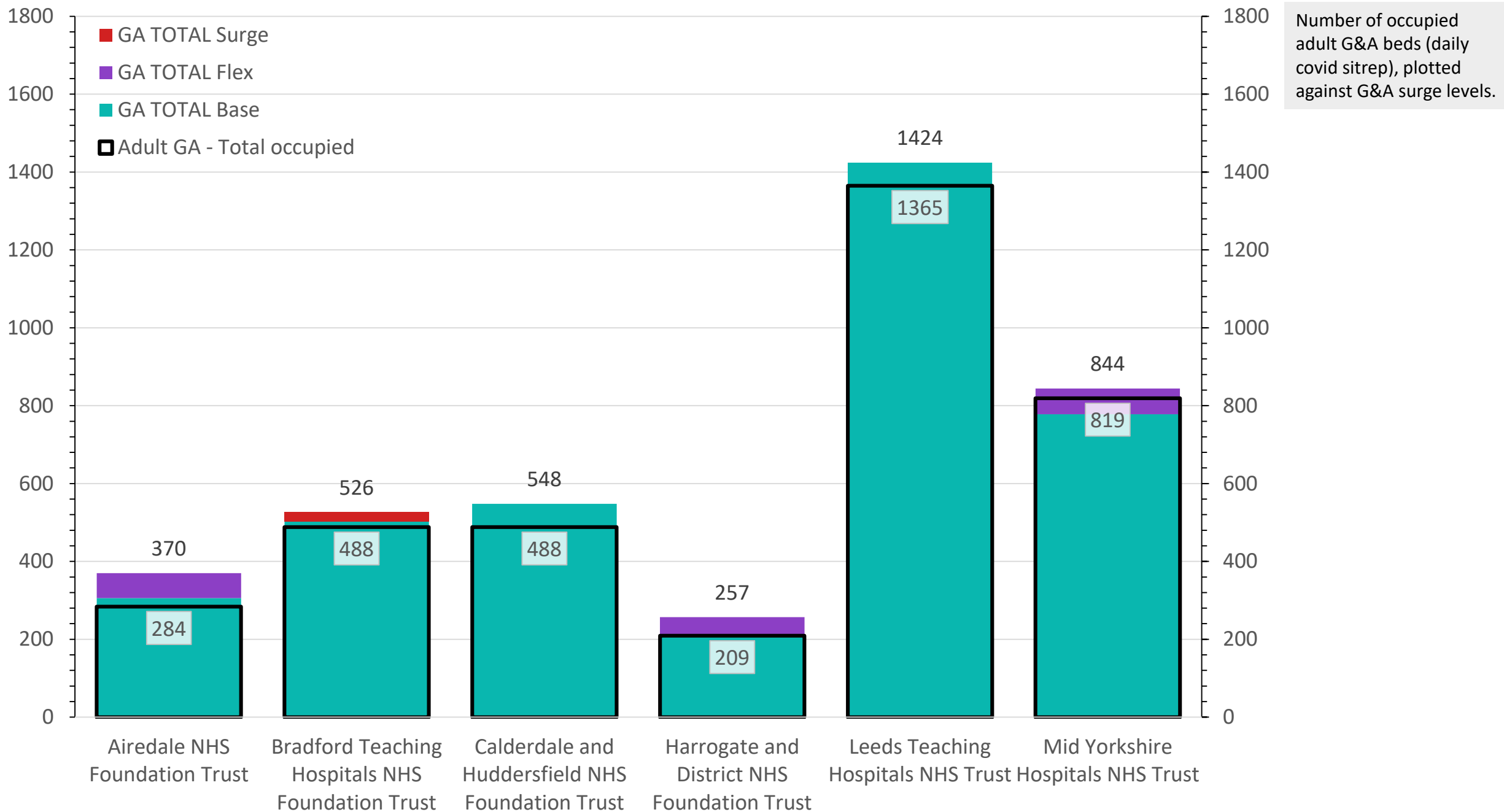
Number of occupied beds with non-invasive ventilation available (daily covid sitrep), plotted against NIV surge levels.

Not all occupied beds will be NIV patients. Patients requiring oxygen support may occupy NIV capable beds due to bed availability on admission.

This metric may include beds occupied by paediatric or neonatal patients



Adult G&A



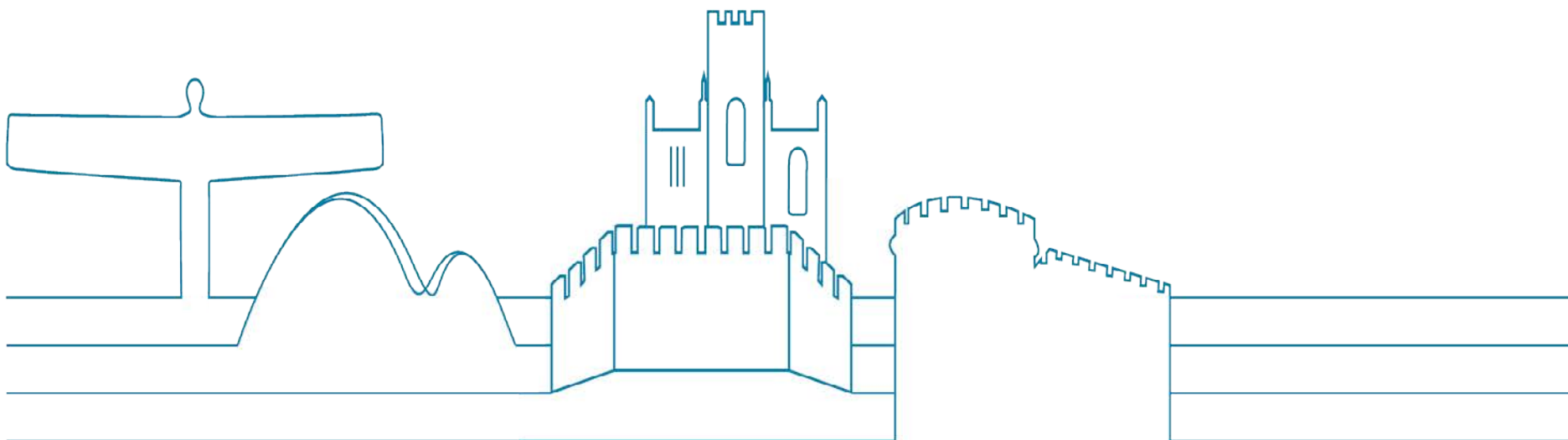
		AIREDALE NHS FOUNDATION TRUST	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	LEEDS TEACHING HOSPITALS NHS TRUST	MID YORKSHIRE HOSPITALS NHS TRUST
To what extent has activity been postponed to date	Elective inpatient ● - 4 postponed - P3, P2 and P1 in operation ● - P3 postponed - P2 and P1 in operation ● - P2 impacted - P1 in operation	A	R	R	A	R	R
	Day case ● - 4 postponed - P3, P2 and P1 in operation ● - P3 postponed - P2 and P1 in operation ● - P2 impacted, P1 in operation	A	A	R	G * reviewing stand down to support surge& mutual aid from w/c 23/11	R	R
	Outpatients & endoscopy ● - Full planned phase III delivery ● - Reduced activity ● - Urgent only	A	R	R	G	R	R
Social distancing	Covid wards adopting social distancing ● - No - social distancing removed ● - Yes - social distancing in force	R	R	R	R	R	R

[illegible]



North East and North Cumbria ICS

Covid 19 Wave 2 Escalation Plan



Wave 2 Surge steps (collectively agreed by trusts)

	Surge steps	Potential Triggers
1.	Accelerate discharge of patients supported by positive risk taking.	<p>The main triggers that will result in trusts escalating through the surge steps link to:</p> <ul style="list-style-type: none"> • General bed occupancy • C19 bed occupancy • Staffing • Critical care occupancy • Critical care staffing <p>Given the clear interdependencies of the above factors, there is limited value in setting out definitive thresholds for individual triggers at an ICS level. It is staffing levels more so than high bed occupancy/C19 occupancy which has resulted in recent escalation in local organisations. Across the ICS, staff absence is circa 5,115 and although this is a lower than the level experienced in the Wave 1 peak ($\approx 10,000$), relatively minimum elective activity has been stood down to date, against a backdrop of increasing C19 bed occupancy, currently at 11% (18,% at Wave 1 peak). Further consideration has been given to accessing 75%+ of the national IS contract and will remain under constant review.</p>
2.	Trusts increase own capacity by opening any closed wards with available staffing.	
3.	Reopen beds on COVID wards closed due to social distancing.	
4.	Postpone non-urgent electives.	
5.	Reopen beds on non-COVID wards closed due to social distancing.	
6.	Reduce staffing ratios in trusts to open all on site beds.	
7.	Open Nightingale with reduced staffing ratios as per in trusts <ul style="list-style-type: none"> a) 26 beds plus 1 ITU bed and transfer team b) 52 beds plus 1 ITU bed and transfer team c) 78 beds plus 1 ITU bed and transfer team 	

North of England Critical Care Network Wave 2 Surge Escalation Principles

Starting position is that at all times trusts will manage their critical care capacity to ensure optimal utilisation of beds. This will include use of flexible cohorting arrangements to manage fluctuation in demand for COVID / Non COVID activity.

The demand for, and availability of critical care beds across the NENC ICS will be monitored and managed by the NoECCN supported by the NENC COO Group.

At all times the network capacity will be managed to ensure that an appropriate critical care bed is made available for all critically ill patients requiring one, whether they are COVID or Non COVID. Capacity transfers will be enabled via consultant to consultant discussion to ensure equity of patient access (standard operating procedure).

It is intended that there would be equalisation of pressure as appropriate.

Principles for elective cancellations

Before any stepped reduction in elective activity local systems will ensure:

- IS capacity is maximised including accessing beyond the 75% level when in surge where this is beneficial and
- any available capacity in neighbouring hospitals is utilised.

Prioritisation of elective activity:

- Outpatients and day case activity will be maintained as far as is feasible.
- Majority of diagnostics and all screening will be continued as long as possible.
- Elective surgery will be prioritised if necessary:
 - Protect capacity for P1 and P2 patients throughout,
 - Remaining capacity to target P3 patients first and then P4 patients.

*It is important to note that whilst activity will be prioritised based on clinical need there may be services/sites that are less impacted by COVID pressures and so are able to continue routine work and at an organisational level this may appear to be out with the prioritisation described e.g. services at Sunderland Eye Infirmary.

Incident management arrangements

All trusts have individual incident management mechanisms in place.

ICPs - Trusts, CCGs and LAs collectively engage in ICP incident management arrangements to ensure coordination across the ICP, escalation of risks and mutual support as appropriate.

ICS – a number of well established weekly mechanisms in place to share intelligence, track delivery and respond to anticipated / emerging pressures including:

- Health Coordination Group brings together all partners to ensure coordination across the system.
- ICS executive and AOs to focus on any system/commissioning pressures.
- ICS executive and Provider CEOs/AOs to escalate and resolve issues.
- Provider Collaborative.
- Comms network to proactively respond to actions agreed from above.

Incident management arrangement continued

Trust COOs and the Critical Care Network meet weekly as a minimum to discuss surge issues, this becomes more frequent as need arises. Critical care occupancy dashboard is produced and reviewed daily.

Trust CEOs and the ICS executive team at times of pressure hold a covid response and critical care surge call. This has been reinstated as of 4th November and is an important mechanism to operationalise support / mutual aid.

CEO group review a heat map that tracks position of trusts across the 7 point escalation – regularly updated.

NHS E/I locality team has an established daily routine around UEC reporting/escalation that will be extended to include other operational pressures.

Forums in placed to review daily position and agree any mitigating actions / mutual support – supported by data pack.

Trusts working with Claire Riley, ICS comms lead to agree comms for any **significant systematic stepping down** of elective activity. No external comms planned for small numbers of cancellations linked to general routine / C19 operational pressures.

Claire Riley, on behalf of the ICS, will link with Caroline Radford NEY comms lead to ensure that NEY colleagues are sighted on any communications regarding any material step changes in operational delivery.

The above arrangements are in place 24/7. Escalation mechanisms linked to routine intelligence / tracking and assessment of risk via regular system calls (ICS, Provider Collaborative, COO's network) will be used to secure advance notice of any decision that would result in systematic cancellation of significant elective activity / step change in operational delivery.

System risks – updated

A number of risks were identified as part of the Wave 2 Development exercise, given the increased in COVID activity in recent weeks, these have been reviewed and the key risks are noted below – a number of which require national / regional support.

1. Asymptomatic testing

There is a significant risk that any policy changes to increase asymptomatic staff and/or community testing will increase staff absence with an immediate detrimental effect on service delivery.

2. Workforce – range of limiting factors including :

- Shielding,
- Sickness absence / need to self isolate.
- Risk Assessment – may need to revisit the original RA's if capacity reduces significantly.
- BAME staff impact.

3. Discharge – designated settings

- Requirement for CQC to designate care providers suitable to accept COVID positive patients is creating additional pressure - need to speed up the CQC designation process to ensure more homes can take this cohort of patients quickly given the NEY has more occupied beds with COVID patients than in Wave One.
- Need for further clarity in relation to designated beds policy – the guidance does not precluded care homes from taking their own residents back from hospital when COVID + with required standards in place.
- Care providers are reluctant to accept returning COVID positive patients following an acute hospital admission.

System risks continued

4. Digital - cyber

- There is a risk with the continued delivery of digitally enabled health and care services as a result of our increased digital dependency and a heightened threat of data and cyber-attack. Health systems in other countries have recently been subjected to targeted attacks, more locally, we have seen attacks in recent weeks on our academic institutions and local authority organisations, with severe consequences. The risk is amplified as a result of the COVID pandemic, emerging winter pressures and imminent influenza impact.
- Specific actions to ensure:
 - Staff: ongoing appropriate data and cyber security training. Provision of timely and appropriate communication channels and processes, to raise the awareness and increased vigilance when accessing external websites or responding to emails that may contain malware etc.
 - Process : Business Continuity Plans in place and tested for immediate implementation in the event of an attack and/or un-planned digital system downtime/outage. In addition, Disaster Recovery and data restoration processes to be tried and tested. Any suspicious activity should be reported through agreed national and regional escalation channels.
 - Technology : Organisations to identify core technology assets and services, and ensure all systems are “warranted”/maintained in accordance with the relevant security patch levels. Actions and advisories from NHS Digital CareCERT should be acted upon without delay.

5. Primary Care

- Focus on admission avoidance- need to establish pulse oximetry @ home service at pace (current deadline end of November). .
- Ensure that copd/asthma/DM/CVD CDM continue to be delivered.

Next steps

Whilst there are well established incident management and escalation arrangements that have been refined and developed, building on the learning / experience of wave 1, it is planned to review/test these out with EPRR and ICP colleagues to ensure that they remain fit for purpose for Wave 2. This will be completed within the next week.

Further development regarding how the ICS/locality team works with the new NEY JROC.

This escalation plan is a live document and will be continually reviewed and enhanced as needed.

SYB Escalation Framework – summary of Wave 2 and Tier 3 Plan (not including mental health)

We have adopted the NEY Regional COVID escalation framework within which the following acute triggers apply. We have been operating at Level 4 since 26 October 2020. The ICS healthcare management team (all CEOs and AOs) meets weekly to discuss and agree next steps in managing the incident.

Level	Description	Response
5	Occupancy > 95% COVID Occupancy > 30% All surge capacity open	<ul style="list-style-type: none"> • All non-emergency work cancelled. • Maintain P1 capacity and prioritise P2 patients (including cancer surgery) • Critical care capacity escalated in line with agreed Framework – capacity available to +300% before Nightingale required.
4	Occupancy > 90% COVID occupancy > 25%	<ul style="list-style-type: none"> • Maintain P1 & P2, • Review and suspension of daycase, outpatients and diagnostics depending on local organisational surge plans • Full surge capacity opened in acute hospitals. • Cancer Alliance prioritising cancer care across the system • Surgical admissions group (Surgical Directors & COOs) prioritising P1 and P2 admissions • Critical care ODN managing critical care capacity across the system – in line with SYB critical care framework • Paediatric Surgical Pathway – all admissions to Sheffield Children’s Hospital • Additional community capacity stood up for discharge (including second designated care home in each place). • CCGs working across boundaries to flex discharge capacity. • Additional hot primary care capacity – hubs and home visiting • BBS Plan and mutual aid from partners for ancillary and administrative staff – to support all sectors. • Daily system call – director level – to agree mutual aid between organisations and places
3	Occupancy > 85% COVID occupancy > 20%	<ul style="list-style-type: none"> • Maintain P1 & P2, long waiters, daycase, outpatients and diagnostics • Surge capacity opened by individual Trusts, as required. • Operational group (COOs) reviews scheduling of long waiters to minimise breaches • Community surge capacity initiated including designated care homes • Primary care hot hubs and home visiting initiated. • Maximise utilisation of independent sector
2	Occupancy > 85% COVID occupancy >5% but less than 20%	<ul style="list-style-type: none"> • Maintain emergency and urgent care services • Maintain P1 & P2, long waiters, daycase, outpatients and diagnostics • SYB Wave 2 plan operationalised • Mutual aid operates within Place and across organisations.

1	Business as usual	<ul style="list-style-type: none">• Phase 3 plan fully operationalised