DEMAND MANAGEMENT PLAN

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
Bicester, Oxfordshire, OX26 6HR

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DOCUMENT INFORMATION

Authors: Tracy Redman, Head of Operations
Tony Peters, Head of EOC South
Dan Holliday, Senior Operations Manager

Consultation and Approval: Operations Level 2 Review Meeting
Operations Level 3 Review Meeting
Operations Policy Review Group

This document replaces: Escalation in Response to Demand V5
Notification of Policy Release: All recipients email, Intranet
Equality Impact Assessment: N/A
Date of Issue: July 2018
First Reviewed: January 2019 – 18months
Review Date: July 2020 – 24 months
Next review: July 2022
Version: Operational Policies and Procedures **Operations Policy 14** v1.10

Review and Amendment Log

This policy is regularly reviewed and updated with the information in line with relevant national guidance and legislation. A full 'Review and amendment' is available on request

1. INTRODUCTION

There is a requirement within SCAS to ensure that Emergency & Urgent ambulance services are delivered to meet the clinical needs of patients and national response targets are consistently achieved throughout the year, to enable safe, effective, and high quality patient care.

It is the intention of SCAS to maintain the highest level of care to the public of the Thames Valley and Hampshire regions including times when capacity pressures and periods of high demand outstrip planned, or actual resource levels.

- Planning & Scheduling
- Operational Support (OSD)

2. AIM

To provide a consistent approach during periods of excessive inbound call volume / event generation and/ or reduction in planned resource levels.

3. OBJECTIVES

To enable SCAS to identify and respond dynamically to service pressures.

To ensure SCAS continues to maintain a safe and clinically appropriate level of care at times of increased demand and resource pressure.

To effectively manage inbound calls into the CCC.

To provide all SCAS staff with a plan in times of increased demand and resource pressure.

To be open and transparent with the wider health economy at times of increased pressure.

4. SCOPE

The DMP is designed to work dynamically to ensure a SCAS wide / local response as required as soon as the triggers are met. Consideration must also be given in regard to appropriate actions within the REAP.

5. EQUALITY IMPACT STATEMENT

The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the aforementioned protected characteristics, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

By committing to a policy encouraging equality of opportunity and diversity, The Trust values differences between members of the community and within its existing

workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

Where there are barriers to understanding; for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the HR Department.

Employees exercising their rights and entitlements under these regulations will suffer no detriment as a result.

6. LEVELS OF ESCALATION

There are four levels of escalation with individual trigger points for each sector. These levels reflect the Operational Pressure Escalation Level (OPEL) ratings as defined by NHS England. A link to the most up to date OPEL Framework can be found below.
https://www.england.nhs.uk/south-east/wp-content/uploads/sites/45/2018/11/NHSE-SE-OPEL-Framework-V-3.0October-2018-TV-Only.pdf

7. DE-ESCALATION

The EOC Duty Manager (EOCDM / EOCSO) must ensure that the Trust deescalates the levels as soon as possible once demand falls below the relevant trigger. It is important that this information is communicated to the authorising SCAS commander and all partners, as directed by the response level.

8. 999 CALL ANSWER

Call handling will be managed dynamically by the EOCDM's and EOC Shift Officers (EOCSOs). Please refer to the relevant EOC Directives regarding call answering.
Emergency Calls during Periods of High Demand (Stacking Responses)

In times of high demand (at OPEL Lv3 and above, by Sector), the Officer in charge of EOC (CDM or CSO) will advise that the CSD demand management process is followed for calls up to and including Category 2 calls, i.e. alternative conveyance (own/other transport or taxi).

CSDPs will contact patients and assess/recommend appropriate conveyance alternatives. If the patient absolutely cannot find alternative conveyance or refuses to, then this should be noted in the Event Chronology and in "Remarks" (to show in stack) and a resource will be sent, according to the relative clinical priority, when available.

9. RESOURCE ALLOCATION

Resource allocation escalation levels take into account demand spikes that can occur at times when a large number of emergency incidents are awaiting allocation of a resource; this can present a significant clinical risk. Inability to respond to any one category can trigger escalation levels within this plan.

10. CLINICAL MANAGEMENT OF UN-RESOURCED INCIDENTS

Management of un-resourced Incidents will be necessary when the workload exceeds available resource levels and there are outstanding incidents awaiting dispatch of an appropriate resource. In these circumstances, the clinical risk to patient's increases as the waiting time for dispatch lengthens. Therefore, focus on the pending queue will ensure that any clinical risk is identified and managed accordingly. The EOCDM, in collaboration with the CSD Team Leader (CSD TL) will be responsible for dynamically managing the clinical risk in the pending jobs queue. The CSD TL will direct clinicians to target specific areas of the queue, it must be remembered that these areas of focus may change and adapt to meet the needs of the situation as and when it changes to reflect the OPEL status. The CSD TL must ensure that all actions taken to manage the clinical risk in the queue with unresourced incidents is documented on the daily EOC shift report.
(NOTE: CDMs don't work through the night so management cover is usually provided by CSOs and CSD TLs)

11. IMPLEMENTATION OF INCOMING CALL DEMAND MANAGEMENT PROCESS (ICDM)

Introduction of incoming call demand management process can be actioned at any stage of OPEL and is dependent on the number of inbound calls being received compared to the number of Emergency Call Takers (ECTs) "available" to answer them.

It must be remembered that inbound call "flurries" that are short term are normal within a call centre environment and can be managed on the floor without the need to implement ICDM process.

Therefore, it could be reasonable to invoke the ICDM at any stage of OPEL to reflect the level of pressure experienced by the Trust.

12. COMMUNICATION OF THE DMP ESCALATION LEVELS

Internal notification of the escalation levels must be through the notification facility and sent to all recipients as identified in appendix 3.

OPEL 3 and 4 must be communicated to the local system partners by the Local Management / Silver Officer.

APPENDIX 1: SCAS TRIGGERS

Triggers are sector specific based on normal activity and resource levels.
EOCs have a spreadsheet to complete which only requires the input of numbers relating to the following information:

- C1 events waiting to be resourced >3min
- C2 events waiting to be resourced >10min
- C3 events waiting to be resourced > 30min
- C4/HCP events waiting to be resourced >2hr
- Crews holding at hospital >30min

The spreadsheet contains a weighted formula which following the input of the ICAD data will auto generate an OPEL level for the sector. Implementation of the action cards will be based on this level.

Call management actions will be undertaken at North / South level based on the cumulative impact at area OPEL levels.

Field operations actions will be undertaken at area level based on the area OPEL level.

NB – North /South level = Thames Valley / Hampshire
Area levels = Dispatch areas e.g., Southeast etc

APPENDIX 2: SCAS ACTIONS

OPEL 1 (Green)

ALL (all lead): Business as usual

EOC (SECT/ EOCSO lead):

- Notify all relevant staff/managers via text service of the OPEL status at 0700hrs and 1900hrs (as per appendix 3)
- Update wallboards with current OPEL level
- ECT Script Stage 1 may be implemented if inbound call flurries are not responding to floor management processes or are sustained (If invoked this must be documented on the EOC daily shift report)

CSD (CSD TL lead): Business as usual

111 (111 TL lead): Business as usual

Field Ops (OPS TL lead):

Support the maintenance of normal operational staffing and vehicle cover

Scheduling & Planning (TL lead): Business as usual

OSD (TL lead): Business as usual

OPEL 2 (Yellow)

ALL (all lead): Ensure all actions from the previous level are completed / ongoing

EOC (EOCSO/EOCDM lead):

- Notify all relevant staff/managers via text service of the OPEL status (as per appendix 3)
- Update wallboards with current OPEL level
- EOCDM / EOCSO to assess situation on the floor and ensure actions / support where required
- Incoming call demand - ECT Script Stage 1 or 2 may be implemented if inbound call flurries are not responding to floor management processes or are for sustained periods
- Review vehicles that are in unavailable status and obtain update / contact local management
- Contact Ops TL/COM to mobilise to ED experiencing delays.
- Duty Manager to liaise with 111 Clinical Shift Manager and ensure they are aware of the increase in OPEL level(s). 111 clinicians will target clinical validation of all Cat 3 and Cat 4 ambulance dispositions to areas with increased demand and increase in OPEL level.
- Duty Manager to liaise with 111 Clinical shift Manager to advise of any issues with local hospitals. e.g., Queueing of ambulance resources at ED and impact on operational ability to respond to emergency calls.

CSD (CSD TL lead):

- Welfare checks of long waits (If any)
- Clinician disposition event outcomes and queue scanning – (upgrades / H&T / alternative transport)
- CSD clinicians will target any 111 events that have been passed over by clinical validation of all Cat 3 and Cat 4 ambulance dispositions to areas with increased demand and increase in OPEL level.

111 (111 TL lead):

- Focus clinical validation of all Cat 3 and Cat 4 ambulance dispositions in clinical queue, with specific attention to those dispatch areas under greatest demand.
- 111 Clinical Shift Manager will liaise with EOC Duty Manager / Shift Officer to see if there is any further assistance that can be provided.

Field Ops (TL /Ops Managers lead):

- Actively support the reduction in LUH

    - Review vehicle availability with OSD
    - Review staffing with scheduling
    - Review skill mix and vehicle ratios with OSD / EOC
  - Support flow and turnaround at Hospitals where required

Scheduling & Planning (Planning Managers): Business as usual

OSD (OSD TL lead): Review unavailable vehicle resources

OPEL3 (Red)

ALL (all lead): Ensure all actions from the previous level are completed / ongoing

EOC (EOCSO/EOCDM lead):

- Notify all relevant staff/managers via text service of the OPEL status (as per appendix 3)
- Update wallboards with current escalation level
- Stage 2 ECT script invoked, and actions must be documented on the DSR depending on incoming calls and if required.

CSD (CSD TL lead):

- Welfare checks (inc HCP calls)
- Consideration for GP conversation to rebook / redirect or alternative transport
- Cat 3 and 4 calls reviewed to assess H&T and use own transport
- CSD to provide support to area under pressure (i.e., virtual working if required unless SCAS wide)

111 (111 TL lead):

- Focus clinical validation of all Cat 3 and Cat 4 ambulance dispositions, with specific attention to those areas under greatest demand.
- 111 Clinical Shift Manager will liaise with EOC Duty Manager / Shift Officer to see if there is any further assistance that can be provided.

Field Ops (TL /Ops Managers lead):

- Team leaders/ Clinical Team Educators on management time log on and to be available to respond as required.
- Managers to be logged on
- Consideration to crewing up solo resources to crew ambulances.
- Specialist Paramedic Hub support for lower acuity calls. Liaise with EOC Duty Manager / Shift Officer.
- Consider requesting additional staff through Private Providers / Overtime / Shift extensions
- Authorise the movement of SCAS assets Trust wide
- Contact on-call press team and consider appropriate media and social media releases

MI Gold (MI Gold lead):

- Convene a SCAS wide Gold call to confirm all previous actions completed / ongoing and determine any further actions required to prevent escalation to OPEL 4.
- Consideration for Command Structure and Cells (virtual or co-located)

Scheduling & Planning (Planning Managers/ Field Ops lead): Business as usual

OSD (OSD TL lead):

- Review unavailable vehicle resources
- Consider additional driver hours if required

OPEL 4 (Black)

ALL (all lead): Ensure all actions from the previous level are completed / ongoing

EOC (EOCSO/EOCDM lead):

- Notify all relevant staff/managers via text service of the OPEL status (as per appendix 3)
- Update wallboards with current OPEL level
- Head of EOC and CSD manager to attend EOC

CSD (EOCSO/EOCDM lead):

- Clinician / Clinicians to complete stack management and further Triage of incidents
- Triage of the longest waits to ascertain clinical need/ priority.

111 (111 TL lead):

- Ensure sufficient numbers of clinicians are undertaking validation of Cat ¾ to prevent any breaches of 30/40 minute timeframe within the specific areas.
- 111 Clinical Shift Manager will liaise with EOC Duty Manager / Shift Officer to see if there is any further assistance that can be provided.

Field Ops (Ops Managers/ Duty Officers lead):

- Notify local system partners and CCG. Consider arranging for refreshments to be distributed to staff on duty
- Attendance at Tactical Command Cell if required
- Activate 'Immediate Handover' at hospitals.
- Invoke MI IRP if required

Scheduling & Planning (Planning Managers):

- Activate additional shifts on Skillstream. - Contact Private Providers for additional availability above plan
- In collaboration with OSD consider possibility of additional shifts for SCAS staff Overtime / Shift extensions

OSD (OSD TL lead): Utilise additional driver hours

APPENDIX 3: TEXT ALERTING RECIPIENTS

- MI Gold Commanders
- Duty Directors
- Silver Commanders
- Bronze Commanders
- Ops Team Leaders
- Ops Clinical Team Educators
- Heads of EOC
- EOC CDMs
- CSD Managers
- CSD TL's
- OSD Managers
- OSD TL's
- 111 Managers
- 111 TLs
- Scheduling Mangers
- Scheduling TLs
- Indirect Resources Managers
- Indirect Resources
- RSO Managers

APPENDIX 4: GLOSSARY

DMP	Demand Management Plan
ECT	Emergency Call Taker
REAP	Resource Escalation Action Plan
EOC	Emergency Operations Centre
CSD	Clinical Support Desk
IUC	Integrated Urgent Care
OPEL	Operational Pressure Escalation Levels
EOCDM	Emergency Operations Centre Duty Manager
EOCSO	Emergency Operations Centre Shift Officer
TL	Team Leader
MI	Major Incident
ACT	Accelerated Clinical Triage
H&T	Hear & Treat
ED	Emergency Department
LUH	Lost Unit Hours
CFR	Community First Responders
CR	Co-Responders
RRV	Rapid Response Vehicle
DCA	Double Crewed Ambulance
OOH	Out of Hours
IRP	Incident Response Plan

APPENDIX 5: NHS ENGLAND OPEL FRAMEWORK– SYSTEM ACTIVITY

Escalation level	Acute Trust (s)	Community Care	Social care	Primary care	Other issues
OPEL One	• Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. No staffing issues identified • No technological difficulties impacting on patient care • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. Pressure on maintaining ED 4 hour target • Infection control issues monitored and deemed within normal parameters	• Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	• Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings	• Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand	•NHS 111 call volume within expected levels
OPEL Two	• Anticipated pressure in facilitating ambulance handovers within 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available but are sufficient to maintain services • Lack of beds across the Acute Trust • ED patients with DTAs and no action plan • Capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)	• Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services	• GP attendances higher than expected levels • OOH service demand is above expected levels • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) • Lower levels of staff available, but are sufficient to maintain services	• Rising NHS 111 call volume above normal levels • Surveillance information suggests an increase in demand • Weather warnings suggest a significant increase in demand
OPEL Three	• Actions at OPEL Two failed to deliver capacity • Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Trusts 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 cannot be rectified within 2 hours	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Pressure on OOH/GP services resulting in pressure on acute sector • Significant, unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests an significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services • Infection control issues resulting in significant pressure on services
OPEL Four	• Actions at OPEL Three failed to deliver capacity • No capacity across the Acute Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Infectious illness, Norovirus, severe weather, and other pressures in Acute Trusts (including ED handover breaches) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 4 hours	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Acute Trust unable to admit GP referrals • Inability to see all OOH/GP urgent patients • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	

APPENDIX 6: NHS ENGLAND OPEL FRAMEWORK – GUIDE TO SYSTEM ACTION

The following list of actions for each level of escalation are not exhaustive and should be added to at the local level and implemented or considered as needed.

Escalation level	Whole system	Acute trust	Commissioner	Community Care	Social care	Primary care	Mental Health
OPEL One	• Named individuals across Local A&E Delivery Board to maintain whole system coordination with actions determined locally in response to operational pressures, which should be in line with business as usual expectations at this level • Maintain whole system staffing capacity assessment • Maintain routine demand and capacity planning processes, including review of non-urgent elective inpatient cases • Active monitoring of infection control issues • Maintain timely updating of local information systems • Ensure all pressures are communicated regularly to all local partner organisations, and communicate all escalation actions taken • Proactive public communication strategy eg. Stay Well messages, Cold Weather alerts • Maintain routine active monitoring of external risk factors including Flu, Weather.						
OPEL Two	•All actions above done or considered •Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate	•Undertake additional ward rounds to maximise rapid discharge of patients • Clinicians to prioritise discharges and accept outliers from any ward as appropriate •Implement measures in line with Trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place • Notify CCG on-call Director to ensure that appropriate operational actions are taken to • Maximise use of nurse led wards and nurse led discharges • Consideration given to elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	• Expedite additional available capacity in primary care, out of hours, independent sector and community capacity • Co-ordinate the redirection of patients towards alternative care pathways as appropriate •Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers)	• Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. • Maximise use of re-ablement/intermediate care beds •Task community hospitals to bring forward discharges to allow transfers in as appropriate. • Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals.	• Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements • Ensure all patients waiting within another service are provided with appropriate service • Where possible, increase support and/or communication to patients at home to prevent admission. Maximise use of re-ablement/intermediate care beds	• Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community • In reach activity to ED departments to be maximised • Alert GPs to escalation and consider alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service • Where possible, increase support and/or communication to patients at home to prevent admission

OPEL Three	•All actions above done or considered •Utilise all actions from local escalation plans • CEOs / Lead Directors have been involved in discussion and agree with escalation to OPEL 4 if needed	• ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff • Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Enact process of cancelling day cases and staffing day beds overnight if appropriate. • Open additional beds on specific wards, where staffing allows. • ED to open an overflow area for emergency referrals, where staffing allows. • Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases	• 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.	• 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	• Social Services on-call managers to expedite care packages • Increase domiciliary support to service users at home in order to prevent admission. •Ensure close communication with Acute Trust, including on site presence where possible	• OOH services to recommend alternative care pathways • Engage GP services and inform them of rising operational pressures and to plan for recommending alternative care pathways where feasible • Review staffing level of GP OOH service	• 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	• All actions above done or considered •Contribute to system-wide communications to update regularly on status of organisations (as per local communications plans) • Provide mutual aid of staff and services across the local health economy • Stand-down of level 4 once review suggests pressure is alleviating • **Post escalation:** Contribute to the Root Cause Analysis and lessons learned process	• All actions from previous levels stood up • ED senior clinical decision maker to be present in ED department 24/7, where possible • Contact all relevant on-call staff •Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical senior clinical decision makers to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7, where possible • **An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG and neighbouring trusts to agree a divert.**	• Local regional office notified of alert status and involved in decisions around support from beyond local boundaries • The CCGs will act as the hub of communication for all parties involved • **Post escalation:** Complete Root Cause Analysis and lessons learned process	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible capacity has been freed and redeployed to ease systems pressures	• Senior Management team involved in decision making regarding use of additional resources from out of county if necessary • Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including supporting ED re prevention of admission & turn around. Identification via board rounds and links with discharge team & therapists. • Hospital Service Manager/Deputy Director to monitor escalation status, taking part in teleconferences as required.	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible actions are being taken on-going to alleviate system pressures	• Ensure all actions from previous stages enacted and all other options explored and utilised • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible