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Community health services two-hour urgent community response standard

Guidance for providers of care, integrated care systems and clinical commissioning groups

Version 2, 14 March 2022

This guidance replaces that published on 16 July 2021; updates are highlighted in yellow.

Contents

Introduction

NHS England and NHS Improvement are committed to developing a consistent NHS urgent community response (UCR) offer nationally. As set out in the NHS operational planning and contracting guidance 2022/23, all integrated care systems (ICSs) must ensure urgent community response (UCR) services (that improve the quality and capacity of care for people through delivery of urgent, crisis response support within two hours) are available to all people within their homes or usual place of residence, including care homes.[1] This is a national standard which was introduced in the NHS Long Term Plan and builds on National Institute of Health and Care Excellence (NICE) guidelines.

In 2021/22, providers, commissioners and systems have taken important actions to improve the capacity and responsiveness of existing UCR services to deliver care within two hours. In line with national rollout of the two-hour standard by April 2022, each ICS should provide a consistent service at scale, from 8am to 8pm, seven days a week (at a minimum) across its full geography. Alongside this, ICSs should accept referrals into UCR services from all appropriate sources and submit complete data returns to the Community Services Data Set (CSDS) to demonstrate achievement of the two-hour standard.

This guidance sets out system requirements for 2022/23 to help realise scale and impact. It sets out a performance framework and national targets, as well as the essential operational and clinical requirements for NHS-funded UCR services that ICSs, providers and commissioners must achieve to meet the national standard. Delivery of a consistent UCR response across the country, in line with the nine clinical conditions/needs included in this document, should be a priority for systems during 2022/23.

Meeting patients' urgent care needs at home is key in improving patient outcomes, preventing avoidable hospital admissions and delivering NHS strategic priorities. For example, in 2021/22 UCR teams have worked closely with ambulance services as part of the NHS response to winter pressures and COVID-19 and the NHS Urgent and

[1] NHS England and NHS Improvement (2021) Urgent community response – two-hour crisis and two-day reablement response standards, Technical data guidance.

Emergency Care Recovery 10-Point Action Plan. Successful delivery of care within two hours requires ongoing close partnership working between a variety of health and social care partners/teams, and ICSs have received additional funds to support this work.

The guidance is a **working document** which was co-developed with clinicians and professionals and will be updated with more evidence, feedback and learning as ICSs implement the standard at scale. Please share feedback on the guidance with us by emailing: england.communityservices1@nhs.net

To learn more about the standard and access further tools and support, visit the UCR FutureNHS page.

We would like to thank and acknowledge the support of the following in developing this guidance: British Geriatrics Society, Age UK, NHS Providers, Association of Directors of Adult Social Services, Local Government Association, Royal College of Nursing, Royal College of Occupational Therapists, The Chartered Society of Physiotherapy, Queen's Nursing Institute, Care Quality Commission, National Institute for Health and Care Excellence and clinicians from across England.

Operational requirements

1. Overview

1.1 All ICS planners, commissioners and providers should have completed the following actions by March 2022:

- providing a consistent service **at scale**: ensuring full geographical coverage of a two-hour UCR and the delivery of the same support across every ICS
- providing services from 8am to 8pm, seven days a week, **at a minimum**
- accepting referrals into two-hour UCR services from all appropriate sources
- submitting complete data returns to the CSDS to demonstrate the achievement of the two-hour standard.

1.2 In line with national planning guidance 2022/23, all ICS planners, commissioners and providers must meet the following additional requirements in 2022/23:

1.2.1 **Provide a consistent service:** Provide a consistent level of response across an ICS footprint, including by providing care in line with the clinical requirements set out in this document and ensuring that referrals are accepted regarding the nine common clinical conditions or needs set out in section 7.

1.2.2 **Maintain full geographical coverage and extend operating hours:** Maintain full geographical rollout and continue to grow services to reach more people by operating at a minimum of 12 hours a day, seven days a week in line with national guidance, and extending operating hours where demand necessitates this.

1.2.3 **Improve outcomes through reaching patients in crisis in under two hours, where clinically appropriate:** Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of two-hour crisis response demand within two hours from the end of Q3.

1.2.4 **Increase the number of referrals from all key routes, with a focus on urgent and emergency care (UEC; including111 and 999) and increasing care contacts.**

Priority areas include:

A. **Partnership working with ambulance services:**

Providers, commissioners and ICSs should:

- work with relevant partners to maximise ambulance and 111 referrals to UCR
- support equipment purchases such as lifting chairs and point of care testing equipment
- ensure accurate and complete data is being submitted via the CSDS for UCR, to track how much the services are being used and helping to reduce service pressures
- access resources regarding partnership working with ambulance services and case studies via the UCR FutureNHS webpage.

B. **Work on pendant alarms:**

Providers, commissioners and ICSs should:

- work together with local councils and providers of local pendant alarm/technology enabled care (TEC) providers and reduce the demand on 999 ambulance services through the redirection of appropriate patients
- use ICS guidance on engaging with TEC providers available on the UCR FutureNHS page.

C. **Directory of Services:**

Providers, commissioners and ICSs should:

- refresh their local Directory of Services (DoS) so that NHS Service Finder profiles are accurate, up to date and updated to show that UCR teams will accept referrals from health and social care colleagues, including TEC providers.

D. **Self-referrals:** providers should accept self-referrals from individuals and carers (who may be directly known to the service).

1.2.5 **Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission.**

Providers should:

A. Ensure the two-hour service team work seamlessly with the new hospital at home (virtual ward) model.

B. Act as a key identifier of local residents who are deteriorating and would benefit from a hospital at home intensity of support, rather than being admitted into an acute hospital.

1.2.6 **Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development.**

1.2.7 **Improve data quality and completeness in the CSDS as this will be the key method to monitor outcomes and system performance.**

Providers should:

A. Use CSDS-extracts data, published via the UCR Dashboard (available on the UCR FutureNHS page) to improve quality of submitted data and achievements against meeting a minimum threshold of 70% of people receiving a response in less than two hours.

B. Align with community digital transformation policies to support shared care record access and other digital efficiencies.

C. Ensure clinical activity is recorded with high quality and completeness, in line with CSDS technical guidance.

D. Support frontline staff with: (i) data completeness improvements to support data quality and the accuracy of data for national standard, (ii) training on data collection methods and use of digital tools to collect data.

E. Submit data for two-hour UCR activities, including those that can be delivered in more than two hours.

1.3 ICS planners and commissioners must ensure full alignment between two-hour UCR provision and other urgent care services:

- **Unplanned care programmes** such as NHS111, urgent treatment centres, same day emergency care and 999. Two-hour UCR care has a crucial role in supporting increased rates of ambulance non-conveyance and ensuring a greater number of people who receive same day emergency care can return home without being admitted.
- **Primary care** such as GP out-of-hours, general practice and primary care network teams.
- **Hospital discharge teams and transfer of care hubs:** these may be integrated with two-hour UCR services.

1.4 Two-hour UCR services will rely on other planned care teams to provide ongoing support and ICSs should work to improve capacity and flow post two-hour response to prevent delays in ongoing care. These include:

- **Adult and older adult mental health services:** as part of the NHS Long Term Plan, a significant expansion in new integrated models of community mental health services is underway, as well as of urgent mental health crisis services. Alignment and close working is expected to be needed for older adults who are more likely to have multiple co-occurring mental and physical conditions.
- **Proactive care services** such as multidisciplinary rehabilitation teams, anticipatory care and enhanced health in care homes, which provide proactive health management support to help people live well for longer.
- **Community and district nursing services** may well provide the core service model for two-hour UCR services. These services could be enhanced to respond to all two-hour community crises with a full multidisciplinary approach. However they are organised locally, district nursing teams will be an important service to provide ongoing planned care after the crisis has been attended to.
- **Planned care** (with set caseloads) such as hospice at-home services, rehabilitation teams and long-term support provided to people in their homes. This will also include hospital at home or virtual ward models of care supporting admission avoidance and transfers of care into community settings.
- **Social care:** urgent social care interventions and social care are integral to supporting people to stay at home or in their usual place of residence and preventing hospital admission.
- **Reablement services:** two-hour UCR services should work closely with reablement services and support such as social care emergency crisis support for unpaid/family carers.
- **Virtual wards:** individuals who receive a two-hour UCR may receive further clinical support in their homes via virtual wards to prevent and monitor deterioration. Virtual ward models can include a blend of digital monitoring and face-to-face care.
- **Diagnostic teams:** UCR teams should work closely with diagnostic teams to enable direct referral routes from UCR teams to community diagnostic centres. Diagnostic centres are designed to support earlier diagnoses for patients and easier, faster and more direct access to the full range of diagnostic tests closer to home.

2. Design and delivery principles in developing the service model

2.1 The service should be commissioned to provide a two-hour UCR and co-ordinated through a local single point of access, ensuring a 'no wrong door ethos is applied'. The single point of access should ensure access to multidisciplinary clinical and non-clinical input as required. Where an individual has been triaged by another service such as 999 or NHS111, there should be no need for further triage. It may be beneficial to bring together existing clinical assessment services (CAS) and providers of UCR to support a streamlined referral process or integrate them into hospital discharge transfer of care hubs. Geographical coverage needs to be considered to ensure the service is accessible by a variety of referrers, e.g. ambulance service, TEC providers and self-referral, as well as general practice and social care professionals; organisation at ICS level may be appropriate. UCR services should be accurately profiled on the DoS and NHS Service Finder so that they are visible to a range of health and care professionals.

2.2 The professional who is deployed to a person in crisis should be matched to their needs to avoid the need for further or repeated assessment. This deployment, while centrally co-ordinated, can involve professionals across a range of teams and organisations depending on how services are configured.

2.3 In line with national multidisciplinary team development guidance, two-hour UCR team members should work in an interdisciplinary way. This involves staff members from different disciplines taking on each other's traditional role by agreement to make optimum use of team skills and knowledge. As part of this way of working assessments may be carried out by different disciplines working together, with insights from one discipline informing the assessments of another.

2.4 The two-hour UCR service should be designed with a focus on reducing the health inequalities in the local population. This can be achieved through increasing access to care in a crisis at home for those who regularly default to using emergency department services or 999 services. Services should accept referrals for people both known and new to their services. They should review population, service data and patient feedback, and then act on this insight with referrers, to ensure all local communities use and benefit from this service when needed.

2.5 Two-hour UCR services should establish shared care approaches with same day emergency care teams and support rapid access to same day diagnostics in acute units and, where appropriate, community diagnostic hubs.

2.6 Crisis assessment and care should be holistic and personalised to avoid layering services and duplication of assessments and visits.

2.7 To meet the national standard of responding within two hours, clock starts and stops need to be consistently recorded and submitted to the CSDS. This requires all services and organisations delivering the response to comply with the CSDS technical guidance, noting this is a legal requirement under the NHS Standard Contract.

2.8 To meet the national standard, the assessment and care should start in under two hours (clock stop), with these short-term interventions typically lasting under 48 hours to ensure the team can continue to respond to new demand.

2.9 Planned or non-crisis care delivered within two hours does not count for this standard but should be recorded as usual in the relevant patient record system.

2.10 Due to its nature, the vast majority of two-hour UCR care should be delivered in person. There may be instances where a two-hour UCR service 'responds' to a patient remotely, using telemedicine or video consultation, such as where their place of residence is a care home. Where this occurs, it should be:

- a comprehensive assessment, not a prioritising and scheduling process
- based on sound clinical judgement only when the person is capable of receiving and participating in an assessment done in this way following an appropriate risk assessment to ensure patient safety
- clinicians should follow guidance on when and when not to conduct video and telephone consultations including when assessing people with serious high-risk conditions.[2]

[2] IRIHS Research Group, University of Oxford (2020) Video consultation information for NHS trusts and foundation trusts.

Demand and capacity

2.11 Demand and capacity modelling is a crucial tool for supporting providers and systems to understand the demand and plan sufficient capacity, so that patients do not wait unnecessarily for treatment and receive a safe, high quality service.[3]

2.12 To support demand and capacity modelling for two-hour UCR services, the following tools could be used:

- NHS England and NHS Improvement demand and capacity models, training and guidance
- The NHS Elect Same Day Emergency Care 'opportunity Identifier tool'. This tool has been developed to provide an insight into the opportunity available within hospital sites for same day emergency care services and acute frailty services. It identifies specific conditions, numbers of patients and length of stay and may provide insights into where two-hour UCR services could have an impact and support demand modelling.

2.13 When modelling capacity and demand, two-hour UCR services should consider the cost of their services and the optimum operating model. ICSs, commissioners and providers should have an understanding of the cost of their service and seek to provide a cost-effective service. More details on cost will be included in future updates of this guidance.

2.14 Demand and capacity modelling needs to be regularly reviewed alongside percentage achievement of two-hour UCR and plans put in place to meet demand.

Case study: Sharing data to support commissioning and capacity management

Overview: The North West London (NWL) system includes five community providers and eight CCGs that have worked together in 2020/21 to develop consistent data reporting that is designed to effectively capture daily demand, capacity and performance levels for rapid response, community nursing and community beds across the eight boroughs.

Establishing a process to share data with commissioners:

- **Establish local data reports:** In NWL, members of the ICS community team have worked closely with operational leads from each provider over the past year to agree measures that rate the demand and capacity levels in rapid response teams, community nursing teams and community beds.
- **Extracting key data:** Providers complete reporting with a 48-hour lag time. This enables retrospective actual data to be pulled automatically from SystmOne or Emis, reducing the burden on provider teams. This data is submitted directly into the Performance/BI team who can upload it and produce trend reports. For example, rapid response data includes the number of referrals accepted, visits completed (in hours), staffing (in hours), percentage of patients triaged and seen within two hours, and the source of referral.
- **Using data to support commissioning:** The trend reports are provided back to the community providers on a daily basis. As the reports provide an up-to-date picture of activity, providers can use the information to make live changes to service lines. Any anomalies and system issues noted are raised weekly with community provider chief operating officers. The data is also shared across the system to give partners confidence that there is capacity in the community and, conversely, to flag when capacity is tight. The data enabled surge triggers to be applied as part of a planned response to wave two of COVID-19.

Next steps: The NWL system plans to embed the reporting processes and refine the trend mapping and analysis. It hopes to use the data to support any increased investment in community services.

3. Monitoring and benchmarking

3.1. All providers of NHS-funded two-hour UCR services are legally required to submit data to CSDS under section 250 of the Health and Social Care Act 2012. Submissions are required monthly and providers should work to improve data quality and completeness of submissions.

3.2. All providers and systems are to improve the data quality and completeness in the CSDS as this data will be used to monitor outcomes, system performance and growth in delivery of care. This will give confidence in the two-hour UCR data, which will be published for every provider and ICS as an official statistic, in line with other key NHS performance statistics, from 2022/23.

3.3 Monitoring of trajectories provided as part of the 2022/23 planning and contracting round will occur each quarter alongside the legally mandated data submissions to CSDS. NHS England and NHS Improvement regional teams will monitor performance and support ICSs in overcoming data collection and reporting issues.

3.4 Regional teams will support ICSs in implementing the two-hour UCR standard and surpassing the minimum threshold of 70% of two-hour UCR demand being met within two hours or less by each provider.

Performance framework for the two-hour guidance: how will we know we are succeeding?

Performance will be monitored by:

1. Consistent delivery of UCR care, ensuring that individuals with any clinical condition/ needs are accepted, in line with this guidance.
2. Delivery of services at scale to ensure full coverage across the ICS footprint.
3. Delivery of services from 12 hours a day, seven days a week, with extended operating hours where demand necessitates this.
4. 70% achievement of the delivery of two-hour UCR care within two hours or less, increasing the number of care contacts. Performance data, taken from CSDS, will be published monthly from April 2022, and all providers and systems are encouraged to make use of the UCR Dashboard (available on the UCR FutureNHS webpage).
5. Submission of robust and reliable data to CSDS.
6. Increasing acceptance of referrals from all appropriate sources, especially 111 and 999.

The System Oversight Framework incorporates oversight metrics, applicable to ICSs, CCGs and trusts, will be used to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners. This include information relating to two-hour UCR and an update will be published in April 2022.

As UCR services mature key impact metrics may include:

- hospital admissions
- inequalities data
- emergency department attendance
- same day emergency care attendance
- ambulance conveyance rates
- NHS111 referrals
- care home referrals
- self-referrals
- onward referrals from the two-hour UCR team.

3.6 ICSs must:

3.6.1 Implement reporting processes that align to the frequency and detail that is required for reporting of both local and national key metrics.

3.6.2 Establish their own monitoring and evaluation plans to maximise the impact of the standard and monitor use of the service to identify potential cohorts who are not benefiting from it. This should include checking geographical coverage, analysing ethnicity data and monitoring patient conditions to identify disparities in access.

3.6.3 Monitor call waiting times and the time elapsed from identifying need to receipt of care.

3.6.4 Understand wider system impact by working with local hospitals to review records of hospital attendances and admissions to identify patients who could have benefited from a two-hour UCR but did not do so, and then identify the lessons that can be learned from this and potential solutions.

Benchmarking

3.7 During 2022/23, NHS England and NHS Improvement will work with NHS Digital to develop how data can be made available in a more timely way, though tools nationally available for the system. This will support quality improvement and benchmarking of two-hour UCR services locally, regionally and nationally. These are crucial in delivering improvements in patient care, identifying unwarranted variation and demonstrating the impact of community services on managing

patient demand. Further information on this topic and next steps will be included in future versions of this guidance.

Challenges and considerations

3.8. Through working with NHS accelerator sites and other providers of UCR some practical challenges with implementing the standard have been addressed. We will continue to gather tools, solutions and case studies that can help with implementation. These will be shared in webinars and learning events and on the UCR FutureNHS page.

Clinical requirements

4. What are the criteria for NHS-funded community two-hour UCR services?

4.1 Community two-hour UCR services are for adults (over the age of 18) and a person should receive a community NHS two-hour response if the following characteristics are present:

- The person is experiencing a crisis which can be defined as a sudden deterioration in their health and wellbeing.
- The crisis may have been caused by a stressor event which has led to an exacerbation of an existing condition or the onset of a new condition or significant deterioration in clinical state or baseline functioning.
- This health or social care need requires urgent treatment or support within two hours and can be safely delivered in the home setting.

4.2 The crisis may be due to:

4.2.1 **A clinical condition such as:**

- a new or acute problem (such as an infection)
- an exacerbation of a chronic condition, where the condition can be safely treated out of hospital, but its functional consequences may mean that the individual is at risk of hospital admission.

4.2.2 **Serious illness where treatment at home is in keeping with the person's wishes as part of a pre-agreed treatment escalation plan, such as:**

- A patient in receipt of palliative care who may in a crisis wish to be treated at home or usual place of residence as part of a pre-agreed treatment escalation plan rather than be admitted to hospital. This will be with the full understanding that the same level of diagnostics and support may not be provided in the community.

4.2.3 **A social crisis such as:**

- A breakdown of unpaid carer arrangements which causes an immediate health risk to an individual, eg if their main carer is admitted to hospital or if carer stress is causing a breakdown in ability to provide safe health and care support.
- Local authorities have a responsibility to respond to people experiencing a social care crisis.[4]

5. What differentiates a two-hour response from other types of responses?

5.1. A two-hour response is typically required when a person is at risk of admission (or re-admission) to hospital due to a 'crisis' and they are likely to attend hospital within the next two to 24 hour without intervention to prevent further deterioration and to keep them safe at home.

5.2. Where a person does not require a response within two hours, they should receive care within the timescales they require and be supported to remain safely at home with appropriate services. The associated data should be collected as described in the CSDS technical guidance, but these responses are not counted as part of the national standard. Full submission of data to CSDS will give an understanding of the volume of this activity.

[4] The Care Act 2014 specifies that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. Department of Health and Social Care (2016) Care Act Factsheet 1: General responsibilities of local authorities: prevention, information and advice, and shaping the market of care and support services

6. Typical inclusion and exclusion criteria

6.1 The person:

Inclusion	Exclusion
• Over 18 years. • Is living in their own home or a residential/care home setting. • Is in a crisis (as defined above) and needs intervention within two hours to stay safely at home/usual place of residence and avoid admission to hospital. • Is living with dementia – best practice is to share responsibility for care with older people's mental health teams.	• Is acutely unwell or injured, requiring emergency care intervention and admission into an acute hospital bed. • Is experiencing a mental health crisis and requires referral/assessment by a specialist mental health team.* • Needs acute/complex diagnostics and clinical intervention for patient safety in hospital.

* Exclusion applies to people with functional mental health crises and no co-occurring urgent physical needs. In these instances, specialist NHS and adult social care mental health crisis services should respond (NHS England and NHS Improvement are expected to set out separate waiting time expectations for urgent mental health crisis response).

6.2 The exclusion criteria above should be applied unless a treatment escalation plan, advance care plan[5] or advance decision to refuse treatment[6] is in place which states the person wishes for treatment to be delivered in their usual place of residence; or where the family have a lasting power of attorney for health and welfare,[7] the patient no longer has capacity to make decisions and the family wish for treatment at home.

Professional judgement should always be used to decide if a person needs a two-hour NHS UCR, or more than two hours, and should take into consideration co-morbidities and the complexity of a person's needs. Where a multidisciplinary response is required, partners in the service should agree that the response is the most appropriate. A two-hour UCR will not always be appropriate and entry into a service should be determined on a case-by-case basis. Where an exclusion criterion is used, the two-hour UCR team should work to find alternative NHS support for the person being referred, rather than simply rejecting a referral.

[5] Gold Standards Framework (2018) Advance care Planning.
[6] NHS (2020) Advance decision (living will).
[7] Lasting power of attorney: acting as an attorney: Health and welfare attorneys.

7. Common clinical conditions or needs

7.1. The following list is **not** meant to be exhaustive or used to exclude patients. These are common clinical conditions or needs that may lead to a patient requiring a two-hour response in a **crisis**. All UCR services, however configured, are expected to provide this care as a minimum.

Condition/need	Supportive definition
Fall	With no apparent serious injury, including to the head, back, hip, or where able to rule out a fracture, and where there has been no loss of consciousness,[8] but where care/support is required within two hours to prevent hospital admission. 'Level 2' patients as defined in the Falls Response Governance Framework for NHS Ambulance Trusts falls response model should be responded to and supported by UCR teams. Lifting equipment and manual handling aids should be available to UCR teams to help a person who has fallen and needs support to get up from the floor.
Decompensation of frailty	A frailty-related condition which may result in loss of strength, speed, energy, activity, muscle mass, resilience to minor health strains and subsequent loss of independence.[9] **Decompensation caused by a minor stressor event, such as a urinary tract infection (UTI), which can cause a sudden or disproportionate decline in function**.[10]
Reduced function/ deconditioning/ reduced mobility	The person may have a gradual change in functional ability or ability to manage at home and with activities of daily living.[11] Mobility loss can also be sudden, leading to an acute need.
Palliative/end-of-life crisis support	If core palliative/end-of-life care services are not available to respond, a two-hour UCR service will help maintain a person close to the end of their life at home, offering symptom control/pain relief in line with a person's wishes.[12]
Urgent equipment provision to support	Alongside an assessment, makes a person safe and optimises functional ability to support prevention of admission. A person

[8] NICE (2017) Falls in older people. Quality Standard 86 [QS86].
[9] Frailty Prevention (2015) What is frailty?
[10] Clegg A, Young J (2011) The frailty syndrome. *Clin Med J* 11(1): 72.
[11] British Geriatric Society (2021) Silver Book II: Geriatric syndromes.
[12] NICE (2017) End of life care for adults.

Condition/need	Supportive definition
a person experiencing a crisis/at risk of hospital admission	should be made safe and ongoing care provided where appropriate by reablement or rehabilitation services.
Confusion/delirium	Increased or new confusion, acute worsening of dementia and/or delirium (excluding sepsis requiring hospital admission[13,14]). The patient should be assessed and physical health needs managed to establish the cause (e.g. UTI, cellulitis, pneumonia) so that their needs are managed safety at home. [15]
Urgent catheter care	Where a person has a blocked catheter and/or pain from a catheter-related issue and is at risk of harm and has a very high risk of admission to hospital. Where a district nurse service does not have the capacity to respond or is part of the explicit function of the two-hour UCR team.
Urgent support for diabetes	Examples of this include urgent injections and where the person has experienced a hypoglycaemic episode (now resolved) or where blood sugar management is a concern and the person is at risk of hospital admission as a result (excluding sepsis requiring hospital admission[16] hyperglycaemia/ketoacidosis).
Unpaid carer breakdown which, if not resolved, will result in a healthcare crisis for the person they care for	Provide healthcare where a carer who meets a person's healthcare needs is no longer able to do this and the person they care for now requires a two-hour UCR. Where two-hour UCR teams identify social care needs rather than healthcare needs – for example, where carer stress means a carer is unable to provide safe care or where either the carer or cared for person is experiencing abuse or neglect – they should: • make an urgent referral to the relevant service where the two-hour UCR team does not have Care Act 2014 responsibilities • provide care in line with the Care Act 2014 where the two-hour UCR team does have Care Act responsibilities • work jointly with local authorities or care providers.

7.2. Where a response is not needed within two hours, the individual should receive an appropriate and timely response in line with a 'no wrong door' approach with the

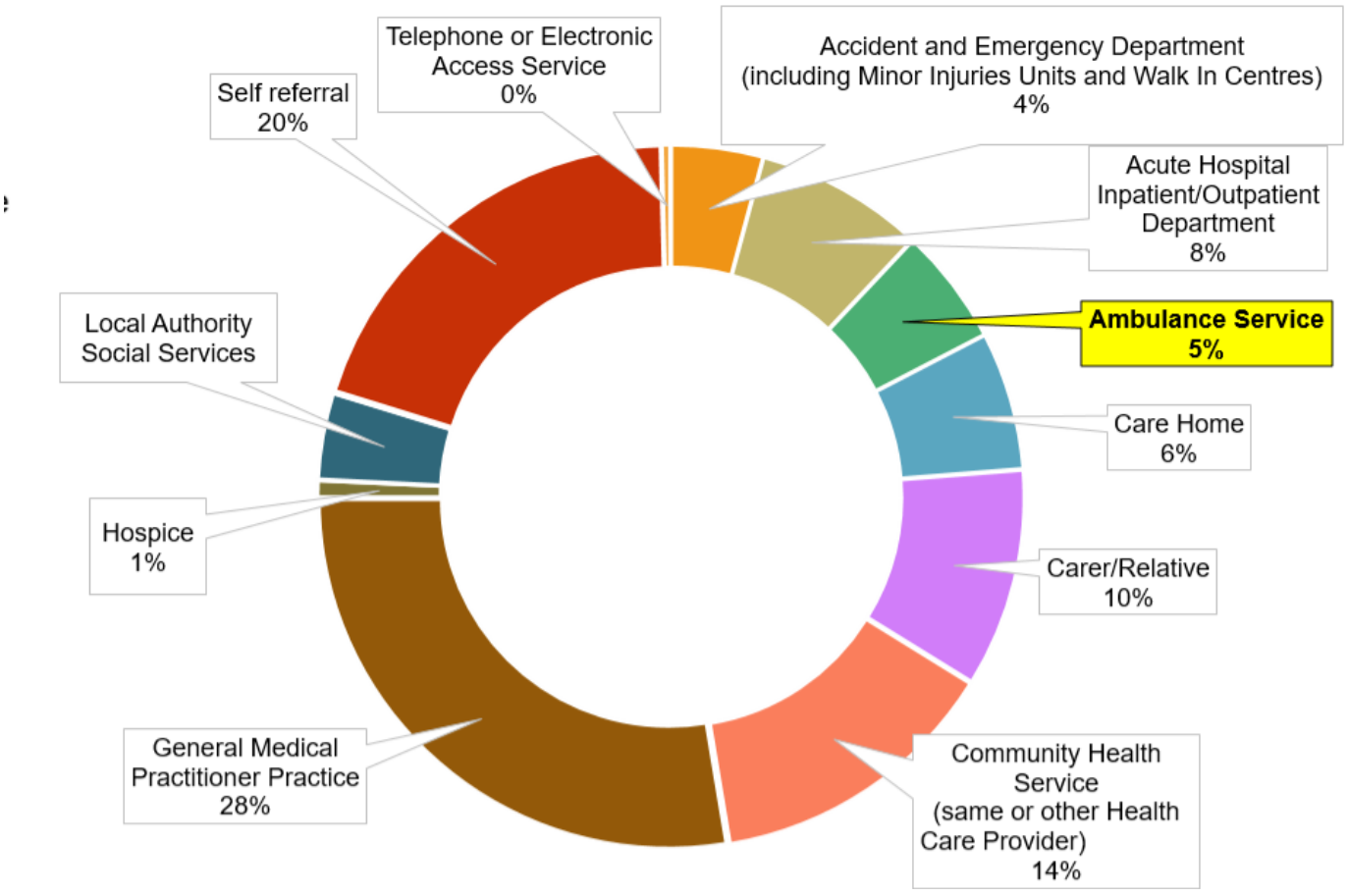
[13] Sepsis Trust (2020) Sepsis Screening Tool Community Nursing.
[14] NICE (2017) Sepsis: recognition, diagnosis and early management. NG51.
[15] British Geriatric Society (2021) Silver Book II: Geriatric syndromes.
[16] Sepsis Trust (2020) Sepsis-Community-12-Version-1.3.pdf (sepsistrust.org)

aim of meeting a person's need. This will require close partnership working with health and social care services, as well as voluntary and community sector support.

8. Referral and assessment processes

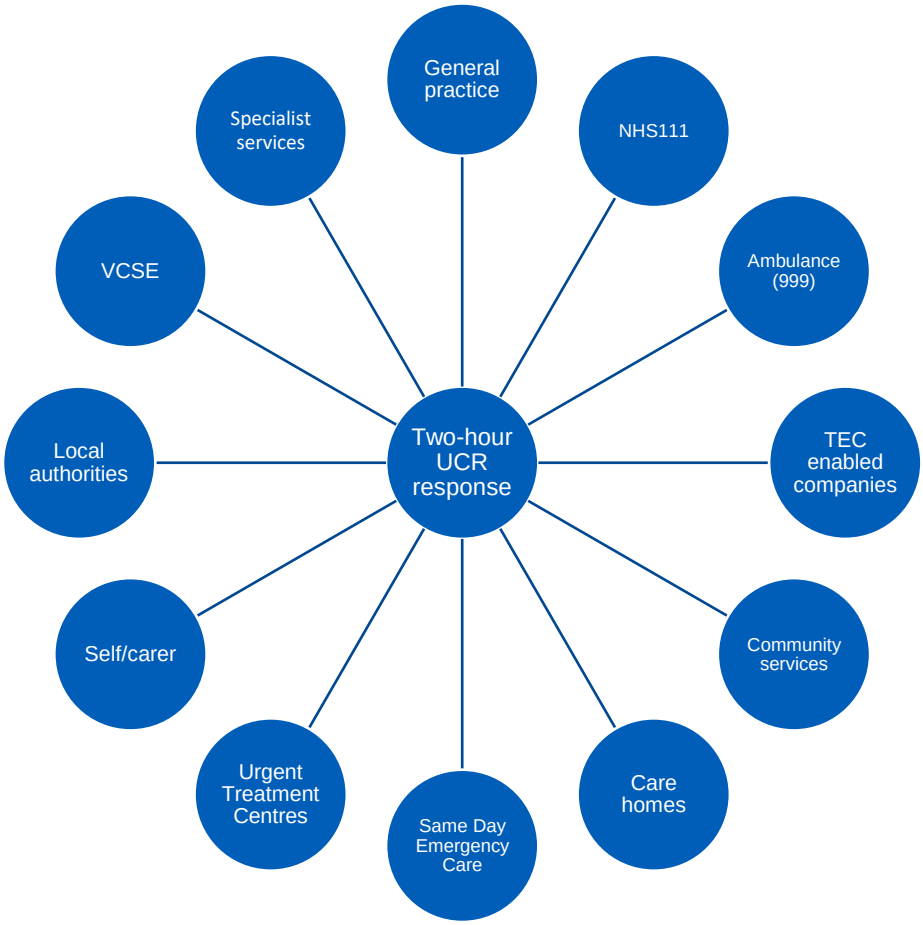
8.1. Referrals to two-hour UCR services will come from a variety of sources. Figure 1 below shows the current referral routes into UCR services.

Figure 1: Referral routes into two-hour UCR services October 2021



8.3 We anticipate that over time as pathways become more established that an increasing number of referrals will come from NHS111, same day emergency care, ambulance services and self-referrals (Figure 2).

Figure 2: Anticipated referral routes into two-hour UCR services



8.3 Providers of a two-hour UCR must work in partnership with their local ambulance trust to ensure appropriate patients who call 999 are redirected to UCR teams. Further guidance will be published and tools to support this work are available on the UCR FutureNHS page.

8.4 Providers of a two-hour UCR must also work with technology enabled care (TEC) companies (providers of pendant alarms), local authorities, ICSs and place-based partnerships to take local actions to allow access to appropriate local pathways, for a response as an alternative to 999.

8.5 This work will require commitment from key stakeholders including:

- local authorities
- UCR services
- pendant alarm providers locally and nationally
- community services
- ambulance services

- primary care
- voluntary community and social enterprise sector
- regional UEC leads
- directory of service (DoS) leads.

Detailed resources to support this work are available on the UCR FutureNHS page.

8.6 Providers and systems should regularly analyse referral and demand data (for two-hour and wider local services) and conduct case reviews with partner organisations to understand current patterns and to shape pathways to ensure impact on admissions avoidance, unnecessary escalations and conveyances. This is likely to increase referrals from UEC, ambulance, NHS111 and technology-enabled service pathways, and prioritise cases where risk of admission is highest.

8.7 The volume of referrals is anticipated to grow and the proportion of referrals is expected to increase from other sources, such as NHS111.

8.8 The following actions will support providers to increase referrals from the key sources outlined above. Further steps will likely be needed to ensure a streamlined referral process is developed.

- Collaborative working with other providers, ICS leads, DoS leads and commissioners. This will also include care home leads, NHS England and NHS Improvement regional ageing well leads, NHS111 providers and local 999 ambulance trusts.
- Adding (profiling) the two-hour UCR service to the DoS, which is regularly updated. This is supported by commissioners.
- Exploring digital solutions to enable the seamless transfer of information between services and organisations. Secure email may initially be used until interoperability between systems develops.
- The sharing of service information, including case studies, to help referring clinicians understand two-hour UCR service capability and with the referral of appropriate patients.

8.9 All two-hour UCR services should have established processes to correctly prioritise and schedule a person into the right care. There should be appropriate systems and processes in place to:

- ensure appropriate skills and expertise of the assessment team
- escalate cases where needed
- monitor call waiting and initial assessment times
- ensure patients receive timely and appropriate care.

8.10 In line with best practice, some services find it beneficial to use trusted assessor principles[17] both within and across teams and organisations. These enable another professional's judgement to determine that a two-hour response is necessary and for the two-hour UCR service to respond. This requires a common understanding of two-hour UCR service capability across places and ICSs and can help reduce the need for multiple assessment activity and provide a seamless service.

9. Two-hour UCR assessment and intervention

9.1. The following is a non-exhaustive list of the common assessments, screening tools and interventions typically undertaken/used by two-hour UCR teams for a person in their home or usual place of residence.

Activities and tools to support assessment and diagnosis:

- make the person/situation safe, provide reassurance and consider any capacity, consent or safeguarding concerns, escalating to appropriate services as required
- holistic history including review of clinical records to understand medical history and presenting issue
- clinical observations, including blood pressure and oxygen saturations
- calculation of NEWS2 (national early warning score) as part of the wider assessment to quickly identify deterioration and to support care decisions or escalation
- blood, urine and other diagnostics

[17] NHS Improvement (2017) Developing trusted assessment schemes: Essential elements.

- assessment and provision of equipment to make a person safe at home and support/maintain independence
- medicines optimisation assessment[18]
- symptom assessment
- administration of medication, to resolve immediate crisis, including nebuliser therapy for chronic obstructive pulmonary disease/asthma exacerbation.

Screening tools:

- nutrition assessment, e.g. Malnutrition Universal Screening Tool (MUST)
- risk of developing pressure sores, e.g. Waterlow or Braden score
- frailty, e.g. Rockwood clinical frailty score
- delirium, e.g. 4AT (Rapid test for delirium).

Interventions that may be required in the first 48 hours:

- prescription and delivery of appropriate care interventions to support nutrition, personal hygiene, continence, wound care, mobility and rehabilitation to regain or optimise functioning, etc.
- prescription and/or administration of medication for pain or symptom relief
- catheter care to relieve immediate discomfort
- antibiotic prescribing, including intravenous antibiotics as skills allow.

9.2. All services delivering two-hour UCR care should aspire to undertake point of care (POC) testing at a patient's side. Where POC testing is not yet readily available, teams should ensure they are able to access advanced diagnostics, to support clinical decision-making, risk management and ongoing care planning.

10. Workforce and workforce development

10.1 Different models are used to deliver two-hour UCR care. Typically, provision includes the use of a flexible workforce who are deployed according to each person's needs. Two-hour UCR teams commonly include:

- registered nurses (including district nurses)

[18] NICE (2015) Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes.

- advanced clinical practitioners (from a range of professional backgrounds including allied health professionals and nurses)
- physiotherapists
- occupational therapists
- health and care support staff
- social workers
- paramedics.

10.2 Teams should be supported by other relevant professionals including GPs, geriatricians, social care teams, mental health, learning disability and autism workers, paramedics and voluntary sector organisations.

10.3 A system-wide approach should ensure collaboration to share workforce skills and expertise in the best interests of system-wide change, e.g. by making senior frailty and learning disability experts available to provide expert resource to two-hour UCR teams.

10.4 Commissioners and providers should ensure that they have the appropriate workforce and skill mix in place to deliver two-hour UCR care and meet local population needs and that teams have access to the following skills, training, tools and support. They should also support newly qualified professionals, students and higher education institutions to develop the necessary skills needed for a career in community two-hour UCR services.

Advanced clinical practice	Teams should be supported to develop and implement advanced clinical practice skills, in line with HEE guidance,[19] and have access to: • Advanced clinicians who have the skills, knowledge and experience to make complex clinical decisions, sometimes in the face of uncertainty and varying levels of risk, and have a high degree of autonomy and accountability (e.g. a community geriatrician, district nurse or GP with a special interest). This will include the ability to make a working diagnosis of the underlying cause of the crisis. • Other specialties, such as hospital-based diagnostics or community diagnostic hubs, phlebotomy, prescribers and 'hot clinics', so that people can be diagnosed quickly if needed.
Training and education	Teams should receive appropriate training so that they can understand and support the diverse needs of their local populations. This includes: • comprehensive frailty training and use of the Frailty Core Capabilities Framework[20] • training on symptom assessment • training on dementia, mental health and mental health first aid • education around the needs of, and reasonable adjustments for, people with a learning disability and/or who are autistic.
Diagnostic tools	Work should be undertaken to enable POC testing to help clinicians make a working diagnosis and support risk management and ongoing care planning for the person.
Current and future workforce development	The capacity and capability of two-hour UCR teams should be enhanced in anticipation of a further expansion of two-hour UCR services to meet the population health needs in the period up to 2024.[21] The workforce and capacity of rehabilitation services and other pathways that two-hour UCR services commonly refer patients onto should also be enhanced and strengthened in anticipation of an increased number of referrals as part of the expansion of two-hour UCR care.
Digital and shared health and care records	Being able to view and record patient information in shared care records will support the delivery of care at home.

[19] Health Education England (HEE) Multi-professional framework for advanced clinical practice in England
[20] Health Education England, NHS England and Skills for Health (2018) Frailty: A framework of core capabilities.
[21] NHS England (2020) We are the NHS: People Plan for 2020/21 – action for us all.

Skill mix

10.5 The skill mix of the two-hour UCR workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed. We are keen to work with local providers to establish what the optimal blend of skill mix and ratio is and will include further information in future versions of this guidance.

Caseload management

10.6 Caseload management is important in improving care outcomes for patients and enhancing patient experience. We plan to work with local providers to understand from best practice what the optimum caseload size of a two-hour UCR team is and will include this information in future versions of this guidance.

Case study: Using digital tools to enhance performance and understand demand

Overview: In 2018, Leicester Partnership Trust (part of the Leicester, Leicestershire and Rutland (LLR) accelerator site), identified a need to improve its understanding of demand in the community and the capacity within its teams. The solution was using Autoplanner, a software built into the Electronic Patient Record system.

Using automatic workforce software:

- Autoplanner allows the trust to look at all open referrals and care plans linked to a team's caseload, giving information on the needs of patients, geographical spread and staffing information. The software also prioritises those in most urgent need, meaning easier identification of those referrals into the UCR teams who require a two-hour UCR or two-day reablement response.
- The software also provides workforce information, such as the number of staff working, their available hours and the team's skill mixes to help match clinician skill sets to the care plans and therefore best use of team time.
- The software matches open referrals to the right professional (eg community nurses or healthcare assistants) and brings significant efficiency to the team. In 2019, 12 hours/day of clinical staff time and 2.5 hour/day of planning time was saved for each of the 30 teams.
- More broadly, the software has influenced the health and wellbeing of staff. It plots the most efficient route to a patient's home, saving travelling time and leaving adequate time to schedule breaks/other commitments into each shift. It also supports organisational development as it can help identify training needs against referral priorities.

The Autoplanner functionality as part of SystmOne modules were made available in August 2018 and can be used by other relevant providers.

Further support

For information and general queries regarding the two-hour UCR standard and related guidance, please email england.communityservices1@nhs.net

To access digital tools, resources and ongoing updates regarding the standard, please visit the FutureNHS platform

Resources

- Technical information for implementing the two-hour UCR standard (including clock starts and stops): Urgent community response – two-hour and two-day response standards 2020/21 Technical data guidance.
- Planning guidance and finances regarding implementation of the two-hour UCR response standard 2022/23 priorities and operational planning guidance.
- Referral, assessment and delivery of home-based services to reduce the need for a hospital admission: NICE guideline NG74.
- NHS England and NHS Improvement demand and capacity models, training and guidance.

Appendix A: Urgent community response operational requirements 2021/22

This table sets out the expectations for ICSs regarding UCR services in 2021/22. This provides the foundation for further actions and expectations in 2022/23 which are set out in section 1.

Requirements	Ambition	Actions for ICS planning leads, commissioners and providers 2021/22
1. Provide services at scale: ensuring full geographical coverage of two-hour UCR care	Ensuring that anyone who requires a two-hour response receives one, regardless of where they live	a) Map the current geographical coverage of two-hour UCR services (including adult social care crisis teams to avoid a risk of duplication) and expanding provision (where necessary) to ensure full geographical coverage across an ICS. b) Align the delivery models used by different two-hour UCR services across the ICS to provide a consistent model for the population of each ICS. c) Use demand and capacity modelling to predict, plan and implement future workforce requirements and workforce development needed to achieve a two-hour response.[22]
2. Provide services from 8am to 8pm, seven days a week, at a minimum	Ensuring that people have access to the same high-quality home-based care at weekends and in the evenings as they do on a weekday	a) Map current operating hours of two-hour UCR teams in ICSs and expand working hours to provide care from 8am to 8pm if not already consistently in place. b) Expand services beyond 8am to 8pm, seven days a week, in areas that are already meeting this requirement, through consultation with local urgent care networks and based on the needs of the local population.

[22] NHS England and NHS Improvement (2021) Demand and capacity training and guidance

		c) Consult with staff and unions regarding changes to working patterns. d) Map demand to understand the variation in need for a two-hour response at different times of the day, night or week and organise workforce according to need. e) Use capacity and demand modelling to prepare for expanded hours of provision. f) Use existing reablement services and support alongside other social care emergency or duty arrangements, eg crisis support for unpaid/family carers.
3. Accept referrals into two-hour UCR services from all appropriate sources	Providing a seamless integrated experience for each person and enabling professionals to easily access the service	a) Ensure referrals can be received from all local health and care partners including: • NHS111 • 999 • general practice • social care providers (such as care homes) including personal assistants • clinical hubs in ambulance control rooms and patient-facing ambulance clinicians • specialist services • care workers • local authorities. Please note this list is not exhaustive. b) Accept self-referrals from individuals and carers (which may be directly to the service or via NHS111). c) Make two-hour UCR services accessible via NHS111 by profiling and adding two-hour UCR services to the local Directory of Services (DoS), to ensure that they are visible to and able to accept transfers of care from clinicians within NHS111/integrated urgent care and other users of the DoS. d) Where technically possible services should be able to send a referral to two-hour UCR services electronically.

4. Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard	Demonstrating impact by collecting data that will support counting of the national standard; quality improvement and improved patient outcomes and experience	a) Ensure clinical activity is recorded in line with CSDS technical guidance including clock starts and clock stops. b) Put processes in place to extract clinical activity from the clinical systems to CSDS. c) Submit data for two-hour UCR activities, including those that can be delivered in more than two hours. d) Use CSDS data for benchmarking and learning locally.

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