

# Direction of Travel for Urgent Care: a discussion document

October 2006



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# Contents

Foreword by the Rt Hon the Lord Warner	1
Introduction	3
Section One: What do service users and carers want?	8
Section Two: Twenty-first century urgent care	11
Section Three: Turning the model into reality	26
Section Four: How to comment	40

# Foreword by the Rt Hon the Lord Warner

The reality for many people needing health and care services urgently is that, while much has changed, much still remains to be done.

Care services are being radically transformed: standards have gone up; waiting lists are the lowest since records began; deaths from the big killer diseases are falling; A&E services have been transformed; there are more new hospitals; there is more extra care housing and intensive home care. New services are being provided closer to or in people's homes by GP practices, pharmacies, ambulance clinicians, community hospitals, Urgent Care Centres and rapid response teams; and through assistive technologies. Direct payments and individual budgets are enabling people to take more control. People with long-term conditions are being supported to manage their care with personalised care plans. Expert Patient Programmes are being made more widely available. NHS Direct is providing a multi-channel service to people in their own homes through the telephone, internet, television and text messaging.

But we need to look at what more needs to be done. The recent report by the Audit Commission on out-of-hours services demonstrated that while most users of these services are satisfied with the advice they receive, the national standards we set are still not being universally met.<sup>1</sup> Standards that apply to out-of-hours urgent care services do not apply to the same services in-hours and people may receive different pathways of care within different timescales depending on when and where they access urgent care. The extensive public consultation around the White Paper *Our health, our care, our say* revealed that many people were unclear about what services existed in their local communities and how they could be accessed. And it showed that some people – those with mental health needs, for example, or carers – are still not well served. We also know that in some deprived areas take-up of urgent or emergency care services is increased where primary care services do not adequately reflect need.

We need to develop services that address what people are telling us about their experience of urgent care, whatever the time of day. Better joint commissioning should realign services to meet those needs, reconfiguring services so that where clinically safe, the right care is provided quickly and accessibly in communities.

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<sup>1</sup> *The Provision of Out-of-Hours Care in England*, National Audit Office 2006.

This document sets out our thinking so far, which has been informed by the evidence we already had, supplemented by consultation with people using services and their carers and with people working in care services. It suggests a set of principles we should use to frame urgent care. It proposes a definition of what we mean by urgent care and it identifies the actions needed nationally and locally to implement change. It identifies the main levers to make change happen: voice, payment by results, joint and practice-based commissioning, standards and quality requirements and clinical and corporate governance. It poses some specific questions on which we need your input.

I hope that you will let us have your views so that we can be clear on the proposals for action set out here for driving change.

A handwritten signature in black ink that reads "Norman Warner". The signature is written in a cursive, slightly slanted style.

NORMAN WARNER  
The Rt Hon the Lord Warner  
Minister of State (NHS Reform)

# Introduction

1. People's expectations of health and care are changing. So are the opportunities for providing care differently: out of hospitals, into communities, and in people's own homes where they can get the care they need safely and conveniently. Changes in medical technologies, in IT and in the NHS and social care workforce are making this possible. This means that the role of hospitals can and should change. Large hospitals have a wide range of specialist services that effectively meet the needs of people with complex needs, providing them with the best possible care. Smaller hospitals may not provide a comparable range of comprehensive services. Locally it makes sense to review the range of services available in each hospital combined with the services available in the community and grasp the opportunities opening up for better, faster, more accessible care for people.

## What people told us they wanted

2. People want services that support them to prevent ill health, that are quick and simple to access and that put them in control. They want to be sure that when they need care, it will be available close to or in their own homes. They want to feel they have been given the advice and care that will keep them safe.
3. When we ask people what they think of services now, they tell us they like some of the things they are seeing change: more emphasis on prevention and support to self-care, the extended role of community pharmacies, NHS Direct telephone services, more Direct Payments and Individual Budgets.
4. But they are frustrated by delays in getting the services they need when they need them, by duplication between services and being passed from one service to another, by having to repeat basic information about themselves and some groups remain disadvantaged in their access to care.
5. Nowhere is this more important to people than when their care need is urgent.

## Delivering on the vision

6. We need to develop urgent and emergency care services that are more responsive to people and more efficient in the way they deploy resources, and make the most of opportunities from medical and technological advances to deliver better care and support more conveniently for people.

7. This means a consistent way of assessing what people need when they contact services with an urgent care need, whether by telephone or in face-to-face settings. It means changing the way services are configured locally, re-deploying existing resources for optimal care.
8. Understanding how people access urgent and emergency care will help commissioners and providers shape services in a way that best responds to changing local needs and the changing healthcare environment. Different solutions will be appropriate in different places but these should be based on the same criteria and evidence of what works best and offers the highest quality.

### **Getting to the right care**

9. If people telephone services, they should make one call to a number familiar to them.
10. The call should result in a rigorous assessment of the degree of urgency, which is consistent and safe. The assessment might result in the caller being given reassurance and advice on self-care. It might result in a prompt face-to-face intervention with a booked appointment. Or it might be assessed as an emergency requiring an immediate response from health or social care services. Whatever the requirement, the caller should feel the issue they have raised is resolved quickly without them having to make several calls and having to repeat basic information several times. And staff responding to the call should be able to share the information they need so that they can provide a seamless service.
11. We want to examine how this approach to the assessment of the urgency of need might be applied in face-to-face settings as well as to telephone responses, and to in-hours services as well as out-of-hours services.

### **Providing high-quality cost-effective services**

12. The development of community-based services means that where a face-to-face intervention is needed, it can more and more be local and not in a traditional hospital setting. That can sometimes mean the response is faster and more convenient than an A&E service, where many people have traditionally expected to go for emergency or even urgent care.
13. Ambulance trusts too are changing their role, with more and more frontline clinicians such as differently trained paramedics and Emergency Care Practitioners trained and equipped to assess people either over the phone or face to face and treat them there and then, without the need to go to A&E or be admitted to hospital. Sometimes, when people do need admission to hospital, they will get better care by being taken straight to a hospital with the right specialist facilities –

patients with a heart attack, for example, could be taken straight to a hospital with cardiac catheterisation laboratories where they can get primary angioplasty, not necessarily via the nearest A&E. Changes in community-based provision, hospital provision and the role of ambulance trusts provide the opportunity for looking at the role of A&E.

14. This means re-configuring the way resources are deployed locally, grasping the opportunities offered through changing technologies to bring services to people rather than people to services. It means developing strong local networks of service providers to integrate care for people.
15. This document asks for views on how we should take our thinking forward.

## Seeking views

16. The White Paper *Our health, our care, our say: a new direction for community services* committed the Department to developing a strategy for urgent care during 2006.

*During 2006 we will develop an urgent care strategy for the NHS, providing a framework within which PCTs and local authorities can work.... This will take full account of the implications for other providers, including social care and ambulance services*

paragraph 4.51 of *Our health, our care, our say*

17. We said the strategy would focus on improving people's experience of services and significantly reducing unnecessary admissions to hospitals. It would:
  - examine simple access so that people are assessed and directed first time to the right service
  - build on best practice
  - ensure consistency of quality
  - take and promote a system-wide integrated approach
  - improve joint PCT and local authority commissioning
  - develop a multi-disciplinary workforce strategy
  - address IT requirements
  - make best use of NHS Direct, particularly in supporting self-care and better information on services
  - support health and social care economies to develop integrated urgent care services meeting people's needs locally

18. Since the publication of the White Paper we have asked people using services and their carers what they need from urgent care. This reinforced what people said in the public consultation *Your health, your care, your say*.

*The present system of urgent and emergency care can be extremely frustrating for patients with delays and duplication, and patients handed over from one service to another. Out of hours patients may have to repeat their details as many as four times in a disjointed journey to definitive care. Nor does the system get the best value for NHS resources*

*Our health, our care, our say*

19. We have worked with Strategic Health Authority (SHA) Urgent Care leads and with local health and social care networks to shape what is meant by urgent care. Those discussions have informed this document, which sets a direction of travel for urgent care and poses questions to help us take forward our thinking.
20. A wide range of partners across health and social care are involved locally in developing and providing integrated urgent care services. They need to work across organisational boundaries through networks with a shared focus on delivery for people. Major partners include patients and the public, local government, social care and independent-sector providers, general practices, pharmacies, dental practices, community nursing, out-of-hours providers, Mental Health Trusts, Ambulance Trusts, A&E and acute medicine, SHAs, and Primary Care Trust (PCT) and practice-based commissioners. We need the views of all those involved in commissioning or providing urgent care.

## **The Structure of this document**

21. This document is divided into four sections, each of which identifies questions on which we would like your comments. There are a lot of questions and we do not apologise for this. Urgent care is a complex area involving a great many partners and organisations and it is important that we have a system-wide view of what needs to be done to improve urgent care.

## **Section One: What do service users and carers want?**

22. This section summarises the views of people using services, carers and the public at large about urgent care and translates these views into six principles to frame the delivery of urgent care.

## Section Two: Twenty-first century urgent care

23. A new definition of urgent care provides the basis for a conceptual model of the provision of urgent care. This is illustrated by some examples of the range of different forms of service provision which could deliver this model in a local community. Some stories of how people experience services are included to show clearly what is happening now and what we need to change. These stories are anonymised real experiences of people.

## Section Three: Turning the model into reality

24. Each of the six principles identified in Section One is explored in more detail, setting out the key challenges in current provision and describing the way in which these will be resolved when the new model of provision is fully implemented. There is a summary of what actions might be taken nationally or locally to deliver these improvements. We particularly need your input on whether these are the right actions.

## Section Four: How to comment

25. This section explains the different ways in which individuals and organisations can comment (both online and on paper) on the views set out here.

**The sooner you let us know your views, the sooner we can take account of them.  
We will continue to take on board your views up until Friday 5 January 2007.**

26. An online questionnaire – our preferred method of receiving comments – is available at [www.dh.gov.uk/consultations](http://www.dh.gov.uk/consultations)
27. Paper copies are available from DH Publications Orderline 08701 555455.

# Section One: What do service users and carers want?

28. Over recent months a number of different initiatives have explored service user, carer and public attitudes towards urgent care. These include:
- the public consultation *Your health, your care, your say*, which informed the White Paper, *Our health, our care, our say: a new direction for community services*
  - a survey of users of urgent care commissioned by the Department of Health
  - workshops with users and carers, many drawn from PPI forums
  - ongoing research by the Medical Care Research Unit at the University of Sheffield
29. These show that many aspects of the current service are highly rated and strongly supported. These include:
- the ambulance service, in terms of both the initial response to 999 calls and the kind of services that paramedics and others can deliver
  - A&E departments, especially the reduction in waiting times and access to services that they provide
  - community pharmacists, particularly the quick and easy access to care and advice in an informal setting
  - increasing integration of services, for example across the community, the NHS and the voluntary sector
30. But a number of consistent concerns about current service provision remain:
- Organisations that provide urgent care have not yet fully developed ways of identifying and responding to people's experience of their services.
  - There is confusion among the public as well as staff providing services about what services are available locally and about how and when to access them.
  - People find that the first service they approach is often unable to meet their needs. They are then passed to a second service which, in the absence of any information passed from the first provider, asks the user or carer to repeat basic information all over again.

- People are unsure how some urgent care services, such as dentistry, can be accessed.
- People recognise that they may not be able to judge the real urgency of their needs, but do expect that they should have prompt access to a professional who can make a safe assessment of that need, and advise what action should be taken. The end result may quite properly be advice and reassurance. People do not expect 24/7 access to every health and social care service. But they do expect prompt access to a consistent and rigorous assessment of the urgency of their need for support.
- The needs of particular groups have not always been addressed: for example, those with mental health needs or learning difficulties, those caring for others, and people at the end of their life.

31. We have identified six principles to address what we have heard. They are defined from the point of view a person using services or their carer. All have important implications for people providing care and support. Together they provide the framework for the development of urgent care services.

One	My <b>voice</b> as a service user or carer is clearly heard and acted on.
Two	I <b>know</b> how to access services if I have an urgent need.
Three	If I have an urgent need I can access care <b>quickly and simply</b> .
Four	My <b>safety</b> is paramount to everyone who cares for me.
Five	I can <b>rely</b> on getting the right care (including support for self-care), <b>whenever</b> I need it and <b>whoever</b> I am.
Six	The care I receive meets my needs <b>appropriately, taking account of the urgency and value for money</b> .

## Questions

- Q.1 Do you agree that delivery of urgent care services can be centred around this set of principles?
- Q.2 Would you want to add to them or change anything?
- Q.3 If so, please explain briefly what you would change.
- Q.4 Are there any issues specific to ethnicity, age, disability or gender that we need to consider in developing urgent care services?
- Q.5 If so, what are they?

## Section Two: Twenty-first century urgent care

32. We want to develop an approach that is clear about the process for assessing the urgency of care need and responding to that need. This means two things:
- First, it means a consistent and rigorous way of assessing the level of urgency, whether someone has contacted services by telephone or by walking in to face-to-face services.
  - Secondly, it means providing the right response to meet that assessed need. There are three main ways of meeting that need: providing advice and reassurance for self-care; booking an appointment for face-to-face care; or providing an immediate, emergency response, which may range from despatch of an ambulance or rapid response team to advising someone to walk in to locally available services with the right set of facilities appropriate to the assessed need. The aim should be to provide this response seamlessly so that people do not have to repeat information about themselves or contact someone else if they need an appointment for booked care.
33. A number of different definitions have been used in recent years, using different terms like 'unscheduled', 'emergency', 'urgent' or 'unplanned'. While none of these definitions or terms are contradictory, they demonstrate differences in emphasis and a lack of clarity about what is meant by urgent care. We need a new definition that provides clarity and informs service development.
34. The new definition aims to address the following weaknesses and ambiguities in previous definitions:
- a focus on health care with no explicit reference to social care
  - confusion about who defines the notion of 'urgency': is it defined by the professionals who provide services, or by the user or carer?
  - the fact that some of the definitions focus explicitly on the out-of-hours period, while others refer to services that are accessible throughout the 24 hours
  - a lack of clarity about what it is that the public needs to be able to access: is it 24/7 access to every health or social care service, or 24/7 access to an assessment of the urgency of an individual's particular needs, with access to care appropriate to the level of urgency?

35. We propose a definition of urgent care based on the following key points:
- Urgent care will only be truly effective when it is able to respond in an *integrated* way to urgent health *and* social care needs.
  - Most people only experience the need for urgent care occasionally and may not be certain just how urgent their need is. Until they have access to a competent professional who can assess the urgency, their anxiety remains unresolved. The longer they wait for that assessment, the greater their anxiety becomes. This means it is the person accessing services who initially defines the urgency of their need.
  - The onset of an urgent care need can happen at any time of day or night. While there is generally more capacity in the system to respond to that need during the day, the assessment of urgency should be consistent across the 24-hour period. Information on demand and patient pathways should be used to inform commissioning of the right capacity in the right places to meet urgent or emergency care in an integrated and complementary way. Not to do so may mean that services are not optimally deployed to meet the most urgent needs quickly and achieve system-wide value for money.
  - Quality requirements and standards should be consistent for urgent care services in-hours and out-of-hours and across health and social care.
36. We therefore propose the following new definition of urgent care:

**Urgent care** is the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.

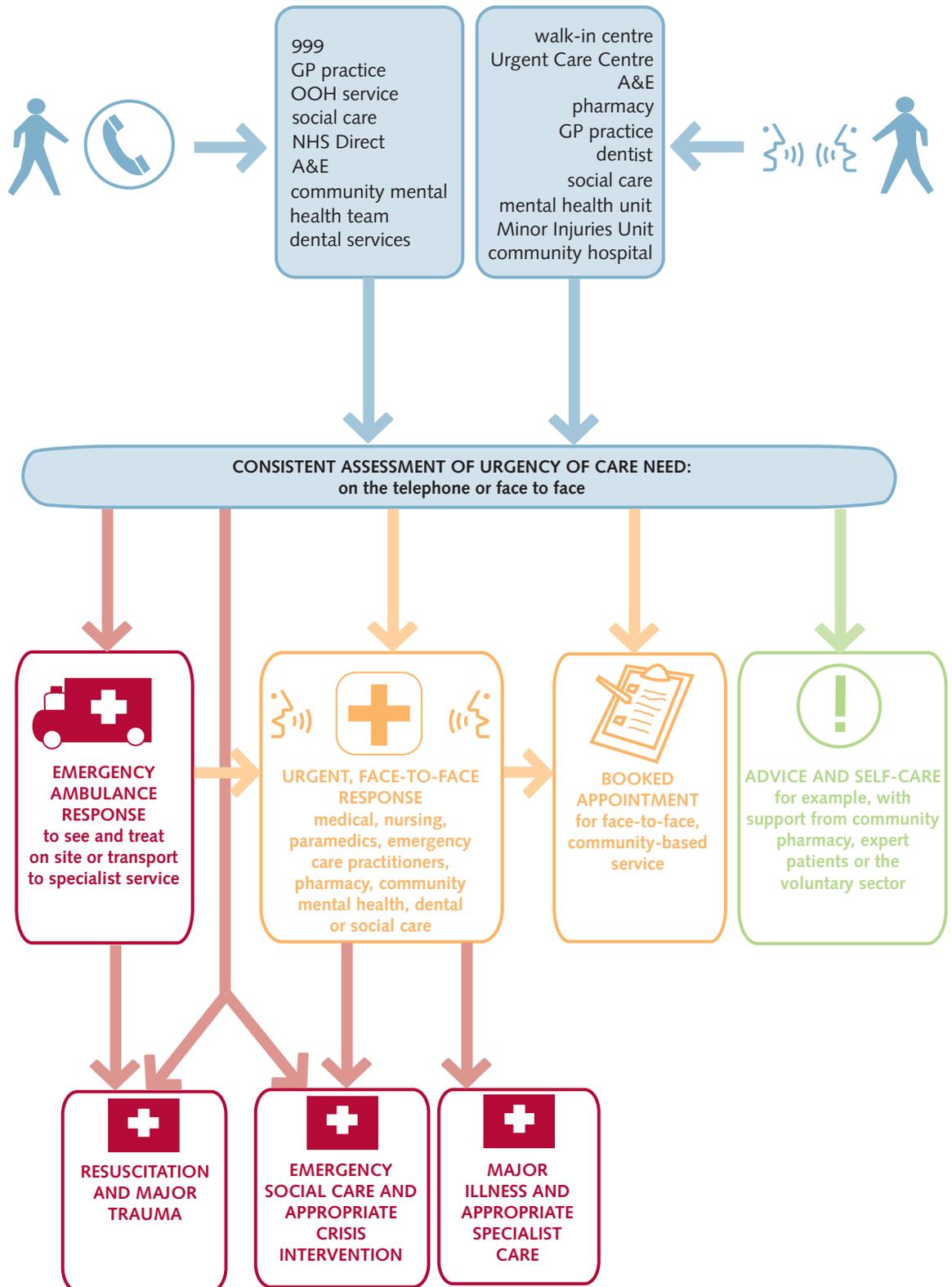
An appropriate response may include anything from telephone advice and reassurance to self-care, through to face-to-face consultation with a clinician or deployment of a crisis team or admission to hospital in an emergency requiring specialised facilities. Wherever clinically safe, care should be delivered as close to home as possible, within a community setting.

## Questions

- Q.6 Do you agree with this definition of urgent care?
- Q.7 If not, what would you change about it?
- Q.8 Is it right to remove the distinction between in-hours and out-of-hours urgent care so that people have access to a consistent and rigorous assessment of the urgency of their need at any time of day or night?
- Q.9 Please explain briefly why you agreed or disagreed.
- Q.10 Do you think health and social care services need to work better together to deliver an effective 24/7 urgent care service?
- Q.11 If so, please explain briefly how this could be achieved.

## Conceptual model of effective urgent care

37. Working from the above definition and the principles described in Section One, we have developed a model of the way in which urgent care should be delivered. This image of an integrated, high-quality urgent care service is conceptual in the sense that it takes no account of the particular services which would deliver each part of the model in a particular local health economy. To make the model real, we have illustrated it with some examples of the range of possible providers that might be involved locally in the delivery of urgent care.



38. The model aims to make clear the following points:

- The assessment of an individual's urgent needs will be delivered by a wide variety of different services. For many of those services the assessment can be either on the telephone or face to face. What matters is that wherever someone chooses to go, or whichever service they choose to telephone, the urgency of their care need is assessed consistently and rigorously and an appropriate response is given, ranging from advice for self-care to booking an appointment for face-to-face care or arranging an emergency response.
- The precise nature of the local service configuration to meet people's needs will take different forms in different places, driven by an understanding of local needs and providing services in communities wherever clinically safe.
- In any local model of care the aim should be to create the right mix of workforce skills and facilities so that, as far as possible, the ability to resolve a person's urgent care need is met at their first point of contact. This is often best met through physical co-location of services, whether telephone or face-to-face care, and also through easy access to accurate information on the availability of services in the area. The ability to share data quickly and easily between providers is key, minimising the need for re-assessment of the needs of the person accessing care where referral onwards is the right outcome.
- Acute/A&E services and urgent care services should be appropriately configured with the aim of caring for people in the community where it is clinically safe to do so. We will be working over the next few months with clinicians and others to identify more clearly what is clinically safe, building on the work of the National Leadership Network.
- Supporting infrastructures should enable the quick and easy transfer of data from one service provider to another. Where the assessment of the urgency of care need shows that the individual needs a particular investigation, treatment or procedure (now or later), the person carrying out that assessment should be able to identify (in real time) which local service provider has the capacity to deliver that service, and to make the appropriate booking there and then.

## Questions

Q.12 Do you agree with the model?

Q.13 If not, please explain briefly what you would change about it.

# Case Study 1: Emily

**Emily, a 28-year-old chiropodist, has a brain tumour. Most of the time she manages her medication herself; but when her condition deteriorates, she depends on her parents for care. This case study describes what happens to Emily over one particular weekend.**

On Friday afternoon, district nurses from Emily's GP practice arrive to set up a syringe driver for her. The next morning, a Macmillan nurse increases her dose of dexamethasone.

Emily's condition continues to worsen, so her parents phone the out-of-hours on-call centre. Centre staff have no record of Emily. They contact her hospital, but the skeleton staff on duty at the weekend can't provide any information.

In the afternoon, Emily becomes very distressed. An on-call duty doctor comes out to give her an injection of midazolam and a prescription for a further vial. He does not give Emily's parents any information about her condition or arrange a follow-up visit, although he promises to brief the twilight nurses at the centre about her.

In the evening, Emily's condition worsens again. Her parents call the on-call centre, but are told the doctors are changing shift. After a delay, it is agreed that Emily needs more midazolam, which takes over two hours to locate.

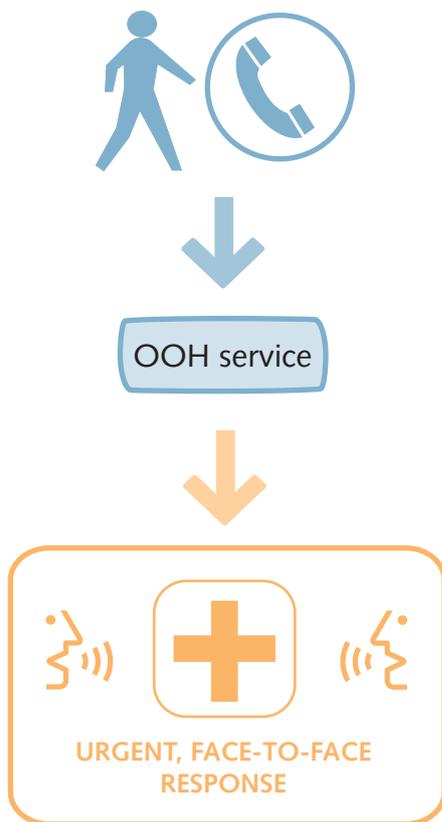
Emily's father has to drive to a local hospice to collect the drug. He is kept waiting in a dark corridor where he can overhear staff talking about his daughter. After 30 minutes, he is told he is not authorised to carry drugs and sent home. Eventually, a doctor arrives with the medication in the early hours of Sunday morning.

Later, Emily's parents, concerned that she will need more midazolam to tide her over until Monday, call the centre and ask for another prescription. They drive to collect it, and call several pharmacies to check that they are open and have the drug in stock. No single pharmacy can fulfil the whole prescription.

They get home in time for the weekend duty district nurses to administer an injection and recharge Emily's syringe driver. Emily needs more pain relief but the nurses won't increase her dose without authorisation. At midday on Sunday, her parents phone the on-call doctor to ask for a prescription for a higher dose.

Her father then drives to pick up the prescription, and drives on to another pharmacy to collect the medicine. The full amount is not available. He returns home and phones the on-call centre to ask for someone to come and administer pain relief. At 2pm, the duty doctor and district nurse return to administer an increased dose.

## How Emily's care could be organised in future



- Emily's primary healthcare team draws up a detailed care plan setting out exactly what should be done if her condition deteriorates, and copies of the plan go to Emily's GP, Emily's parents and the out-of-hours service.
- The care plan is updated by all of those involved in her care as and when needed, at least once a week.
- The out-of-hours service is told that Emily's condition can change suddenly, and the care plan sets out the actions that should then be taken.
- Emily's care plan identifies additional medicines that she may need, and these are prescribed and kept in the home, so that whoever is looking after her can access them easily.
- Emily's parents are given an out-of-hours telephone number for a service which can take full responsibility for her care at weekends and other times when her primary healthcare team is unavailable.

## Case Study 2: Joan

**Joan, an 82-year-old widow, lives alone. Her son lives in the USA and her daughter in London. She often relies on an elderly friend in the village, Margaret, for support. This case study explains what happens when a small fire breaks out at Joan's home.**

Since her husband died, Joan has been finding it difficult to cope. She has had a number of falls and is struggling to pay her bills and keep her house clean, but refuses all offers of help.

At 11pm one Friday, the emergency services are called when a fire breaks out at her house. Joan, who is in a confused state, is taken to the emergency department at the local hospital. Her daughter, Lizzie, and Margaret are alerted.

Margaret drives to the hospital and Lizzie, a GP, arranges to travel up on the first train in the morning. She also phones the hospital and speaks to a senior nurse and a junior doctor. She asks them not to discharge her mother without a care plan and, if possible, to keep her in overnight.

However, Joan, who now seems less confused, asks to go home with Margaret, who is reluctant to refuse. Joan is assessed as medically stable and discharged in Margaret's care.

The next morning, Lizzie arrives and finds her mother unable to walk more than a few steps, doubly incontinent and not capable of washing or dressing herself. Her home is uninhabitable because of the fire and Joan's inability to look after it. Margaret is very distressed.

Neither the community nursing service nor social services can visit or provide support until Monday. Lizzie manages to arrange for Joan's GP to visit her on Sunday afternoon. Between them, they persuade Joan to go into temporary nursing home care while her home is made fit for her to live in again.

Joan is referred for geriatric and psychogeriatric assessment. Lizzie settles her mother into the nursing home and returns to London. The following day she receives a call to say that Margaret has had a heart attack.

## How Joan's care could be organised in future



- A community health or social care practitioner draws up an anticipatory care plan for Joan, which sets out exactly what should be done if her condition deteriorates, including emergency respite.
- In a crisis, urgent care practitioners identify Joan as a vulnerable older person and refer her to intermediate care or specialist old age services.
- Margaret and Lizzie agree the steps to be taken to resolve the crisis with the urgent care practitioners taking care of Joan.
- Joan is transferred from urgent care to a bed-based intermediate care service (in a community hospital or residential or nursing home) or admitted under an old age specialist team until an intermediate care bed becomes available.
- The old age specialist team carries out a comprehensive assessment (including a medicines review) and asks old age mental health services for their input.
- Diagnostic tests for falls and confusion are carried out in the general hospital or in the day assessment unit of a community hospital.
- A long-term support plan is agreed with Joan, Margaret and Lizzie and put in place within six weeks of the urgent care response.

## Case Study 3: Polly

**Polly, a teacher in her early 40s, has been suffering from severe depression for six months. She has spent time in an in-patient mental health service but is now being treated in the community. This case study describes the events following Polly's suicide attempt.**

One evening, Polly feels suicidal. She doesn't know how to get help after 5pm. She becomes increasingly desperate and attempts suicide, but is found in time. Her GP arrives and refers her to the local A&E department.

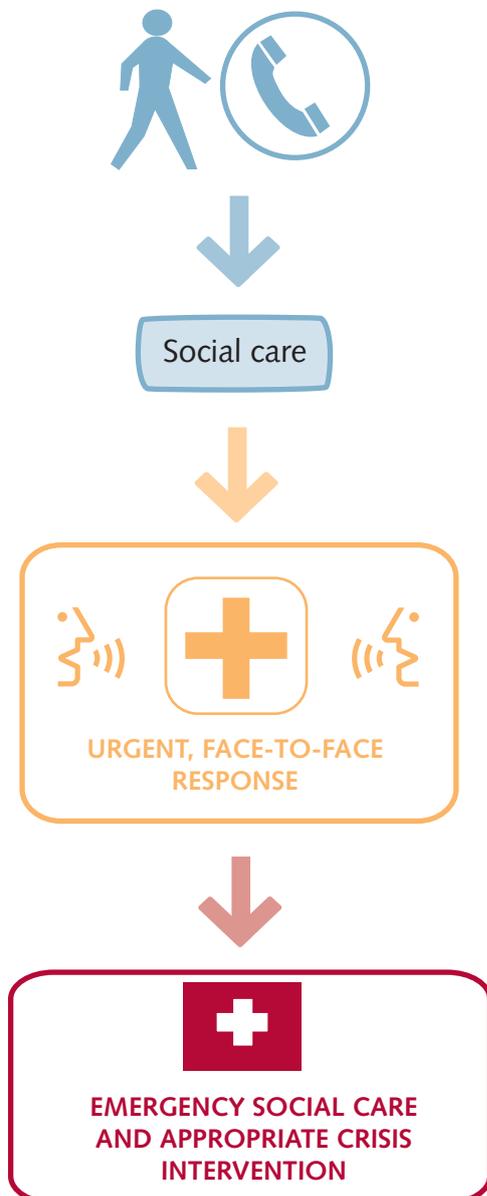
Polly arrives at A&E at 7.35pm. An agency nurse takes her history in public and tells her she needs blood tests. At 11.45pm she finally sees a doctor, who tells her the test results will be sent to her GP the next day. At no time is she seen by a mental health professional or referred to a mental health service.

The next evening, feeling suicidal again, Polly rings her out-of-hours GP service at midnight. The doctor, who lives elsewhere, tells her he doesn't know what services are available locally and promises to call her back.

Polly starts to feel better, and goes to bed. She wakes up at 2am to find two police officers at her front door. After checking that she hasn't harmed herself, they leave. Two hours later, she is woken by another knock at the door. This time it is two men, claiming to be from the local crisis team. Polly hasn't been told to expect them and can't verify their identity. She refuses to let them in.

The next morning, Polly has a visit from her own GP. He arranges for her to be taken on by an appropriate local service for more intensive treatment.

## How Polly's care could be organised in future



- Polly has a detailed care plan which includes information about whom to contact in an emergency.
- Her emergency contact can arrange immediate support from a crisis resolution team.
- The crisis resolution team can visit Polly at home to assess the risk and identify her needs. They have direct access to a duty psychiatrist.
- The team draws up a short-term management plan for Polly, which includes input from other health and social care professionals.
- The team stays in contact with Polly until the crisis passes.
- The team can, if necessary, arrange for Polly to be admitted for in-patient care.

## Case Study 4: Jack

**Jack, aged 3, is a normal, healthy little boy. This case study describes what happens when he suddenly falls ill while spending a week in June with his father.**

Jack's father notices that he is a bit off-colour, and that he hasn't eaten all day. The next day, the little boy develops a cough, runny nose and sore eyes. His father goes to the local pharmacy for cough medicine, and is advised to give Jack a hayfever remedy.

Over the next two days, Jack continues to feel unwell and develops a high temperature. Although he is drinking, he still hasn't eaten anything and is becoming withdrawn. In the evening, he develops a slight rash on his neck, so his father calls the GP. The surgery is closed.

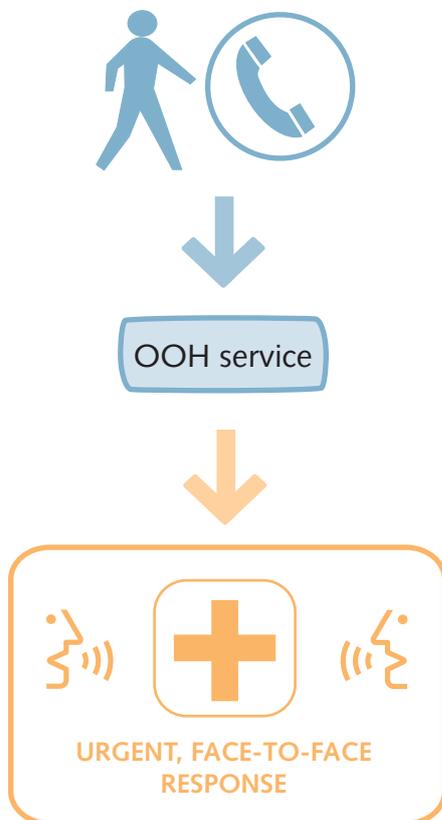
A neighbour suggests ringing NHS Direct. He does this, and is advised to go to the local walk-in centre or A&E department. The walk-in centre is nearer, so Jack's father takes him there.

A nurse looks at Jack. She finds that his rash blanches under pressure, and diagnoses a viral illness. She suggests that Jack is given antipyretics.

The next day, Jack is still very hot. He develops a rash on his face, which then spreads to his trunk. His father arranges an evening appointment with his own GP. The doctor says Jack is quite ill and refers him to the assessment centre at the local paediatric unit.

The paediatrician diagnoses measles. By this time, Jack is very dehydrated and hasn't eaten for five days. He spends several days in hospital being rehydrated and fed by tube while his illness is treated.

## How Jack's care could be organised in future



- Carers are clear about how and where to access urgent care assessment and support in and out of hours.
- Carers and health professionals have a knowledge of common childhood illness and how to assess a developing disease.
- Minor ailment protocols are agreed and used across the health community, including by community pharmacies, with the ability to refer cases to other appropriate services and professionals.
- Walk-in centres have access to health professionals with specific experience in paediatrics, and ability to refer on, if appropriate, for prompt secondary opinion and care.

# INDIVIDUAL CASE STUDIES: MODELS OF PROVISION

## **Maidstone Emergency Care Centre**

On first sight the accident and emergency department at Maidstone hospital looks like any other. Few patients probably notice the red sign above the walk-in entrance which says Emergency Care Centre (ECC), rather than A&E. Once inside the building the patient is greeted by staff at a large open reception desk rather than behind a grille. The overall atmosphere and appearance is of a modern GP surgery rather than a hi-tech hospital.

The waiting area is not large and patients can be seen at all times by the reception staff or by the 'nurse navigator', whose job is to observe and rapidly assess patients in terms of urgency categories.

The 'major' patients come through a separate entrance and move into a resuscitation area if required, or most often beyond this to a 'bayed' area around a central nurse station. The majors side of the A&E department is physically part of the urgent care centre, to permit rapid transfer in either direction if required, but in many cases walk-in patients will be unaware of its presence.

The emergency care centre is modelled around the walk-in centre concept and is largely nurse-led. It is managed by a partnership including the PCT, the local out-of-hours provider, the acute trust and the ambulance service. The setting up and running of this service, which crosses a number of traditional provider boundaries, has been catalysed by an energetic board of four directors drawn equally from primary and secondary care.

Patients are seen in a GP-style consultation room rather than a curtained cubicle. This gives patients greater privacy and dignity. Diagnostic procedures are kept to a minimum. Emergency care practitioners also see patients and do home visits using the emergency care centre as a base.

The OOH operations hub is located behind the ECC reception and shares the facilities of the centre for its face-to-face consultations.

A social services care manager and occupational therapist are based in the department and can make needs assessments and, if necessary, set up or adjust care packages to assist the discharge or transfer process direct from the ECC. They also give telephone support and set up services for professional staff in the community, such as GPs and community nurses who consider whether a patient's situation requires additional support as an alternative to referral to hospital.

Having a range of different services under one (well designed) roof is seen as a major factor in the success of this project. The physical proximity of primary, secondary and social care and the joint management arrangements enhance the ethos of providing, wherever possible, seamless patient care.

## Harrogate Fast Response Team

The Harrogate Fast Response Team aims to prevent avoidable hospital admissions, facilitate early discharge, and provide out-of-hours skilled nursing care. Service users are helped to be as independent as possible within their own home or care setting. The team consists of district nurses, community nurses, community care officers, occupational therapists, physiotherapists, and generic and healthcare support workers, and provides health and social services. The team deals with:

- people in crisis in the community due to an acute illness, an exacerbation of a previous medical condition, deterioration in a chronic condition, or an accident which would be likely to lead to a hospital admission
- people who present in A&E with a condition or injury not requiring in-patient treatment and who with support could be safely looked after at home
- people who no longer require acute medical intervention within an acute hospital, and who, with a package of health, social or rehabilitation care, could be discharged
- people who have an identified nursing need that extends beyond the normal working day

Services provided by the team include: first contact, specialist and holistic assessments, intermediate care, rehabilitation to reduce long-term care needs, practical advice, follow-up support following discharge from hospital, and arrangements for care when the normal carer is unable to care for the patient.

Information is shared between organisations in order to avoid duplicating assessment, and joint case conferences are held if service users require long-term health and social care, ensuring a smooth transition for the service user.

Excellent working relationships have developed between the local health and social care organisations through the team, and it is clear from joint working that the same values and outcomes are shared, ensuring service users are receiving a safe, equitable, high-quality service. Joint working has reduced the need for initial community-based services and unnecessary acute admissions by providing access to community intermediate care beds funded by the local PCT and social services.

# Section Three: Turning the model into reality

## Implementing the six principles set out in Section One

39. The six principles set out in Section One set the framework for urgent care. Under each principle we describe how people experience urgent care now, how we would expect people to experience urgent care in the future, and the key actions needed to implement changes to make that vision a reality. The actions are split between what could be done nationally, largely led by the Department of Health, and what could be done locally. They include actions on local communications to explain to people how they can access services appropriately.
40. The actions described are all-important and will shape how change can be delivered. We would be particularly interested to hear your views about these actions. The questions we would like you to answer are summarised at the end of each section.

## ONE: My voice as a service user or carer is clearly heard and acted on

**Where we are:** Commissioners and providers of urgent care services increasingly seek users' views of the services they provide. While satisfaction with care services is generally high, there is a need to explore the user's experience more widely and ensure people's knowledge and experience are used to improve the services they use.

### Where we should be:

- People are in control and informed of their care choices.
- All providers of urgent care regularly assess users' experience of their services and share such information with commissioners. Questionnaires provide a regular, ongoing source of data, but they are supplemented by a range of other techniques which allow for a more detailed understanding of the user experience (focus groups, mystery shoppers, citizens' juries etc), and they pay particular attention to understanding the experiences of disadvantaged and vulnerable groups.
- Findings are made public and providers regularly report on the steps they have taken to improve the quality of their service in the light of their better understanding of the user experience.
- Members of the community and people using services are involved at every level in urgent care provision (from the system-wide network group down to

the individual provider), bringing their knowledge and insights both to the formulation of strategic policy and to its implementation, and to the clinical and corporate governance of the services.

- Those responsible for the public oversight of the local NHS recognise the importance of urgent care and ensure that it is subject to the same scrutiny as all other NHS services.

### Possible further actions

National	Local
<ul style="list-style-type: none"> <li>• good-practice examples of rigorous and effective ways of exploring the user experience of urgent care</li> <li>• good-practice examples of effective public involvement at all levels of service provision, from urgent care networks to individual providers, and within different kinds of provider organisations</li> </ul>	<ul style="list-style-type: none"> <li>• personalised care plans</li> <li>• Direct Payments or Individual Budgets</li> <li>• regular auditing by service providers of the user experience of services through, for example, questionnaires, focus groups, mystery shoppers, citizens' juries and so on; results acted upon by providers and commissioners to improve services</li> <li>• particular attention paid by providers and commissioners to the experience of disadvantaged and vulnerable groups, understanding the barriers that may stand in the way of their effective use of the services</li> <li>• regular public reporting on the user experience of the services (including complaints and significant incidents analysis) and the steps that commissioners and providers have taken to improve services as a result</li> <li>• effective public and service user involvement at the heart of services that provide and commission urgent care, enabling members of the public to play their part in the formulation of policy and its implementation, and in the clinical and corporate governance of the service</li> <li>• those responsible for the public overview and scrutiny of the local NHS and local government giving attention to the provision of urgent care</li> </ul>

## Questions

- Q.14** Do you agree with the description of 'where we should be' for principle one?
- Q.15** If not, briefly explain what you would add or change about it.
- Q.16** Have we identified the right national and local actions to address 'where we should be'?
- Q.17** If not, briefly explain what you would add or change about them.
- Q.18** What else would make this difficult to deliver?
- Q.19** Can you tell us about any examples where people or services are already doing things like this? (Please include contact details so that we can follow up on these.)

## **TWO: I know how to access services if I have an urgent need**

**Where we are:** People using services are often uncertain about where to go for help and may be redirected from service to service, leading to a lengthy, frustrating and disjointed journey to the care they need. People find new roles, such as the developing role of community pharmacy and Emergency Care Practitioner, and new services, such as the dental out-of-hours telephone services, helpful, but they are confused by the different terms used, such as 'walk-in centre', 'minor injuries units' and 'Urgent Care Centres'. Many health and social care staff are also unsure of the full range of locally available services. This includes the times services are open and what they offer as well as the support available for self-care. This means people providing care do not feel confident in directing people to the right service or support networks.

### **Where we should be:**

- Commissioners provide clear, accurate and up-to-date information about the range of current services both to local health and social care staff and to the communities they serve. This includes support for self-care and a focus on supporting independence.
- Users and carers know when, where and how to access services, and service providers can give this information. People with a long-term condition have agreed a personalised care plan with their primary carers, which they hold along with relevant care records. This includes clear information about the most appropriate services to contact if their condition changes unexpectedly.

## Possible further actions

National	Local
<ul style="list-style-type: none"> <li>• definition of an Urgent Care Centre and the minimum range of services to be available there, and review of the language used to describe this type of facility, including 'walk-in centres', 'minor injuries units' and 'dental access centres'</li> <li>• facilitation of the seamless patching (voice and data) of information between urgent care providers so that people contacting services make one call only and do not have to repeat their information</li> <li>• exploration of whether there is a need for a simple national telephone number for 24/7 access to assessment of the urgency of need, building on the work above to facilitate patching in the short term</li> <li>• development of communication templates for effective local information (press advertisements, posters, leaflets, bookmarks etc) about how to access care</li> <li>• facilitation of provision of online access to accurate and up-to-date information about local services and their opening times, including self-care support</li> <li>• provision by nhs.uk of up-to-date postcode-based information about local services providing urgent care, including opening times</li> <li>• prompt access to urgent care, as clarified by the new strategy for End of Life Care</li> </ul>	<ul style="list-style-type: none"> <li>• provision by local authorities and PCTs of accurate and up-to-date information about how users and carers should access urgent care in their locality, the information being regularly maintained and visible to all</li> <li>• development by providers of care pathways between each other for the commonly occurring conditions, agreeing responsibilities and referral pathways and participating in joint training to maximise understanding of and familiarity with each other's services</li> <li>• personalised care plans for users with predefined needs including information about what steps to take themselves if their condition deteriorates and how to access urgent care if additional help is needed</li> <li>• users with predefined needs holding details of agreed personalised care plans and their health and social care records</li> </ul>

## Questions

**Q.20** Do you agree with the description of 'where we should be' for principle two?

**Q.21** If not, briefly explain what you would add or change about it.

**Q.22** Have we identified the right national and local actions to address 'where we should be'?

**Q.23** If not, briefly explain what you would add or change about them.

**Q.24** What else would make this difficult to deliver?

**Q.25** Can you tell us about any examples where people or services are already doing things like this? (Please include contact details so that we can follow up on these.)

### **THREE: If I have an urgent need I can access care quickly and simply**

**Where we are:** The provision of urgent care varies from area to area to meet local needs. Within a locality, several services may provide urgent care, and a lack of clarity about the role of each may mean that users are passed from one service to another before they access definitive care. Changing technologies mean that many diagnostic and treatment services can be made available closer to the patient, in community settings, to improve patient experience. Hospital-based services are changing, transferring service provision to primary care services operating in the community and providing specialist care for more complex needs. In some places, first-contact staff are rotated in different care settings to develop a shared understanding of an integrated, user-focused service.

#### **Where we should be:**

- With a clear understanding of what urgent care is, commissioners map demand in their local community, including care for disadvantaged areas and groups, and develop a range of local services that give users and carers quick and easy access to the services they need, including appropriate diagnostic services and services that are culturally sensitive.
- Hospital services provide specialist care where needed.
- The telephone provides one form of access, and everyone in the local community knows what number to call; users can also walk in to local centres, which are sited in easily accessible and well-known locations.
- Most services are provided in the local community or at home by a flexible workforce that has a sufficiently wide range of competencies and understanding of local service providers to enable them to work across provider boundaries in multi-disciplinary teams.
- All users and carers have quick and simple 24/7 access to a consistent assessment of the urgency of care need and the appropriate response to that need, including telephone advice and reassurance, self-care and timely face-to-face consultation.
- For social care needs, the assessment will, if appropriate, direct them to the nearest service best placed to provide a detailed single assessment of their needs and a care package, or to services to meet their urgent need.

- Referrals between services are minimised, with users' and carers' needs met wherever possible by the first service they contact. Where this is not possible, the next service to which they are referred for urgent care will complete the episode of care.

### Possible further actions

National	Local
<ul style="list-style-type: none"> <li>• a new national definition of 'urgent care'</li> <li>• guidance on improving access to diagnostic services</li> <li>• good-practice examples of mapping demand for urgent care</li> <li>• good-practice examples of integrated, whole-system networks of urgent care assessment, diagnosis and treatment</li> <li>• good-practice examples of high-quality, consistent approaches to the assessment of the urgency of care needs</li> <li>• guidance on workforce development</li> </ul>	<ul style="list-style-type: none"> <li>• development by PCTs and local authorities of a detailed understanding of the nature of local demand for urgent care, mapped against time of day, day of the week and month of the year, including an assessment of appropriate, supportive diagnostic services – right test, right time, right place</li> <li>• commissioners using this understanding as the basis for joint and practice-based commissioning of services</li> <li>• services being commissioned in such a way that the urgency of health and social care needs is assessed consistently, ending either with reassurance and advice, or with onward referral to a service which can provide more detailed single assessment of needs and a care package, or meet those needs, minimising the need for onward referrals</li> <li>• face-to-face urgent care sited in easily accessed and well-known locations, services providing urgent care being co-located wherever appropriate</li> <li>• appropriately trained staff who work flexibly and have the right mix of skills and competencies to support a multi-disciplinary workforce</li> <li>• commissioners and providers having the necessary workforce planning skills and experience</li> <li>• commissioners ensuring that there is an accountability framework in place identifying clinical and organisational responsibilities that include inter-organisational functions and governance</li> </ul>

## Questions

- Q.26** Do you agree with the description of 'where we should be' for principle three?
- Q.27** If not, briefly explain what you would add or change about it.
- Q.28** Have we identified the right national and local actions to address 'where we should be'?
- Q.29** If not, briefly explain what you would add or change about them.
- Q.30** What else would make this difficult to deliver?
- Q.31** Can you tell us about any examples where people or services are already doing things like this? (Please include contact details so that we can follow up on these.)

## FOUR: My safety is paramount to everyone who cares for me

**Where we are:** A variety of different standards and quality requirements apply across services, with especially marked differences between services provided in hours and out of hours. Multiple hand-offs between professionals and limited access to care records may compromise care, and users who need medicines urgently out of hours sometimes find it difficult to access them. This is particularly pertinent to end-of-life care.

### **Where we should be:**

- *Standards for Better Health* includes Urgent Care Quality Requirements and defines the minimum standards that all users and carers can expect when they access urgent care, regardless of the time of the day, the location or the organisation that provides the service.
- Acute and urgent care services are commissioned and configured to allow care to be provided as close to home in a community setting as is consistent with safety and good quality.
- The appropriate governance arrangements, including clinical governance and supervision, are in place.
- Urgent care services are jointly commissioned to ensure a fully integrated health and social care response to the urgent care needs of the population.
- The care histories of individual users are easily accessed by all who need to see them when assessing or caring for them. People with long-term conditions, or those requiring palliative care, hold their own care records, and generic pathways of care are agreed and shared across providers.

- Information about particular users is transferred electronically between providers, a record of the episode of care added to their record, and their primary care giver is notified.
- Wherever a user accesses help for urgent care, their needs are rigorously and consistently assessed.
- Users who need urgent access to medicines are supplied with full-course medicines at the same time and the same place as the consultation, against the existing out-of-hours formulary, with information being transferred to the practice record.

### Possible further actions

National	Local
<ul style="list-style-type: none"> <li>• <i>Standards for Better Health</i> reviewed and Urgent Care Quality Requirements included</li> <li>• good-practice examples of effective clinical and corporate governance, both for individual providers and across networks of provision</li> <li>• development of computer decision support software which will enable first-contact staff (telephone or face-to-face) to make safe and appropriate decisions about the service that is able to meet some callers' needs, while referring others for further assessment</li> <li>• integrated IT systems allowing electronic access to and transfer of user information</li> <li>• all those engaged in the delivery of urgent care having access to the electronic patient record</li> <li>• development of urgent care workforce resource packs</li> </ul>	<ul style="list-style-type: none"> <li>• compliance with <i>Standards for Better Health</i> demonstrated through the annual health check</li> <li>• clear governance arrangements and clear lines of accountability, especially where there are multiple employers</li> <li>• effective joint commissioning that addresses health and social care needs in an integrated way</li> <li>• patient pathways that are designed to limit hand-offs and are systematically reviewed</li> <li>• local health and social care providers working together to ensure appropriate clinical responses to people in urgent need in different settings, for example medical input to emergency intermediate care services</li> <li>• records being shared and personal care plans being held by those with long-term conditions</li> <li>• quick and easy access to full-course medicines for those who need them urgently against the existing out-of-hours formulary, with information being transferred to the practice record</li> <li>• development of integrated workforce development plans by PCTs</li> </ul>

## Questions

- Q.32** Do you agree with the description of 'where we should be' for principle four?
- Q.33** If not, briefly explain what you would add or change about it.
- Q.34** Have we identified the right national and local actions to address 'where we should be'?
- Q.35** If not, briefly explain what you would add or change about them.
- Q.36** What else would make this difficult to deliver?
- Q.37** Can you tell us about any examples where people or services are already doing things like this? (Please include contact details so that we can follow up on these.)

## **FIVE: I can rely on getting the right care (including support for self-care), whenever I need it and whoever I am**

**Where we are:** There is a growing emphasis on self-care, and the public's health, well-being and independence. Access to a wide range of urgent services is available in most local health communities in hours. But there remain variations in the extent to which those services are available out of hours across health and social care. Urgent care and support for some groups is less effective: for example for people with mental health issues and people who are disadvantaged.

### **Where we should be:**

- All local health communities provide users and carers with 24/7 access (on the telephone and through walk-in locations) to consistent and rigorous assessment of the urgency of their care needs.
- Communities understand that while they will always have quick and easy access to a consistent assessment of the urgency of their care needs, many needs can be met by self-care or a later appointment in routine care.
- People are helped to take greater responsibility for maintaining their own health.
- Local service provision is tailored to the needs of the particular communities it serves (one size does not fit all), and every local community ensures that there is 24/7 access to the services and staff that will be able to deliver high-quality, prompt responses to people's urgent needs.

- Services are commissioned to meet the needs of particularly disadvantaged groups, and commissioners and providers work proactively together to enable those groups to make the most effective use of those services.

### Possible further actions

National	Local
<ul style="list-style-type: none"> <li>• good-practice examples of high-quality, consistent approaches to the assessment of the urgency of care needs</li> <li>• templates for local media campaigns to explain what people can expect from services, including the message that while all should have 24/7, easy access to assessment of the urgency of needs, many needs can be met through self-care or a later appointment in routine care</li> <li>• good-practice examples of successful initiatives to deliver high-quality urgent care to disadvantaged groups</li> </ul>	<ul style="list-style-type: none"> <li>• commissioners designing their network of provision to ensure 24/7 access to the services and staff that must be available if urgent needs are to be met effectively</li> <li>• commissioning of services that can meet the needs of people who are disadvantaged</li> <li>• commissioners, providers, and voluntary and community groups working proactively together to help vulnerable groups make effective use of those services</li> </ul>

### Questions

- Q.38** Do you agree with the description of 'where we should be' for principle five?
- Q.39** If not, briefly explain what you would add or change about it.
- Q.40** Have we identified the right national and local actions to address 'where we should be'?
- Q.41** If not, briefly explain what you would add or change about them.
- Q.42** What else would make this difficult to deliver?
- Q.43** Can you tell us about any examples where people or services are already doing things like this? (Please include contact details so that we can follow up on these.)

## **SIX: The care I receive meets my needs appropriately, taking account of the urgency and value for money**

**Where we are:** People do not always get an appropriate response when they access urgent care and, while they do not expect 24/7 access to every service, they do expect prompt access to a rigorous and consistent assessment of the urgency of their needs and equitable access to care. In many areas, out-of-hours access to an appropriate range of health and social care services is incomplete. People are sometimes admitted to hospital when they could be effectively cared for at home. Health reforms are bedding in. There is scope to realign services to meet demand in local communities and to achieve better value for money.

### **Where we should be:**

- Commissioners have a clear and detailed understanding of the nature of local demand for urgent care, and re-engineer service provision to ensure that the right services are provided to meet those needs and that, wherever people access urgent care, consistent and rigorous assessment of the urgency of their care need directs them to the nearest appropriate service.
- Users and carers access first time the service that can meet their needs, often community-based. In this way their experience is improved and inappropriate admissions are eliminated.
- Service configurations reflect people's behaviours, so that, for example, if people consistently go to A&E for care needs that are not immediate or do not require the facilities of these services, Urgent Care Centres are developed, co-located with A&E.
- Joint commissioning, payment by results and other system reforms enable, support and drive a whole-system approach to resourcing care, shifting the balance from hospital to home and community-based care. The provision of services across the local health economy is configured in such a way as to simplify access and maximise value for money.
- Regular benchmarking of the cost and quality of individual services across the urgent care system as a whole enables further improvement in the quality of the service and effective benefits realisation.

## Possible further actions

National	Local
<ul style="list-style-type: none"> <li>• good-practice examples of health communities that have remodelled their service provision to maximise value for money and improve quality</li> <li>• good-practice examples of mapping demand for urgent care and defining the data set required</li> <li>• published guidance on Urgent Care Networks</li> <li>• national guidance on joint commissioning, practice-based commissioning and tariffs (payment by results) to facilitate the delivery of care in an appropriate local setting</li> </ul>	<ul style="list-style-type: none"> <li>• development by PCTs of a detailed understanding of the precise nature of local demand for urgent care and re-engineering of service provision to both simplify access and maximise value for money</li> <li>• joint commissioning between health and social care, and practice-based commissioning, to ensure that services are commissioned in ways that are able to meet changing patterns of demand, enhance quality and reduce costs</li> <li>• development by PCTs of Urgent Care Networks, including all partners across health and social care, to advise on the development of an integrated urgent care service and to guide commissioning</li> <li>• development of locally sensitive, consistent and rigorous assessment of the urgency of care needs, to enable users and carers quickly and easily to access the nearest appropriate service</li> <li>• commissioners regularly benchmarking the quality and costs of their service against other appropriate health communities</li> </ul>

## Questions

Q.44 Do you agree with the description of 'where we should be' for principle six?

Q.45 If not, briefly explain what you would add or change about it.

Q.46 Have we identified the right national and local actions to address 'where we should be'?

Q.47 If not, briefly explain what you would add or change about them.

Q.48 What else would make this difficult to deliver?

Q.49 Can you tell us about any examples where people or services are already doing things like this? (Please include contact details so that we can follow up on these.)

## Supporting the service to implement the strategy

41. In each of the detailed summaries of the actions needed to implement the six principles, the suggested local actions identify the steps that local communities may need to take. Many of the national actions will provide local communities with the help and support that they will need to be able to do this.

42. There may be some more general omissions, cutting across all six principles. The final set of questions below asks for your views on this.

43. For example:

**Attitudes to risk:** Some people say that the protocols for assessment of the urgency of care needs are designed to be risk-averse, leading to unnecessary referral on to urgent and emergency face-to-face services. We have also heard people say in the consultation on adult social care *Independence, Well-Being and Choice* that they would like more control and the chance to do things other people take for granted. They want the risks of independence to be shared with them and balanced openly against benefits. Attitudes to risk may have important implications for models of clinical governance and there should be a risk assessment process and shared agreements on risk management between professionals as well as for the design of protocols for initial assessments of need.

**Integrated service responses:** This document has focused on health and social care. We know that improved outcomes and experiences for people include other services, such as housing, which can be important in supporting independence or preventing the need for urgent or emergency care, for example because of falls.

**Rural and urban communities:** We know that there will be many differences in needs between urban and rural communities. Service configuration and the provision of community-based services, including community hospitals, community nursing and social care support, will differ to match the location and needs of the population. Transport needs are a key issue. There will also be issues specific to providing both an assessment of and a response to urgent care needs in rural and urban settings.

## Questions

Q.50 How can we – at national level (the Department of Health or other national organisations) – best help local communities to implement change?

Q.51 Are there sufficient system levers for change in place (e.g. voice, payment by results, commissioning, standards and quality requirements, governance) and, if not, how could they best be supplemented?

- Q.52** What, if anything, do we need to do nationally or locally on approaches to risk?
- Q.53** What do you see as the major differences between delivering urgent care in rural and urban settings?
- Q.54** How can we address some of these issues (e.g. transport issues) to help deliver improved urgent care?

## Section Four: How to comment

44. We are seeking views on the initial ideas set out here to inform our thinking on urgent and emergency care. It will make analysis easier if your responses are presented in a systematic way. We have therefore identified throughout the document a series of explicit questions to which we would particularly welcome your responses.
45. We have created a dedicated website at which you can record your comments electronically, helping us to analyse what we are hearing quickly. The address is [www.dh.gov.uk/consultations](http://www.dh.gov.uk/consultations)
46. If you prefer to comment on paper, a Microsoft Word document can be downloaded at [www.dh.gov.uk/consultations](http://www.dh.gov.uk/consultations), or you can obtain a copy by writing to DH Publications Orderline, PO Box 777, London SE1 6XH
47. This consultation follows the revised Cabinet Office code of practice which is available from the Cabinet Office website. This requires government departments to:
  - consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of policy
  - be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses
  - ensure that consultations are clear, concise and widely accessible
  - give feedback regarding the responses received and how the consultation process influenced the policy
  - monitor their effectiveness at consultation, including through the use of a designated consultation co-ordinator
  - ensure consultations follow better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate

The Code also invites respondents to “comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process”. For DH consultation, comments or complaints (but not your response to this consultation) should be sent to:

Steve Wells  
Consultations Coordinator  
Department of Health  
Skipton House  
80 London Road  
London SE1 6LD

[steve.wells@dh.gsi.gov.uk](mailto:steve.wells@dh.gsi.gov.uk)



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